IMProVE – Integrated Management and Proactive Care for the Vulnerable and Elderly

Better Care for the vulnerable and elderly in South Tees

Recommendations on proposed changes to community services

October, 2014
1. Purpose of the report

This report provides the Governing Body with recommendations around the progression of our vision to improve services for the vulnerable and elderly. These recommendations have been based upon a review of:

- the key drivers for change;
- our proposed model of care based on best practice;
- how we reached an option for delivering our model of care;
- how we have engaged and consulted with members of the public, clinicians and other key stakeholders; and
- feedback received from our formal consultation and recommendations made by South Tees Joint Overview and Scrutiny Committee.

The report also aims to provide assurance to the Governing Body that we have fulfilled our duty to secure services to meet the needs of people in our area; that we have followed national best practice guidance, ensuring our consultation was conducted fairly and legally; and that we have fulfilled our responsibilities to consult in line with the Health and Social Care Act 2012.

2. Case for change

2.1 The Health of our population

While the health of people in Tees is generally improving, it is still worse than the England average. Historically, our local area has been highly dependent on heavy industry for employment which has left a legacy of industrial illness and long term conditions. This, coupled with a more recent history of high unemployment as the traditional industries have declined, has led to significant levels of deprivation and health inequalities that rank amongst the highest in the country. South Tees also ranks higher than the England average for almost all disease prevalence, eg, respiratory disease, stroke, heart disease and diabetes.

2.2 Increasing elderly population

The total population of South Tees is 273,742 of which 48,689 are over the age of 65. By 2021 it is predicted that this number will increase by 20% and for those living beyond the age of 85 by 3%. Whilst it is good news that people are living longer, this represents a challenge for health and social care with older people more likely to access services. We also have high numbers of people living in residential homes rather than remaining in their own home compared to other parts of the country. Therefore it is imperative for the NHS and local authorities to work more closely together; commissioning integrated services.

2.3 Clinical considerations

Frail Elderly People

Nationally, South Tees has the fourth highest number of emergency admissions to hospital and at present, elderly and vulnerable people in our area go into hospital more often than in other parts of the country. An independent analysis (Medworxx
Study) of community beds showed that 49% of patients did not need to be in hospital and could have been cared for at home with the right community support. We also know that the average length of stay for patients who are transferred to a community hospital after a period in James Cook Hospital is 28 days.

National and local evidence also tells us that unnecessary time in hospital can be detrimental to frail older patients, exposing them to risks, such as hospital acquired infections as well as increasing the likelihood of depression and loss of confidence and independence.

**Stroke Services**

Stroke is the leading cause of adult disability and costs the NHS over £3 billion a year. Around one in four people who have a stroke die as a result and around half of stroke survivors are left dependent on others for everyday activities. Stroke services provided by South Tees Hospitals NHS Foundation Trust are highly rated nationally, but the stroke rehabilitation element of the service needs to be improved in line with best practice. According to NICE (National Institute for Health and Care Excellence) guidance, stroke patients recover much better if they have rehabilitation in their own homes delivered by community based stroke teams. Currently there are no community stroke teams in South Tees. The National Clinical Guidelines for Stroke (Royal College of Physicians, 2012) recommend that hospital rehabilitation services are carried out in a single dedicated stroke unit. Stroke rehabilitation in South Tees is delivered across three separate hospital sites.

**General Rehabilitation**

GPs and hospital consultants say that patients currently do not receive the same level of rehabilitation support at home or in a community hospital as they do in James Cook University Hospital. We need to improve this as effective rehabilitation can lead to better outcomes for people, enabling them to live more independent lives.

**2.4 Local & national plans**

The CCG’s plans are based on the health needs of our local population and have been developed in partnership with patients, health professionals and key organisations across the South Tees community. The introduction of Health and Wellbeing Boards has been the key to building strong and effective partnerships ensuring that all local organisational plans are aligned to an overarching health and wellbeing strategy in order to achieve improved health and wellbeing for local people.

Our plans also reflect national guidance and good practice. For example, NHS England’s National Medical Director, Sir Bruce Keogh, calls for system wide changes so care can be delivered in or as close to peoples’ homes as possible; the NHS England’s planning guidance, calls for CCGs and key partners to lead the development and implementation of a ‘modern’ integrated model of care. This planning guidance also advocates:
• Improving the health related quality of life of the 15 million+ people with one or more long-term condition, including mental health conditions
• Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital
• Increasing the proportion of older people living independently at home following discharge from hospital
• Increasing the number of people with mental and physical health conditions having a positive experience of care outside hospital, in general practice and in the community.

The announcement of Integrated Care Funding in July 2013, now known as the ‘Better Care Fund’ aims to assist this integrated transformation, with a single pooled budget to support health and social care services to work more closely together in local areas.

IMProVE is therefore one of a number of planned areas of work which will lead to improvements in local services for the whole population and should not be progressed in isolation.

CCG Urgent Care Strategy

In 2013, there was a national review of emergency and urgent care in England. Sir Bruce Keogh managed this review with NHS England. The review suggested that current service provision is fragmented and confusing. Following this guidance and recommendations, South Tees CCG reviewed its urgent care provision in December 2013. In line with Sir Bruce Keogh’s report, the CCG has found that services in South Tees are complex and difficult to navigate, with multiple points of access for patients. Our emerging urgent care strategy, again developed with key partners, recommends the development of a 7 day a week urgent care community service providing more comprehensive care for a broader range of conditions.

2.5 Community facilities

South Tees CCG is in an unusual position compared with neighbouring CCGs in that community based estate includes four community hospitals that between them have 132 beds. These beds are currently under-utilised or as stated previously, are occupied by patients who could be better supported in the community. Not all of our community hospitals were designed to provide the modern, flexible, health services local people need. They are not fully occupied, resulting in empty space with recurrent costs of £1.95 million per annum.

2.6 What our public say

Throughout the development of our vision and proposals, we have engaged with the public and we learned that co-ordination of services between health and social care was really important to patients and carers. People want access to more information about services and care options and they value care at home or in local community settings. The quality of community provision was identified as extremely important with a number of people commenting that if there were to be a reduction in the
number of community beds, they would want first to see improvements in community health and social care services.

2.7 A summary of the challenges faced across South Tees are as follows:

- People are living longer and therefore the number of people living with long term conditions is increasing.
- Nationally South Tees has the fourth highest number of emergency admissions with too many elderly and vulnerable residents admitted to hospital or residential care when they could be better supported in their own homes.
- Older patients spend more time in hospital than they need to, which can often be detrimental to their recovery.
- Stroke rehabilitation services are not delivered to best practice; local people should have access to the same high quality care as those in other parts of the UK.
- We do not deliver the same level of rehabilitation in community hospitals as we do in the acute hospital (James Cook University Hospital).
- Any proposals to change our community services need to reflect existing and future strategies particularly in relation to the way we deliver urgent care.
- We have a community bed surplus across South Tees.
- We need to gain most value from the money we spend; the CCG is currently spending £1.95 million per year on empty space.
- Some of our buildings are not designed to deliver the modern, flexible services people need and incur high maintenance costs.
- Our public tell us that we need to improve the quality of our community services and that the NHS and local authorities need to work closely together so that services are more joined-up.

3. Developing our proposed model of care

3.1 Working in partnership

Over the last two years, we have been working closely with key partners across South Tees in order to agree a joint vision and develop plans to improve services for the vulnerable and elderly. We recognise that this is the only way to achieve true transformation. This vision and planning has been progressed through the IMProVE Advisory Group which comprises representatives from:

- NHS South Tees Clinical Commissioning Group
- South Tees Hospitals NHS Foundation Trust
- Tees Esk and Wear Valleys NHS Foundation Trust
- Middlesbrough Borough Council
- Redcar and Cleveland Borough Council
- Durham, Darlington and Tees Area Team (NHS England)
- Healthwatch (Middlesbrough and Redcar)
- Redcar and Cleveland Housing providers
As well as developing the vision above, this partnership group also set a number of key objectives:

- To offer targeted and proactive individualised case management in a community setting with a range of additional support services for patients aimed at maintaining and improving their current health.
- To improve routine care for all patients with long term conditions to prevent deterioration of their overall condition.
- To identify the need for and improve access to a range of integrated support services on a 24 hour, 7 day a week basis to allow patients to better manage their own condition and remain as independent as possible.
- To improve outcomes for elderly and frail patients and those with long term conditions.
- To identify early, via the use of a predictive risk tool, those patients at risk of a future admission.
- To effectively deliver care and support for patients through making the best use of our available resource.

The work of the IMProVE Advisory Group to date has culminated in the development of a proposed new model of care for South Tees based on the following patient centred principles:

- **Stroke rehabilitation** delivered in line to national best practice – Implementing a community stroke team delivering rehabilitation at home for up to 40% of patients Centralising in-patient stroke rehabilitation onto a single site to ensure patients
receive faster, more streamlined and regular access to consultants and other specialist staff.

- **Step up** in-patient care - Beds for elderly patients requiring stabilisation or treatment in order to avoid deterioration and potential acute hospital admission such as: remobilisation following falls; exacerbation of long-term conditions; end of life support and treatment of minor illnesses, e.g. urinary tract infections and chest infections.

- **Step down** in-patient care - High quality packages of planned care supporting vulnerable adults in effective recovery and reablement, in particular those patients recovering from stroke, fractured neck of femur or requiring stabilisation for heart failure.

- **An assessment hub** - where elderly patients could be quickly assessed and diagnosed.

- **Community based medical day treatments** - where treatments such as intravenous therapies and cancer therapies can be delivered closer to patients’ homes.

- **A greater range of outpatient clinics** - with supporting diagnostics to help clinicians make quicker diagnoses and reduce travelling for patients.

- **Improved palliative/end of life care** - where the individual’s preferred place of death would be in hospital, buildings will be conducive to providing privacy and dignity for individuals and their carers, eg provision of single rooms and facilities for relatives to stay.

### 4. Option appraisal process

#### 4.1 Reviews and studies

In order to gain a wider view on the future vision and to assess the ability to implement the proposed new model of care over the next two to five years, the IMProVE Advisory Group commissioned a number of reviews and studies. These included:

1. A clinical review of community hospital provision
2. A bed modelling study
3. An estates review
4. A workforce review
5. A series of clinical and public engagement initiatives
6. An accessibility travel plan

#### 1. Clinical review of community hospital provision

A set of quality criteria, based on a clinical view of what would need to be in place to deliver the best model of care was developed and agreed. The criteria were informed and influenced by broad clinical engagement including GPs, Consultants and Clinicians working within the hospital and the community, the general public, council members and members of voluntary organisations. The criteria were based around key aspects of our proposed model which requires delivery within community buildings and it was divided into what was considered essential or desirable. The quality requirements are summarised in the table below:
<table>
<thead>
<tr>
<th><strong>Generic to all services</strong></th>
<th><strong>Essential</strong></th>
<th><strong>Desirable</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Meets NHS essential standards for environment</td>
<td>Yes</td>
<td>Desirable</td>
</tr>
<tr>
<td>Meets environment standards for dementia.</td>
<td>Yes</td>
<td>Desirable</td>
</tr>
<tr>
<td>Adequate numbers of staff who can deal with elderly patients, co-morbidities, and dementia.</td>
<td>Yes</td>
<td>Desirable</td>
</tr>
<tr>
<td>Impact upon other services delivered from that Estate</td>
<td>Yes</td>
<td>Desirable</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Accessibility</strong></th>
<th><strong>Yes</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>The percentage population living within 30 minutes’ drive of that Estate</td>
<td>Yes</td>
</tr>
<tr>
<td>The percentage population able to access the Estate via public transport within 1 hr.</td>
<td>Yes</td>
</tr>
<tr>
<td>The percentage population able to access the Estate via public transport during the day</td>
<td>Yes</td>
</tr>
<tr>
<td>The percentage population able to access the Estate via public transport in the evenings/weekends</td>
<td>Yes</td>
</tr>
</tbody>
</table>

| **Affordability of required development** | Yes |

<table>
<thead>
<tr>
<th><strong>Stroke Rehab</strong></th>
<th><strong>Essential</strong></th>
<th><strong>Desirable</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialist stroke rehabilitation delivered on one site according to NICE guidance</td>
<td>Yes</td>
<td>Desirable</td>
</tr>
<tr>
<td>Access to X-ray facility</td>
<td>Yes</td>
<td>Desirable</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Step Up/Step Down</strong></th>
<th><strong>Essential</strong></th>
<th><strong>Desirable</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Fit for purpose rehabilitation facilities</td>
<td>Yes</td>
<td>Desirable</td>
</tr>
<tr>
<td>X-ray facility</td>
<td>Yes</td>
<td>Desirable</td>
</tr>
<tr>
<td>Ultrasound facility</td>
<td>Yes</td>
<td>Desirable</td>
</tr>
<tr>
<td>Near Patient Testing or urgent access to labs</td>
<td>Yes</td>
<td>Desirable</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Assessment Hub/Day Treatments</strong></th>
<th><strong>Essential</strong></th>
<th><strong>Desirable</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Estate capacity to accommodate patients for up to 4hrs for assessment and 24hrs for treatment.</td>
<td>Yes</td>
<td>Desirable</td>
</tr>
<tr>
<td>Access to X-ray</td>
<td>Yes</td>
<td>Desirable</td>
</tr>
<tr>
<td>Access to Pharmacy</td>
<td>Yes</td>
<td>Desirable</td>
</tr>
<tr>
<td>Critical mass of patients requiring assessments and medical day case therapies</td>
<td>Yes</td>
<td>Desirable</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Outpatients</strong></th>
<th><strong>Essential</strong></th>
<th><strong>Desirable</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Critical mass of outpatient activity</td>
<td>Yes</td>
<td>Desirable</td>
</tr>
<tr>
<td>Access to x-ray</td>
<td>Yes</td>
<td>Desirable</td>
</tr>
<tr>
<td>Access to ultrasound</td>
<td>Yes</td>
<td>Desirable</td>
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</tbody>
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<table>
<thead>
<tr>
<th><strong>Palliative Care – Inpatient Care</strong></th>
<th><strong>Essential</strong></th>
<th><strong>Desirable</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Room for relatives to stay</td>
<td>Yes</td>
<td>Desirable</td>
</tr>
<tr>
<td>Private room to maintain privacy and dignity</td>
<td>Yes</td>
<td>Desirable</td>
</tr>
</tbody>
</table>
On considering further development of the criteria it was necessary to make a number of assumptions that would support delivery of the proposed model of care and to ensure efficient, quality services. Again these assumptions were made and agreed through a process of continued engagement between GPs and hospital/community clinical staff.

- The sites being considered in this process are: Redcar, Guisborough, East Cleveland and Carter Bequest Primary Care Hospitals.
- The services that need to be delivered are: Step up / Step down Rehab, Stroke, Outpatients, Assessment Hub / Medical day unit and Palliative/End of Life Care.
- The Assessment Hub is dependent on being in close proximity to a bed base.
- Outpatients can be provided at any site and other current community locations.
- Bed utilisation is to be maintained at 85% with an occupancy tolerance of 75 – 95%.
- In line with best practice, stroke rehabilitation should be provided on one site.
- X-ray facility and near patient testing/access to urgent laboratory reporting is essential for Assessment Hub.
- Redcar Primary Care Hospital is to be retained as it is a Private Finance Initiative (PFI) with a 35 year lease contract (30 years still to run).

2. Bed Modelling Study

We know that we have variable use and occupancy of the beds across our four community hospitals. In order to better understand both the current and potential future requirements of our community bed base, we commissioned a number of studies. One of these studies undertaken by Medworxx focused specifically on bed occupancy within both the Acute and Community Hospitals. The report concluded that 49% of patients in community beds and 33% of patients in acute hospital beds did not have an acute medical need and could have been appropriately supported by other services such as nursing and social reablement support at home.

We also commissioned a further independent report to model the impact of introducing new models of care across South Tees including its potential impact upon bed requirements. This study highlighted that, based on current utilisation levels, and without further development of existing community infrastructure, we require 102 community beds; currently we have 132 beds (i.e. 30 more than we require). Through implementing the proposed model of care, the study indicates that by 2016/17 we will require around 68 community based beds. The bed modelling analysis demonstrates that this is a conservative estimate and also takes into account the anticipated growth in demand from our increasing frail and elderly population. These studies have been shared previously with the Governing Body and made available to the public on our website.

3. Estate review

The CCG received a final estate report from NHS Property Services (NHSPS) in February 2014. The report related to the utilisation and condition of NHS owned and leased community buildings. The report refers to all community estate but concentrated specifically on the condition and functionality of the four community hospitals in the South Tees area.

The review:
- Identified issues with the long term viability of Carter Bequest Hospital and Guisborough Primary Care Hospital due to the condition and the assessment of
current functionality;
• Illustrated some significant issues that need to be addressed primarily: ‘void’ space in these hospitals equating to £1.95 million per annum in value;
• Assessed the condition and functionality of Carter Bequest Hospital to be poor with a high maintenance backlog; and
• Noted that Guisborough Primary Care Hospital requires an investment of £1.2 million in its engineering infrastructure.

The NHSPS report does not recommend a course of action. It outlines a series of options and opportunities relating to the potential disposal or part disposal of community hospitals and facilities. It recommends that Redcar Primary Care Hospital is retained on the basis that:
• void space at Redcar could accommodate new service models for stroke, an assessment hub, outpatients and rehabilitation; and
• Redcar Primary Care Hospital was built in 2010 and is subject to a further 30 year PFI lease agreement.

4. Workforce review

In response to developing a new model of care for the future, we recognised that the workforce required to provide quality care is key for successful delivery. Acknowledging the significance of this, we commissioned an external workforce analysis and plan in order to assess the capacity and skills of the current workforce and the capacity and skills required for the future.

The preliminary findings of this work identified:
• a potential shortfall in funded therapy staffing to meet patient need;
• no major cause for concern over the supply of suitably competent staff to meet increased demand for community service staff; and
• challenges around changing culture to deliver care closer to home requiring staff to work differently.

We will work with providers to establish a specific work stream to support workforce changes and developments as part of the overall programme.

5. A series of clinical and public engagement initiatives

We have sought to extensively engage with the public around IMProVE. A ‘Call to Action’ event held in December 2013 had a specific focus on the vulnerable and elderly and a pre-engagement consultation from 23 September to the 22 November 2013 was also undertaken with the specific aim of engaging a range of stakeholders, services users, carers and providers and the general public in a discussion around the IMProVE vision. This was carried out with our partner organisations including representatives of Middlesbrough and Redcar and Cleveland Council and South Tees Hospitals NHS Foundation Trust who were all involved in developing the consultation document and associated questionnaire.

Questionnaires were further supported by an in-depth survey of patients and their carers carried out by the independent voluntary organisation Carers Together, particularly targeting the elderly and vulnerable. Five public drop-in events across South Tees were also held as part of the consultation designed to offer interested individuals, stakeholders, service users
and carers the opportunity to contribute their views and opinions. We received around 100 replies to questionnaires with limited attendance at the drop-in events. The in-depth survey gave us a wealth of information with 348 respondents. There was positivity around current services but a number of key themes emerged with suggestions for improvement:

- **Co-ordination of services** – The need for better collaboration and co-ordination between health and social care and different services;
- **GP access** – Sometimes poor access to appointments, continuity of care and more home visits required;
- **Access to information** – Consistency and the importance of carers and families understanding information;
- **Care closer to home** – There was considerable support for the suggestion that more care should be provided in the home or in a community setting. Respondents felt that this could aid recovery, prolong independence and keep hospital beds free for the seriously ill. Many commented that for this vision to become a reality, community-based care would need to improve significantly;
- **Quality of community provision** – The quality and extent of community-based services was a recurring theme. Respondents identified a number of areas for improvement including more frequent and longer home visits from both health professionals and home care providers, more rapid assessment of need and access to services and equipment, more practical support in the home, and on-call support available on weekends and in the evenings. There were a number of comments about hospital discharges being delayed because of lack of community provision;
- **Hospital beds** – There was some confusion about the difference between community and acute beds with a number commenting that beds were needed in case of a flu epidemic or major incident. Opinions differed on the impact of closing community beds with some reflecting that it would take pressure off the hospital system and others claiming it would increase demand for acute beds. Around half supported the idea of closing beds and providing greater care in the community. Amongst other things, respondents felt that this would aid recuperation and promote independence. Many qualified their support for the closure of beds with the need to improve community health and social care services first. Some questioned whether there was sufficient budget/staff to develop and improve community services in line with the CCG’s vision;
- **Physiotherapy and Occupational Therapy services** – There were a number of comments about the length of time taken for assessments/access to services. Some commented that this was impacting upon recovery and hospital discharge; and
- **Dementia services** – The need for improvement in services was mentioned by a number of people. This ranged from the need for better information for patients and their carers through to the extent of the services available locally.

6. **An accessibility Travel Plan**

The CCG area includes a number of urban centres and a significant rural area in East Cleveland. In recognition of the feedback received via the public engagement exercises and by listening to patients’ views regarding accessibility to services as being an important factor in the patient experience, the CCG commissioned Tees Valley Unlimited to undertake an accessibility study for the hospitals within the CCG area. This study demonstrated that:

- In terms of private car travel to any of the sites, given the data available at this stage, analysis indicates that all sites are accessible within a 30 minute timescale.
• Both James Cook University Hospital and Guisborough Primary Care Hospital provide access during regular hours to 75% of the population of Middlesbrough and Redcar & Cleveland within one hour’s travel by public transport. Both sites benefit from a wide variety of public transport services relatively close to the hospital. James Cook University Hospital will see an increase in options with the opening of the rail station at the hospital. However accessibility to Guisborough Primary Care Hospital reduces significantly later in the evening with only two buses serving the hospital hourly.

• Carter Bequest Hospital can be accessed by around 45% of the population within the hour; this would be increased with the opportunity to change buses at the undercover Middlesbrough Bus Station. Accessibility to the site via public transport is lower than that of all the other locations in this report.

• East Cleveland Hospital provides access to a wide area of East Cleveland which would have significant travel times to access care in Middlesbrough, Redcar or Whitby. Even with the lower population density in this rural area, greater than 50% of the population can access the hospital within the one hour target.

• Redcar Primary Care Hospital’s location has relatively good accessibility; the bus service serving the hospital is high frequency and serves a significant proportion of the population, with 74% being able to access within the hour, and 61% able to access the facility later in the evening. The bus interchange possibility in Redcar would further increase accessibility. Improvement works to the existing waiting facilities would be favourable; providing a better option for bus users, and is something to consider in the longer term.

4.2 Option appraisal

The next stage of developing our options involved applying our agreed criteria individually to each of our four community hospitals to assess their quality and ability to deliver our proposed model of care now and into the future. It was agreed that our criteria could be divided into three key areas:

• **Quality** – ability to deliver services now and provide a quality service;

• **Sustainability** – ability to deliver future developments and accommodate expansion of community services; and

• **Efficiency** – cost effectiveness and ability to deliver the model currently and into the future.

The following tables illustrate the results of that exercise:
<table>
<thead>
<tr>
<th>Criteria</th>
<th>Redcar</th>
<th>Guisborough</th>
<th>East Cleveland</th>
<th>Carter Bequest</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ability to deliver improved stroke rehabilitation model</td>
<td>Fully met – Modern rehabilitation facilities, benefits from hydrotherapy pool and transition flat</td>
<td>Partially met short term only – would need significant remedial work to incorporate all associated stroke services/therapies</td>
<td>Partially met – would require reconfiguration of ward areas at cost</td>
<td>Not met – does not have x-ray facility</td>
</tr>
<tr>
<td>Ability to deliver improved step/up and step down in-patient rehabilitation</td>
<td>Fully met – Modern rehabilitation facilities</td>
<td>Partially met – would need some remedial work to improve environment and co-location of associated services</td>
<td>Partially met – would require reconfiguration of ward areas at cost</td>
<td>Not met – does not have x-ray facility</td>
</tr>
<tr>
<td>Ability to deliver improved in-patient palliative/end of life care</td>
<td>Fully met – All single rooms</td>
<td>Partially met – Only 4 single rooms. Would require significant remedial work to expand and reconfigure</td>
<td>Partially met – 6 single rooms – would require remedial work to expand and reconfigure</td>
<td>Partially met – 8 single rooms. Would need remedial work to expand at significant cost</td>
</tr>
<tr>
<td>Meets NHS essential standards for environment</td>
<td>Fully met – A standard for quality</td>
<td>Partially met – B standard, would require significant investment to achieve A grading</td>
<td>Partially met – B standard but with no significant issues</td>
<td>Partially met – C standard and will never be able to achieve A standard due to the age and nature of the building</td>
</tr>
<tr>
<td>Accessibility</td>
<td>Good accessibility for whole population</td>
<td>Good accessibility for whole population</td>
<td>Least accessible for Middlesbrough patients but offers good accessibility for rural East Cleveland</td>
<td>Fairly good accessibility for Middlesbrough but limited access for East Cleveland’s rural population</td>
</tr>
</tbody>
</table>
### Sustainability

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Redcar</th>
<th>Guisborough</th>
<th>East Cleveland</th>
<th>Carter Bequest</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ability to deliver future Out Patients developments</td>
<td>Fully met</td>
<td>Partially met – would need</td>
<td>Fully met</td>
<td>Not met – no room for OPD expansion</td>
</tr>
<tr>
<td></td>
<td></td>
<td>some remedial work and</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>investment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ability to deliver future assessment hub/day treatments development</td>
<td>Fully met – has</td>
<td>Partly met – would need</td>
<td>Partially met – would</td>
<td>Not met – no room for expansion, no</td>
</tr>
<tr>
<td></td>
<td>capacity now and</td>
<td>remedial work and investment</td>
<td>need remedial work with</td>
<td>x-ray facility</td>
</tr>
<tr>
<td></td>
<td>benefits from</td>
<td></td>
<td>minimal investment</td>
<td></td>
</tr>
<tr>
<td></td>
<td>attached pharmacy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maintenance of building over next five years</td>
<td>New building – no</td>
<td>Older building – high</td>
<td>Partially met – fairly</td>
<td>Older building – high maintenance</td>
</tr>
<tr>
<td></td>
<td>significant issues (PFI)</td>
<td>maintenance costs £1.6 million</td>
<td>modern building 25</td>
<td>cost for the smallest hospital – £420K</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>years old – will</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>require maintenance</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>programme over next 5</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>years – £900K</td>
<td></td>
</tr>
<tr>
<td>Workforce</td>
<td>Met</td>
<td>Met</td>
<td>Met</td>
<td>Met</td>
</tr>
</tbody>
</table>

### Efficiency

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Redcar</th>
<th>Guisborough</th>
<th>East Cleveland</th>
<th>Carter Bequest</th>
</tr>
</thead>
<tbody>
<tr>
<td>Flexibility to utilise void space</td>
<td>Current cost of</td>
<td>Current cost of void space</td>
<td>Current cost of void</td>
<td>Current cost of void space = £82K</td>
</tr>
<tr>
<td></td>
<td>void space =</td>
<td>£364K</td>
<td>space = £592K</td>
<td>Limited. Would offer some office space</td>
</tr>
<tr>
<td></td>
<td>£942K Modern</td>
<td>Opportunities for clinical,</td>
<td>Building could be split</td>
<td></td>
</tr>
<tr>
<td></td>
<td>property, layout</td>
<td>office and other services</td>
<td>easily and offers a</td>
<td></td>
</tr>
<tr>
<td></td>
<td>of building is</td>
<td></td>
<td>variety of potential</td>
<td></td>
</tr>
<tr>
<td></td>
<td>really designed</td>
<td></td>
<td>uses</td>
<td></td>
</tr>
<tr>
<td></td>
<td>for specialist</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>health care use</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cost for any required development to deliver model</td>
<td>None</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Impact upon other services delivered from that Estate</td>
<td>None</td>
<td>Minor Injuries Unit</td>
<td>Minor Injuries Unit</td>
<td>GP Surgery Limited number of other</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Out-patient services</td>
<td>GP Surgery</td>
<td>services</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Limited Community Estate in</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Guisborough to transfer OPD</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>services</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
4.3 Preferred option

Community hospitals

The modelling work demonstrates that the need for beds will diminish over time as a result of improving and investing in alternative community provision, despite the predicted increasing elderly population. In fact it demonstrates that there is already a significant bed surplus. As a result of feedback from the pre-engagement work with the public, we have acknowledged the need to ensure the new model of care is working effectively before further reducing our community bed base in line with the modelling analysis.

The clinically agreed criteria used to assess whether South Tees community hospitals are capable of delivering the proposed new model of care clearly demonstrates that:

- Only Redcar Primary Care Hospital is capable of delivering the proposed full model of care;
- Guisborough Primary Care Hospital and East Cleveland Primary Care Hospital deliver elements of the proposed model but would require investment to realise full delivery; and
- Carter Bequest Hospital is not capable of delivering the model of care to the standards required and would not be capable of doing so in the future without significant investment. Carter Bequest Hospital could never reach an A standard for quality environment due to the age and nature of the building, and therefore it is unsustainable and not fit for the future.

It is important that the rurality of East Cleveland is taken into account and as such there is a need to provide accessible services in this locality. East Cleveland Primary Care Hospital is a fairly new building and has a large amount of empty space which lends itself to redevelopment.

Guisborough Primary Care Hospital is split into two buildings; the building which houses beds is an old building (main building) and not sustainable in the long term, a second, newer building (the Chaloner Building - primarily used for administration), houses a number of out-patient and community services. Guisborough lacks alternative community health estate. Retaining and developing outpatient services are central to the planned model and it was therefore proposed to retain and develop the newer building to support the delivery of the model for increased outpatient services.

It is important to ensure any new service model is working before any reduction in the bed base. Redcar Primary Care Hospital is the estate of choice for stroke rehabilitation and the assessment hub, offering excellent modern rehabilitation facilities without the need for additional investment. In centralising stroke beds at the Redcar Primary Care Hospital site, the need for beds at Carter Bequest Hospital and Guisborough Primary Care Hospital is significantly reduced.

Carter Bequest Hospital, as previously stated, scores low for quality, sustainability and efficiency, does not support the delivery of the proposed model of care and is
therefore not sustainable for the future. There are very few community services delivered from this site and these could be easily accommodated elsewhere. Middlesbrough already has alternative community estate from which outpatient and community services are delivered, e.g. One Life and North Ormesby Health Village which have available capacity. In view of this, the age and unsustainability of the building, it is proposed that Carter Bequest Hospital should be the first facility to reduce bed numbers with transfer of all other services/office accommodation. A General Practice is located at the building and we recognise that this is an important service for our local population. Our preferred choice is to maintain a general practice facility on the site. NHS England, responsible for GP services, is working closely with the practice to agree a preferred option.

As the model develops and becomes embedded, the need for community beds will further reduce. As previously stated, Guisborough Primary Care Hospital is unable to deliver the best practice model of care for stroke and therefore its bed base will reduce when stroke rehabilitation is centralised. The quality and age of the building are such that this building is unsustainable without significant financial investment. Thus the proposal is that Guisborough Primary Care Hospital should be the second bed base to close, whilst retaining and expanding out-patient and community services.

East Cleveland Primary Care Hospital, a newer more sustainable building capable of increasing capacity and suitable for re-development is therefore the best choice for retention. This site provides accessible services to the more rural population and will be retained together with Redcar Primary Care Hospital.

**Minor Injury Units**

Minor Injury Units exist at Guisborough and East Cleveland Primary Care Hospitals and were therefore considered as part of this option appraisal process. As previously stated in section 2.4, it was important to consider the impact of the IMProVE proposals upon our other plans and strategies. Minor injury units form part of the future strategy for urgent care.

A review of minor injury services in East Cleveland and Guisborough has shown that demand for this service is low and that the services have struggled to attract the skilled staff they need to operate 24 hours a day, seven days a week. As a result they are open 9 a.m. to 5 p.m. Monday to Friday and 8 a.m. to 8 p.m. on weekends and bank holidays. The service is currently nurse-led. Each service treats between six and eight people a day compared to around sixty a day at other similar services in the area. Our emerging urgent care strategy proposes to develop a centralised, 7 day a week urgent care service in Redcar. This will enable a broader range of urgent care conditions to be diagnosed and treated and will deliver a better and more clinically robust service for patients. By delivering this more comprehensive support, there will be less need for patients to be directed to James Cook Hospital.
4.4 Summary of our proposed option

Discussion was based on the model of care and how our estate could support its delivery. The option is summarised as below and supplemented by an implementation plan (Appendix 4):

<table>
<thead>
<tr>
<th>PHASE</th>
<th>DESCRIPTION</th>
<th>DATE/S</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Development of community services which focus on improving pathways of care and discharge processes. Implement a community stroke team, increase reablement, rapid response and therapy services. Implement a single point of access and implement an assessment hub.</td>
<td>April 2014 – March 2016</td>
</tr>
<tr>
<td>2</td>
<td>Centralise stroke rehabilitation services to one specialist unit (Redcar Primary Care Hospital). Closure of Carter Bequest Hospital and transfer of services within the community. Closure of the two minor injury services in East Cleveland and Guisborough Primary Care Hospitals. Consolidation and enhancement of minor injury services onto one single site (Redcar Primary Care Hospital).</td>
<td>By April 2015</td>
</tr>
<tr>
<td>3</td>
<td>Closure of Guisborough Primary Care Hospital (main building) and removal of community bed base Redevelopment of Chaloner Building only in order to retain existing services and also increase the range of community based services.</td>
<td>April 2015 – March 2016</td>
</tr>
</tbody>
</table>

5. Overview and scrutiny engagement

As part of statutory public sector duties, we have worked and engaged with a number of Overview and Scrutiny Committees (OSC), Tees Valley OSC, Redcar OSC, North Yorkshire OSC and primarily South Tees Joint Health Overview and Scrutiny Committee, as we have progressed our IMPROVE programme. OSC have been invaluable with their advice and support around the process, particularly in suggesting ways in which we could better engage with the public. Their suggestions were built in to our communication and engagement plans, particularly with regard to engaging Black Minority Ethnic (BME) communities.
North Yorkshire OSC was satisfied that the consultation process would receive appropriate consideration and simply asked to be kept informed.

In addition we have worked closely with both Health and Wellbeing Boards in developing and progressing these proposals.

6. **Formal public consultation**

The NHS Act 2006 (as amended by the Health and Social Care Act 2012) places legal duties on CCGs to make arrangements to involve service users in the development and consideration of proposals for change in commissioning arrangements where this will impact on how services are delivered, or the range of services that will be available.

Following development and agreement of the IMProVE proposals, we developed robust plans to deliver engagement and formal consultation, and to communicate the scope of the consultation and case for change effectively to patients, the public, political and wider stakeholders and the media. A range of communications and consultation mechanisms were utilised to ensure sufficient information and involvement opportunities were available to identified stakeholders. These plans were informed by learning from IMProVE pre-engagement, guidance from the Joint Overview and Scrutiny Committee, local Healthwatch and feedback from the stakeholder meeting held on 29 January 2014.

The formal public consultation on the proposals ran from 30th April, 2014 to 31st July 2014.

The timing of the consultation period took account of the period leading up to local and European elections taking place during May 2014. A key consideration was to ensure that key messages and options were not confused with wider debates about the NHS. We aimed to ensure that informed views were received from patients, the public and all other stakeholders on the consultation proposals. We responded to ongoing requests for information throughout the consultation period.

6.1 **Equality Impact Assessment**

Throughout the IMProVE consultation, persons offered protection under the equality act 2010 that are referred to as ‘protected groups’ have been considered through an Equality Analysis to eliminate any discrimination and to advance equality. The details of the Equality Analysis are enclosed with this paper. The impact assessment also covered the consultation process, resulting in a significant targeting of some of the more vulnerable and ‘hard to reach’ groups, such as older people’s groups, stroke condition groups and BME community both before and during the formal consultation. We have worked closely with South Tees Hospitals NHS Foundation Trust to engage their staff in the process, allowing opportunities for them to talk to CCG executive GP members.

Responses to the formal consultation survey were received from different groups and individuals. The support of partner community and voluntary sector
organisations working with protected groups, as defined by the Equality Act 2010, is evidenced through the survey response rates, including BME groups (Everyday Language Solutions) and the elderly and carers (Carers Together).

6.2 Consultation Process

The consultation process included:

- 24 public, community and councillor meetings;
- Opportunity to provide questionnaire feedback by post or electronically;
- Presentation at formal Scrutiny Forums/Committees, Health and Wellbeing Boards and a range of clinical meetings;
- Individual letters and e-mails etc;
- Independent analysis of questions; and
- Triangulation of public and clinical meeting responses.

As part of the consultation process people were asked for their views on the vision for improving services and ensuring that more elderly and vulnerable patients with long-term conditions are able to remain independent for longer. The consultation questions posed were developed with clinical input and following stakeholder feedback and are outlined within the consultation report (Appendix 1).

6.3 Consultation document and supporting information

The formal consultation document presented the case for change and outlined the background to the proposals. This document included a questionnaire distributed within a consultation booklet and was also hosted on the NHS South Tees CCG website. An accessible summary document was also produced. Consultation documents and questionnaires were delivered to all GP practices, community based health facilities and libraries in South Tees. The questionnaire was also available as an online survey.

Supporting information made available on the NHS South Tees CCG website included the IMProVE Case for Change and the Outline Business Case. This supporting data was provided in order to enable as much informed engagement in the consultation process as possible.

6.4 Consultation events and mechanisms

A number of formal public meetings, drop-in sessions and engagement with individual groups were held at a variety of locations and times which were selected to ensure equitable opportunities across South Tees. Venues were selected based on accessibility. A total of 24 events were held across the South Tees area; five of these were formal public meetings.

The format of the formal public consultation events was an open forum ‘market place’ style session with dedicated discussion tables for those attending who wished to participate. The aim was to enable understanding of the proposals and issues so that responses would be more informed. Each of the events held took place outside of normal working hours (5.30-7.00pm) to support the general public’s attendance.
A core team of clinicians, managers from the acute Trust and local authorities and CCG GPs and commissioners were present to facilitate each event and to address and manage concerns, particularly from people attending with specific concerns about their own experiences.

This format was chosen as an alternative to a presentation and question and answer session with representatives on a top table as it provided an opportunity for discussion and dialogue which supported more informed responses to the questionnaire. The drop-in style format was also chosen to provide more flexibility in when people could attend. Those who attended were keen to speak to clinicians. A number of supporting staff from North of England Commissioning Support (NECS) were also present to capture themes from the discussions.

To ensure opportunities for face to face discussion were as wide-ranging as possible, further local public events and group discussions were organised throughout the consultation period.

A full list of events is contained within the consultation report (Appendix 1).

6.5 Meeting the four key tests as outlined in the NHS Operating Framework

The Secretary of State for Health introduced four key tests which CCGs are required to meet when introducing major changes in service. These are:

1) Support from GP commissioners;
2) Strengthened public and patient engagement;
3) Clarity on the clinical evidence base, and;
4) Consistency with current and prospective patient choice.

A detailed report (Appendix 2) gives a full account of how the CCG has met these four tests but they are summarised below:

1. GP commissioner support

There is recognition that it is not always possible to gain unanimous support from all member practices. Overall, the consultation option has received substantial support from clinical members of the CCG whose patients are affected by the changes, both in their capacity as commissioners and as providers of GP services.

2. Patient and public engagement

We have actively sought the views of patients, public and other key partner organisations on the IMPROVE programme. Our formal public engagement was preceded by a 13 week formal pre-engagement consultation.

3. Clinical evidence base

We have clearly set out our clinical case for change, aligned to the best available evidence and ensuring it has considered improvements that could deliver further benefits for patients. This is outlined in the Case for Change Document and the
Outline Business Case previously shared with Governing Body members and published on our website.

4. Patient choice

The NHS Constitution states: “If your GP refers you to see a consultant you may have a choice of a number of hospitals. You might want to choose a hospital that has better results for your treatment, or one near your place of work.” This will not change with our new proposals. In fact, it is expected that with plans to deliver more outpatient clinics and diagnostic services out in the community, the choice of localities available to patients will increase.

Currently, patients discharged to community hospitals are not guaranteed a choice of hospital site as beds are allocated on a clinical needs basis. This is in line with legal requirements. This arrangement will continue under new proposals with a focus on clinical need but with choice of site where capacity allows.

Changes to minor injury units will mean that patients will have less choice of where they might attend across the South Tees community but they will have access to improved minor injury services. The proposed enhancement of services in Redcar, increasing diagnostic capacity and increasing the skills of staff working in those units is intended to improve the patient experience and potential outcome, enabling a broader range of conditions to be treated in minor injury units without the need for transfer to the A & E department at James Cook University Hospital.

It is important to state that our IMProVE proposals do not include any change to existing providers.

7. Feedback from the formal consultation

The majority of respondents agreed with the key proposals for better care for the vulnerable and elderly in South Tees. Feedback from the formal consultation is contained within appendix 1. Of note is the above average response rate to our consultation, 2.2% as opposed to the national average of around 1.7%.

The CCG has shared and presented the results of the formal consultation with a number of key partners at various meetings:

- IMProVE Advisory Group – 10/09/14
- Middlesbrough, Eston and Langbaurgh CCG Locality Meetings – 10/09/14
- South Tees Integration Programme Board – 18/09/14
- South Tees Clinical Professional Forum – 25/09/14

No concerns on the consultation process were expressed and members of groups who attended the IMProVE drop-in events felt that the report reflected their observations.

The report was presented to the Joint OSC on 17 September. The full report is contained as appendix 3. With regard to the consultation process, the Committee were generally supportive of the process that had been undertaken by the CCG.
Members had the opportunity to contribute to the questionnaire and suggest people/organisations that the CCG should include in their consultation’.

With regard to whether this was the right thing to do for the people in Redcar and Cleveland and Middlesbrough, the Committee were ‘broadly supportive of the proposals on the basis of the clinical improvements that will take place and the improvements to community services’ however, they did make a number of recommendations which are summarised below:

- **Transport** - Although they recognise that transport is not an issue for the CCG to solve alone, they recommend that the CCG should take every opportunity to influence public transport design. They also ask whether the eligibility process for patient transport could be made easier.

- **Stroke** - That the CCG works with both Councils to ensure that the community stroke provision will provide a sufficient level of support and care and ensure services are in place before closing community beds currently provided for stroke rehabilitation.

- **Evidence of investment** – Members would like to see evidence and examples of reinvestment into community services.

- **Involvement in future stages** – OSC were keen to engage with the CCG to receive updates on the implementation of a phased approach.

### 7.1 Themes arising from the consultation

#### Transport

Whilst any patient who is admitted to a community hospital will arrive by planned ambulance transport, it is recognised that there will be implications for some families and carers who might need to travel further to visit a relative. Indeed the CCG and other partners did include access as part of the option appraisal criteria. Although not seen as an essential criterion by our stakeholders (including members of the public), they did feel it was desirable to have good access to venues during the day and in the evenings. In addition to commissioning an independent transport plan, we also undertook a ‘snapshot’ questionnaire over a ten day period in order to gain a greater understanding of how our patients access our Community Hospitals. This revealed that the majority of people arrived at community hospitals by car (69%) with only 13% arriving by public transport.

Although access by car to Redcar has been shown to be within a 30 minute journey for all of our South Tees population, it is recognised that it is more difficult for those travelling by public transport. This does cause inconvenience and this is not underestimated. However, particularly around stroke, the main aim is to ensure delivery of high quality rehabilitation which will achieve better outcomes for our local population. We believe that the clinical gains made by having a centralised high quality stroke service balance the short-term inconvenience of increased travel time for some visitors. It is important to note that with the introduction of a community stroke team and other home based services, fewer people will require an inpatient stay and there will therefore be fewer visits by relatives.
As travel has been raised as such an important issue throughout our consultation, we have re-visited our travel plan and our local GPs have also travelled by public transport to and from all venues to coincide with visiting times, including weekends to gain more of an understanding of issues. We recognise that we are not able to solve issues around public transport alone and therefore we will set up meetings with local authority partners and public transport providers to raise concerns and try to influence the future design of routes which take into account patient flows. We will also involve the voluntary sector, such as Tees Valley Community Council, the Red Cross and the Royal Voluntary Service who currently offer some support with transport for the vulnerable and elderly.

In respect of outpatient visits and day treatments, we plan to deliver more appointments in the community, therefore transport issues for this group of patients should lessen.

Concern was also raised that our changes to community venues would ‘overstretch’ the ambulance service. It is important to state that community hospital transfers are planned and therefore emergency ambulances will not be required as Patient Transport Services will be dealing with the majority of planned cases as they do now. The reduction in community beds is also expected to decrease the demand on transport services.

The Joint Overview and Scrutiny Committee also highlighted the need to make accessing Patient Transport Services easier. In line with national guidance for eligibility we will explore how improvements could be made to the process. We also plan to raise awareness of the Patient Transport Service further as part of the IMProVE programme.

**Minor Injury Units**

We recognise that the area of our proposal with the lowest level of agreement was around the provision of a minor injury service at a single location, and although this proposal also achieved majority support (68%), nearly a third of respondents disagreed. The key concern of those who disagreed was around ease of access. It is the view of our clinical leads that the clinical gains made by having a centralised high quality, urgent care centre balances the short-term inconvenience of increased travel time for the small number of people accessing the service.

From discussion at the consultation events, (and supported by the data) it is clear that patients are not getting to the right place first time. 12% of patients in our area who attend minor injury units need to be referred somewhere else. It was also recognised that some conditions for which patients were attending could have been seen more appropriately by their own GP. In line with the national direction of travel and guidance, our strategy identifies the need to streamline access points and to provide better information to support the public getting to the right service, first time. It is the clinically held view that when people do require support for an urgent issue, this should be available with the support of appropriate diagnostics and clinical staff.

It was also apparent from the consultation that within the Brotton community, where there have been recent changes to GP provision, there is concern that without a
minor injuries service, people will have to travel for ‘simple’ treatments such as
wound dressing, injections etc which could probably be carried out within general
practice if access was available at weekends. In light of the strength of feedback
from this locality, we propose to pilot and evaluate weekend district nurse clinics
within East Cleveland Hospital. This would be planned to be in place by April, 2015.

In addition it is also proposed that we lead a local publicity campaign to raise
awareness of what services are available and what they are able to provide.

Credibility in delivering the proposals

It is clear that concerns have been expressed around the ability to deliver our
proposed changes and improvements, particularly in relation to improving community
and home based services. We will continue to work with partners and use robust
project planning to ensure that changes are delivered (Appendix 4) and we remain
committed to a phased approach to implementation which we agreed in response to
public feedback from our pre-engagement phase. We will ensure that improvements
and new pathways have been achieved and scrutinised with partners before
progressing to the next stage. For example, our community stroke team will be in
place before stroke beds are centralised.

We have already committed to a period of financial ‘double-running’ in order to
initiate new services, such as rapid response and integrated community care teams
and further investment will follow as we progress through our plans.

Critical to the success of the programme will be the continued support of our
partners in health and social care. The commitment and involvement demonstrated
to date by all partners has been extremely positive and the development of a South
Tees Integration Board comprising Chief Officers across key South Tees
organisations and the appointment of an Integrated Programme Manager, jointly
funded by all organisations, further demonstrate commitment to working together.
The IMProVE Advisory group comprising all key partners will have an ongoing role in
managing delivery.

Workforce issues

We recognise that the workforce is essential to delivering a new model of care and,
as such, commissioned an independent workforce review. This review showed that
there was no major concern over the supply of additional suitably competent staff to
provide more care in the community. The report highlights the need for additional
training and development to support new ways of working.

Members of the CCG have worked closely with the provider as it has consulted and
engaged with staff during the IMProVE consultation process and will continue to do
so as we move into the implementation phase. We have attended South Tees
Hospitals NHS Foundation Trust Board meetings and a number of meetings with
clinical staff groups.
Attachment to buildings

Throughout the consultation, we acknowledged and recognised that some of the existing community estate was viewed as a community asset. We understand that there is often an emotional attachment to buildings, however, as a Clinical Commissioning Group, we need to be clinically focussed on the services we commission and how the estate enables that delivery.

Access to GP practices

We acknowledge the concern expressed around the importance of good access to primary care if more patients are to be treated in the community. We continue to work closely with NHS England as they review GP practice contracts. To date there has been no reported negative impact on access to primary care with analysis indicating that patients have been able to register with another GP practice in their area. This observation was supported by Healthwatch at the Joint Overview and Scrutiny meeting in September 2014.

Although the CCG is not responsible for managing GP contracts, we have a well-established work stream which focusses on improving quality in primary care. In addition we have also commissioned general practice to develop and implement initiatives which could improve their access, reducing reliance on urgent care services.

Why deliver stroke services in Redcar?

A number of people asked our GPs at the drop-in events, why we chose Redcar to deliver stroke services rather than Guisborough Hospital or Carter Bequest Hospital, both of which already deliver this service. Section 4.2 describes in greater detail how we developed and applied criteria to develop our option. It was agreed that to deliver the best outcomes for patients, stroke services need to:

- be centralised on one site to ensure daily support from one dedicated, specialist stroke team as recommended by national guidance;
- have purpose built, modern, fit-for-purpose rehabilitation facilities – NICE guidance recommends a dedicated stroke environment with access to a dining area, gym and assessment kitchens;
- have an x-ray facility on site for those patients fitted with naso-gastric tubes;
- be accessible to a high majority of the population within 30 minutes by car and 1 hour by bus;
- be sustainable into the future; and
- ensure the service was cost effective to deliver.

After applying these criteria to all four hospitals, only Redcar Primary Care Hospital is able to deliver the full model without incurring significant additional costs. It also offers the best rehabilitation facilities with a purpose built gym and hydrotherapy pool with space to accommodate all associated stroke and therapy services. Redcar offers reasonably good accessibility for the whole population. It scores the highest for quality of estate in general and as this is a PFI with a 30 year lease, it is both cost-effective and sustainable.
8. Factors used in decision making

The Department of Health outlined in its *Real Involvement Guidance, 2008* that three key factors should be taken into consideration when reaching a decision:

![Diagram showing the factors of affordability, clinical safety, and acceptability]

These themes have been used to inform our decision-making process and we have ensured that our recommended decision is balanced between all three.

In terms of **affordability**, the key drivers for change associated with the development of our new model of care do not include a cost-saving element. Our proposal represents a shift of resource from funding empty space and maintenance of buildings to investment in staff to deliver improved services. It is also important to state that monies raised by the sale of land following disposal of any of the community buildings will be paid to the Department of Health via NHS Property Services.

**Clinically** our case for change has outlined the need to improve quality standards for our South Tees population which are equal to the rest of the country. The key driver for change is to ensure people receive the best possible rehabilitation and support at home in order to remain independent for longer. With regard to minor injuries, we want to ensure that patients receive the right treatment, at the right time, at the right place. This too will improve the outcomes for people requiring urgent care. We also need to ensure that services are sustainable in the long term.

In terms of **acceptability** to patients, staff, and the public, the consultation has highlighted that our proposals are acceptable, by a majority of the respondents. We acknowledge the concerns and issues raised; notably transport and the minor injury service in East Cleveland and in response, these issues have been explored and analysed with recommendations to address the concerns set out in this paper.

9. Summary

This paper has summarised our ‘IMProVE’ journey so far, culminating in a series of recommendations. These recommendations support our initial aims of developing a model of care which is based on the principles of ‘right care, right place, at the right
with the overall aim of providing care as close to home as possible, wherever this can be done safely and cost effectively.

The public consultation on the IMProVE proposals has been a carefully planned exercise in moving towards significant improvements for our vulnerable and elderly population. Prior to and during the formal consultation the CCG has sought expert independent legal advice and an external Department of Health Gateway Review on our decision making procedure (Appendix 5) to ensure we have followed due process.

Through this paper and the associated documentary evidence we can provide assurance to the Governing Body that we have undertaken a robust process, taking into account relevant legislative frameworks and national guidance in arriving at our proposed recommendations. For example:

- The four key tests have been met as set out in appendix 2;
- The consultation was undertaken in accordance with the relevant legislative framework
- The Equality Act 2010 has been followed accordingly

10. Recommendations

After seeking a balance between what is clinically safe and effective, what is acceptable to patients, staff and the public and what is affordable, it is recommended that we should progress all of our proposals for the IMProVE programme including the consolidation of minor injury units onto a single site in Redcar. The clinically led view is that it is in the best interests of our South Tees population to do so. It is important to address the issues highlighted by our public and as such; we are proposing a number of recommendations to the Governing Body for consideration and agreement.

We have welcomed the opportunity to discuss these proposals with local people and with organisations across South Tees and the surrounding area in order to gather as wide a range of views as possible.

We have followed best practice to ensure that the consultation process has been transparent and open in presenting the clinical evidence and views which supported our IMProVE proposals.

Therefore the Governing Body is asked to:

1. Note and support the work undertaken to develop proposals for a new model of care for the vulnerable and elderly;
2. Consider the independently analysed outcome of the full public consultation proposals on IMProVE - Better Care for the vulnerable and elderly in South Tees;
3. Consider the feedback from South Tees Joint Health and Social Care Scrutiny Committee;
4. Consider whether the Governing Body are assured that we have undertaken a robust process, taking into account relevant legislative frameworks and national guidance in arriving at our proposed recommendations.

5. Agree that the proposals from the consultation are taken forward in a phased approach as referenced within the enclosed implementation plan, specifically:
   a. Centralisation of stroke services to Redcar Primary Care Hospital by April 2015
   b. Closure of the two minor injury services in East Cleveland and Guisborough Primary Care Hospitals. Consolidation and enhancement of minor injury services onto one single site (Redcar Primary Care Hospital) by April 2015
   c. Closure of Carter Bequest Hospital and transfer of services within the community by April 2015 alongside the progression of improved community infrastructure
   d. Part closure of Guisborough Primary Care Hospital (main building), removal of the bed base subject to implementation of improved community infrastructure by April 2016
   e. Redevelopment of the Chaloner building in order to house transferred services as well as additional community based services by April 2016

6. Work with key partners to monitor and assure phased implementation, providing and receiving regular update reports.

7. Agree that a system-wide group is established in order to explore the potential to influence travel plans and routes to take into account future patient flows.

8. Agree a public campaign to raise awareness around eligibility for the Patient Transport Service.

9. Develop a public communication plan to support understanding of what is urgent care and where to access services.

10. Agree to pilot a weekend district nursing clinic within East Cleveland Hospital to commence by April 2015 in line with consolidation of minor injury services.

Appendices

1. Report on the outcome of IMProVE public consultation
2. Four Test Paper
4. High Level Implementation Plan
5. Gateway Healthcheck - Department of Health, August, 2014

Julie Stevens
Commissioning & Delivery Manager
8 October, 2014
Report on outcome of IMProVE public consultation

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Introduction

The purpose of this report is to provide feedback to NHS South Tees Clinical Commissioning Group (CCG) following a public consultation from 30th April to 31st July 2014 on proposed changes and improvements to local community services as part of the Integrated Management and Proactive Care for the Vulnerable and Elderly (IMProVE) programme.

In terms of governance and accountability, North of England Commissioning Support (NECS) supported the engagement and consultation process for NHS South Tees CCG, and is providing this report.

NECS commissioned independent specialist consultants (Explain Research) to receive and independently analyse consultation responses from the consultation survey. Respondents to the consultation survey fed back by email, freepost address, telephone or via the website.

This report covers:

- stakeholders who have been consulted
- what information was provided to those stakeholders
- what matters those stakeholders were consulted about
- the result of the consultation, including a summary of the differences expressed by those consulted

This report aims to inform decisions or changes made by NHS South Tees CCG following the consultation who will account for the influence the results of the consultation have had on those decisions or changes.

Background

NHS South Tees Clinical Commissioning Group recognises the challenges it faces in meeting the needs of a growing population of older people. The CCG wants to improve health services for local people who are elderly, vulnerable or living with a long-term condition and other health and social care requirements. This includes those with diabetes, heart disease or chronic obstructive pulmonary disease (COPD) as well as people who have suffered strokes or heart failure.

For two years the CCG have been working with local GPs, hospital clinicians, nurses, service managers and local authority partners to consider the challenges. They have involved the public, service users and carers at each stage to make sure they understand their experiences and expectations of existing services, what they think of the CCG vision for future development, and can take those views into account in their planning and decision making.
NHS South Tees CCG have undertaken a comprehensive programme of engagement to involve the public, service users and carers, elected representatives, and other stakeholders and partners.

In January 2014, a public event was held to feed back what the CCG had learned to their partners and stakeholders, and to elicit their further input and views.

The information gathered during the engagement programme has been used to shape the CCG’s final proposal for service change. This proposal was presented to the public and stakeholders during a three-month period of formal consultation. This document is the report on the outcome of that consultation.

What is IMProVE?

NHS South Tees Clinical Commissioning Group (CCG) is working in partnership with South Tees Hospitals NHS Foundation Trust, Tees, Esk and Wear Valleys NHS Foundation Trust and with Middlesbrough and Redcar and Cleveland local authorities to improve services for the vulnerable, elderly and those with long-term conditions in the area.

This improvement programme is referred to as the Integrated Management and proactive Care for the Vulnerable and Elderly (IMProVE). NHS South Tees CCG are now proposing to make some changes and improvements to local community services, including changes to the minor injury services provided from a number of these locations.

This is one of a number of planned areas of work which will lead to improvements in local services for the whole population. The changes made through the IMProVE programme will also help NHS South Tees CCG to invest in services which will benefit not only the elderly and vulnerable but the whole of the South Tees population by reducing reliance on hospital based services.

A formal public consultation to seek views on the proposals began on Wednesday 30th April 2014 and closed on Thursday 31st July 2014.

Consultation scope

The formal consultation document presented the detailed case for change and outlined the background to the proposals.

The changes proposed in the formal consultation document were to:

- Centralise all stroke rehabilitation and supporting services
- Invest in a community stroke team to help patients return to their home more quickly following a stroke
• Provide community beds in two locations
• Provide a more comprehensive minor injury service at a single location with enhanced medical and diagnostic cover
• Increase community nursing and support services by reducing the amount spent on maintaining ageing buildings.
• Deliver more care in the community closer to where people live

A full description of the options proposed is included in the consultation document in Appendix 2 at the end of this report.

Aims and objectives of the consultation
• To raise awareness and understanding of why it is important that the NHS has a plan to deliver sustainable and viable services for the next three to five years.
• To ensure that appropriate mechanisms are in place so that the public, key stakeholders and partners feel engaged and informed throughout the process.
• To contribute to shaping public, and health services’ staff, expectations of NHS services in Middlesbrough, Redcar and East Cleveland.
• To maintain credibility by being open, honest and transparent throughout the process.
• To monitor and gauge public and stakeholder perception throughout the process and respond appropriately.
• To be clear about what people can and cannot influence throughout the consultation phase.
• To achieve engagement that is meaningful and proportionate, building on existing intelligence and feedback such as previous engagement/consultation activities, complaints, compliments etc.
• To provide information and context about the proposals in clear and appropriate formats which are accessible and relevant to the target audiences.
• To give opportunities to respond through the formal consultation process.
• To maintain trust between the NHS and the public that action is being taken to ensure high quality NHS services in their local area.
• To demonstrate the NHS is planning for the future.
Overview of the approach to engagement and consultation: ‘Right people, right methods, right feedback, right questions, right time’.

NHS South Tees CCG followed good communications and engagement practice, and aimed to ensure that pre-consultation engagement and the formal consultation were as fair, robust and inclusive as possible. Adherence to Public Sector Equality Duties is also demonstrated.

The approach took into account the need for reconfiguration proposals to meet the four Tests for reconfiguration proposals in order to demonstrate:

- support from commissioners
- strengthened public and patient engagement
- clarity on the clinical evidence base
- consistency with current and prospective patient choice.

Good practice criteria applied included ‘right people, right methods, right feedback, right questions, right time’.

The broad stages of consultation being followed are:

- pre-consultation
- consultation dialogue
- post consultation influencing

Section 244 of the consolidated NHS Act 2006 (became Section 23 of the NHS Act 2012) requires NHS organisations to consult relevant Overview and Scrutiny Committees on any proposals for a substantial development of the health service in the area of the local authority, or a substantial variation in the provision of services.

The approach supported the right to information and transparency as a cornerstone of involvement and the principles of the NHS Constitution which commits the NHS “to make decisions in a clear and transparent way, so that patients and the public can understand how services are planned” and “be involved, directly or through representatives, in the planning of services commissioned by NHS bodies”.

NHS South Tees CCG took account of NHS England good practice guidance - Transforming Participation in Health and Care - ‘The NHS Belongs To Us All’ by:

- Engaging communities with influence and control e.g. working with CVS and HealthWatch
- Engaging the public in the planning and delivery of service change e.g. engage early and build on insights
Providing good quality information
Providing a range of opportunities for participation
Working with patients and the public from the initial planning stages

NHS South Tees CCG requested the Department of Health to undertake a ‘healthcheck’ of the Improve Programme in order to gain assurance with regard to the consultation process and legal requirements during August 2014. The healthcheck report indicated:

‘During this period the CCG has made significant efforts to involve patients, the public and representative bodies in ensuring that the new integrated health and social care models are appropriate and in the best interests of patients. It was clear to the Review Team that the CCG had used the information gained from this pre-consultation period to inform the preferred option outlined in the Consultation Document.

‘The public consultation period closed on 31st July 2014 and the consultation report is now being produced for the CCG. The Review Team was impressed with the determination that the CCG showed to ensure that the consultation involved as many stakeholders as possible and that the process was in line with the guidance provided by NHS England and legal advice.’

Healthcheck ID: DH803, Department of Health

Pre-consultation engagement
Throughout the development of the IMProVE pre-engagement and formal consultation, NHS South Tees CCG met frequently with Middlesbrough Council, Redcar & Cleveland Council, South Tees NHS Foundation Trust and Tees and Esk and Wear NHS Valley Foundation Trust, Health and Wellbeing Boards for Middlesbrough and Redcar and Cleveland to discuss and seek views on the IMProVE programme.

Representatives from local HealthWatch organisations and the voluntary sector, and South Tees Joint Health Overview and Scrutiny Committee were engaged on an ongoing basis.

Local HealthWatch organisations contributed to this consultation by representing the interests of patients and the public and contributed to the consultation approach.

(See Stakeholders involved in the pre-engagement and development leading to the formal consultation.)

A range of formal pre-consultation engagement activities were undertaken in order to generate dialogue, gather feedback and views, and understand the themes emerging from these. This intelligence was used to scope the proposals for consultation, and to clarify key
messages around the context to the IMProVE programme. This provided valuable context and built understanding.

NHS England’s ‘Call to Action’ Programme launched in 2013 invited the public and staff to join in a discussion about the future of the NHS so it can plan how best to deliver services, now and in the years ahead. Call to Action focuses on a number of challenges but specifically an ageing population and a rise in the number of people with long term conditions. As part of their ‘Call to Action’ engagement strategy, NHS South Tees CCG sought the views of local people; patients, carers and stakeholders about how to address these issues in their area.

A ‘Call to Action’ event on 11 December 2013 provided an opportunity to widen the dialogue around the IMProVE programme, further enhanced by a range of other engagement activities. Responses from this were used to shape proposals for the IMProVE programme.

At the event stakeholders (including representative local groups) were asked to consider the following question: “Older people account for the majority of health care contacts. The proportion and numbers of older people will grow in the coming decades. What should the NHS do to support older people to live with a better quality of life and reduce the need for a stay in hospital?”

The following themes emerged:

- More care at home - more equipment available, 24/7 services
- Carers - more support, education and information
- Discharge – safe discharge process with early discharge step down care
- Better information - hospitals/ professionals to give better information – this would include letters of discharge and out patient’s appointments.
- Integration - there were comments about community projects and the need for practical support and to see more integration between groups.
- Mental health - there was a general call for the need to improve social isolation and loneliness. Palliative care - concerns were expressed that dignity needs to be a fundamental part of services and Care for the Dying.
- Self-management – the need to facilitate self-management in the community
- More care and services in the community - from all of the health, local authority and voluntary sector.
- Stroke services – people who are discharged from these services need more support in the community once discharged.
- More use of voluntary sector organisations
- Redcar Primary Care Hospital – concerns about under-use
**Formal pre-engagement**
Between 23 September 2013 and 22 November 2013, NHS South Tees CCG engaged formally with a range of stakeholders including partner organisations, services users, carers, providers and the general public to discuss the vision for services. Representatives of Middlesbrough Council, Redcar and Cleveland Council and South Tees NHS Foundation Trust were involved in developing the consultation document and the scope of the associated questions. Representatives of respective local HealthWatch organisations were also involved.

**Survey of elderly and vulnerable groups**
An in-depth survey of patients and their carers was undertaken by Carers Together, an independent charity providing support to patients and carers in Redcar. Carers Together worked proactively with other organisations in the area to ensure elderly and vulnerable groups, such as the housebound, had access and support to complete the survey. These groups are less likely to give their views by attending events and public meetings.

The aim was to get 250-500 questionnaires completed by people aged 65+ across the areas of Redcar, Eston, Brotton, Middlesbrough and Guisborough. Joint analysis of the findings (below) was undertaken between Carers Together and NHS South Tees CCG.

The full findings are available at Appendix 5.

There were 348 completed surveys from which some strongly consistent themes emerged:

- Appointments could be improved, including access and waiting times.
- Many people with arthritis and mobility problems find it difficult to either give or receive information and worry about whether it is accurate, and whether they are listened to.
- More information and communication
- Integration between services and more visits and continuity from the people who come to their home
- More carer involvement.
- There were a number of services suggested that people felt they either wanted more of, or wanted delivered in the home.
- There was support for a mix of services venues and for more services in the home, but acknowledgement that this requires more staff, networks and information.
- Lack of public transport.
- Very elderly carers receive a variable level of support from health and social services in the community. Some advised they had no information, out of date information or did not know where to go, although the GP usually was a ‘first port of call’.
Patient participation groups
GP member practices were encouraged to include IMProVE as an agenda item for their patient participation group meetings, and to encourage their groups’ members to respond to the formal consultation.

Drop in events
Five public drop-in events across the South Tees area were held, designed to offer interested individuals, stakeholders, service users and carers an opportunity to contribute their views and opinions face to face. Around 30 people attended the drop-in sessions.

Summary of feedback from formal pre-engagement
There were many positive comments which supported the IMProVE vision. However a number of key themes emerged with suggestions for improvement:

- **Co-ordination of services** – the need for better collaboration and co-ordination between health and social care and different services
- **GP access** – sometimes poor access to appointments, continuity of care and more home visits
- **Access to information** – consistency and the importance of carers and families understanding information
- **Care closer to home** – there was considerable support for the suggestion that more care should be provided in the home or in a community setting. Respondents felt that this could aid recovery, prolong independence and keep hospital beds free for the seriously ill. However, many commented that for this vision to become a reality, community-based care would need to improve significantly.
- **Quality of community provision** – the quality and extent of community-based services was a recurring theme. Respondents identified a number of areas for improvement including more frequent and longer home visits from both health professionals and home care providers, more rapid assessment of need and access to services and equipment, more practical support in the home, and on-call support available on weekends and in the evenings. There were a number of comments about hospital discharges being delayed because of lack of provision.
- **Hospital beds** - there was some confusion about the difference between community and acute beds with a number commenting that beds were needed in case of a flu epidemic or major incident. Opinions differed on the impact of closing community beds with some reflecting that it would take pressure off the hospital system and others claiming it would increase demand for acute beds. Around half supported the idea of closing beds and providing greater care in the community. Amongst other things, respondents felt that this would aid recuperation and promote independence. Many qualified their support for the closure of beds with the need to improve community health and social care services first. Some questioned whether
there was sufficient budget/staff to develop and improve community services in line with the CCG’s vision.

- Physiotherapy and Occupational Therapy services - there were a number of comments about the length of time taken for assessments/access to services. Some commented that this was impacting upon recovery and hospital discharge.
- Dementia services - the need for improvement in services was mentioned by a number of people. This ranged from better information for patients and their carers through to the extent of the services available locally.

### January 2014 stakeholder event

A stakeholder event held on 29 January 2014 was attended by 52 representatives of voluntary sector organisations, local councillors and clinicians.

The aim of the meeting was to feed back on the pre-engagement outcomes, engage with stakeholders around the future consultation approach and to gain their input into the development of quality criteria to be used to appraise the proposed model of care. This included assessment against standards relating to clinical quality, sustainability/flexibility, equity of access, efficiency, workforce, functional suitability, acceptability.

Similar to the separate meetings with clinicians, those who attended were invited to add to or amend the quality criteria and state what they felt were essential and desirable. There was general consensus between the group of clinicians in the room and other stakeholders on what was desirable and what was essential. In particular, access to estate within 30 minutes’ drive and adequate parking was felt to be a desirable rather than an essential factor.

There were also comments and concerns raised about:

- Services for patients with dementia and support for carers – addressed as part of 2014/15 commissioning intentions.
- Making sure the necessary community services are in place before reducing beds. This was taken account of in options proposed in the formal consultation.
- Proposed changes to stroke services, working with partners to improve discharge through the development of a Single Point of Access and the requirement to improve community provision, particularly therapies.

These issues, concerns and suggestions for improvement from the public during both the formal pre-engagement period and from the January 2014 stakeholder event were used to further shape the new model of care and service reconfiguration as part of the formal consultation.
Stakeholders involved in the pre-engagement and development leading to the formal consultation

Local HealthWatch
NHS South Tees CCG have actively engaged with local HealthWatch organisations about the redesign and commissioning of health service. HealthWatch members from Redcar & Cleveland and from Middlesbrough were invited to an event to discuss their commissioning intentions on 27 January 2014. The event was led by HealthWatch. The aim was to provide members with the opportunity to contribute to and influence the way in which health services are developed in South Tees.

A total of 34 members from both HealthWatch organisations attended this event. Four CCG representatives provided support to answer questions and provide a wider context to the commissioning intentions.

HealthWatch representatives have also supported NHS South Tees CCG in an on-going advisory/critical friend capacity throughout the IMProVE pre-engagement and formal consultation process. They are also represented on the IMProVE Advisory Group and also an IMProVE Programme Reference Group as detailed below.

IMProVE Programme Reference Group
This group, with representation from HealthWatch, the voluntary sector and South Tees NHS Foundation Trust, acted as a critical friend on processes and plans for engagement and consultation.

The IMProVE Advisory Group
The multi-agency IMProVE Advisory Group has taken forward the integrated agenda as a health community. This system wide group has provided oversight for monitoring the progress of the IMProVE formal consultation process.

Overview and Scrutiny Committee
NHS South Tees CCG has liaised with the South Tees Joint Health Overview and Scrutiny Committee around both pre-engagement consultation and the progression to the formal IMProVE consultation.
Formal consultation

The NHS Act 2006 (as amended by the Health and Social Care Act 2012) places legal duties on CCGs to make arrangements to involve service users in the development and consideration of proposals for change in commissioning arrangements where this will impact on how services are delivered, or the range of services that will be available.

Following development and agreement of the IMProVE proposals, NHS South Tees CCG developed robust plans to deliver engagement and formal consultation, and to communicate the scope of the consultation and case for change effectively to patients, the public, political and wider stakeholders and the media. A range of communications and consultation mechanisms were utilised to ensure sufficient information and involvement opportunities are available to identified stakeholders.

These plans were informed by learning from IMProVE pre-engagement, guidance from the Joint Overview and Scrutiny Committee, local HealthWatch organisations and feedback from the stakeholder meeting held on 29 January 2014.

The formal public consultation on the proposals ran from 1st May 2014 to 31st July 2014.

The timing of the consultation period took account of the period leading up to local and European elections taking place during May 2014. A key consideration was to ensure that key messages and options were not confused with wider debates about the NHS. NHS South Tees CCG aimed to ensure that informed views were received from patients, the public and all other stakeholders on the consultation proposals.

NHS South Tees CCG responded to ongoing requests for information throughout the consultation period.

Equality Impact Assessment

A formal equality impact assessment was carried out on the consultation process, resulting in a significant targeting of some of the more vulnerable and ‘easily overlooked’ groups, such as older people’s groups, stroke condition groups and the Black Minority Ethnic (BME) community both before and during the formal consultation. NHS South Tees CCG worked closely with South Tees NHS Foundation Trust to engage their staff in the process, allowing opportunities for them to talk to CCG executive GP members.

Responses to the formal consultation survey were received from different groups and individuals. The support of partner community and voluntary sector organisations working with protected groups, as defined by the Equality Act 2010, is evidenced through the survey response rates, including Black Minority Ethnic groups (Everyday Language Solutions) and the elderly and carers (Carers Together).
Consultation Process
The consultation process included:

- 24 public, community and councillor meetings.
- Opportunity to provide questionnaire feedback by post or electronically.
- Presentation at formal Scrutiny Forums/Committees.
- Individual letters and e-mails etc.
- Independent analysis of questions.
- Triangulation of public and clinical meeting responses.

As part of the consultation process people were asked for their views on the vision for improving services and ensuring that more elderly and vulnerable patients with long-term conditions are able to remain independent for longer. In particular, people were asked:

1. Do you think we should centralise stroke rehabilitation services in a single specialist unit in line with best practice?

2. Do you think we should provide community beds in two locations within the South Tees area in order to be able to invest in more community services for elderly and vulnerable people?

3. Do you agree with our proposal to provide a more comprehensive minor injury service at a single location (Redcar Primary Care Hospital) with enhanced medical and diagnostic cover?

4. Do you agree with our proposal to spend more of our money on increasing community nursing and therapy services rather than on maintaining ageing buildings which are not able to support the delivery of our model of care?

5. How else do you think we could increase and improve community based services for people who are elderly, vulnerable or who have long-term conditions? This would include, for example, occupational therapy and physiotherapy services.

6. Do you agree with our vision to improve prevention and deliver more care in the community, closer to where people live, i.e., more consultant out-patient clinics, diagnostics and treatments in the community?

7. For views on our proposed plans for change and understand any concerns you may have about these proposed changes to services, and how they would be implemented.

8. How do you think our plans could have an impact on specific groups or individuals within our community? For example people from black and ethnic minority backgrounds, males/females, those with disabilities, carers.
Consultation document and questionnaire

The formal consultation document presented the case for change and outlined the background to the proposals. This document included a questionnaire distributed within a consultation booklet and was also hosted on the NHS South Tees CCG website. An accessible summary document was also produced. Consultation documents and questionnaires were delivered to all GP practices, community based health facilities and libraries in South Tees. The questionnaire was also available as an online survey.

Supporting information made available on the NHS South Tees CCG website included the IMProVE Case for Change and the Outline Business Case. This supporting data was provided in order to enable as much informed engagement in the consultation process as possible.

Consultation events

A number of formal public meetings, drop-in sessions and engagement with individual groups were being held at a variety of locations and times which were selected to ensure equitable opportunities across South Tees. Venues were selected based on accessibility.

A total of 24 events were held across the South Tees area; five of these were formal consultation meetings.

The format of the formal consultation events was an open forum ‘market place’ style session with dedicated discussion tables for those attending who wished to participate. The aim was to enable understanding of the proposals and issues so that responses would be more informed.

Each of the events held took place outside of normal working hours (5.30-7.00pm) to support the general public’s attendance.

A core team of clinicians, managers from the acute trust and local authorities and CCG GPs and commissioners were present to facilitate each event and to address and manage concerns, particularly from people attending with specific concerns about their own experiences.

This format was chosen as an alternative to a presentation and Q&A session with representatives on a top table as it provided an opportunity for discussion and dialogue which supported more informed responses to the questionnaire. Those who attended were keen to speak to clinicians.

A number of supporting staff from North of England Commissioning Support (NECS) were also present to capture themes from the discussions.

To ensure opportunities for face to face discussion were as wide-ranging as possible, local groups and public events were organised throughout the consultation period.
A full list of events is below:

- **30 May**  Step out for Stroke – partnership event with service users
- **4 June**  **Eston formal public meeting**
- **6 June**  Lifestore Middlesbrough MELA – engagement with general public
- **11 June**  **Brotton formal public meeting**
- **13 June**  Lifestore Middlesbrough – partnership work to engage with the general public around IMProVE to capture their responses to the Q & A document
- **16 June**  Aapna (BME Communities) Organisation – engagement of service users including those with physical and learning disabilities to ensure they fully understood IMProVE and to support them in capturing their responses to the Q & A document
- **18 June**  **Guisborough formal public meeting**
- **1 July**  Redcar & Cleveland Overview & Scrutiny Committee
- **2 July**  Grangetown Library – Over 50’s club - Service User Event
- **2 July**  **Middlesbrough formal public meeting**
- **3 July**  Redcar Library – public engagement
- **4 July**  Lifestore Middlesbrough – James Cook Hospital public and staff engagement around IMProVE
- **7 July**  Positive about Stroke – Service User Event
- **8 July**  Central Library – public engagement
- **9 July**  **Redcar formal public meeting**
- **9 & 10 July**  Action for Blind People/Teesside Blind Society – Service User Events
- **11 July**  Ormesby Library – Service User Event
- **14 July**  Dormanstown Library – public engagement
- **15 July**  Roseberry Library – service user event
- **22 July**  James Cook Hospital – AGM public and staff engagement
- **23 July**  Guisborough Library – Service User Event

Two drop in events for local councillors were held in Middlesbrough on 3 June 2014 and in Redcar and Cleveland on 18 June.

A total of 176 people attended the **formal public meetings**.

**Awareness raising activity**

The consultation and response mechanisms were promoted through a range of mechanisms to give local people and organisations the opportunity to comment. This included the following:

- Widespread distribution of the full consultation document to local organisations and interested parties which included questions seeking views on the implementation of the proposals e.g. care homes, libraries, GP Practices, pharmacies, opticians and dental practices
• An event flyer distributed to community venues and businesses in Eston, Brotton, Guisborough and Middlesbrough
• Information about the consultation and an online survey on the NHS South Tees CCG website
• A full ‘rolling’ advert schedule in the Evening Gazette
• CCG promotion columns were used, using Dr Henry Waters’ Waters’ (Chairperson for South Tees CCG) regular update on health matters, in the Evening Gazette
• In-house mail-outs promoting events to stakeholders, NHS Trusts, Hospitals, Local Authorities and Key Advisory Groups
• Social media, Twitter and Facebook, promotion of the consultation
• Carers Together distributed 1,000 questionnaires to service users and carers
• Everyday Language Solutions distributed 500 questionnaires to BME communities
• A video was developed to support the materials and messages for the consultation with input from stakeholders
• Personal invitations issued to elected representatives, i.e. all councillors and MPs to attend the events.

Media
The consultation was extensively covered by the local media throughout the formal consultation period. Overall, media coverage was balanced and key messages about the consultation in the media were reinforced throughout this time.

Early interest in the local media about the future of the community hospitals meant that a wide audience was reached across the area at the beginning of the consultation (potentially over 80,000 people).

Tailored press releases were produced to publicise the public engagement events that were arranged in May, June, and July.

A total of 37 media items were published through the course of the consultation. All of the public events were well publicised in the local press and on the news section of the CCG website.

Mid-stage review - HealthWatch
Local HealthWatch representatives attended a mid-stage review meeting on 12 June 2014. They provided valuable mid-stage feedback on further engagement activities which would enhance the consultation process, and contributed suggestions for improving public facing ‘language’ to increase understanding which were adopted in further public facing communications.
Outcome of the public consultation

Overview
An independent research company, Explain Research, was asked to analyse responses to surveys that were completed as part of the consultation process. Observations and concerns drawn from comments made at from the events are summarised for additional context to the survey responses. A summary of responses from key stakeholders is also included in this section.

Survey results
Headlines from the survey responses are summarised in Table 1. The full survey report from Explain Research is at Appendix 4. A breakdown of the proportion of responses received through the different mechanisms is also given in Appendix 3. The total number of responses was 586.

Key findings from the survey
The majority of respondents agreed with the key proposals for better care for the vulnerable and elderly in South Tees.

Table 1 – Summary of survey responses

<table>
<thead>
<tr>
<th>Proposed centralisation of the stroke rehabilitation centre</th>
<th>568 responses</th>
<th>84% agreed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Most common reason for those agreeing was enhanced expertise/quality of care. Most common reason for those disagreeing was need for more than one location</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Provide community beds in two locations in order to invest in more community services for elderly and vulnerable people</th>
<th>522 responses</th>
<th>87% agreed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Most common reason for those agreeing was care should be provided closer to home. Most common reason for those disagreeing was that there should be more than two.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Provide a more comprehensive minor injury service at a single location (Redcar Primary Care Hospital) with enhanced medical and diagnostic cover</th>
<th>561 responses</th>
<th>68% agreed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Most common reason for those agreeing was reducing burden on other places. Most common reason for those disagreeing was problems with access/locality</td>
</tr>
<tr>
<td>Question</td>
<td>Responses</td>
<td>Conclusion</td>
</tr>
<tr>
<td>-----------------------------------------------------------</td>
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<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Spend more money on increasing community nursing and therapy services rather than on maintaining ageing buildings which are not able to support the delivery of the model of care</td>
<td>548 responses</td>
<td>89% agreed Most common reason for those agreeing was money should be spent on healthcare. Of those disagreeing, the most common theme was that buildings are important to delivering care.</td>
</tr>
<tr>
<td>How best to improve community services</td>
<td>385 responses</td>
<td>Range of responses but most common (13%) was more / longer home visits and home care.</td>
</tr>
<tr>
<td>Improve prevention and deliver more care in the community, closer to where people live</td>
<td>559 responses</td>
<td>96% agreed Most common reason for those agreeing was simply a general agreement. Most common reason for those disagreeing was that it would not make any difference.</td>
</tr>
<tr>
<td>General views</td>
<td>338 responses</td>
<td>Those more likely to need these services in the short term were more likely to agree with the proposals, i.e. older respondents, respondents who were carers and those who had a disability.</td>
</tr>
<tr>
<td>How people think our plans could have an impact on specific groups or individuals within our community?</td>
<td></td>
<td>Most respondents thought everyone would be affected the same regardless of their demographic profile.</td>
</tr>
</tbody>
</table>

Responses by question and themes identified are included in Appendix 4.

**Responses by question and themes identified**
The following information details the percentage responses to the questions in the survey and common themes arising from the comments from people who submitted responses.

**Do you think we should centralise stroke rehabilitation services in a single specialist unit in line with best practice? 568 responses**

Overall, 84% of respondents agreed that stroke rehabilitation services should be centralised in a single specialist unit. In general, a higher proportion of those who were likely to need these services in the short term agreed with the proposed centralisation of the stroke rehabilitation services, such as older respondents compared to younger respondents and carers compared to non-carers. A higher proportion of White respondents agreed with this proposal than non-White respondents.

Of those who agreed with the proposal, the most common reasons were:
• Enhance expertise/quality of care (104)
• General agreement (40)
• Convenience/accessibility (24)
• Comfort/familiarity (22)
• Best practice (19)
• Cost benefits (11)
• Saves travel (8)
• Saves time (7)

Of those who didn’t agree with the centralisation of the stroke rehabilitation services, the reasons given were:

• Need more than one location (42)
• Accessibility/travel (31)
• General disagreement (4)
• Quality of care (3)

Do you think we should provide community beds in two locations within the South Tees area in order to be able to invest in more community services for elderly and vulnerable people? 522 responses

Overall, 87% agreed with the proposal to provide community beds in two locations within the South Tees area in order to be able to invest in more community services for elderly and vulnerable people. Similar to opinions on stroke rehabilitation services, older respondents and carers were more likely to agree with this proposal. Also a higher proportion of respondents with a disability than without a disability agreed with this proposal (89% and 83% respectively).

Of those who agreed with the proposal for community beds in two locations within the South Tees area, the main reasons given were:

• Care would be provided closer to home (79)
• Two or more would be sufficient (44)
• Better care (36)
• Will relieve pressures on hospitals (36)
• Elderly/vulnerable people should be prioritised (14)
• Should be in particular area (15)
• Good idea (4)

Of those who disagreed with the proposal, the reasons given were:

• There should be more than two (16)
• Travel issues/more local services (15)
• Should be one centre of excellence (4)
• General disagreement (4)

Do you agree with our proposal to provide a more comprehensive minor injury service at a single location (Redcar Primary Care Hospital) with enhanced medical and diagnostic cover? 561 responses

Overall, 68% of respondents agreed with the proposal to provide a more comprehensive minor injury service at a single location (Redcar Primary Care Hospital) with enhanced medical and diagnostic cover. Again, the older the respondent, the more likely they were to agree with this proposal. A higher proportion of carers (76%) than non-carers (60%) agreed with the proposal and a higher proportion of respondents with a disability (70%) than without a disability (65%) agreed. White respondents were more likely to agree with the proposal (71%) than Asian/Asian British (67%) and other ethnic groups (55%).

Of those that stated they agreed with the proposal to provide a more comprehensive minor injury service at a single location, reasons for this opinion included:

• Reduces burden on other places (34)
• Better service/quality (32)
• Easier for transport (30)
• General agreement (28)
• Local services still needed (18)
• Easier access (17)
• Facility currently underused (14)
• Good to have one recognised place (10)
• Save money (4)

Of those who didn’t agree with this proposal, further comments provided included:

• Problems with access/locality (43)
• Travel/transport might be an issue (31)
• Need more than one location (28)
• Cost (8)
• Overcrowding (8)
• People will just go to A&E (7)

Do you agree with our proposal to spend more of our money on increasing community nursing and therapy services rather than on maintaining ageing buildings which are not able to support the delivery of our model of care? 548 responses
Overall, 89% of respondents agreed with the proposal to spend more money on increasing community nursing and therapy services rather than on maintaining ageing buildings which are not able to support the delivery of the model of care. Those aged 75 and over were most likely to agree with this proposal (93%), and those aged under 26 least likely (75%). A higher proportion of respondents who were carers (92%) and those with a disability (92%) agreed with the proposal compared to non-carers (86%) and those without a disability (86%).

Of those who agreed with the proposal to spend more money on community nursing, the main reasons were:

- Money should be spent on healthcare (125)
- Community/Home care should be utilised more/ best form of care (58)
- As long as services are maintained (23)
- Maintaining buildings would be inefficient (23)
- General agreement with the proposal (17)

Of those who didn’t agree with this proposal, the most common theme was that buildings are important to delivering care (12).

**How else do you think we could increase and improve community based services for people who are elderly, vulnerable or who have long-term conditions? This would include, for example, occupational therapy and physiotherapy services.** 385 responses

The most common responses were more/longer home visits/home care (13%), more local facilities (11%) and more occupational and physiotherapy (8%).

**Do you agree with our vision to improve prevention and deliver more care in the community, closer to where people live, i.e. More consultant out-patient clinics, diagnostics and treatments in the community?** 559 responses

Overall, 96% of respondents agreed with the vision to improve prevention and deliver more care in the community closer to where people live. There was very little difference between the demographic groups for this question, although again those aged over 75 and respondents who were carers were the most likely to agree with this proposal (99% and 98% respectively).

Respondents were then asked if they had any comments regarding this section of the proposal. Of those who said they agreed the main comments given fell into the following themes:

- General agreement (69)
- Less travel (33)
- Better to be more local (26)
• In favour of a move away from central location (22)
• Prevention is good (22)
• Makes it easier (18)
• Quicker access (16)
• Less stress (6)

Of the respondents who disagreed with the vision to improve prevention and deliver more care in the community closer to where people live, the most common themes in response were:

• It wouldn’t make any difference (7)
• It wouldn’t be any closer (4)

Respondents were asked about any concerns they had about the proposed changes and literal responses have been themed. Almost a third responded to this question by saying they didn’t have any concerns or that the change will be beneficial. Of those who did have concerns, they were mainly general worries about changes to services and also transport issues.

**We want to get your views on our proposed plans for change and understand any concerns you may have about these proposed changes to services, and how they would be implemented. 338 responses**

Finally, respondents were asked how the proposals could have an impact on specific groups or individuals within the community. The largest proportion of respondents thought everyone would be affected the same regardless of their demographic profile.

**Key themes from the events**

The sections below highlight key themes gathered from discussions at the councillor, public and community events, and as well non-survey comments by post, online and by email.

Where observations and concerns drawn from comments made at the events can be linked to survey questions, this is indicated.

More general comments are also indicated as key observations. It should be noted that many comments and questions were addressed and resolved directly at the events by CCG GP members, commissioners and representatives from partner organisations. Some were relevant to the scope of the consultation; others were outwith this.
Comments linked to survey questions

Do you think we should centralise stroke rehabilitation services in a single specialist unit in line with best practice?

There was general support; the main concern was transport to Redcar Primary Care Hospital for both patients and visitors, and ensuring a simple solution to ensure ambulance services are not overstretched. This was an issue for people in Middlesbrough, Brotton, Eston and Guisborough, due to poor public transport.

Other observations:

- Support for the change but some felt patients prefer to access their local community hospitals
- A minority questioned the Redcar location
- Some questioned single room provision
- Training for home nurses
- Equipment needed in patient’s own homes is a potential barrier to care

Do you think we should provide community beds in two locations within the South Tees area in order to be able to invest in more community services for elderly and vulnerable people?

There was mixed support and some concerns over overcrowding, waiting times and the number of hospital beds available.

Do you agree with our proposal to provide a more comprehensive minor injury service at a single location (Redcar Primary Care Hospital) with enhanced medical and diagnostic cover?

There was mixed support and some concerns people would not be able to access treatment due to lack of transport links.

Do you agree with our proposal to spend more of our money on increasing community nursing and therapy services rather than on maintaining ageing buildings which are not able to support the delivery of our model of care?

There was positive support for this proposal.

How else do you think we could increase and improve community based services for people who are elderly, vulnerable or who have long-term conditions? This would include, for example, occupational therapy and physiotherapy services.
Suggestions were increased night sitting, and robust care plans with a social services / district nursing interface.

**Do you agree with our vision to improve prevention and deliver more care in the community, closer to where people live, i.e. More consultant out-patient clinics, diagnostics and treatments in the community?**

There was positive support for the vision and questions about how community care will work in practice. These focussed on having robust care plans, trained professionals and effective recruitment and organisation of community staff.

**Key observations**

Respondents in attendance of both councillor and also community groups were the most positive about the plans to centralise services and focus on care in the community, but did have some questions and concerns as to how this may work in practice. Key recurring themes have been identified from all three groups, resulting in the following observations.

Travel was a serious consideration for all three groups, and many respondents felt that by moving away from local community hospitals, their ability to access these services would be more difficult. Respondents highlighted the lack of public transport in place to Redcar, especially for residents in Brotton, Eston and Guisborough in terms of the limited availability of routes but also timetables.

Although the vast majority of respondents were positive about the move to care for patients in a community setting or in their own homes, all respondent groups questioned how this may work in practice. Areas for improvement identified stemmed from the initial discharge from hospital to link up to community services and respondents felt that improved communication and a robust care plan from the outset were essential to ensure that this process runs smoothly. Once out of hospital, public respondents required reassurance that nurses would be specially trained to deal with stroke patients and there were concerns about carers in the home in terms of the level of care provided compared to that in hospital. Key interfaces for care were felt to comprise of social services and district nursing teams and respondents emphasised the importance of a lead nurse for each patient.

To alleviate these concerns, information about building a care plan, including links to community services and the provision of trained nurses may be beneficial with an emphasis on improved levels of communication. Information around the recruitment and organisation of community staff may also be useful, to alleviate concerns about there being adequate staffing to meet demand.
Other areas in which respondents required more information were the rapid response service and also night sitting. Many respondents were interested to find out more detailed information about the services and also the specific criteria to receive them and councillors in particular felt it would be beneficial to communicate how patients could be referred. Simple access to rapid care was felt to be important, especially during the night to prevent patients falling back on emergency services, but again respondents required more detail as to how this would work in practice. One area in which public respondents were interested to know more was the financial impact of sending healthcare professionals out to patients during the night as opposed to admitting them to stay in hospital, and reassurance that this was the most financially viable option would be preferred.

In addition to concerns about patient provisions under the new plans, both community and public respondents raised concerns about the plans for staff currently positioned at each community hospital. There were questions over redundancies or de-skilling staff in the move and some suggested that the stress placed on staff could work to demotivate which would then impact on patient care. Respondents in the community groups in particular confirmed that there was uncertainty amongst staff in Middlesbrough and that effective communication was key to keep them in the loop and ensure a strong sell to counteract the challenges of change. In this way, more information about staff restructuring and relocation in both internal and external forums could be beneficial to provide reassurance on this issue.

Summary
Support for the plans appeared largely positive with some mixed responses; however the key concerns requiring attention going forward were:

- Transport to Redcar Primary Care Hospital for both patients and visitors and ensuring a simple solution to ensure ambulance services are not overstretched
- How community care will work in practice, including robust care plans with trained professionals and the recruitment and organisation of community staff
- Service offering and eligibility for rapid response and night sitting services and whether they are financially viable
- Concerns over plans for staff stationed at community hospitals including more information about restructuring to tackle uncertainty

Examples of stakeholder responses
Below is a sample of the direct comments taken from a range of events.
Public perception

“Taking a leap of faith to make decisions; people don’t like change – similar situation with libraries in Redcar – once changes are made for the better people will see how things improve and will trust the decision.” IMProVE Councillors Drop in Event

“No use complaining - over 80 on scrapheap.” Teesside Blind Society engagement event

“Does anyone take any notice of these meetings?” Grangetown Library over 50s Club

“Don’t believe a word you’re saying.” Guisborough Methodist Church Brotton engagement event

“Nobody has been listening to what the NHS is saying but now they are; you are giving us confidence.” Middlesbrough, Acklam Green engagement event

“Read beneath the headlines – Stevens – fits with this debate, focus is on services and not buildings.” Freebrough Enterprise Centre, Brotton engagement event

Care at home

“Don’t want to be in hospital, would rather be at home.” Teesside Blind Society engagement event

“Not a good standard – Cousin (80s) looked after at home – Carers come in, don’t know how to shave patient. Don’t know how to – not had training! Can complain to social worker. Not the same person each day – important.” Redcar – Sacred Heart School engagement event

“Some people cannot get the care they need in hospital, community care is better.” Ormesby Library, Knitting Group/Mother and Toddlers

“Honestly there is no ideal, hospital beds are taken up by people who have no one to care for them at home.” Ormesby Library, Knitting Group/Mother and Toddlers

“Personal assistants need to be better paid. They need to have more interaction with patients.” Dormanstown Library, Redcar engagement event

“What is a community matron? My husband was referred and we’ve been waiting for one to come for months.” Dormanstown Library, Redcar engagement event

“We need to keep people out of hospital – to be able to do this we need to keep people in own homes with appropriate staff.” Guisborough Methodist Church Brotton engagement event
“Sometimes it takes weeks & months to get equipment in.” Positive About Stroke- Service User Group Engagement, Ormesby

Money

“Think when we get to 70 they will shoot us. They can’t afford us. It’s frightening and it all comes down to money.” Roseberry Library Redcar – Craft Group

“Agree with putting money into staff rather than buildings.” Redcar Library engagement event.

“I don’t think there is enough money to care for everyone at home 24/7.” Positive About Stroke- Service User Group Engagement, Ormesby

Communication

“Clearer ways to communicate - Know who to talk to when you need to complain. Same people each time. Organisations talk to each other, they need to communicate more effectively.” Redcar – Sacred Heart School engagement event

“People don’t know what services are available, it should be made clearer.” Freebrough Enterprise Centre, Brotton engagement event

Transport and location

“If you haven’t got a car Brotton and Redcar are almost impossible to get to.” Guisborough Library engagement event

“I want a hospital where I am.” Guisborough Library engagement event

Formal responses

Local HealthWatch organisations
Redcar and Cleveland HealthWatch consulted with their membership and the wider public and have confirmed support is given to the proposals for the development of community services in the area:

“We particularly support the proposals including development of services from East Cleveland and Redcar Primary Care Hospitals, the latter being perceived by members of the community as an underutilised but potentially valuable healthcare asset. Engagement with local people has emphasised the underuse of current services provided at Redcar Primary Care Hospital including audiology, endoscopy and x-ray, causing patients to travel further to
James Cook University Hospital (JCUH) to receive treatment. While accepting that ‘high tech’ investigations and treatment need to be carried out in centres of excellence such JCUH, many more basic investigations, treatments and follow up could be carried out at our two above named primary care hospitals to the benefit of our local population. This would also have the potential to reduce traffic congestion in the South Tees area with resultant health and economic benefits for the population as a whole.

“The further development of Redcar Primary Care Hospital as an urgent care centre is also an initiative which this HealthWatch would strongly support, providing that supporting services such as radiography are also made available and that the hours of service provision are extended to enable it to be recognised by the community as a viable alternative to JCUH for minor injuries. We do, however, have concerns about the proposal to close minor injuries services at East Cleveland Primary Care Hospital, predominantly due to the removal of the GP service/walk-in centre in Skelton. Although underutilised at present, this service has the potential to provide for a socially disadvantaged community, many of whom, for example single parent families and pensioners, are not car owners and must rely on indifferent public transport provision. This is likely to impede the access of such people to the minor injuries service at Redcar Primary Care Hospital (or A & E at JCUH). Should it be necessary to close the minor injuries service at East Cleveland Primary Care Hospital, could it not be provided from some other permanent site by an alternative agency within East Cleveland to enable it to be recognised as a minor injuries service by the local community?”

Dr Ian Holtby - Chair of HealthWatch Redcar and Cleveland

Response from MPs
MP for Middlesbrough Andy McDonald and MP for Redcar Ian Swales both expressed support for the proposals in the media. There was ongoing dialogue between these MPs and the CCG.

There were also responses outside of the analysis of the formal public that will be fully acknowledged and taken account by NHS South Tees CCG. A petition of 1,759 signatures submitted to NHS South Tees CCG by MP for Middlesbrough South and East Cleveland Tom Blenkinsopp. This urged the CCG not to close the minor injuries units at Guisborough and East Cleveland. No other commentary on the vision and options within the formal consultation was given through the petition.

Middlesbrough Council
Middlesbrough Council expressed concern about the closure of two facilities to be provisioned in one site could place additional pressure on social care residential care services as a consequence of demand exceeding supply. They asked for reassurance that there will not be a reduction in places being provided given rising demand. The council
committed to working with NHS South Tees CCG to ensure that community stroke provision provides sufficient level of support and care and acts as an alternative to stroke within residential care.

The council

- did support early intervention and community based services as these provide improved outcomes for those who use them, are more cost effective; they consider this is what local people say that they want
- were also supportive of an effective service which release funding for other services
- agreed with the proposal to spend more of money on increasing community nursing and therapy services rather than on maintaining ageing buildings which are not able to support the delivery of the existing model of care.

Middlesbrough Council said they wished to support the NHS South Tees CCG’s ambition through improved low level support for long-term conditions to improve compliance with medication and to reduce unplanned admissions.

“We are keen to develop community hubs as a way to co-develop and deliver such services, commissioning VCS organisations to deliver such a service based on the Wigan community model.”

They also agreed with the vision to improve prevention and deliver more care in the community, closer to where people live.

The council confirmed they do not consider that any specific groups would be disadvantaged by reconfiguring services away from inpatient and acute services to community based services.

(Richenda Broad, Executive Director of Well-Being, Care and Learning, Middlesbrough Council)

Durham, Darlington and Tees NHS England Area team

The Area Team is supportive of the aims of IMProVE and welcomed the plans to deliver more integrated care, closer to the homes of some of the most vulnerable people in local communities. They are keen to see these plans brought to fruition with minimal impact on the two primary care services impacted by the proposed changes, as outlined below. They were, however, partially supportive on some aspects relating to clinical sustainability and workforce, dependent upon further work and assurance on plans. Their response and a summary of key points is included in Appendix 6.

South Tees Hospital NHS Foundation Trust

“The trust is pleased to be a partner with you (NHS South Tees CCG) in work that we consider to be of value to the population of South Tees enhancing the quality of care
patients receive and developing a more integrated approach to health and social care that we believe will improve the experience for patients and their carers.

“We share your vision for healthcare in the South Tees area and will be happy to work with you to implement the proposed changes.

“After considering the options being presented there is one area where we believe additional consideration should be given. This relates to the proposed centralisation of stroke beds. While we accept the clinical arguments in favour of centralising this facility we believe that there may be an alternative to the proposed location at Redcar Primary Care Hospital.

“You are aware of the Gateway development in Middlesbrough run by the Keiro Group. We have been in discussion with this service and believe the facilities they offer to be of a high physical standard with the potential to scope staffing and support services to the specification required by you as commissioners. We are still evaluating the financial impact of this approach but early indications suggest this would be an economically viable approach based on current tariff and other payment structures and would suggest this is given due consideration in your review of the consultation findings. Our clinical staff have indicated that they would also find this an acceptable approach.

“We will continue to work with you over the next few months to ensure that all of the agreed changes are delivered in a way that supports patient care but is also responsive to the needs of our staff who will also be affected by this strategic approach.”

Professor Trisha Hart, Chief Executive, South Tees NHS Foundation Trust

Overview and scrutiny committees

South Tees Joint Health Scrutiny Committee
Local health overview and scrutiny committees have been continually consulted throughout the development of ideas, pre-engagement and formal consultation process. On 22 July 2014, a formal joint meeting of the South Tees Joint Health Scrutiny Committee was held to discuss the options in the consultation. A presentation was given, followed by discussion of the issues.

In general the committee were supportive of the process that had been undertaken by the CCG. Members had the opportunity to input in to the questionnaire and suggest people/organisations the CCG should include in their consultation.

Members did have some concerns regarding transport, including the current difficulties concerning local transport services with particular regard to Redcar and East Cleveland and also getting from Middlesbrough to Redcar using public transport.
The committee wanted to receive the results of the public consultation exercise before making any comment on the proposals themselves.

The committee had highlighted that in terms of meeting future demands and determining what services needed to be in place that references should be made to the influences of the Joint Strategic Needs Assessment and recognition that there are some differing needs between Redcar and Cleveland and Middlesbrough.

The committee welcomed the proposed community development and re-investment which would take place between April 2014 and March 2016 which included the recruitment of additional staff and ongoing appropriate training of current staff.

The committee welcomed the opportunity to be involved in any future stages which would involve regular updates to Members any implementation of the phased approach.

Redcar and Cleveland People Services Scrutiny and Improvement Committee
NHS South Tees Clinical Commissioning Group (CCG) presented to the Committee on 1 July 2014.

Member’s comments included:

- need to identify people who were at risk and put the support in place required.
- a shift to care being community and home based needed the correct resources.
- patients were on long waiting lists for assessments; these plans could expedite assessments and impact positively on quality of life.
- the importance of having a named GP. Members were advised that patients over the age of 75 would have a named GP.
- important that the changes were driven by clinicians and there should be more accountability through the democratic process.
- although there was a small number of people using the East Cleveland and Guisborough minor injuries service, these areas had a smaller number of residents.
- sometimes ill health was due to social reasons and elderly people not going out of their homes. Members were advised that there was an Ageing well group in Redcar and this had been discussed with them.

Neighbouring Clinical Commissioning Groups

Hambleton, Richmondshire and Whitby CCG
A response was received from Dr Charles Parker, GP, of Hambleton Richmondshire and Whitby (HRW) CCG. He expressed their concerns that the vision will affect the care of patients within their CCG area.
They asked NHS South Tees CCG to consider this smaller group of patients in their pathway development and ensure that their care moves closer to home as speedily as possible. NHS South Tees CCG provided assurance that the pathway for these patients would remain as commissioned, without patients being diverted to services further away from their homes.
Summary

The surveys

Conclusions from the survey
The majority of respondents agreed with the key proposals for better care for the vulnerable and elderly in South Tees. Those who were more likely to need services for the vulnerable and elderly in the short term were more likely to agree with the proposals, i.e. older respondents, respondents who were carers and those who had a disability.

- 84% agreed with the proposed centralisation of stroke rehabilitation services, and the majority of those who agreed did so because they thought it would enhance the expertise and quality of care. Those who didn’t agree with centralising stroke rehabilitation services thought more than one location was needed and travel and accessibility would be an issue.

- 87% thought the CCG should provide community beds in two locations within the South Tees area in order to be able to invest in more community services for elderly and vulnerable people. Care being provided closer to home was the main reason for this response. A minority, however, did think this service should be provided in more than two locations.

- 68% agreed with the proposal to provide a more comprehensive minor injury service at a single location (Redcar Primary Care Hospital) with enhanced medical and diagnostic cover. Of those who agreed with this proposal, the reasons for this included reducing the burden on other places, better service/quality and that it would be easier for transport. Respondents who disagreed did so because of problems with accessibility and transport or that they thought more than one location is needed.

- 89% agreed with the proposal to spend more money on increasing community nursing and therapy services rather than on maintaining ageing buildings which are not able to support the delivery of the model of care. Those who agreed with this proposal did so because they thought money should be spent on health care. A minority did think that maintaining buildings is important in delivering care.

- Home care/home visits and more local facilities were suggested ways of improving community based services for people who are elderly, vulnerable or who have long-term conditions.

- 96% agreed with the vision to improve prevention and deliver more care in the community, closer to where people live. Respondents thought being local with less travel needed was a positive thing, however concerns about the proposal centred around travel issues as well as general concerns about change.
Final commentary from the independent analysis on the survey results

The independent analysis shows that, out of the five changes proposed in the consultation, four achieved majority agreement of over 80% and clear, very strong public support for the following changes to go ahead:

- 84% agreed with the proposed centralisation of the stroke rehabilitation centre
- 87% thought the CCG should provide community beds in two locations within the South Tees area in order to be able to invest in more community services for elderly and vulnerable people
- 89% agreed with the proposal to spend more money on increasing community nursing and therapy services rather than on maintaining ageing buildings which are not able to support the delivery of the model of care
- 96% agreed with the vision to improve prevention and deliver more care in the community, closer to where people live

The area with the lowest level of agreement was the provision of a minor injury service at a single location and although this proposal also achieved majority support (68%), nearly a third of respondents disagreed. The key concern of those who disagreed was ease of access in terms of distance from the respondents’ home and ability to travel, which will be important to address.

In addition, although agreement was high across all other areas of the proposals, transport and accessibility was a recurring theme and something to consider.

Finally the concept of ‘Care Closer to Home’ was clearly very well supported and something to continue to consider to improve care for the vulnerable and elderly across the board.

Final conclusions

The process of pre-engagement and formal consultation was comprehensive and provided numerous opportunities for members of the public to find out more about the proposals and to make their views known. It is clear that there has been considerable local discussion about these proposals.

As the local commissioner of health services leading this consultation, NHS South Tees CCG has welcomed the opportunity to discuss these proposals with local people and organisations across South Tees in order to gather as wide a range of views as possible. NHS South Tees CCG has followed best practice in aiming to ensure that the consultation process has been transparent and open in presenting the clinical evidence and views which support the IMProVE programme proposals.
Appendices

- Appendix 1: IMProVE Consultation plan
- Appendix 2: Consultation Document
- Appendix 3 Response Statistics
- Appendix 4. IMProVE public consultation survey analysis – Explain Market Research
- Appendix 5. Carers Together Vulnerable Groups Survey
- Appendix 6. Response from Durham, Darlington and Tees NHS England Area Team
## Appendix 1: Consultation Plan
### IMProVE Consultation Implementation Plan 2014

<table>
<thead>
<tr>
<th>Task</th>
<th>Details</th>
<th>Responsible</th>
<th>Timescale</th>
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</thead>
<tbody>
<tr>
<td><strong>Planning and preparation</strong></td>
<td></td>
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<tr>
<td>Stakeholder contacts</td>
<td>Update/agree stakeholder contact list to include N Yorks community/voluntary groups and GPs</td>
<td>NECS/CCG</td>
<td>Dec/Jan 2013/2014</td>
</tr>
<tr>
<td></td>
<td>Agree selected stakeholders to participate in January event</td>
<td>NECS/CCG</td>
<td>Dec/Jan 2013/2014</td>
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<tr>
<td>Option discussion with GPs</td>
<td>Informal operation group</td>
<td>CCG</td>
<td>11 Dec 2013</td>
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<tr>
<td>Liaise with Area Team</td>
<td></td>
<td>NECS/CCG</td>
<td>On-going</td>
</tr>
<tr>
<td>Other meetings</td>
<td>Identify targeted meetings/voluntary and third sector groups to approach for input and plan attendance</td>
<td>NECS</td>
<td>Dec 2013</td>
</tr>
<tr>
<td>Prepare presentation and briefing</td>
<td>To include feedback from engagement activity and outline communications plan. Also options?</td>
<td>NECS/CCG</td>
<td>Dec/Jan 2013/2014</td>
</tr>
<tr>
<td>HealthWatch</td>
<td>Meeting held with Healthwatch re input/support available. Discussions on-going</td>
<td>NECS</td>
<td>27 Jan 2014</td>
</tr>
<tr>
<td>Task</td>
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<td>Responsible</td>
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<td><strong>GP events</strong></td>
<td>Clinical Council of Members (CCOM) Meetings</td>
<td>CCOM/CCG</td>
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<td>Eston Locality Council</td>
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<td>Middlesbrough Locality Council</td>
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<td>13th February</td>
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<td>Langbaurgh Locality Council</td>
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<td>20th February</td>
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<td></td>
<td>Member GP Practice visits</td>
<td>CCG/NECS</td>
<td>31 Mar 2014</td>
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<td></td>
<td>Meet with practices by request to update on IMProVE:</td>
<td></td>
<td>9 Apr 2014</td>
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<tr>
<td></td>
<td>Brotton &amp; Woodside</td>
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<td>15 Apr 2014</td>
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<td></td>
<td>Cambridge Medical</td>
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<td>Hemlington, Park End &amp; Skelton</td>
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<td>Garth &amp; Springwood</td>
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<td>Meetings at James Cook University Hospital</td>
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<td>Consult on Option</td>
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<td>27 Feb 2014</td>
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<td>31 Mar 2014</td>
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<td><strong>Stakeholder event</strong></td>
<td>Presentation of engagement report findings and further</td>
<td>NECS/CCG</td>
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<td>Task</td>
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<td>South Tees Joint Overview and Scrutiny Meetings</td>
<td>feedback sought on criteria and feedback</td>
<td>NECS/CCG</td>
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<td>CCG Governing Body Extraordinary Meeting</td>
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<td>Middlesbrough Health and Wellbeing Board</td>
<td>Presentation of engagement report and next steps discussion.</td>
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<td>Update on IMProVE Option &amp; Consultation</td>
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<td>Redcar and Cleveland Health and Wellbeing Board</td>
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<td>Update on IMProVE Options and Consultation</td>
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<td>Ian Swales (Redcar)</td>
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<td>Andy McDonald (M’bro)</td>
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<td>Communicate with provider staff</td>
<td>Plan to be developed</td>
<td>South Tees NHS FT</td>
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<td>Draft engagement document</td>
<td>Agree questions/options</td>
<td>NECS</td>
<td>14 Feb</td>
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<td>Draft fact sheets</td>
<td>For use throughout consultation</td>
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<td>Book public events</td>
<td>Eston</td>
<td>NECS</td>
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<td></td>
<td>Brotton</td>
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<td>Guisborough</td>
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<td>Redcar</td>
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<tr>
<td></td>
<td>- Set dates</td>
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<td>- Book venues</td>
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<td>- Confirm format of events</td>
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<td>- Confirm dates for attending representatives</td>
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<td>- Plan advertising</td>
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<td>- Prepare poster/flyer and distribute to households and other outlet</td>
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<td>- Plan advertising</td>
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<td>- Prepare presentation</td>
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<td>- Prepare facilitators’ recording materials</td>
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<td>- Draft and issue press release with contact details</td>
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<td>Consultation video</td>
<td>Video prepared for use on CCG website and at events</td>
<td>STFT/NECS</td>
<td>Apr 2014</td>
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<tr>
<td>Media training</td>
<td>Organise media training for identified leads</td>
<td>NECS</td>
<td>Apr 2014</td>
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<tr>
<td>Website</td>
<td>Information for CCG website drafted and agreed</td>
<td>NECS</td>
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<td>Task</td>
<td>Details</td>
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<td>Media</td>
<td>Draft media release/s Prepare Q&amp;As for reactive work Prepare key message for CCG leads/spokespeople</td>
<td>NECS</td>
<td>By end April</td>
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<td>Patient Reference Group (PRG) toolkit</td>
<td>Prepare discussion material for distribution to PRGs</td>
<td>NECS</td>
<td>By end February</td>
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<tr>
<td>Social media</td>
<td>Establish Facebook and Twitter channels</td>
<td>NECS</td>
<td>Mar/Apr 2014</td>
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<td>Community/voluntary sector engagement/liaison</td>
<td>Work with 3rd sector to establish series of meetings/presentations and take advice on further actions necessary to ensure adequate involvement. Particularly in relation to BME community</td>
<td>NECS</td>
<td>Mar/Apr</td>
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<tr>
<td>Carers Together</td>
<td>Engage agency to facilitate completion of formal consultation questionnaires</td>
<td>NECS</td>
<td>Mar/Apr 2014</td>
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<tr>
<td>Everyday Language Solutions</td>
<td>Engage to facilitate completion of formal consultation questionnaires</td>
<td>NECS</td>
<td>Apr 2014</td>
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<td>Community Service User Groups</td>
<td>Identify service users groups to host engagement with and facilitate completion of formal consultation questionnaire</td>
<td>NECS</td>
<td>Mar 2014</td>
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<td>Councillor events for elected representatives:</td>
<td>OSC chair offered to stage event.</td>
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<td>Task</td>
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<tr>
<td>* Middlesbrough Council  * Redcar and Cleveland Council</td>
<td>Discussion/planning/promotion</td>
<td></td>
<td>3/6/14 18/6/14</td>
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<tr>
<td>FOI/PALS</td>
<td>Advise staff of engagement activity</td>
<td>NECS</td>
<td>By end April</td>
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<tr>
<td>Evidence log</td>
<td>Prepare log and agree recording protocol</td>
<td>FT/CCG/NECS</td>
<td>On-going</td>
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<tr>
<td>Reporting process</td>
<td>Agree reporting process and commission external support where required</td>
<td>FT/CCG NECS</td>
<td>On-going</td>
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<tr>
<td><strong>Implementation</strong>  w/c 28 April 2014 – w/e 31 July 2014  (Including 6 week break for European elections)**</td>
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<tr>
<td>Briefing to GP practices in S Tees and North Yorks</td>
<td>Information on consultation, plus electronic resources</td>
<td>NECS</td>
<td>w/c 28 Apr 2014</td>
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<tr>
<td>Website content inc Social Media</td>
<td>Live on CCG site with links to/from FT/Partners</td>
<td>NECS</td>
<td>w/c 28 Apr 2014</td>
</tr>
<tr>
<td>Disseminate public facing document</td>
<td>Prepare letters and mail/email with appropriate documents to: Stakeholder list My NHS Patient reference groups Practice managers across South Tees and North Yorks FT membership TEWV membership Healthwatch PALS</td>
<td>NECS</td>
<td>w/c 28 Apr 2014</td>
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<td>Task</td>
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<td>GP practices MPs LMC</td>
<td>NECS</td>
<td>w/c 28 Apr 2014</td>
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<td>Local Shops Households in key areas</td>
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<td>Media relations</td>
<td>Brief editors Issue via usual channels in support of consultation and</td>
<td>NECS</td>
<td>w/c 28 Apr 2014</td>
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<td>public events On-going media handling</td>
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<tr>
<td>PRG toolkit</td>
<td>Disseminate to PRGs</td>
<td>NECS</td>
<td>w/c 28 Apr 2014</td>
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<td>Communications with staff</td>
<td>FT plan implemented NHS S Tees practice bulletin also see GP locality</td>
<td>FT/CCG/ NECS</td>
<td>10 April 2014</td>
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<td>and member practices</td>
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<tr>
<td>Event Briefings</td>
<td>Issue event briefs to all staff hosting at public/councillor events</td>
<td>NECS</td>
<td>w/c 26 May 2014</td>
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<td>Public Drop-in events</td>
<td>Organise and manage consultation meetings Record attendance/ discussions</td>
<td>NECS</td>
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<td>Arrange interpreting services if necessary</td>
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<td>Wed 11 Jun 2014</td>
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<td>Information dissemination</td>
<td>Checks on distribution/display of consultation information at key venues</td>
<td>NECS</td>
<td>From w/c 28 April 2014</td>
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<td>including libraries and</td>
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<td>Community and voluntary sector liaison/engagement</td>
<td>Manage and record outcomes from targeted engagement events/voluntary and third sector groups:</td>
<td>NECS</td>
<td>May-Jul 2014</td>
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<td>Public/service user engagement events:</td>
<td>Host discussions, engage and facilitate completion of consultation questionnaires</td>
<td>NECS/CCG</td>
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<td>PE – Public Engagement</td>
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<td>SUE – Service User engagement</td>
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<td>Collate requests for alternative format materials and distribute</td>
<td>Requests and distribution completed</td>
<td>NECS</td>
<td>3 July 2014</td>
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<td>Council event with elected representatives/staff/providers</td>
<td>Event management /attendance and collection of responses</td>
<td>NECS/CCG/CA</td>
<td>3 Jun 2014</td>
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<td>On-going liaison with OSC, Healthwatch, LMC, GP locality groups</td>
<td>Healthwatch</td>
<td>CCG/NECS</td>
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<td>Joint OSC Committee</td>
<td>CCG/NECS</td>
<td>22 Jul 2014</td>
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<td>Clinical Council of Members</td>
<td>CCG/NECS</td>
<td>3 Jul 2014</td>
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<td>MP – Tom Blenkinsop</td>
<td>CCG</td>
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<td>Meeting with HRW CCG</td>
<td>Discussion of plans</td>
<td>CCG</td>
<td>8 Jul 2014</td>
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<tr>
<td><strong>Post – engagement</strong></td>
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<td>Collation of consultation feedback and Q&amp;A responses</td>
<td>Manage ongoing handling of postal and online responses</td>
<td>NECS</td>
<td>End July - mid Aug 2014</td>
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<td>Log, collect and collate responses from events, meetings (meeting summaries and notes).</td>
<td>NECS</td>
<td>End July – mid Aug 2014</td>
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<td>Summarise and provide analysis of responses received</td>
<td>NECS</td>
<td>Aug 2014</td>
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<td>Reporting</td>
<td>Prepare consultation report</td>
<td>NECS</td>
<td>w/e 15 Aug 2014</td>
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<td>CCG Executive Meeting</td>
<td>Guidance to Governing body on decision making process and format of report</td>
<td>NECS/CCG</td>
<td>13 Aug 2014</td>
</tr>
<tr>
<td>Final Consultation Report Information Circulation</td>
<td>Report completed and issued to CCG Governing Body members</td>
<td>CCG</td>
<td>27 Aug 2014</td>
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<td>Present timetable summary and decision making process</td>
<td>NECS/CCG</td>
<td>Papers 1/9/14 Mtg 3/9/14</td>
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<td>Present timetable summary and decision making process</td>
<td>NECS/CCG</td>
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<td>NECS/CCG</td>
<td>10 Sep 2014</td>
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<td>TBC 10/11 Sep 2014</td>
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<tr>
<td>Social Media</td>
<td>Publish links to consultation report via social media streams</td>
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<td>TBC 10/11 Sep 2014</td>
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<td>IMPROVE Reference Group Meeting</td>
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<td>CCG Locality Groups</td>
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<td>Joint OSC Committee Meeting</td>
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<td>CCG/Chief Officers</td>
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<td>CCG Executive Meeting</td>
<td>Receive all comments/issues, make recommendations for final decision</td>
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<td>Booked in pending CCG approval</td>
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<td>1 Oct 2014</td>
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<tr>
<td>CCG Governing Body Extra-ordinary Meeting</td>
<td>Present final decision on IMProVE</td>
<td>CCG</td>
<td>15 Oct 2014</td>
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Integrated Management and Proactive Care for the Vulnerable and Elderly (IMProVE)

Better care for the vulnerable and elderly in South Tees:

A public consultation on proposed changes to community services
Who are we?

We are NHS South Tees Clinical Commissioning Group (CCG) which is the NHS organisation responsible for the planning, choosing and buying (commissioning) of the majority of healthcare services for people in South Tees such as those from hospitals and community services. We are made up of 49 member GP practices serving a population of around 280,000 people. The CCG is working in partnership with Middlesbrough and Redcar and Cleveland local authorities, South Tees Hospitals NHS Foundation Trust and with Tees, Esk and Wear Valleys NHS Foundation Trust along with the voluntary sector to improve services for the vulnerable, elderly and those with long-term conditions in our area.

The IMPROVE programme is one of a number of planned areas of work which will lead to improvements in local services for the whole population. The changes we make through this programme will also help us to invest in services which will benefit not only the elderly and vulnerable but the whole of the South Tees population by reducing reliance on hospital based services.
Introduction

Thank you for taking the time to read this booklet.

If you live in South Tees, and if you, a member of your family or someone you care for is elderly or vulnerable, it is important that you read this booklet.

The number of people who are elderly, vulnerable and living with a long-term condition in South Tees is increasing. Over the next seven years the number of people aged over 65 will increase by 20%.

It is good news that people are living longer. However older people experience more ill health than other groups. This represents a challenge for our CCG but also an opportunity to improve the way we care for our elderly population.

Many people who are frail, elderly or have long-term conditions have told us that they would prefer a community or home-based service. Improving the range and type of healthcare available close to home can help people to live independently for longer.

While we have already helped to make significant improvements to community services, we recognise that much more needs to be done to ensure all patients have access to the best possible services in the most appropriate setting.

Our vision is that more people who can be treated in the community will be and those who do require a hospital stay for medical reasons will be given the additional support they need to regain independence.

We know we must do more, but to do more we need to change the way that we provide services.

We need to see a significant improvement in the range and extent of services available in the community. This includes services like physiotherapy, occupational therapy and community nursing, along with providing more treatments in patients’ own homes. We want to deliver more outpatient appointments at local community venues.

We also need to improve rehabilitation services for people who have a stroke, so we can bring services in line with national best practice. We believe people in South Tees must have the same high quality services as those in other parts of the country.

In addition, we have to improve the way health and local authority social services work together to ensure that support is delivered in a timely and coordinated way.

We know that the services currently being provided for vulnerable and elderly patients could be much better and more focused on their actual needs. At present there are too many older and vulnerable people spending too much time in hospital when they don’t need to.
Local clinicians and professionals are telling us that more joined up services will improve the care we can deliver. This will support a move towards our new model of care ensuring our patients are given the right care, in the right place and at the right time to meet their needs.

Delivering more services in peoples’ own homes and in the community will reduce the need for community hospital beds. Because of this, we are proposing to make some changes and improvements at local community hospitals, including changes to the services that are delivered there.

South Tees Clinical Commissioning Group is committed to achieving the best possible care for all people across the South of Tees area. Our challenges are clear; an ageing population, variation in access to services and ageing community estate with high maintenance costs. In response to this we need to make changes to deliver the best outcomes for our people now and into the future.

The views of local people are important to us. This public consultation is therefore designed to listen to your views on our proposal; no decision will be made until the end of the consultation. This document summarises the proposed changes to services for patients who are vulnerable, elderly and have long-term conditions. It will also inform you about the many ways in which you can have your say.

We look forward to hearing your views on our proposed changes.

Dr Henry Waters Amanda Hume
Chair Chief Officer
What is this document about?

NHS South Tees CCG has a duty to commission (buy) high quality, safe and sustainable health services for its local population.

When we want to make any changes to services we must seek the views of local people, patients, carers and representative organisations before taking action.

This document is designed to give you more information about the changes we would like to make to local services for the elderly, vulnerable and those with long-term conditions. It also looks at the future of a range of services delivered within community settings including out-patients, in-patients and minor injuries.

We want to encourage as many people as possible to give their views on these proposed changes. This document contains a questionnaire, along with more information about the changes we would like to make and how you can have your say.

This public consultation will close on Thursday 31 July 2014.

Our vision for healthcare in South Tees

We want to improve health services for local people who are elderly, vulnerable or living with a long-term condition (such as respiratory disease and stroke).

To make local services better we need to do a number of things, including:

- Improving stroke rehabilitation services
- Improving community support for elderly and vulnerable people
- Setting up a single point of contact for all community health and social care needs
- Making sure that minor injury services (such as sprains, strains and minor cuts and wounds) in our area are safe, sustainable and meet the needs of local people.
We want to use money wisely to gain the greatest benefits for people in our area.

We believe we can do this best by:

- Investing more in care rather than buildings. Meaning that;
  - We spend more of our money on increasing skilled teams that can deliver community based services from a range of settings, including patients own homes.
  - We reduce the need to spend money on maintaining old buildings which are not able to support the delivery of our model of care.

- Making the best possible use of our community buildings to deliver a model of care that is fit for now and the future

We want to make some big changes, but in a safe and carefully managed way over time.

Based on what people have told us, we will make these changes by:

- Putting new services in place and testing them before moving existing services.

- Making step by step decisions about the changes we are making and the impact that they have on patients and their health before continuing to the next step.

- Introducing these changes over the next two years with all services in place by April 2016.

Why is change needed?

At present, elderly and vulnerable people in our area go into hospital more often than in other parts of the country. People spend longer there than they need to because we don’t currently have enough support available in the community.

Many people who are frail, elderly or have long-term conditions have told us that they would prefer a community or home-based service. Improving the range and type of healthcare available close to home can help people to live independently for longer.

We need to develop health services which allow people to be cared for in a way that meets their needs and is closer to home.
This view is supported by NHS England’s National Medical Director, Sir Bruce Keogh, who has called for system wide changes so that care can be delivered in or as close to people’s homes as possible.

Stroke services provided by South Tees Hospitals NHS Foundation Trust are highly rated nationally, but the stroke rehabilitation element of the service needs to be improved in line with best practice. According to NICE (National Institute for Clinical Excellence) guidance, stroke patients recover much better if they have rehabilitation in their own homes delivered by community based stroke teams. Currently we do not have community stroke teams. For people who need rehabilitation in hospital, they should receive this in a specialist stroke unit. This does not happen in South Tees at the moment, as stroke rehabilitation is delivered across three separate hospital sites.

The NHS and local authorities need to work more closely together to offer more responsive and personal services for the increasing number of older people who are living longer with health conditions.

At the moment, people receive different levels of care depending on where they live and we need to address this.

There are a number of ways people can access urgent care services in the South Tees area, which can be confusing. Many people use urgent care services when they could have been seen and treated by their local GP practice. We need to develop a more consistent approach to urgent care across our area.

Not all of our four community hospitals were designed to provide the modern flexible health services local people now require. Two of our hospitals would need a large amount of money invested to bring them up to standard. If we continue to pay for the high running and maintenance costs of these ageing buildings, we cannot invest in improving services for people in their own homes or local communities.

The issues we face are as follows:

- Too many elderly and vulnerable residents are admitted to hospital when they could be supported in their own homes.
- There is too much variation in local health and social care services.
- We need to improve the way health and local authority social services work together.
- Our local minor injury services must be safe and sustainable
- Local people should have the same high quality care as those in other parts of the UK.
- We need to gain most value from the money we spend.
What you told us

In late 2013 we asked local people, carers, patients and others about local health and social care services and what they would like to see in the future. Over 400 people responded. Most people felt that the care they received was good, but there were many suggestions about how services could be improved:

- ‘Joined up working between doctors, nurses and social services.’
- ‘Better communication between staff about what is being done and what needs to be done.’
- ‘Easier access to a GP.’
- ‘More time for carers to do their job.’
- ‘More community nurses.’
- ‘More support for elderly at home.’
- ‘I would have benefitted from more physiotherapy, occupational therapy, community nursing support.’

We also asked people where they felt care should be delivered:

- ‘You would recover better in your own home.’
- ‘Everyone has different needs. The main thing should be continuity of care with someone that can be contacted when a problem arises whether in hospital or at home.’
- ‘Preferable [if] people are able to live at home, with help available from as many sources as needed.’
- ‘It’s good when GPs can visit us/me at home but sometimes going into hospital/surgery is important.’
- ‘At home if possible with sufficient caring support and time …’
- ‘If they have to go to hospital it should always be the local hospital.’
- ‘I wish to stay in my own bungalow if possible for the remainder of my life.’
What have we done so far?

Across the South Tees area we are already working to improve care for people who are elderly, vulnerable or living with long term conditions. Here are just some of the ways we are providing care in patients’ homes or their local communities:

Last year we set up an integrated community care team who work alongside GPs to identify and support people at risk of a future admission to hospital. Patients using the service have their needs assessed and then get help to better manage their own health.

We have started work on improving the health of people with respiratory problems. Last year GPs began regularly screening people who might be at risk of having chronic obstructive pulmonary disease (COPD). They can then be offered information, further tests and appropriate treatment to reduce their risk and/or any complications arising from the disease.

To help prevent people being admitted to hospital unnecessarily we have set up a Rapid Response Team. This team of nurses and therapists provide extra support and monitoring for people during a short illness so that they can remain at home.

We are also looking at a range of actions to reduce pressure on GP practices and improve the way patients get primary care support, e.g., making more appointments available and offering telephone consultations.

Redcar Primary Care Hospital now offers local people minor surgery, such as skin grafts, and the service is already proving popular with patients with skin complaints who have been among the first to use the new service.

Case Study 1

Redcar resident, Doug Boyes has seen for himself the benefit of the Integrated Community Care Team. Doug, 53, has chronic obstructive pulmonary disease (COPD) and other long-term health conditions. Regular emergency admissions to his local hospital to stabilise his illnesses were a common theme, a “vicious circle” as Doug described it.

Playing a crucial role in helping Doug to take control of his own health and avoid going into hospital is Redcar locality community matron, Rachel Sedgwick. Rachel says that Doug has embraced support from the team and is now much more aware of how he can take responsibility for his own wellbeing through self-care. For example, Doug has a pulse oximeter which he uses to check his oxygen saturation level when he feels unwell. If necessary, he can then use his prescribed medication.

According to Doug, Rachel has made a “massive difference” to the quality of his life. He recently started drawing and is looking forward to spending more time outdoors to benefit from the local sea air, and at the cinema.
Case Study 2

Doug’s feelings are echoed by Sadie Lennon, of Ormesby. The 72 year-old, like Doug, has COPD but she also has heart trouble. Following a recent serious episode when Sadie had been in hospital, her case was brought to the attention of the Integrated Community Care Team.

Sadie said: “At the start they were coming to see me four times a day then, as I got better, it was three times a week and now it’s only once a fortnight. They really have been absolutely brilliant. There’s no way I’d have managed on my own and I’m sure that the care they’ve given me has helped keep me out of hospital and in my own home.”

Our vision and proposals in more detail

Overall, our aim is to deliver a range of different services that work together to provide better quality patient care.

This means moving away from a situation where care is mainly unplanned and provided in acute hospitals following an unpredicted health crisis, towards a more proactive approach, where patients’ needs are anticipated and support given closer to home. Bringing health and social care together to deliver services 24 hours a day, seven days a week will be crucial to us changing the way local people are cared for. By doing this we believe we can improve the long term health of local people as well as the quality of care they receive. To deliver our vision for better care, we need to make some changes to the way that services are delivered. These are outlined below:

Improved stroke services

In 2013, 426 people from the South Tees area were treated for stroke at The James Cook University Hospital. Of these, 39 were hospitalised more than once for their condition. The number of people experiencing a stroke in our locality is projected to grow by around 12% by 2020.

The facilities provided by South Tees Hospitals NHS Foundation Trust are highly rated nationally, but there are areas that need to be improved in line with best practice. The Royal College of Physicians National Clinical Guidelines and NICE (National Institute for Clinical Excellence) stroke rehabilitation guidelines recommend:
• An inpatient stroke unit capable of delivering stroke rehabilitation for all people admitted to hospital following a stroke

• Supported discharge to deliver stroke specialist rehabilitation at home or in a care home in liaison with hospital services

• Rehabilitation services capable of meeting the specific health, social and vocational needs of people of all ages

Currently in our area, patients suffering from stroke go to a dedicated stroke unit at The James Cook University Hospital. However, following the initial critical stage of care, patients needing rehabilitation either remain in The James Cook University Hospital or are transferred to one of two community hospitals - Carter Bequest Hospital in Middlesbrough or Guisborough Primary Care Hospital. Delivering stroke services across a number of sites makes it difficult to maintain high quality care for all patients. Staff are spread thinly; diluting the level and amount of specialist therapies and care they can give to individual patients.

We know that the longer an elderly or vulnerable person stays in hospital – whether that is a community hospital or an acute hospital like The James Cook University Hospital – the more likely it is that they will lose their independence and be unable to return to their own homes. South Tees lags behind other areas of the country in the support available to patients to get home from hospital as soon as they are fit enough. This is largely due to a lack of home or community services available and is something we need to change.

Improving stroke rehabilitation is a priority for us. We want local services to meet national best practice guidelines, and to do that we are proposing to:

• Centralise (put onto one site) all stroke rehabilitation and supporting services, e.g. physiotherapy, occupational therapy and dietetics at Redcar Primary Care Hospital. This will include 12 dedicated beds for stroke rehabilitation. This means that stroke rehabilitation beds at Guisborough Primary Care Hospital and Carter Bequest Hospital will be re-provided at Redcar Community Hospital.

• Invest in a community stroke team to help patients return to their own home from hospital more quickly following a stroke. The team will provide a range of services in patients’ own homes or a local community setting. This team is being developed now.

Community hospitals

At the moment we use community beds to provide care for patients who cannot stay at home but do not need to be in an acute hospital such as The James Cook University Hospital. As we improve and expand the range of high quality support and therapies available in patients’ own homes, we will not need so many community hospital beds.
Community hospital beds for non-stroke rehabilitation patients in our area are currently under-used, with an average of only 66% in use at any one time. Evidence shows that almost half of the patients in community hospital beds do not need to be there and could be discharged if support was available in the community or in their homes.

Under-use of our community hospitals costs us around £1.9 million a year in our local area. A number of our community hospitals would need significant investment over the next few years to ensure they could provide the modern health services local people need.

So we are proposing to:

- Develop unused space at East Cleveland Primary Care Hospital in Brotton to provide a range of services, including outpatient, diagnostic and therapy services. We will keep the 30 existing community beds and support services currently at the hospital. There is good potential for expanding services here if needed in the future.

- Re-develop the Chaloner building at Guisborough Primary Care Hospital, retaining existing services and further extending the range of outpatient, diagnostic and therapy services for local people.

- Re-provide stroke rehabilitation beds at Redcar Primary Care Hospital and retain the community bed base at Redcar and East Cleveland Primary Care Hospitals

- Re-provide all services delivered from Carter Bequest Hospital, Middlesbrough because with the developing community services and proposed centralised stroke service we will no longer need the hospital. Administrative services in the hospital will be moved. GP services will continue to be provided.

Urgent care services

There are a range of urgent care services across the South Tees area including minor injury services. Currently most of the minor injury services in South Tees are under used. In services where the numbers of patients attending are low, it can be very difficult to train and develop highly skilled staff as needed to maintain safe high quality services. It is also poor value for money to run a service only used by a small number of patients.

In recent years the minor injury services at Guisborough and East Cleveland Primary Care Hospitals have struggled to attract the skilled staff they need to operate 24 hours a day, seven days a week. As a result they are currently open 9am to 5pm Monday to Friday and 8am to 8pm on weekends and bank holidays. Each service treats between two and six people a day compared to around sixty a day at other similar services in the area.
As part of our plan to ensure that we continue to provide safe and sustainable services over the long term, we are proposing to:

- Re-provide minor injury services at both Guisborough and East Cleveland Primary Care Hospitals through GP practices and other community-based urgent care services. Urgent care, including minor injury services, will be provided from Redcar Primary Care Hospital.

Patients in these areas will continue to be able to access primary care through their GP practice and out-of-hours service in the usual way. Urgent care support is provided via the free NHS 111 telephone number.

We are currently developing an urgent care strategy for the South Tees area which is designed to improve the quality and safety of services. Plans will include new urgent care facilities as well as extended GP opening hours.

**A single point of contact for all health and social care needs**

Patients, carers, and health and social care professionals tell us that services for older people need to be more joined-up. In the long term our aim is to develop an approach that links primary, community, acute and social care to provide seamless support for elderly patients and people with long-term conditions.

As the first step towards achieving this aim, we propose to develop a single point of contact as a telephone based service for care professionals to co-ordinate access to a range of health and social care services, avoid unnecessary hospital stays, and support timely discharge for those who need hospital care. This will mean professionals can quickly set up the right packages of care for patients.

**Improved community support for elderly and vulnerable people**

Before making changes to services at our four community hospitals, it is essential that we improve community-based support. We have already started this and we will continue to develop services over the next two years to make sure that more people get the right care, closer to home.

Planned changes include:

- Increasing the capacity of services that promote independent living (reablement) services. Community teams who provide a rapid response to a crisis to meet the needs of patients who would benefit from early supported discharge from hospital will be expanded.
- Further improving discharge processes from The James Cook University Hospital into appropriate services. This will cut the length of time people have to spend in hospital and give patients faster access to community-based care.
- Further expanding the rapid response service to give more people care in their own home.
Improving and promoting the use of outpatient and diagnostic services e.g. X-ray and clinics close to patients’ homes,

Improving community based rehabilitation services, e.g. offering more occupational therapy and physiotherapy in patients’ own homes

Case for change

In developing our plans, we considered a wide range of factors including:

- national best practice guidance
- capacity and use of existing services
- the skilled workforce available
- the standard and location of our current hospitals
- running costs of hospitals
- transport issues.

We used each of those factors to determine our best option for meeting the needs of elderly and vulnerable people, as well as those with long term conditions. Full details can be found on our website or contact us for a copy of our ‘case for change’ document but here is a summary of those options:

Community hospitals

We are in the unusual position of having four community hospitals in our local area which together provide 132 beds. A number of independent reviews have shown us that we have more community beds than we need and our plans to develop more community based services would further reduce the need for beds. The reviews estimate that in future we will need approximately 62 beds.

We have reviewed each of the community hospitals’ premises and identified problems with the long term viability of Carter Bequest and Guisborough Primary Care Hospitals because of their age and condition. Over the next five years, it would cost the NHS an estimated £2.7m in maintenance costs to keep these hospitals up to an acceptable standard. Redcar Primary Care Hospital was built as part of a private finance initiative (PFI) building and it has 30 years of its lease remaining so we must keep this site. It is a high quality, modern facility which can be used flexibly to meet needs.

Transport considerations

An independent travel review was carried out which shows that all community hospital sites are accessible within 30 minutes’ drive using private transport for people living in the South Tees area. Access by public transport to the four sites varies by site during the day and evening:
75% of the population of Middlesbrough and Redcar and Cleveland can get to both The James Cook University Hospital and Guisborough Primary Care Hospital within one hour.

Only 45% of the population can get to Carter Bequest Hospital within the hour.

East Cleveland Primary Care Hospital provides care for people from a wide geographic area. Whilst it is not easily accessible for patients living in Middlesbrough, it does provide good access to rural communities in East Cleveland.

Accessibility to Carter Bequest Hospital by public transport is lower than that of all the other community hospital sites.

Redcar Primary Care Hospital has relatively good accessibility. Buses to the hospital run often and serve a large part of the population, with 74% of people being able to get to the hospital within the hour, and 61% able to get there later in the evening.

**Clinical and quality criteria**

A clinical review has been carried out to look at the quality, sustainability and efficiency of all the community hospitals. The review ranked Carter Bequest and Guisborough Primary Care Hospitals the worst when measured against a range of criteria developed together with GPs, patients and carers, and local voluntary organisations. These are:

- Adequate numbers of ward staff who can deal with elderly patients with co-morbidities, including dementia
- Adequate therapy services, e.g. physiotherapy and occupational therapy
- NHS Standards for quality and safety
- NHS essential standards for environment
- Environmental standards for dementia
- Fit-for-purpose rehabilitation facilities
- Access to x-ray facility
- 85% utilisation of beds as a minimum bed occupancy
- Community staff with necessary palliative care training
- Opportunity for patients at the end of their life to die where they choose, with good services around them
- Near-patient testing
- Ultrasound facility
- Adequate parking
- Impact upon other services delivered from that location
Workforce

The availability of a suitably skilled workforce is central to the successful delivery of the CCG’s vision for healthcare in South Tees. An external workforce review has established that there are enough suitably skilled staff to meet future demand. We will ensure there is suitable training and development to support staff in working differently, delivering more care in patients own homes and community settings rather than in hospital.

Our proposals at a glance

Redcar Primary Care Hospital

- Centralise all stroke rehabilitation and support services, e.g. the community stroke team, physiotherapy, occupational therapy and dietetics at Redcar Primary Care Hospital.
- Keep the 32 existing community beds on this site; 12 of which will be dedicated for stroke rehabilitation.
- Continue to provide urgent care services, including minor injury services.

East Cleveland Primary Care Hospital, Brotton

- Develop unused space on this site to provide a range of hospital services as well as outpatient, diagnostic and therapy services.
- Keep the 30 existing community beds and support services
- Re-provide minor injury services at other sites

Guisborough Primary Care Hospital

- Re-develop part of the hospital site to make sure it can continue to provide current services to local people and support newly developed services.
- Continue to provide a range of outpatient, diagnostic and therapy services.
- Invest in new community based services.
- Re-provide stroke rehabilitation beds at Redcar Primary Care Hospital and community beds at Redcar Primary Care Hospital and East Cleveland Primary Care Hospital.

- Re-provide minor injury services at other sites.

**Carter Bequest Primary Care Hospital**

- Re-provide all services at other sites and invest in a range of additional community based services leading to the closure of the hospital

**Additional investment**

We propose to invest in a range of new community based services such as:

- stroke rehabilitation and a community stroke team to provide more support to patients’ in their own homes or in the local community.

- a single point of contact for all community and social care services.

- more rehabilitation, outpatient and diagnostic services.

**Timetable**

Based on what people have told us, we will make these changes in a phased way by:

- Putting new services in place and testing them before moving existing services

- Making step by step decisions about the changes we are making and the impact that they have on patients and their health before continuing to the next step

We are proposing to introduce these changes over next two years with all services in place by April 2016.
Table 1 – Outline of current and future model of care

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<th>DESCRIPTION</th>
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<td>1</td>
<td>Development of community services which focus on improving pathways of care and discharge processes. Implement a community stroke team, increase reablement, rapid response and therapy services. Implement a single point of access and implement an assessment hub.</td>
<td>April 2014 – March 2016</td>
</tr>
<tr>
<td>2</td>
<td>Centralise stroke rehabilitation services to one specialist unit (Redcar Primary Care Hospital). Closure of Carter Bequest Hospital and re-provision of services within the community. Consolidation and enhancement of Minor Injury services onto one single site (Redcar Primary Care Hospital).</td>
<td>By April 2015</td>
</tr>
<tr>
<td>3</td>
<td>Redevelopment of Guisborough Primary Care Hospital (Chaloner Building) to provide increased range of community based services, closure of community bed base in Guisborough.</td>
<td>April 2015 – March 2016</td>
</tr>
</tbody>
</table>

What our plans could mean

What would be different for services and the patients that use them?

<table>
<thead>
<tr>
<th>The patient's story</th>
<th>What happens now?</th>
<th>What will happen in the future?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tom was admitted by ambulance to The James Cook University Hospital after suffering a stroke. He was left with some weakness down one side of his body and some speech difficulties</td>
<td>After a period of medical treatment and assessment at The James Cook University Hospital, it was determined that Tom required a range of therapies to aid his recovery. Tom was transferred to Guisborough Primary Care Hospital where he</td>
<td>After a period of medical treatment and assessment at The James Cook University Hospital, it was determined that Tom required a range of therapies to aid his recovery. The community stroke rehabilitation team assessed his home</td>
</tr>
</tbody>
</table>
received 8 weeks’ rehabilitation as an inpatient.

environment and determined that he would benefit from receiving therapy at home.

Tom returned home after 5 days. He received regular therapy support at home for the next six weeks, based around his normal daily routine.

<table>
<thead>
<tr>
<th>Have your say</th>
</tr>
</thead>
<tbody>
<tr>
<td>We would like your views on our vision for improving services and ensuring that more elderly and vulnerable patients with long-term conditions are able to remain independent for longer.</td>
</tr>
<tr>
<td>You can provide feedback by completing the attached questionnaire or via our website where you will find an online questionnaire and further details and documents relating to this consultation.</td>
</tr>
<tr>
<td>We are also working with the voluntary and community sector across South Tees to understand the views and opinions of patients and their carers.</td>
</tr>
<tr>
<td>We are holding a number of drop-in events for the general public. There will be no formal presentation at these events, visitors can attend at any time during the stated hours in order to learn more about our vision and future plans, and have their say.</td>
</tr>
<tr>
<td>In addition, we are working with a range of community and voluntary groups to help us seek the views of carers, patients and those with long-term conditions.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Public drop-in events</th>
</tr>
</thead>
<tbody>
<tr>
<td>Come along to one of our public drop-in sessions below. You will be able to talk to hospital clinicians, professionals and local GPs to find out more about our plans and give us your views. You do not have to book to attend.</td>
</tr>
<tr>
<td>If you want to attend and have any access requirements, please call us for further support on 01642 745318 or email <a href="mailto:Lesley.barker8@nhs.net">Lesley.barker8@nhs.net</a>. Please note that translators and other support will only be available on request.</td>
</tr>
<tr>
<td>Time 17:30pm - 19:00pm</td>
</tr>
<tr>
<td>------------------------</td>
</tr>
<tr>
<td>Date</td>
</tr>
<tr>
<td>------------</td>
</tr>
<tr>
<td>4/6/14</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>11/6/14</td>
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<td></td>
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<tr>
<td>18/6/14</td>
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<tr>
<td></td>
</tr>
<tr>
<td>2/7/14</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>9/7/14</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

**What happens next?**

We will use the information you provide to help us make decisions on the plans for the future shape of services across South Tees.

No decision will be made until the consultation has ended; the consultation will run until the end of July.

All comments, views and feedback will be collated and considered by the CCG. They will be used to inform decisions made by the CCG’s Governing Body at its meeting in late summer.

We will review the information shared with us by the public and our partners alongside the evidence we have gathered and presented for the proposed changes to services. This will enable us to identify the best way forward that provides the best balance of evidence, public support and clinical need. We will share our decision on the future model of services with the public and it will also be reviewed by local authorities’ Health Scrutiny Committees.

As a Clinical Commissioning Group we have a duty to secure services to meet the needs of people in our area. We are following national, best practice guidance from NHS England to ensure our consultation is conducted fairly and legally, and delivers our responsibilities to consult with the people of South Tees under the Health and Social Care Act 2012.

Thank you for sharing your views with us and helping to improve services for vulnerable and elderly people.
## Glossary of terms

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Acute services</strong></td>
<td>Medical and surgical treatment provided mainly in hospitals.</td>
</tr>
<tr>
<td><strong>Carer</strong></td>
<td>A carer is a person giving assistance to an ill, disabled or frail person, usually a relative, for no wage.</td>
</tr>
<tr>
<td><strong>Clinical Commissioning Group (CCG)</strong></td>
<td>A CCG is an NHS organisation that commissions (plans and buys) healthcare services for local residents. CCGs were established under the Government’s Health and Social Care Act 2012 and replace Primary Care Trusts (PCTs).</td>
</tr>
<tr>
<td><strong>Commissioning</strong></td>
<td>Commissioning in the NHS is the process of ensuring that the health and care services provided effectively meet the needs of the population. It is a cycle of work from understanding the needs of a population and identifying gaps or weaknesses in current provision, to procuring services to meet those needs.</td>
</tr>
<tr>
<td><strong>Delayed Discharge</strong></td>
<td>When it is intended to discharge a patient from hospital as they no longer require acute medical treatment, but they are retained, as no suitable alternative provision is available</td>
</tr>
<tr>
<td><strong>Home care</strong></td>
<td>Home care is where paid care professionals come to the home of the person you are looking after to provide support to them.</td>
</tr>
<tr>
<td><strong>Local Authority</strong></td>
<td>Your Local Authority provides most of your local public services, such as refuse collection, road maintenance and social care. There are different systems in operation across the country. Also known as your ‘council’</td>
</tr>
<tr>
<td><strong>Long-term condition</strong></td>
<td>We define a long term condition as something that can’t be cured at the moment, but can be controlled by</td>
</tr>
</tbody>
</table>
medication and/or other therapies, including self-care and changes to lifestyle. This definition covers lots of different conditions including diabetes, asthma and multiple sclerosis.

<table>
<thead>
<tr>
<th>Planned care</th>
<th>Planned care means services where you have a pre-arranged appointment. This includes things like being referred by your GP to see a physiotherapist or consultant or being sent for diagnostic tests such as an X-Ray.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Providers/Service Providers</td>
<td>Anyone who is commissioned to supply a health or care-based service. For example, GPs are primary care providers. Social care providers include social workers and home support workers. Hospitals like The James Cook University Hospital are also providers.</td>
</tr>
<tr>
<td>Primary care</td>
<td>Primary care is the services provided by GP practices, dental practices, community pharmacies and high street optometrists. Around 90% of people's contact with the NHS is with these services. Most primary care services are commissioned by NHS England, not the CCG.</td>
</tr>
<tr>
<td>Secondary care</td>
<td>Secondary care is the services provided by medical specialists, quite often at a community health centre or a main hospital. These services are provided by specialists following a referral from a GP, for example, cardiologists, urologists and dermatologists.</td>
</tr>
<tr>
<td>Social services/Social Care</td>
<td>Social services is the department of your local authority that deals with issues around disability and caring.</td>
</tr>
<tr>
<td>Step-down Care</td>
<td>Part of intermediate care facilities that are outside acute hospitals, enabling people who strongly value their independence to leave acute hospital and get ready to return home.</td>
</tr>
<tr>
<td><strong>Step-up Care</strong></td>
<td>Part of intermediate care facilities that are outside acute hospitals, enabling people who strongly value their independence to receive more support than is available at home</td>
</tr>
<tr>
<td>------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>NICE guidance</strong></td>
<td>NICE stands for National Institute for Health and Care Excellence. NICE sets standards for quality healthcare and produces guidance on medicines, treatments and procedures. Visit their website for more information: <a href="http://www.nice.org.uk">www.nice.org.uk</a></td>
</tr>
</tbody>
</table>
Questionnaire

1. Do you think we should centralise stroke rehabilitation services in a single specialist unit in line with best practice?

Yes / No

Please explain why you do or you don’t:

…………………………………………………………………………………………………
…………………………………………………………………………………………………
…………………………………………………………………………………………………

2. Do you think we should provide community beds in two locations within the South Tees area in order to be able to invest in more community services for elderly and vulnerable people?

Yes / No

Please explain why you do or you don’t:

…………………………………………………………………………………………………
…………………………………………………………………………………………………
…………………………………………………………………………………………………

3. Do you agree with our proposal to provide a more comprehensive minor injury service at a single location (Redcar Primary Care Hospital) with enhanced medical and diagnostic cover?

Yes / No

Please explain why you do or you don’t:

…………………………………………………………………………………………………
…………………………………………………………………………………………………
…………………………………………………………………………………………………
4. Do you agree with our proposal to spend more of our money on increasing community nursing and therapy services rather than on maintaining ageing buildings which are not able to support the delivery of our model of care?

Yes / No

Please explain why you do or you don’t:

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5. How else do you think we could increase and improve community based services for people who are elderly, vulnerable or who have long-term conditions? This would include, for example, occupational therapy and physiotherapy services.

Any comments:

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6. Do you agree with our vision to improve prevention and deliver more care in the community, closer to where people live, i.e., more consultant out-patient clinics, diagnostics and treatments in the community?

Yes / No

Any comments:

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7. We want to get your views on our proposed plans for change and understand any concerns you may have about these proposed changes to services, and how they would be implemented.

Please tell us:

--------------------------------------------------------------------------------------------------------------------------

--------------------------------------------------------------------------------------------------------------------------

--------------------------------------------------------------------------------------------------------------------------
8. How do you think our plans could have an impact on specific groups or individuals within our community? For example people from black and ethnic minority backgrounds, males/females, those with disabilities, carers.

Please tell us

........................................................................................................................................................................
........................................................................................................................................................................
........................................................................................................................................................................

Personal details

Age – please choose the category which best describes you: **Tick as appropriate.**

- Under 16 years
- 16-25 years
- 26-35 years
- 36-45 years
- 46-55 years
- 56-65 years
- 66-75 years
- Over 75

Carer – Do you provide care for someone who is elderly or living with a long-term condition? **Delete as appropriate.**

- Yes
- No
- I do not wish to disclose

Ethnicity – please choose the category which best describes you: **Delete as appropriate.**

- White
- Mixed Asian/Asian British
- Black/Black British
- Chinese
- Other ethnic group
- I do not wish to disclose my ethnicity

Disability – do you consider yourself to have a disability or a long-term health condition? **Delete as appropriate.**

- Yes
- No
- I do not wish to disclose

Gender

- Male
- Female

Please tell us the first four characters of your postcode: .................................
You can email responses to the questions above to: mynhstees@nhs.net

Or by post to:

Communications and Engagement Team
Freepost RTGC-XBHS-JUSS
North of England Commissioning Support Unit
Teesdale House
Westpoint Road
Thornaby
Stockton on Tees
TS17 6BL

The closing date for responses is Thursday 31st July 2014

Contact details

Lesley Barker
Communications and Engagement Assistant
Tel: 01642 745318
Email: Lesley.Barker8@nhs.net

This document is available in alternative formats on request from 01642 745318
Appendix 3: Response statistics

Responses by postcode

<table>
<thead>
<tr>
<th>Postcode</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>TS1</td>
<td>17</td>
</tr>
<tr>
<td>TS10</td>
<td>86</td>
</tr>
<tr>
<td>TS11</td>
<td>36</td>
</tr>
<tr>
<td>TS12</td>
<td>56</td>
</tr>
<tr>
<td>TS13</td>
<td>33</td>
</tr>
<tr>
<td>TS14</td>
<td>92</td>
</tr>
<tr>
<td>TS15</td>
<td>3</td>
</tr>
<tr>
<td>TS16</td>
<td>1</td>
</tr>
<tr>
<td>TS17</td>
<td>9</td>
</tr>
<tr>
<td>TS18</td>
<td>10</td>
</tr>
<tr>
<td>TS19</td>
<td>2</td>
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<tr>
<td>TS20</td>
<td>1</td>
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<td>TS21</td>
<td>1</td>
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<tr>
<td>TS22</td>
<td>2</td>
</tr>
<tr>
<td>TS23</td>
<td>1</td>
</tr>
<tr>
<td>TS3</td>
<td>16</td>
</tr>
<tr>
<td>TS4</td>
<td>10</td>
</tr>
<tr>
<td>TS5</td>
<td>43</td>
</tr>
<tr>
<td>TS6</td>
<td>43</td>
</tr>
<tr>
<td>TS7</td>
<td>28</td>
</tr>
<tr>
<td>TS8</td>
<td>11</td>
</tr>
<tr>
<td>Unknown</td>
<td>3</td>
</tr>
<tr>
<td>Grand Total</td>
<td>504</td>
</tr>
</tbody>
</table>

Survey responses
A total of 586 responses were received to the survey.

People attending the public events
The following table shows the numbers of people attending the public drop in events held during the consultation period:

- Note that staff include CCG GP members and commissioners, and NECS staff providing support.

<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
<th>Public</th>
<th>Staff*</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>4 June</td>
<td>Eston Civic &amp; Learning Centre</td>
<td>12</td>
<td>11</td>
<td>23</td>
</tr>
</tbody>
</table>
There were 11 requests for copies of the consultation documents including one asking for a braille copy of the documents.

**Completed responses using the questionnaire**

**Received by post** (responses entered onto Online portal) 52

**Completed at events** (responses entered onto Online portal)
- Middlesbrough Councillors Drop-In 2
- Redcar Councillors Drop-In 1
- Eston Public Drop-In 3
- Brotton Public Drop-in 11
- Guisborough Public Drop-in 16
- Middlesbrough Public Drop-in 8
- Redcar Public Drop-in 5
- Public Engagement/Service User Events:
  - Grangetown Library 6
  - Redcar Library 3
  - Ormesby Library 5
  - Dormanstown Library 2
  - Central Library 1
  - Guisborough Library 3
  - Roseberry Library 7
  - AAPNA (BME) (Learning Disabilities/Physical Disabilities SU) 13
  - AAPNA (BME service users) 21
  - Ormesby Positive Stroke Group 5

52
Action for Blind People/Teesside Society for the Blind 9/7/14 20
Action for Blind People/Teesside Society for the Blind 9/7/14 14
James Cook Public/Staff engagement 4

Completed with the help of partner organisations
(responses entered onto Online portal)
Everyday Language Solutions – BME Engagement 124
Arabic/Afgan/Iranian/Ethopian/ Eritean/Iraqi 243
Carers Together

Responses direct through the online portal 17

Total number of responses to the survey questions 586

Queries during the consultation period
Enquiries by email 4
Total 4

Telephone enquiries
Member of public – requesting details of events 2
Request for copy of document 7
Braille copy requests 5
Total 14
Appendix 4. IMProVE public consultation survey analysis – Explain Market Research
Executive summary

South Tees Clinical Commissioning Group (CCG) commissioned Explain via the North East Commissioning Support Unit (NECS) to analyse data they had gathered from a questionnaire carried out with residents of South Tees as part of a public consultation. This questionnaire gained opinions on proposed changes to community services to offer better care for the vulnerable and elderly in South Tees.

- The majority of respondents agreed with the key proposals for better care for the vulnerable and elderly in South Tees
- 84% agreed with the proposed centralisation of the stroke rehabilitation centre
- 87% thought the CCG should provide community beds in two locations within the South Tees area in order to be able to invest in more community services for elderly and vulnerable people
- 68% agreed with the proposal to provide a more comprehensive minor injury service at a single location (Redcar Primary Care Hospital) with enhanced medical and diagnostic cover
- 89% agreed with the proposal to spend more money on increasing community nursing and therapy services rather than on maintaining ageing buildings which are not able to support the delivery of the model of care
- 96% agreed with the vision to improve prevention and deliver more care in the community, closer to where people live
- Those who were more likely to need these services for the vulnerable and elderly in the short term were more likely to agree with the proposals, i.e. older respondents, respondents who were carers and those who had a disability
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<tr>
<td>Conclusions</td>
<td>23</td>
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<td>5.0 Appendices</td>
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<td>26</td>
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<td>Appendix 2 – Literals</td>
<td>29</td>
</tr>
</tbody>
</table>
1.0 Introduction

This section of the report outlines the project background and methodology.
Background

South Tees Clinical Commissioning Group (CCG) ran a public consultation to capture opinion in their geographical area in regards to proposed changes for improving health services for the vulnerable and elderly in South Tees.

The proposed changes were:

- Centralise all stroke rehabilitation and supporting services
- Invest in a community stroke team to help patients return to their home more quickly following a stroke
- Provide community beds in two locations
- Provide a more comprehensive minor injury service at a single location with enhanced medical and diagnostic cover
- Increase community nursing and support services by reducing the amount spent on maintaining ageing buildings.
- Deliver more care in the community closer to where people live

Methodology

This public consultation included a questionnaire distributed with a consultation booklet and also hosted online. In total 586 responses to the survey were received and Explain was commissioned by the North East Commissioning Support Unit (NECS) on behalf of the CCG to analyse the data gathered and produce this report.

Notes on analysis

‘No replies’ and ‘don’t knows’ have not been included in the analysis; therefore the sample sizes fluctuate from question to question, as some respondents didn’t feel that they could answer every question. Base sizes have been included on all charts within the legend. A full breakdown of all free text comments can be found in Appendix 2.
2.0 Respondent profile

Details of the sample achieved are detailed in this section.
Demographics

Over half of all respondents (55%) were aged 66 and over, with only 5% under the age of 26. The majority (72%) of respondents were White. More female respondents participated compared to males (64% and 37% respectively). 53% of respondents agreed they had a disability and 47% agreed they were a carer.
3.0 Results

This section details the results based on the analysis that has been completed.
Proposed changes

Overall, 84% of respondents agreed that stroke rehabilitation services should be centralised in a single specialist unit. In general, a higher proportion of those who were likely to need these services in the short term agreed with the proposed centralisation of the stroke rehabilitation services, such as older respondents compared to younger respondents and carers compared to non-carers. A higher proportion of White respondents agreed with this proposal than non-White respondents.

Do you think we should centralise stroke rehabilitation services in a single specialist unit in line with best practice?

[Bar chart showing the percentage of respondents who agree or disagree with centralising stroke rehabilitation services, broken down by age, gender, and ethnicity.]

Yes  No
Respondents were then asked reasons for their response regarding the centralisation of the stroke rehabilitation services. Of those who agreed with the proposal, the most common reasons were:

- Enhance expertise/quality of care (104)
- General agreement (40)
- Convenience/accessibility (24)
- Comfort/familiarity (22)
- Best practice (19)
- Cost benefits (11)
- Saves travel (8)
- Saves time (7)

Of those who didn’t agree with the centralisation of the stroke rehabilitation services, the reasons given were:

- Need more than one location (42)
- Accessibility/travel (31)
- General disagreement (4)
- Quality of care (3)

Full literal responses can be found in Appendix 2.
Overall, 87% agreed with the proposal to provide community beds in two locations within the South Tees area in order to be able to invest in more community services for elderly and vulnerable people. Similar to opinions on stroke rehabilitation services, older respondents and carers were more likely to agree with this proposal. Also a higher proportion of respondents with a disability than without a disability agreed with this proposal (89% and 83% respectively).
Of those who agreed with the proposal for community beds in two locations within the South Tees area, the main reasons given were:

- Care would be provided closer to home (79)
- Two or more would be sufficient (44)
- Will relieve pressures on hospitals (36)
- Better care (36)
- Should be in particular area (15)
- Elderly/vulnerable people should be prioritised (14)
- Good idea (4)

Of those who disagreed with the proposal, the reasons given were:

- There should be more than two (16)
- Travel issues/more local services (15)
- Should be one centre of excellence (4)
- General disagreement (4)

Full literal responses can be found in Appendix 2.
Overall, 68% of respondents agreed with the proposal to provide a more comprehensive minor injury service at a single location (Redcar Primary Care Hospital) with enhanced medical and diagnostic cover. Again, the older the respondent, the more likely they were to agree with this proposal. A higher proportion of carers (76%) than non-carers (60%) agreed with the proposal and a higher proportion of respondents with a disability (70%) than without a disability (65%) agreed. White respondents were more likely to agree with the proposal (71%) than Asian/Asian British (67%) and other ethnic groups (55%).
Of those that stated they agreed with the proposal to provide a more comprehensive minor injury service at a single location, reasons for this opinion included:

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduces burden on other places (34)</td>
<td>Better service/quality (32)</td>
<td>Easier for transport (30)</td>
</tr>
<tr>
<td>General agreement (28)</td>
<td>Local services still needed (18)</td>
<td>Easier access (17)</td>
</tr>
<tr>
<td>Facility currently underused (14)</td>
<td>Good to have one recognised place (10)</td>
<td>Save money (4)</td>
</tr>
</tbody>
</table>

Of those who didn’t agree with this proposal, further comments provided included:

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Problems with access/locality (43)</td>
<td>Travel/transport might be an issue (31)</td>
<td>Need more than one location (28)</td>
</tr>
<tr>
<td>Overcrowding (8)</td>
<td>Cost (8)</td>
<td>People will just go to A&amp;E (7)</td>
</tr>
</tbody>
</table>

Full literal responses can be found in Appendix 2.
Overall, 89% of respondents agreed with the proposal to spend more money on increasing community nursing and therapy services rather than on maintaining ageing buildings which are not able to support the delivery of the model of care. Those aged 75 and over were most likely to agree with this proposal (93%), and those aged under 26 least likely (75%). A higher proportion of respondents who were carers (92%) and those with a disability (92%) agreed with the proposal compared to non-carers (86%) and those without a disability (86%).

Do you agree with our proposal to spend more of our money on increasing community nursing and therapy services rather than on maintaining ageing buildings which are not able to support the delivery of our model of care?
Of those who agreed with the proposal to spend more money on community nursing, the main reasons were:

- Money should be spent on healthcare (125)
- Community/Home care should be utilised more/best form of care (58)
- As long as services are maintained (23)
- Maintaining buildings would be inefficient (23)
- General agreement with the proposal (17)

Of those who didn’t agree with this proposal, the most common theme was that buildings are important to delivering care (12). Full literal responses can be found in Appendix 2.
Respondents were then asked how else South Tees CCG could improve community based services for people who are elderly, vulnerable or have long-term conditions. Literal responses have been themed and the most common responses were more/longer home visits/home care (13%), more local facilities (11%) and more occupational and physiotherapy (8%). Full literal responses can be found in Appendix 2.

How else do you think we could increase and improve community based services for people who are elderly, vulnerable or who have long-term conditions? This would include, for example, occupational therapy and physiotherapy services (385)
Overall, 96% of respondents agreed with the vision to improve prevention and deliver more care in the community closer to where people live. There was very little difference between the demographic groups for this question, although again those aged over 75 and respondents who were carers were the most likely to agree with this proposal (99% and 98% respectively).
Respondents were then asked if they had any comments regarding this section of the proposal. Of those who said they agreed the main comments given fell into the following themes:

- General agreement (69)
- Less travel (33)
- Better to be more local (26)
- In favour of a move away from central location (22)
- Prevention is good (22)
- Makes it easier (18)
- Quicker access (16)
- Less stress (6)

Of the respondents who disagreed with the vision to improve prevention and deliver more care in the community closer to where people live, the most common themes in response were:

- It wouldn’t make any difference (7)
- It wouldn’t be any closer (4)
Respondents were asked about any concerns they had about the proposed changes and literal responses have been themed. Almost a third responded to this question by saying they didn’t have any concerns or that the change will be beneficial. Of those who did have concerns, they were mainly general worries about changes to services and also transport issues.

<table>
<thead>
<tr>
<th>Concern</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>The change will be beneficial</td>
<td>15%</td>
</tr>
<tr>
<td>No concerns</td>
<td>14%</td>
</tr>
<tr>
<td>Transport concerns</td>
<td>13%</td>
</tr>
<tr>
<td>Changes to services</td>
<td>11%</td>
</tr>
<tr>
<td>Other</td>
<td>11%</td>
</tr>
<tr>
<td>General concerns</td>
<td>9%</td>
</tr>
<tr>
<td>Communication</td>
<td>7%</td>
</tr>
<tr>
<td>Cost</td>
<td>7%</td>
</tr>
<tr>
<td>Some find change difficult</td>
<td>5%</td>
</tr>
<tr>
<td>Transport positives</td>
<td>2%</td>
</tr>
<tr>
<td>Centralisation concerns</td>
<td>2%</td>
</tr>
<tr>
<td>Needs to happen quickly</td>
<td>2%</td>
</tr>
<tr>
<td>Staff need to be trained appropriately</td>
<td>1%</td>
</tr>
<tr>
<td>Previous good experiences</td>
<td>1%</td>
</tr>
</tbody>
</table>
Finally, respondents were asked how the proposals could have an impact on specific groups or individuals within the community. The largest proportion of respondents thought everyone would be affected the same regardless of their demographic profile.
4.0 Conclusions

This section outlines our conclusions and recommendations for Integrated Management and Proactive Care for the Vulnerable and Elderly.
Conclusions

The majority of respondents agreed with the key proposals for better care for the vulnerable and elderly in South Tees. Those who were more likely to need services for the vulnerable and elderly in the short term were more likely to agree with the proposals, i.e. older respondents, respondents who were carers and those who had a disability.

84% agreed with the proposed centralisation of stroke rehabilitation services, and the majority of those who agreed did so because they thought it would enhance the expertise and quality of care. Those who didn’t agree with centralising stroke rehabilitation services thought more than one location was needed and travel and accessibility would be an issue.

87% thought the CCG should provide community beds in two locations within the South Tees area in order to be able to invest in more community services for elderly and vulnerable people. Care being provided closer to home was the main reason for this response. A minority, however, did think this service should be provided in more than two locations.

68% agreed with the proposal to provide a more comprehensive minor injury service at a single location (Redcar Primary Care Hospital) with enhanced medical and diagnostic cover. Of those who agreed with this proposal, the reasons for this included reducing the burden on other places, better service/quality and that it would be easier for transport. Respondents who disagreed did so because of problems with accessibility and transport or that they thought more than one location is needed.

89% agreed with the proposal to spend more money on increasing community nursing and therapy services rather than on maintaining ageing buildings which are not able to support the delivery of the model of care. Those who agreed with this proposal did so because they thought money should be spent on health care. A minority did think that maintaining buildings is important in delivering care.

Home care/home visits and more local facilities were suggested ways of improving community based services for people who are elderly, vulnerable or who have long-term conditions. 96% agreed with the vision to improve prevention and deliver more care in the community, closer to where people live. Respondents thought being local with less travel needed was a positive thing, however concerns about the proposal centred around travel issues as well as general concerns about change.
Final observations

Out of the five changes proposed in the consultation, four achieved majority agreement of over 80% and thus it is clear that there is very strong public support for these changes to go ahead:

- 84% agreed with the proposed centralisation of the stroke rehabilitation centre
- 87% thought the CCG should provide community beds in two locations within the South Tees area in order to be able to invest in more community services for elderly and vulnerable people
- 89% agreed with the proposal to spend more money on increasing community nursing and therapy services rather than on maintaining ageing buildings which are not able to support the delivery of the model of care
- 96% agreed with the vision to improve prevention and deliver more care in the community, closer to where people live

The area with the lowest level of agreement was the provision of a minor injury service at a single location and although this proposal also achieved majority support (68%), nearly a third of respondents disagreed. The key reason for rejection of this proposal was ease of access in terms of distance from the respondents’ home and ability to travel, which will be important to address.

In addition, although agreement was high across all other areas of the proposals, transport and accessibility was a recurring theme and something to consider.

Finally the concept of ‘Care Closer to Home’ was clearly very well supported and something to continue to consider to improve care for the vulnerable and elderly across the board.
5.0 Appendices

The questionnaire and literals can be found in this section.
## Questionnaire

<table>
<thead>
<tr>
<th>Q1</th>
<th>Do you think we should centralise stroke rehabilitation services in a single specialist unit in line with best practice?</th>
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<tbody>
<tr>
<td></td>
<td>[ ] Yes</td>
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<tr>
<td></td>
<td>[ ] No</td>
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</table>

| Q2 | Please explain why you do or don’t                                                                             |

<table>
<thead>
<tr>
<th>Q3</th>
<th>Do you think we should provide community beds in two locations within the South Tees area in order to be able to invest in more community services for elderly and vulnerable people?</th>
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<tr>
<td></td>
<td>[ ] Yes</td>
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<td></td>
<td>[ ] No</td>
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| Q4 | Please explain why you do or don’t                                                                             |

<table>
<thead>
<tr>
<th>Q5</th>
<th>Do you agree with our proposal to provide a more comprehensive minor injury service at a single location (Redcar Primary Care Hospital) with enhanced medical and diagnostic cover?</th>
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<tr>
<td></td>
<td>[ ] Yes</td>
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<tr>
<td></td>
<td>[ ] No</td>
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</table>

| Q6 | Please explain why you do or don’t                                                                             |

<table>
<thead>
<tr>
<th>Q7</th>
<th>Do you agree with our proposal to spend more of our money on increasing community nursing and therapy services rather than on maintaining ageing buildings which are not able to support the delivery of our model of care?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>[ ] Yes</td>
</tr>
<tr>
<td></td>
<td>[ ] No</td>
</tr>
</tbody>
</table>
Q6  Please explain why you do or don’t

Q9  How else do you think we could increase and improve community based services for people who are elderly, vulnerable or who have long-term conditions? This would include, for example, occupational therapy and physiotherapy services. Any comments:

Q10  Do you agree with our vision to improve prevention and deliver more care in the community, closer to where people live, i.e. more consultant out-patient clinics, diagnostics and treatments in the community?

☐ Yes
☐ No

Q11  Any comments

Q12  We want to get your views on our proposed plans for change and understand any concerns you may have about these proposed changes to services, and how they would be implemented. Please tell us:

Q13  How do you think our plans could have an impact on specific groups or individuals within our community? For example people from black and ethnic minority backgrounds, males/females, those with disabilities, carers. Please tell us:

Personal details
Q14 Age - please choose the category which best describes you:

- Under 16 years
- 16-25 years
- 26-35 years
- 36-45 years
- 46-55 years
- 56-65 years
- 66-75 years
- Over 75

Q15 Carer - Do you provide care for someone who is elderly or living with a long-term condition?

- Yes
- No
- I do not wish to disclose

Q16 Ethnicity

- White
- Black/Black British
- Mixed
- Chinese
- Asian/Asian British
- Other ethnic group
- I do not wish to disclose my ethnicity

Q17 Disability - do you consider yourself to have a disability or long-term health condition?

- Yes
- No
- I do not wish to disclose

Q18 Gender

- Male
- Female

Q19 Please tell us the first four characters of your postcode:
Appendix 2 – Literals

Q1. Do you think we should centralise stroke rehabilitation services in a single specialist unit in line with best practice?

Positive (257)

Enhance expertise/quality of care (104)

A centralised unit will group skills. Also, for the public focus where the location is i.e. not in different units across the county

All the experts in one place; consultants, nurses, physiotherapists and occupational therapists etc.

As long as the centralisation process works with the GP nearby, it will only add to the quality of the service and can make controlling easy

Because centralising the stroke rehabilitation to one unit will help to ease the workload from the doctors and nurses, if it’s in one place

Because if they can’t be helped, their life might be in danger

Because it might help the patients to recover more easily

Because it will enable a good, professional relationship between workers and service users to get the best quality care possible. It should be spread so everyone gets the care they need

Because people who had a stroke need more care and rehabilitation

Because they are not like healthy people, they need more help and treatment

Because treatment is very essential

Better area for all who attend as more specialist care

Better standard of care for major illness

Centralising public services will head to the private competition in terms of quality, this might make the rich people shift towards it

Centralising things gives better service and better use of a skilled team (10)

Concentrated specialist care is the best care for stroke victims(22)

Experienced diagnosis by clinicians together with timely rehabilitation measures are crucial
I think you should centralise it because people then can get faster treatment (3)

If it improves the quality of care and improves outcomes, then yes it is the correct thing to do. They need to put patients first.

I'm not able to explain why because thankfully, I have had no experience. I assume all the expertise would be better in one place.

Improved specialist care will free up the acute stroke beds, giving more capacity for new patients.

In hope that immediate treatment with specialist staff may be given.

In my opinion, centralising stroke rehabilitation services is more likely to encourage best medical units.

It is more economical and gives a chance of more knowledgeable staff.

It will enable better equipment and staff (10).

It will permit the most experienced staff and facilities to be on hand, but it could require more beds for that purpose and other services being moved.

Quality comes from centralising.

So that a high standard of care can be given with all specialists in one place. However, people should also be given enough support at home too.

Stroke rehabilitation centres could provide the specialist services, support and encouragement patients need. Patients may feel more encouraged in the community rather than large ward based.

The centralisation of this service with twelve beds will enhance care, and give the service a ‘???’ for ongoing development.

The patient could get quality information and service.

The patient will get what he/she exactly needs.

The quality of care would be more effective and more efficient (16).

There is no need to replicate; provision of resources at multiple units have the best at one.

There will be all expertise in one place, rather than spread thinly across the area. Therefore hopefully, there will be better communication between agencies.

They don't have the facilities in Carters that we need for strokes. They have great service at James Cook so others should be same, all best specialists should be in one area.
This allows better focus on people who suffer a stroke

This will enable specialised staff to work in a better controlled environment, and better access for patients with stroke problems

This would provide a better quality of care as people will know where to go and what to expect. (This is aimed mainly at stroke rehabilitation centre of excellence)

To strengthen the service and provide a wider range of aid to suit each individuals needs

We need to focus on specialist teams for the faster recovery of patients, giving them the confidence that they would feel from a single unit and continuity of care with smaller group members and staff.

Cost effectiveness for NHS regards to referrals, which should be under the same

With the doctors who are specialised in treating stroke victims, they can train others there

You can focus on one, specialist centre rather than a few (7)

For (General) (40)

I do, instead of people having to go to different places. If everything is under one roof it must be better

In this case, all facilities will be in the centre

It could mean that all separate units are united, so there is less chance of cases getting lost

It is better for local residents and many disciplines in one location

It makes sense to centralise expertise but if the wards are too big like in James Cook, the care part of rehabilitation can be lost. Carter Bequest has the most compassionate and caring stroke care in the area. It’s small, staffed by a team of nurses who understand the need not only for the clinical needs of the patients, but they treat those in their care with kindness and treat them as people with personalities who need love and understanding.

It makes sense, it seems like a good idea (10)

It sounds like a good idea but I don’t feel qualified to tell you what to do in this area (2)

One stop for patients. As long as there is good sign posting and follow ups in place

So the service is in one place, it works better (10)

There are staffing and economy benefits
There is a great need for stroke victims to have more help, the unit would need to be central for all districts

This would benefit everyone (3)

To make the whole process easier for the patient

To try to get people back on their feet

We don’t need more than one stroke rehabilitation at this area (5)

**Convenience/accessibility (24)**

As long as it is easy to access

Because centralisation reduces accessibility and hence people will suffer to get services

Because everything would be together

Because making one central location helps in reducing waste of resources

Centralising means it's accessible for everyone

Having all facilities on one site reduces cost, travel, missed appointments and gives better access and quicker delivery for patients

I think centralising the stroke rehabilitation service could make work easy for the medical team

I think decentralisation makes the services easily accessible to people

I think yes you should. Because it will be useful for those are local (2)

Initially excellent, but, convalescent beds must be available locally

It makes sense to have services in one place

It will be easier for people to access and be seen in one place (centre)

It will simplify and bring about ease of access to the services required

It would make it easier for relatives, carers and staff. Also, I feel communication would be better

It would make things easier

It’s more convenient
Providing that it is accessible to all

So people who have had a stroke know that the rehabilitation service is in one place, and don’t have the worry of finding out where to go

There would be less fuss

To make it more accessible to everyone who needs it

To make it more easily available and closer

Yes, as long as it is accessible within the time span. Accommodation may be necessary for relatives

Yes, if they are in one unit, it is easier to treat them

**Comfort/familiarity (22)**

Always one recognised centre works better

Because it is a known and recognised place for people (4)

Because rehabilitation services make people with a stroke happy

Centralisation is mainly important for controlling resource and personnel

For those who need help in travelling to a single specialist unit but not for others

I think it would help knowing that you only had to attend just one department, and see familiar faces

I think the patients bounce off each other and will strive to reach the levels of improvement as their friends there. Seeing someone’s improvement must boost a new stroke patients hope of achievement

If all stroke patients were in the same place, I think they would feel better

It is better to be in one recognised location

It makes sense to have the expertise together

It will allow patients to develop trust and confidence in the unit knowing that everything is under one roof

It would feel like something has been done and you aren’t on your own

People would know how to access appropriate services, most people have little understanding how
to contact services

Single units help to calm people, they are dealt with by teams that can access the persons improvements/communications

So the patients are all together and can help each other

The nurses there will have more experience with stroke patients

Then people would be made aware of all the different facilities on offer to them

There is one point of contact with specialist care

They would have better care, there used to be a hospital in Leeds that did this and patients couldn’t speak more highly of it

**Best practice (19)**

A single centralised unit is best practice. The Redcar Primary Care Hospital would seem to be the most appropriate and central location for this single specialist unit

Because best practice is important, to deliver top skills and knowledge. It is important for NHS

**Best practice (2)**

Best practice hopefully means that

Best practice should be the aim for any service

If only one can be afforded since I want the best practice

In line with best practice, yes. As long as transport links are okay

In my opinion, centralising stroke rehabilitation services is more likely to encourage best medical care units

It is better to be in one centre with best practice

It is better to be in on facilitated practice

It is important to strive for best practice

My wife had stroke in 1989 there was nothing then, 2014 best practice should be used at all times

One centre with best practice is better than a few less for some services
One centre with best practice is ideal

The best practice is needed for a full recovery

They should have a centre with best practice in one specialist unit, rather than a few

This would be the best practice option for patients. This would ensure they get dedicated care, bringing peace of mind to patients and families, knowing they are getting the best help and support

To ensure skills of professional staff and resources are coordinated, monitored and managed (ensuring best use/cost effective/best practice)

Yes, I do agree the centralised stroke rehabilitation services are one of the fundamentals, with the best practice in societies

Cost (11)

All of the affordable resources would be in one place for that condition

As long as parking charges are not introduced at Redcar Primary Care Hospital

Because by centralising we can reduce the cost of NHS

I believe that the proposed centralisation of services is based on financial considerations, not necessarily on patient well-being. The question asked is loaded and biased ‘in line with best practice’ phrase should have been left out.

It is much better value for money

It’s cheaper to have all the necessary equipment in one area

One to one service will be provided in people’s homes, it is more personalised to meet the persons needs

Saving money, hopefully there will be more connections between service provider, joint administration and site management

This should make more sense financially and will benefit people

To have patients and care staff under one roof must be cheaper to run

To save money

Travel (8)
A sensible idea. The chosen site must have good access for vehicles and pedestrians. Also good parking facilities (free?)

If the unit is close and more central out patient care, therapy is more accessible. It will reduce travel cost, time and distance

If there are good bus routes, is easy to get to and there is plenty of parking

It is good for elderly patients to meet people in a similar position; making new friends but of course, travel must be provided

Put them all together, it will make it easy for people to get to

Within Redcar and Cleveland one such unit should suffice - distances travelled to it will be short

Yes but with reservations. As I understand it, you have to get the patient to hospital within two hours of the stroke. With waiting for a doctor, then an ambulance you don’t want to be too far away from a hospital so maybe more hospitals are needed also for rehabilitation

Yes, they should pool resources in one unit but ensure adequate public transport infrastructures from East Cleveland, so visitors can see their families. They are as much an integral part of their rehabilitation.

Time (7)

Because the quicker you are seen to, the quicker you recover

Centralising services saves more professional time for patients, staff do not have to travel

Facilities should be available in the primary care unit in Redcar - speed is essential

I think it would help the patients to recover sooner

Patients will receive the correct care immediately

Travel time is vital for the elderly and ill people, so the nearer the hospital bed, the best. It will result in less stress and time saved

Yes, so it would save time

Other (22)

After care for stroke victims of any source would be good
Because of cancer and other health problems, there are too many heart attacks and strokes nowadays

Better centralised, but locality base

Community support is better than James Cook University Hospital, it is too large and intimidating

Comparisons could then be made regarding requirements of differing age groups

For continual care

For Teesside area, it’s enough to have one single centre

I have had firsthand experience of stroke rehabilitation at Guisborough hospital, it was excellent

It is a regrettable necessity

It is not like a normal and usual hospital, so it’s for special need

Medical practice in all forms is a continuing learning experience, learning from each other as well as patients

My experience with my brother’s stroke and my friend’s stroke show a clear improvement in central care

My mother had a stroke and therefore I know how important this is

Nice recommendations

Recently visited new Redcar hospital for a pre med, very impressed with all facilities and staff care

Redcar Primary Care hospital has physiotherapists, OT’s all in place, and beds

Strokes are on the increase and people need to be made aware of how to reduce the risks

That carer stroke rehabilitation service

That could cover

They will always have something there

This area has the majority of people who need this service

To include the community as well
Negative (105)

Need more than one (42)

All around for people

As a specialist unit is needed in every area to give care to everybody who needs it

But, centralised in which centre? It should be local to a specified point within that locality. Not, for example, Middlesbrough itself

East Cleveland residents would have difficulty travelling to one single unit

For people who have had strokes, surely it is sensible for them to go to the nearest hospital, which for Guisborough people it is the Guisborough hospital

I am worried that one centre wouldn’t be enough

I do not believe that Redcar Hospital can be properly configured to accommodate such a unit (in my view a special purpose ward design is required). A twelve-bed unit is too small to become a centre of excellence or best practice

I do not want it moved away from local community

I don’t believe in ‘centralising’ services, if these means them being in Redcar PCH, in the far North Eastern corner of the area

I don’t think one centre is enough

I feel that when too many services are in the same location, it can be detrimental to the patient

I have found that a smaller unit is better for the progress of a family member. They still need specialist care but not on busy ward

I think centralising will further reduce efficiency and effectiveness of the existing services

I think decentralization makes the service more accessible to people in different location without moving too much

I think it is more important for them to be close to home and near family

I think you need more than one hospital or specialist unit

In this case there would be long queue to get in and use the service

It offers better care if you spread it out more
It seems that to centralise in only one place would make it difficult for elderly people, you must want to help those who live outside the immediate area

It would not be enough

It’s better to spread facilities out. Easier access for all

Keep as many places open

Local services are better for OPD services; time is stretched if centralised services are the only ones available. Often carers are elderly themselves and parking is stressful at large centralised units

Middlesbrough Council are concerned that the closure of two facilities to be provisioned in one site could place additional pressure on social care, residential care services as a consequence of demand exceeding supply. We wish to be assured that there will not be a reduction in places being provided given rising demand. We wish to work with the CCG to ensure that community stroke provision provides sufficient level of support and care and acts as an alternative to stroke within residential care.

One centralised unit would not be enough for the population as it is now

One centre would not be enough

Patients need to be close to home in order to make it easy for elderly relatives to visit regularly

People are best left in the town where they live or as near as possible

Putting resources in a single location will result in overcrowding and delay in delivery of services

Redcar is too far for visitors from Guisborough to travel. Also, GPs will no longer visit their patients

Services need to be closer to the patients home to reduce transport time and cost. More centres means more patients can be treated quickly

Stroke patients need to attend hospitals close to home. What extra arrangements will be made to provide additional transport

Stroke rehabilitation services should be near to a patient’s home, not centralised being further away from supportive family and friends. This has nothing to do with what the patient needs or wants - it is purely a cost cutting exercise.

Stroke victims may need a length of time requiring nursing care – an acute hospital will need beds

The area which it would cover would be to large
These services are needed across the area. One single unit is not enough

Too much 'centralisation' of services. Small and local for me, equals a higher quality of service

Two centre’s will be more useful

We don’t need a few centres, one with more facility is better than a few without

We need improved services closer to people’s homes, especially for those living in rural communities, not larger towns

We need it in different areas to cover everybody

We need that service in our local areas

Accessibility/travel (31)

Because it is too big an area to cover for people, travel, timing of buses - elderly people will have to travel every day

Because of distance and travel time. Should have more than one

But accessibility for elderly people without transport, who have a mobility problems, is an issue

But it may be too far for some people to travel

Creates big travel problems to attend or visit, shorter distance means less stress for people

If it is central it might be difficult to get to, if you’re housebound

It brings some difficulty to people’s transport

It could be difficult to get there

It is not always possible for people who have suffered from a stroke to travel long distances for rehabilitation

It may be too far away to help everyone, if there is a closer place than can be used, use it

It may be too far for elderly people to travel

It means that there will be long journeys to and fro

It would be better if it was in Middlesbrough

It would be expected to cover too much of a big area. It would be difficult for people to travel to,
talking mainly about older patients who then have to rely on poor transport links to units and for relatives to visit

It's advantage is only for controlling and management purposes

People find the travelling too difficult

People who have suffered from a stroke or strokes should not have to travel any greater distance than necessary, with their carers or relatives

Redcar just have single rooms, staff are not able to monitor all patients at all times and it is not local enough for Guisborough/Loftus people

The only drawback for one single unit is travel. It is not handy for anyone, not living in Redcar without transport

There would be a lack of accessibility

These are usually further away from home, this makes it more difficult for family to visit

They should provide transport to those without

To cover all areas, we need a local service

Travel for carers is an issue (already two buses)

Travelling may be a difficulty (2)

We need it to be local and closer to home, it would also involve travelling time, and long journey

When people (young or old) are ill, they don't want to be travelling miles for treatment

Where will it be, how easy will access be for the outlying area, will priority be given to the central area

You say this is a consultation. It is taking place in June. You plan to start phase 1 in April. Its information on plans already decided, not consultation providing there is adequate public transport. Especially evenings and weekends for visitors

You should have a hospital close to you, because elderly need to be close, and travelling time

Against (general) (4)

I think we should make best use of existing local facilities
It would depend on where it was based, smaller units offer better care

Twelve beds for stroke rehabilitation does not seem a sufficient number

Quality (3)

Get expertise together, but they should consider transport issues for people

I think there should be a centre on the lines of the clinical development centres, where anyone who has had a stroke could be registered with the centre and have easy access to physiotherapy, OT, speech therapy, orthotics etc. Without having to go to the GP for a referral when problems arise

Stroke rehabilitation is not what it ought to be in 2014, in the UK. France has far better after care in all-round services. Obviously money (lack of) shows in our not so good service. If specialist unit is improvement then it has to, yes.

Other (20)

As long as there is adequate service delivery

But I am aware that they were centralised at Guisborough hospital, this is not new policy

Excess to hospital

Facilities should be available at all local hospitals albeit at limited times (days) to ease accessibility (transport)

Having seen all of the single rooms at Redcar hospital I feel that stroke patients may become isolated thus hindering their recovery

I had a stroke several weeks ago; I went to James Cook University hospital then Carter Bequest. I returned to James Cook three times and was refused for treatment (close to Carters)

I think nurses and other workers should learn how to look after these poor people better

Is Redcar the best place?

It is not the kind of service that is needed everyday

It should be part of the 'closer to home' and transforming community services

Only because I feel personal help should be used at home; physiotherapists, OT, speech therapist and dieticians etc. The downside to just one unit would be getting there if require to be in specialist unit
People are human beings, some people aren’t lucky enough to have family to look after them and support them no matter what age they are. So they just put them in homes and are forgotten about?

Should utilise small Brotton, Redcar and Guisborough hospitals for patients in East Cleveland (parking etc)

Since there is a whole range of disabilities arising from stroke

Stroke victims are aware of things taking place, whereas people with mental illness can disturb the feelings of that individual

The aftercare of stroke victims, once patients are home is practically non existent

Too central, Redcar having specialist services

We don’t have to go to the main centre for every problem

We know that the result of massive technological interventions in what is the process of dying leave us with a lot of significantly disabled patients. The people doing the heroic Golden Hour rescues do not follow up with the rehabilitation. From personal experience of that sort of activity, I would say take the injured service person, they need vigorous rehab therapy to get them going again and make something of the sixty or so years they face with disability. We used to say 80 per cent of NHS resources devoted to a patient with be expended in the last 12 weeks of their life. In end of life care dignity and management of the strain on friends and family are more important than added hours of life or responsiveness. It may ‘look bad’ to allocate a patient to either vigorous therapy of dignified palliative care but so long as it is done on an individual and not a post code lottery basis it is the appropriate course of action Specialist care centres – of all sorts – should have family support halls of residence to keep families together during intensive therapy and that facilitates centralised specialist care for patients likely to actually benefit from it.

Unsure (5)

I am not sure as I have had little experience with stroke victims

I don’t know

I don’t know. Carter Bequest offered a stepping point from hospital to home for a relative who had a stroke. I live with them and had to care for them. Carter Bequest offered her the opportunity to prepare for home e.g. sitting around a table with others to eat and walking with walker. The stroke ward in James Cook may not be the best place always

I have no views either way, whichever is best for patient

It seems fine as it is, but I have no experience of this service only from friends who praise the care
highly
Q.2 Do you think we should provide community beds in two locations within the South Tees area in order to be able to invest in more community services for elderly and vulnerable people?

Yes

Would mean care would be provided closer to home (79)

As close as possible to where people live

Availability of beds close to home will suit elderly patients & their families

Because it would be better for family if it’s closer to home

Because more beds are needed and elderly people often can’t travel any distance to visit

Because then people may choose the nearest one for family and friends to visit

Because this being local will give the elderly & vulnerable more peace of mind that they are being cared for near their homes and relatives & friends

Best for patients and visitors hopefully near to the area that they live

Better access

Better than having to be offered Northallerton!!

But also support cross boundaries, where access is easier i.e. parts of Redcar & Cleveland may be closer to N.Yorks services (?)

By having 2 locations we can help elderly & vulnerable people in a better environment

Care closer to home

Community services in local areas for the elderly are essential

Convenience for visiting

Different areas need community beds so the people are near their visitors

Ease for relatives to visit, once a person on way to recovery - to stop bed blocking at say the stroke hospital

Easier for families to visit

Elderly patients often have elderly carers/relations who have difficulty travelling far (may have ceased to drive/can’t afford taxi’s/limited public transport access) Psychologically better for patients
to feel ‘closer to home’ not isolated and adrift

Elderly people have great difficulty in travelling

Everyone wants to be treated at home if possible. It is even more important that people with dementia can stay at home

Excellent idea - transport is a big issue for people - also older people, who have to hospitalized feel more comfortable somewhere more local and smaller

For elderly family visiting is a stress so shorter travel is both good for patient and family

Having to wait for a close to home bed adds to stress

I think it would be beneficial for the elderly and vulnerable people to have treatment locally. This would enable them to keep in touch with family & friends

I think it would help families, it would be perhaps nearer to home

I think people would be better being in their own home

If an elderly person is ill in hospital, visitors may be elderly and cannot always travel long distances

Important to reduce travelling

In such a wide area covering coastline, inland sprawling communities have a better chance to visit relatives, keep patients in area nearer home + for those with dementia familiar people places etc

Investment should be in the community as more easily accessible

It will be easier to visit

It will make it easier for patient’s to be near to family + friends

It would be better for the patient & patients family & carers to visit

It would be easier for families to visit

Keeping local services for local people

Living in Loftus, health care services seem too far away. When you are elderly or disabled. Moving more services to East Cleveland Hospital Brotton would be a bonus for the rural community

Local care is vital for elderly - less travelling, more accessible for visiting less stressful than large hospital
Local people travelling

Local services + transport for local people

make for more availability

Makes it easier for relatives and friends to visit

More convenient for families

More chance of people remaining in the community they’ve always lived in - reduce stress to both patient + family

More community for elderly

Most elderly people prefer to be in local area whilst being cared for

Much easier for family if patient located closer to home. JCUH is not very accessible to everyone

Patient & visitor accessibility

Patients find travelling difficult - car and bus journeys are essential - so beds being close to their community is good

Patients need to have relatives and friends nearby for visiting

patients would be more relaxed and recover quicker if they were aware of the familiar outside surrounding plus it is easier for visitors to visit

People feel better when treated nearer home i.e. rural communities easier for visiting etc

People have difficulty driving/parking @ JCUH

People need to stay close to home and return home as soon as possible

people should be able to choose location most convenient for family

People would have more choice

Providing transport is available. What assurances can be made to guarantee that lost savings in buildings will reinvested in additional care and not simply as a way to cut overall costs

Reduce some transport difficulties

Services should be available as locally as possible
So people can stay as close to home as possible

So people have more choice

Some people don’t have transport

The area is quite large & accessibility for visitors can be awkward. If families are in any way struggling to see patients it can be frustrating for patients at the expense of poor recovery

The area of South Tees is considerable in size and therefore re availability of services is paramount to patients

The elderly and vulnerable would be more confident in community areas

This will give quick access to vulnerable people and helping them, as facilities are closer

This would be easier for families to visit

This would give more options to be closer to home if this proposal goes ahead

To enable patients to access ‘local’ care away from a busy central hospital at James Cook to enable people to remain in the local community making them feel safe in familiar place and enabling relatives/friends easy access for visitation and to provide additional support

To enable visiting and holistic approach to stroke rehab

To stop people having to travel far

Travel problems

Visitors should not have to travel a long way to visit relatives or friends

We need to have patients living near their relatives if they have any so they may visit, elderly people need to feel wanted in fact needed & if they are well enough encourage neighbours to be more friendlier as they used to be

Yes but - PLEASE think where to locate them, there should be one in the East and one in the West

Yes but do not forget access & transport issues make it simple

Yes it’s better that family can get to visit easily

Yes it’s better to see them more often if nearer home

Yes or no depends where they are situated: East Cleveland demographically lowest car ownership in
UK - so depends where the locations are and if possible for relatives/friends to visit!

**Two locations or more would be sufficient (44)**

Again save time travel, old people don’t like to be too far from their relatives and home, so there should be two locations

As it costs a lot so two could be enough for this area

Because if community beds could be provided in two areas people can find shelter for themselves easily without any transport costs

Because South Tees area is very big and it needs at least two centres with community beds

Because Tees area is big and less than two is not enough

Because Tees area is very wide and it needs at least two locations

Because Tees area is wide and services should be easily available to all

Because there might be many people who would use the services its good if it could be in two locations

Because, South Tees area can get enough services with community beds in two locations

For these area two community beds are perfect

However two locations are insufficient for such a large area

I think community beds would be best in two locations, one in Middleborough, one in Redcar to minimize travelling for relatives and take pressure off the James Cook. Like the old system of cottage hospitals

I think two centre is better than one single centre

I wonder if this is a realistic number and how much better it is than the present situation

If four location was a lot definitely two would be perfect

If NHS can manage of course two, otherwise even one could be ok

In order to easy access two locations is better

it is not the services that you need to use everyday no matter how close or far, two locations is perfect
Less confusion to have two facilities

One or Two

one or two

Two centre makes sense as one could not be enough for this area

Two centre would be enough

Two in different location

Two is ideal and reasonable

Two location far from each other to cover our area

Two locations better than one but three would be better

Two locations or even one

two locations would aid people in care to be more local to where they live

Two or even one enough

Two or more

Two or more depend on budgets

Two or on location as its not routine necessary

Two or one

Two or one location

Two should be ok

Two with distance of each other

Two with distance of each other

Two would be ideal

Two would be more than enough

Using 2 locations saves travelling time for visitors etc, if it’s used for elderly patients it figures visitors will be older
We must have two areas, travelling we are such a large area, make it easy for visiting to suit everyone

Yes so that people don’t have too far to travel

Yes, two locations allow for easier access for relatives and often elderly friends

**Will relieve pressures on hospitals and create more beds (36)**

As the factsheet says, people are living longer, so we need more beds in hospitals

Because it can avoid overcrowded sleeping places

Because those people are in need, they need more. Look after

Beds available at Redcar would be a great help

Beds nearer to home provide more security

Better facilities are always a good thing

Certainly if that gives more people the opportunity to use the service than before (I don’t know how many locations were previously available!)

Community bed it’s not really necessary so 1 or 2 could be enough and accessible

Community beds are a good idea and would benefit the old and vulnerable people

Community beds are not needed as much as other services

Considering the numbers of patient could be enough

Considering the vast number of users in Middleborough and surrounding area

Everything can be done in one single community beds

For more beds

For most people it is preferable to be treated in their own homes. However some people who live alone might prefer a hospital setting. They may feel more secure there

Hopefully more locations mean more beds! Halfway houses are needed for more time to decide on the appropriate placement of patients

it is important because elderly and vulnerable people in need have nowhere else to go
It would open up more options of where to choose to go

James Cook is getting beyond capacity

Lack of community beds

More beds means shorter waiting list and faster treatment

More beds will be needed in the future

More beds, less overcrowding i.e. better service

Of course more beds, more professional help, this issues/illness is not going away

Providing beds for vulnerable people is always helpful + using different location would be helpful

Providing beds in the South Tees area could be beneficiary for the elderly and vulnerable people

Reduces hospital waiting times for more serious ailments

Reducing the number of sites will provide better value and staffing

Tees area is big and it needs more hospitals

The more facilities the better

The move beds you have, the more service gets easier

There will always be a need for ‘beds’. The need for respite for carers will increase due to ageing population

This would help more in hospital and best practice can be used

To assist with shortage of beds

To relieve pressure on hospital beds

Too many patients in James Cook, better personal care in smaller units

Better care (36)

Because it is very important, especially for elderly people and for kids

Because the problem with stroke victims is they need as much help from family & friends

Because they are old and vulnerable people. Therefore we should provide them with any means
Because those people they need more treatment

Better service for increasing elderly population

Because action would be more likely to respond to patients needs

Care in the community must be better than keeping people in hospital if they don’t need to be there

Community being smaller will be more settling for the elderly

Community services are vital services that are currently hard to obtain

Community services I feel are the way forward. Individual patients feel just that, individual. Small group networks would promote familiarity with seeing the same faces, which would in turn give patients + Drs etc medical history

Community services should be one of the key priorities and can only be achieved through transfer of resources

Elderly and vulnerable people require a lot of attention. Sometimes a secure location is the only answer

For people between acute hospitalization and care home residence

Good to invest the care should be better

Good use of resources

Having nursing care directed at elderly patients, with staff most interested & suited to elderly care, has to be better for the individual

I feel some elderly can be missed when they need more care GP’s are very busy I know I think it would improve quality of care

I feel very strongly about this, as there is nothing available in the community for elderly when they are discharged from NHS hospitals

I think it’s something the elderly and vulnerable people need. They would get proper care

I think the elderly and vulnerable people need to know they is somewhere for them to go

It is not always the best option for the patient to have a long stay in hospital, community based services will ensure they can be discharged into their home more quickly

It makes more sense to care for the vulnerable and elderly people in small units than in hospitals
It will enable a majority of elderly people to get care rather than only a few

It will enable the elderly to have more comfortable care and it will give care to majority of individuals rather than only a few

it will help the user to get full help and peace of mind

it would save lives

More GP beds are desperately needed: - elderly & disabled people need to feel an individual not a number!

My mum had a stroke, it was not convenient for my brother to come to hospital etc. he had to leave work and make time. If home help is available, it would be much better and also it would be personalized service to meet individual needs of a service user/patient

Offering a good service

Providing there is better home care services

Referring to some vulnerable people they should be separated from the main A&E they will be better treated and looked after if a team that understands their needs know how to deal with them or they will get better than society

So it would be company for the patient

So that patient receives care they are entitled to

The older people can benefit from it

While people still need hospital treatment they may not require acute care. Community hospitals are better placed to provide this

Yes if this is best practice

Should be in a particular area (15)

As long as it is in one area

But need to ensure equitable access across Middleborough/Redcar/Cleveland

One should be in the East of South Tees area and one in the West

But would prefer Guisborough to be one of the locations
For people to have a choice of Redcar or Middleborough for patients/carers

If these are in Redcar & Brotton, but the bulk of the population is in the Middleborough conurbation (including the west of Redcar & Cleveland LA area), there needs to be services in Middleborough, possibly at James Cook site?

It would be great if one of them was close to Middleborough

It’s difficult, I don’t know what is on in Redcar

One in East Cleveland

Only if they are used - not all beds currently being used by GPs at Redcar hospital as too expensive for practices

Please don’t forget east Cleveland hospital. We may love on the edge of your catchment area but our local primary care hospital is East Cleveland

Time, waiting, parking is atrocious at James Cook same as above answer (should utilize small Brotton + Redcar + Guisborough hospitals for patients in East Cleveland (parking etc)

Yes providing beds in the South Tees area able beneficially for the elderly people

yes providing beds in the South Tees area able beneficiary for the elderly people

Yes you should provide facilities in two locations and additional unit in order able to give services for elderly and vulnerable people

Elderly/vulnerable people should be prioritised (14)

Elderly people had paid into health care all their lives and should be well looked after

For young and old. Cost must always be considered for people going to visit the old and they need compassionate and the caring

In order to help those who are in need

Many elderly & vulnerable don’t have family support, are often confused and by the very meaning of the ‘vulnerable’

Priority for the elderly should come first

So you are aware of what the support is needed for the elderly

Specially for elderly will give enough room restoring his/her health
The elderly need to be covered for

The elderly require more care as they lose support from the government"

These groups should be highest priority

Vulnerable people need help

Vulnerable people should be top priority

Yes that should be better for elderly + vulnerable people

Yes the more the services are the better for the elderly and vulnerable people

**Good idea** (8)

Good idea, goes part of the way to solve the drawbacks

I think it is a good idea

It seems reasonable

Like that

Much needed

Seems economically wise

Very good idea as it gives opportunity for the elderly to meet up new people with common problem

Yes a good thing

**Other (47)**

Advantageous for patient + their families

All patients are NOT elderly

Any additional investment is good for the health of the elderly and vulnerable people

As long as it is true investments & not just a cost cutting exercise

As underlined - invest in more community services for elderly and vulnerable people?

Because money is then focused on 'lives' rather than things
Both proposed sites have more modern buildings and are on bus routes (not direct)

But how can we be sure that the community service will improve

Carers need some respite

Concern over no dates for reutilizing empty beds at Brotton

Even one could be enough

Even one location with more beds can cover

For less confusion of facilities etc.

Good in principle but hospitals need to be easily accessible by bus as well as car and it takes two buses to get to Redcar unless you live in Middleborough

I have no idea about numbers, but I guess that would be ok

If one is inefficient if can’t be compared with the other

If there are distance between them is better

If there is enough money yes, otherwise even one could cover this area

If this money could be spent on community service its more useful

Investment is paramount

It depends on the number of patient which I have no idea

It depends on the number of patients

It lets me avoid the James Cook hospital

It makes sense to close old expensive buildings and utilize fully the two newer hospitals

It would cover a lot more people more easily

Fewer beds will result in more patients needing home nursing - going back to olden times. Community services is a fancy way of saying home nursing

Many elderly people cannot go home, if they have stairs and only 1 toilet/bathroom. It would avoid falls for the frail

Middleborough Council support early intervention and community based services because they provide improved outcomes for those who use them, are more cost effective and are what our
citizens tell us they want.

*Older buildings with deteriorating condition are a financial drain*

*Provide community beds and rehabilitation services, it is basic services for community*

*Provided that the ‘investment’ does not demand a high degree of monetary expenditure which would drain resources required for their development*

*Redcar and Broton are modern hospitals and should be kept, a third would be useful for Middleborough area*

*Services are together and less confused*

*The answers is in the wording ‘more’ community services as the population is funding to live longer therefore ‘more’ elderly people than cover’*

*The number of homeless people would decrease*

*The number of sites appears to be irrelevant - again - good access essential*

*The patient can benefit from this service if it was closer*

*Then all the attention will be on the patient with special nurses who will have time to spend with them, and not have different to attend to them. They will open up to and relate to; it’s hard enough for them*

*To enable you to invest in more services*

*To give adequate specialist recuperation*

*Use them properly – train staff – dedicated staff*

*We don’t have enough choice in nursing care for stroke sufferers*

*we had these facilities years ago which were not replaced*

*Yes as more economical and community services could then be developed*

*yes then everyone is the community is cared for not just in hospital*

*yes, however, should utilize more care homes as intermediate care within a ‘step up step down’ pathway*

*You should provide this in four locations*
**No**

**There should be more than 2 (16)**

3 hospitals would be a more realistic model to serve the frail elderly and chronic illnesses closer to home. Middleborough, Redcar and Cleveland is an area that is a mixture of urban to extremely rural and unfortunately the north east does not have an efficient public transport infrastructure. For example to get return bus from Guisborough to Redcar costs £7.50 for a day saver unless on some form of benefits. Part of recovery is having the ability to socialize with those you love and the geographical area of the region will make this very difficult. The metal well being of individuals should be taken into consideration when planning such radical changes to the delivery of health care.

All locations should have community beds

East Cleveland would suffer if only two locations

I don’t think two locations is enough

I think every hospital should have community beds in their area

In as many locations as possible - to ease access by vulnerable patients and carers

It is not clear why community beds are needed or why there should be 20 (32-12 stroke rehab) at Redcar and 30 at Brotton. This is not an acceptable geographical split for the smaller number of community beds in the long term. Ultimately a new site at Hemlington Grange should be considered for 50% of the requirement

It makes it so difficult to access

Making them in more than two location will reduce, will further reduce costs and time consumed for getting the services

Need MORE than 2 locations if we are to increase care in community (as the population ages how can think of reducing them?) - This is a misleading and unfair question!

There should always be more than 1 location in case of infection outbreak & it may give a degree of choice to the patient

There should be more

Three needed

Two community beds, could be distance for some people and it makes the visit and support from
Carer more difficult

Two locations will not be enough. If Carter is to close, MORE beds will be needed in Guisborough, not fewer. I was recently asked to visit a Middleborough resident who on discharge from the James Cook Hospital had to be taken to Guisborough for convalescence because no beds available in Middleborough ANYWHERE

We should have beds in every hospital

Travel could be an issue / more local services (15)

2 locations where? Again, what thought has been given to people’s ability to access these services, both as a patient and visitor

Again, surely this will make it hard for people outside the immediate area to travel there; to be visited; especially as many elderly people have to use public transport

Because it is too far for visitors to travel

Beds will be nearer to home for visiting relatives. Especially as my family don’t drive

For the same reason as above (People are best left in the town where they live or as near as possible)

Good idea but perhaps more locations

I think we should make best use of existing LOCAL facilities

I would like community beds to remain at Guisborough General Hospital to serve residents locally

If we have in different location its easier for close family to visit more often

People in East Cleveland deserve the local hospital at Guisborough

Removing beds local to patients home, makes it harder for family + friends to visit, transport issues due to poor public transport links

This takes clients away from familiar area and people by only keeping in two places clients and their families may have trouble with cost getting there

This will isolate certain areas of the community and cause a lot more travelling for people. Can the car parks cope, will extra traffic. Will buses be available from all location’s

Want a hospital near me

When you are paralysed travelling can be a nightmare
There should be only 1 centre of excellence (4)

Bringing together all the resources available will help enhance effectiveness

Making beds in one location is better for economising services

One centralised area that has the services and equipment needed is more beneficial

Spending all money on one centre brings more quality to services

Other (20)

As above (Redcar is too far for visitors from Guisborough to travel. Also, GPs will no longer visit their patients)

As this would be a reduction to the number of Community based beds currently available I cannot see how this benefits the patient. Too many day care services for the elderly have already been closed down and I don’t have faith in the robustness of home based care as it is currently provided. Too often home based ‘carers’ are low paid workers who have no experience or evidence of ‘caring’.

Community services have been cut back to invest more means returning it to past levels which doesn’t deal with the problems which need community hospitals.

Elderly and vulnerable people are in need of a lot and constant care

Extra funds spend on hospitals

I do not see how you are going to recruit enough district nurses to see all these patients at home.

I think it is better to prepare more social care workers and to visit them in their homes

I think it is good to prepare for them community nursing

I think you should invest in good quality care both in the community & in community hospitals, there is not a one size fits all

I would rather see better care at home

Investment in more community services should not depend on the closure of hospitals

It’s difficult, I don’t know what is in Redcar

Leave them as are
Middleborough should stay open or be one of the places this happen. You are closing ward 11 in James Cook and now Carter Bequest Hospital

Not necessary

Some existing facilities already work well and new is not necessarily better

The community services needed aren’t always health related

The existing facilities should be upgraded and community services should be enhanced in line with the proposals. Once again financial considerations are the reason for the proposed changes. You use the word “local” many times in your documentation yet propose to remove services from local communities at a stroke.

The present set up works well. A home service cannot be as good. As health staff will spend time travelling to visit patients rather than seeing them in small groups

What is needed is a complete new idea and within financial constraints
Q.3 Do you agree with our proposal to provide a more comprehensive minor injury service at a single location (Redcar Primary Care Hospital) with enhanced medical and diagnostic cover?

Yes (212)

Reduces burden on other places (34)

At present the James Cook hospital seems to be fully occupied, coping with a high demand for its more serious injury services

GP appointments are difficult to make

I think it's a good idea to provide a more comprehensive minor injury service at a single location, because it will help people to get immediate service

It is clear that there is not sufficient demand for these services. Therefore, having a more effective service will release funding for other services.

It would ease the burden at James Cook University Hospital (11)

It would free queues and waiting times up (3)

It would relieve the burden on major trauma centres, provide local, speedier services and fully utilise this hospital

It would take the strain off A&E services (6)

Medical attention will be faster, taking the pressure off hospitals (3)

Redcar Primary Care Hospital is a new hospital and should be able to deal with minor operations, to relieve James Cook hospital

There is too much pressure and too many departments at James Cook, which increases waiting times

We all thought that when Red Primary care hospital opened that it was going to be alternative A&E for people in this area, thus relieving James Cook university hospital of already overloaded services

Better service/quality (32)

A single location with high quality is better than a few with low quality (3)

A well recognised centre works better
Again concentrating expertise should lead to a better level of care

All help will be under one roof, and patients won't be sent from one hospital to another to get treatment

As I said, one with better quality

Because people could get help more easily

Because what we think might be a minor injury, might have long term impacts

Communities can get service without losing time in the nearest location

Everything will be easy & you can get emergency treatments

Fairly central for the needs of swift action, by staff

I agree, because it will help people to get a fast and easy service

I can't see a problem, if service is better

I have always been against large hospitals, smaller units make it easier to get to and they can be more easily cleaned

I think any service provided becoming more comprehensive in what it can offer can only be a good thing. As long as funding is not taken from other services to cover the costs

If the budget is going to help and improve services in one location, sure

Improving the services in Redcar Primary Hospital is enough for the Teesside area

In order to provide help to those who are in need

Injuries could be diagnosed at an early stage

It is easier to get the best from one centre, which is facilitated

It should be used like Stead hospital; small and welcoming, not like James Cook Hospital. People complain that it’s too big. People, nurses and porters even complain that it’s too big. You don’t know where you’re going. Believe me, it’s scary enough going into hospital. You need to try and make them feel special

It will mean centralised, specialist staff, equipment and training

It’s better to be done in one centre with all facilities
Minor injuries separated from more serious injuries. It will enhance all treatment

That would increase efficiency and effectiveness

There will be a better staffing level with medical input and diagnostic facilities, which will only be achieved in a single location

This sounds like a more improved service to the one we currently have (2)

This will provide quicker treatment and diagnosis without the need to travel to another hospital

This will reduce waiting time, as long as the skills necessary are available. At present some very simple/basic skills are missing. Some skills could easily be mastered by nurses

This would again benefit more patients

Transport (30)

As both myself and my wife are disabled, we are not always able to help one another if we are having to travel long distances

As long as you also provide minor injury facilities at local GP surgeries, so you don’t have to travel a long way by bus

Big new hospital with good parking, minor injuries could be seen to much quicker, with a quicker diagnosis. It stops people getting frustrated

It is frustrating when arriving at Redcar Primary Care Hospital to be told that you need to go elsewhere, when you have no transport

It is more convenient than travelling to James Cook University (4)

It would reduce travelling time for any treatment. It would be very beneficial to this area

It would save patients travelling elsewhere

It’s not so far to travel for East Cleveland patients, to James Cook University Hospital A&E

James Cook University Hospital is difficult and expensive to park at and it is a long walk from the car parks. The hospital is so huge that it’s tiring visiting

James Cook University is difficult to get to without your own transport. Taxis are expensive.

My husband is aged 85, suffering from vascular dementia. He scrubbed his shins badly and received first class treatment there. If we had, had to go Middlesbrough twelve times, it would have been
very tiring

Probably. It depends how comprehensive is it, patients will have to travel further. They might then have to wait for ages, only to be told “you need to go to James Cook for this”?! 

Quicker emergency access is desirable, with less travelling and a speedier service. Staff will have more time to deal with people

There should be a transport service in place for those who will have to travel further (7)

There should be easier access to smaller hospitals, as it reduces stress and time travelling to larger ones

This has to be better for an ever growing community and outlying areas, instead of having to travel to Middlesbrough

Transport could be a problem (3)

Yes, if they have good parking and is on a bus route

You would need to think about the distance for the elderly

Agree (28)

Because it is a good thing and it’s for health

Centralising provision for minor injuries would seem appropriate for the Redcar & Cleveland LA area with residents of Middlesbrough encouraged to use the Linthorpe One Life Centre and North Ormesby Health Village

I am not sure what you mean by more comprehensive, but it sounds good

It is a good idea to have a more comprehensive care unit (9)

People suffering from minor injuries can come to the service centre from any locations

There is no need for more than one centre, for minor injuries (12)

This can only be a successful proposal due to the ever growing ageing population

We don’t need these services that often because it’s not urgent (2)

Local still needed (18)

As long as the A&E section at James Cook remains as a point, if going there is needed, then we are
for a single location at Redcar for minor injury service

Good idea, but what will local people do with their bleeding wounds or sprained ankles? They can’t be expected to get two buses to Redcar, they will just go directly to A&E at James Cook Hospital

Health care from different sectors needs to be given in all areas to enable everyone to get care and treatment

I agree, but some care in Guisborough would be very helpful

I think it is a good idea for minor injury people to go nearer home for treatment

If this means that East Cleveland Hospital can also provide a minor injury service. Local is better

I’m unsure if one site would be sufficient

It is necessary to have a closer service in this area, as getting to James Cook University can be quite traumatic from Redcar, and adds to stress

It is too far from East Cleveland for people

It will save a lot of stress to people who have a minor injury, being able to get local treatment

It would be better having it local, instead of going to Middlesbrough

It would help especially with children and old people. Getting taxis to South Cleveland can be expensive, old and young couples maybe cannot afford it. Brotton, Guisborough and Redcar should all be kept going. Also the walk in centre at Skelton is a Godsend with young children who are not always ill when you can get a doctor

People from Redcar, Skelton and Brotton should be treated at the nearest hospital, not somewhere miles away

People need a minor injury service fairly close to where they live. We have drop-in services nearby but most people don’t know about them. These should be used more, with more specialist care at Redcar hospital

We need more local treatment, there should be one everywhere (2)

Yes it is near where I live, but it could be difficult for people who live outside Redcar. There should be an increase in ambulances, as people can’t drive to Redcar if they are injured

Yes, if patients from the West side of the area are considered when arranging appointments - especially if they are elderly
Access (17)

Access, convenience and professionalism. There will be much less traffic and easier parking.

As long as elderly residents from East Cleveland can get there. Those ‘at the centre’ need to understand that ‘excellent services’ are wasted if people can’t actually get to them in the first place. Sometimes ‘less than excellent’ is better, if they are at least accessible.

Because it is much closer, we have the Redcar, let’s use it.

Easier access for elderly patients

Easy access to a local hospital is very important, with good facilities.

For me, it is ideal. I live in Lingdale, so it’s usually James Cook Hospital.

If minor injuries can be diagnosed and treated at Redcar, this will be more central to most residents and easier to access than James Cook hospital.

It is good because it is local.

It will be easier to get to the destination and park.

Local hospital but it is able to centralise urgent minor injury care in one centre, and Redcar is easily accessible in the Redcar and Cleveland area.

Local people are able to access the hospital, which provides an excellent service.

Providing there is still opportunity to access James Cook casualty department for people nearest to it.

Redcar is a convenient location for most people.

Redcar is not easy access for some area. Middlesbrough is more central.

Redcar is very near to us and much more accessible than James Cook Hospital.

Then it will be easier for people without cars to get to, quicker to be seen maybe.

There is easy access to Redcar Primary care for minor injuries. When Stead hospital was open, I received X-ray’s straight away, for two falls, as I have osteoporosis.

Facility underused (14)

I believe the location identified is totally under used. To have such a unit would in the long term produce value for money (2).
I don't think Redcar is used to its full advantage, it has the best quality facilities (9)

I have never stayed, it's new to me but people speak well of it

Redcar Primary Care hospital is a new build with new opportunities, which appears to be underused. It should be embraced to its full potential and services increased to the general public. Money would be better spent by the health authority

There are plenty of people who are unable to go to Middlesbrough, so Redcar is the best at the moment. It isn't being used to its full potential

One recognised place (10)

It brings more confidence when a patient goes to the centre with one facility of a special purpose (4)

It's better for it to be done in one recognised centre

People will know where to go, it will be a well known place for people (4)

Specialist services should be in one location, to effect economies of scale

Cost (4)

For obvious reasons; it is a waste of money not to

It will save on costs, rather than having two places to do one thing - by having one (2)

We don't need to spend money on staff and buildings for minor injury

Other (25)

Any improvement for elderly is helpful

As long as it is not at James Cook hospital, I don't mind

As long as its appropriately staffed

Based on existing usage at existing sites this seems like a rational decision

But there needs to be a doctor available at all times, that is able to treat a wider range of injury

But what is the future of the NHS walk-in services?

Existing minor injury services are too fragmented and staffing is a problem, anything more than
requiring a plaster not covered

Hands on approach is best

I do, as long as they have nurses who can stitch. Which they haven’t at the moment

I have used the NHS, for my husband

If only one unit can be afforded

If you have a sprained ankle, you would go to the doctors

Instead of a patient going to James Cook University Hospital after being seen at Redcar, it would shorten the time factor

It also needs advertising, where the hospital works

It needs to be clearer; what a ’minor injury’ is, and who will provide the medical cover

No comment (2)

Such items, as such as, blood transfusion would be useful for patients requiring a ’top up’

This has been promised for at least 50 years in my experience

This would take from James Cook

Why not Brotton hospital?

Yes and no; the answer above applies. Dependant on where they are situated; East Cleveland is demographically the lowest car ownership in the UK, so it depends where the locations are and if it is possible for relatives/friends to visit. How do you get a 90 year old person to a minor injuries centre using a bus?!

Yes most priority things on medical issues (2)

Yes, but what has this got to do with “elderly and vulnerable people”? Minor injuries happen to everyone

No (133)

Access/locality (43)

Again we are on the edge of your catchment area; time to get to a minor injuries centre is very
Again, local communities in Guisborough and East Cleveland will be left with no minor injuries cover. In your documentation you quote figures for attendance at minor injuries clinics and the figures for Guisborough are inaccurate and much lower than actual, is this a genuine error or concocted to suit your argument? Once again financial considerations are the reason for change not necessarily patient welfare.

Because that (Redcar primary care hospital) is enough for minor injury

Brotton is closer and better for us to get to in this area (2)

Definitely not. By closing East Cleveland hospital minor accidents deprives East Cleveland of a vital facility. Having had to use this service in the past, it should not be closed

Due to ease of access (9)

I disagree with centralisation as it consumes time and energy for the elderly to reach the location, from any place in the Tees area

I think we should make best use of existing local facilities (2)

I would prefer to see the minor injuries unit at Guisborough Hospital continue. I have needed to use it several times

If the service in Guisborough closes and the surgery was closed, we would go to James Cook Hospital not Redcar (3)

If you are not a car owner, accessing a minor injury clinic at Redcar in the middle of the night is difficult or well nigh impossible. Keep the minor injury unit at Brotton

It (or they) needs to be located where access is required most. Have you looked at where minor injuries occur? What are the consequences of limiting local access? Could this force more people to attend A&E? E.g. Guisborough to James Cook hospital might well be quicker than travelling Guisborough to Redcar.

It is difficult to get to Redcar (6)

It needs to be more local to be seen, if it is serious then you can be referred

It’s good to have single location, but I’m not sure Redcar is the ideal one

Minor injuries need to be dealt with promptly and locally. Guisborough and Brotton patients would have to travel to Redcar. How is that a better service for them?

Needs to be Guisborough and Redcar, to provide skilled and convenient care. If we don’t upgrade
Guisborough buildings and facilities it will be demolished and sold off for redevelopment. The money only happens once as a ‘benefit’ to the health services. The need is ongoing for the community - the area around Guisborough.

People with bleeding wounds, minor head injuries etc. need somewhere local; you can’t get on buses with bleeding wounds. Could GP surgeries provide cover for this? Patients now wait days for re-dressings because there are no appointments available.

Please keep minor injury facility at Brotton.

Redcar is not easy to get to from some areas (4).

There is a community hospital at Guisborough which should remain open, especially as we have more elderly residents in the community that require a local hospital.

They need to utilize more pharmacist premises closer to home, ‘faster care, productive series’ - utilize pharmacy contract.

Vulnerable old people need local care. i.e. Brotton hospital.

**Travel/transport (31)**

*Being centralised, people at various areas will have to travel too far for treatment.*

For people who rely on public transport, local community hospitals are more important for those who do not suffer from an acute condition.

*How do we get there from Brotton?*

I don’t really know about this as the small local units provide a good service. They make good decisions as to travel when the need arises rather than going to Redcar every time.

If people are relying on public transport, it is far easier for the residents of Guisborough to travel to the James Cook University Hospital A&E than it is to go to Redcar. It is well reported how increasing numbers in A&E are causing extreme pressures, yet the plan to close a minor injuries unit at Guisborough does not fit with the national aspiration to move care closer to home.

It adds transportation costs, and the GP’s in one area can provide that kind of service with some help.

*It is difficult to get to because the bus service doesn’t go past the hospital.*

*It is too far and too difficult to get to from East Cleveland Villages (10).*

*It is too far to travel with a minor injury without a car (6).*
It would be better if it was localised, you are covering a large area and older people will have trouble travelling large distances for a minor injury

Minor injury usually means exactly that and if the elderly and vulnerable have to travel into Redcar, they might not and it could easily become major. Not everyone has a car

Most people have travel issues, plus South Tees is too big of an area to just have one centre

Redcar is too far to travel from Middlesbrough

The area we cover is massive and patients living in the outlying villages have no ability to travel to Redcar. They are often elderly people and the public transport has been drastically cut in recent years. Has the cost of additional use of ambulance transport services been considered?

Transport is a problem for older people.

Travelling is an issue for some people (12)

Why should patients have to travel when a hospital is on their doorstep

**Should be more than one (28)**

Because minor injuries are the most frequent health problems and their treatment should be widely available in many locations (3)

Every community needs a minor injury service around their area (4)

I think more than one minor injury service would be better e.g. keeping the Guisborough one. If it can’t be dealt with there, then people would go to Redcar (2)

I think providing only in one location is not enough and easy for more people at least it should be in two locations (4)

I think you should have more than one single location (8)

I want to go somewhere closer to where I live in Middlesbrough

We need injury services to be available in every hospital (6)

**Overcrowding (8)**

I don’t believe the infrastructure at Redcar will cope with the additional patients brought to them, by the closure of the minor injuries and drop in centres at Brotton and Skelton
I think putting injury service to a single place might make the service busy

Improve local minor injury services rather than block of congest at one place. Put an explanation on what is a minor injury

It’s going down the same path as South Tees Hospital, with long waits when it could be more urgent than it looks

Maybe in local GP’s as there is too much of a waiting time in big hospitals

Minor injuries can be urgent. Waiting times may increase if there is only one unit

The alternative at James Cook hospital is usually extremely busy, on Tuesday afternoon about 3pm, 22/7/14 it was announced "two hour wait for trauma patients"

There is congestion encountered at present in the James Cook University Hospital. A&E will be far better received at two or three points rather than just one. There is also a need for better publicity indicating the mobility of doctors surgery to provide minor injury care

Cost (8)

Concentrating all patients in one location will result in longer waiting times. Redcar now has a reputation of sending patients to James Cook anyway - so people will bypass Redcar and go straight to Middlesbrough

I believe funds should be spent on more minor injury facilities as they are more important

It is a good idea to provide help in GP surgery’s to save money and time

It is a waste of money and personnel

This money is better spent on hospitals and vulnerable people (3)

While I believe the Redcar Primary Care Hospital should be more fully utilised given the cost of its construction, I do not feel that this should be to the detriment of the services provided more locally to people at e.g. the East Cleveland Hospital at Brotton. For people in Loftus and surrounding areas it is far more convenient to get to Brotton than Redcar.

People will just go to A&E (7)

I live in Guisborough. Redcar is too far away for minor injuries and the hospital is not well-served by public transport from here. If you close the minor injuries department in Guisborough, I might as well
go to A&E at James Cook Hospital - which is probably not what you intend

If minor injuries cover is restricted to Redcar. Then people will consider going to James Cook University A&E

It is a lovely hospital but I don’t feel one centre could cope with the population locally and more people will then attend A&E at James Cook. Where did the attendance figures come from for local minor injuries units. It can’t be true that they only see 2 – 6 people per day on 2 occasions, I have had cause to use, and there have been many more patients in waiting areas.

Minor injuries being moved further away is an inconvenience due to poor public transport links. There is no incentive to go to Redcar over James Cook University Hospital, there will be an increasing demand in A&E

On one hand it will teach people to take responsibility and look after themselves, they will think twice about whether the injury warrants being seen at urgent care. But it is very difficult for elderly and vulnerable people to access Redcar Hospital by public transport from the East Cleveland area, unless transport provision is addressed. Patients are still confused as to what urgent care centres are able to treat and if an X-ray is available when it is needed. Also you will not want to risk taking two buses to Redcar with an injury to be told you then have to get to A&E on a further two buses - many people will just go to A&E first.

There are a lot of rural villages that would have too far to travel. A lot poorer families, with young children possibly, will call for an ambulance to James Cook University Hospital, therefore there will be more burden on major hospitals

There are already long waiting times at Redcar with minor injuries; they will be longer if Brotton and Guisborough close. More people will travel to James Cook University Hospital A&E, it is already overstretched

Other (8)

"Minor injuries are lover in priority hospitals etc"

We have no ambulance service at Guisborough

As with question 1; I think it is unnecessary to treat minor injuries in a way which suggests great expertise or equipment is needed

Only serious injuries should be focussed on

Rotation of staffing already exists to maintain high standards of staffing. It appears there are issues with equipment NOT staffing
This will mean some outlying hospitals would shut.

We need better hospitals.

What about the vulnerable people in East Cleveland. Don’t people care about these?
Q4. Do you agree with our proposal to spend more of our money on increasing community nursing and therapy services rather than on maintaining ageing buildings which are not able to support the delivery of our model of care?

Yes

Money should be spent on health care (125)

100% It’s spending money on something that we can get more benefit

Absolutely - invest in district nursing + provide spaces for offices - community services

Although building need improvement but nursing priority

Always training nurses and provide some carers at home its easier and less costs

Any increase in nursing and therapy services is a benefit - ageing buildings do not help care for patients

As a patient I care about the service that I receive not building itself

As long as it doesn’t affect the quality of the service provided

As long as you also address the gaps in the service which occur out of hours - community nursing needs to provide 24hr care

As long as you do delivery community nursing. The nurses in community continually complain they do not have the resources or man power to support elderly

As Q2 (Older buildings with deteriorating condition are a financial drain)

as underlined - increasing community nursing and therapy services rather than on maintaining ageing buildings

Because community nursing is very important and appreciated

because I think increasing community nursing and therapy services will be for the best

Because it is better to save peoples life than to maintain buildings

Because it makes sense

Because it makes sense providing the old sites are sold off for funding

Because it will improve the standard of care for all service users and get the support that they need

Because nursing and therapy services save peoples life and I think priority should be given to that
Because people are more important than buildings

Because people who are elderly or vulnerable are in need then you can help them more

Because people will get more concentrated care

Because priority should be given to community's health

Because this relieves the hospitals and is a big factor in helping people to stay in their own homes before anything patient need good care

Best way to use funds

Better nurses

Better to have quality and reliable services than having old system

Better use of money, resources & people able to stay in known family environment

Both are needed but nursing has more priority over building

Both important but nursing comes first

Building and nursing both are needed for treatment but nursing has priority

Care is uppermost

Care should be about people not ageing buildings

Carers and care therapy services need more funding and availability to ensure mental wellbeing & stress of caring/being cared for

Common sense. Better to repair old people rather than old buildings

Community based care + treating people in their homes generally appears to be better for patients

Community care hopefully with their care at home is what most people prefer

Community care is more important than ageing buildings

Community nurses are brilliant, and give a very caring service, more important than a building

Community nursing & therapy services more important than ageing buildings - use Brotton & Redcar hospitals more
Community nursing is the way forward

Community nursing is VITAL where as old buildings are not

Community treating people in their own home we'll provide a less stressful experience & alert the nurse to the patients living conditions

Could cause more than the old buildings are worth. The money would be best spent on community nursing

Elderly and frail patients on the whole prefer to be seen at home if possible for nursing and therapy. Money spent on trying to maintain old buildings would be better spent on staff

Funds are limited; use them to provide services to the local community. Services that are wanted + needed

Good building with bad services is meaningless

Health is much more important than buildings, however you cannot pass by the goodness of building can have a positive impact

I agree because people are more useful than a building. It is good to increase community nursing

I agree in ‘principle’ but there is much more evidence needed of how this is proposed to be provided and how patients will access it For instance, Mental Health services were moved to Kirkleatham which is the most out of the way/inaccessible/impersonal place imaginable. In this instance I don’t believe the needs of patients were a priority over costs

I agree only if the money saved is used for community nursing and does not ‘disappear’

I think spending money on old building is part of mission and still we need trained nurse

If it improves healthcare and reduces costs

If we don’t have enough nursing service, no matter if the building is old or new, we have no use of them

If we have the modern building without good care and service there is no use to it

Increase community staffing will help keeping patients in community and reduce pressure on beds

Investing in personnel development and satisfaction can improve the services given by them

It is a more effective use of decreasing financial resources

It is better to spend money on something that is ongoing and more useful
It is waste of money to spend on old building while improving nursing area are better way

it saves money for better purpose

It sounds like a better idea than maintaining old buildings that could probably be sold off.

It’s better to help people than to maintain buildings, but of course building will also need to be maintained as shelter is very important

Money should spent on nursing + therapy services, definitely not on buildings

Money spent on nursing is obviously more important. But if ageing buildings e.g. Guisborough are to close, another in the vicinity should be provided

Money will be reinvested + not saved. We feel this is very important because the demand for personal home care is there

More budget funds to be utilized directly on people

More cost effective

More cost effective and meet needs of local population/community

More cost effective in financial and environmental terms

More cost effective to increase community care

Nursing always come first, if we have a perfect building with not enough nursing service then is no use to it

Nursing and caring are very important and has priority over other issue

Nursing and therapy services are essential for community

Nursing are important issue which can be done in old building

Nursing has priority over building

Nursing is better as it’s the people working in hospital, not the technology that saves lives

Nursing is more important and vital compare with building itself it can be delivered anywhere

Nursing is more important than building although we need building to provide the service

Nursing is more important than building itself so it comes first
Nursing is very important, sometimes can be done at patients home

Obviously more “feet on the ground” should mean better care, need dedicated staff for this

Of course the funding for increasing community services have a great role in serving community

Of course the funding for increasing community services have a great role in surviving community

Older, vulnerable ref Q2 (vulnerable people should be top priority)

Patient care if vital to health and needs of response can help recovery

Patient expect good care first, the building not as important as nursing

Patient needs care first it could be done even at home

People are more important than buildings

People matter they come first

People more important. Comfort knowing these facilities are there for us

People need this service, perhaps a grant could be made available to repair buildings

People’s lives are more important than buildings. If people are healthy they can manage living in ageing buildings, but new buildings cannot guarantee health of people

Personally all I care about is to receive a good service doesn’t matter where

Prioritizing the most important thing is wise

Quality of the service can only be improved by investing in nursing therapy services

Quality service comes first

Receiving nursing this valuable

So more money can be saved for other purpose

Some of the services can be done at patients house or local centre, so it’s better to spend money on better purpose

Spend more money in increasing community nursing

Spending money on trained nurses help to save time and costs in future
Spending on individual people is important

Support in the community essential

Surely... I prefer nursing over the location

The building itself is not useful unless we have good nursing

the older the building the more the cost to maintain- if the staff trained to go out its better/no contest

The overheads for maintaining ageing buildings will increase, this money would be better value used in the community

The way this question is asked it would be very difficult to disagree. I do agree with the statement however I believe it would be better to close 1 hospital rather than 2.

They both as important but having enough community nurses is essential

To make community services better

To make community services better

To make services better

Too much money wasted on old buildings, better spent directly on people

We always have to consider priority and in this case nursing is more important

We have to consider which one is more important and have priority which is nursing

We require the money in ‘doing’ the services rather than spending on maintenance

Without a good service of nursing, building doesn’t have any use

Without building we still can receive good nursing but without nursing no use of buildings

Yes - as long as the money saved DOES actually go towards enhancing the services, rather than ‘saved’

Yes definitely, therapy and similar care are more important

Yes I agree on increasing community nursing rather than building? I believe there is a shortage of nursing
Yes I do agree the funds on increasing community nursing and therapy services

Yes it is always better to spend on the community rather than buildings, people first

**Community/ Home care should be utilised more/ it is the best form of care (58)**

A lot of people need support in homes, they don’t get much personalized one to one service

Although a good nursing needs location, but most or some of it can be done even at home

As my relatives surgery has just closed making an extra journey necessary to the next available surgery more community contact would be a bonus

Being treated at home instead of going to an old hospital has a better feeling possible aiding the patient recovery

But how do we know that community nursing services will be properly IMPROVED? Ten minute visits are ineffective

**BUT it isn’t always nursing interventions that people require – it is social support especially out of hours or there isn’t anywhere near enough!**

But make sure there are sufficient community nurses to cover all this extra work. Not enough now before any changes

But with reservations. It is good to keep people in their own homes, but it can be a great strain on the family carers. Caring help is appreciated but it is not always easy to get. Good carers are few and far between an caring at home family can be frightening if you don’t understand the case

Could you also look at providing health facilities that the community need i.e. autism/dementia

Definitely. Community care should be a priority

Especially if it means working with the elderly in their own homes or immediate locality

Especially if these increased services are accessible through GP services

For many patients, being in their own home is often a help in them getting better quicker, they are able to feel more relaxed in familiar surroundings

Have physiotherapy service at home. My husband was sent out of hospital with no real physio, only one physio came to show two carers what to do

Help in the home gives people easier access to services and communications
Here again it would be local and not involve so much travel

Home + community services reduce travelling times and reduce pressure on main hospital

Home visits would be wonderful

I believe in care, wherever possible going to people in their homes

I do feel the community nurses do a good job, but some changes need to be put in place. Some people locked in on their own over night is a no no. More time is needed if the nurse requires it to make safe and secure some patients

I feel it better to have treatment at home close by

I have found nursing care from community nurses second to none

I have great faith in our community nurses, they do an excellent job

I think it is very important to care for people in the community - at home wherever possible. This service is invaluable

Improve the level of communication between nursing therapies. This is largely absent at present

It gives people more independence

it is helpful because when you increase community nursing those vulnerable people will get more attention

It will allow community nurses to see the environment that some patients are living in? and money can be saved by not having to maintain old buildings

It will enable service users to get more specialist care and a high quality of treatments

Keep more people at home as possible

Keep people in their own homes must be cheaper than - ambulances and waiting in hospitals

Less hospital nursing, more community nursing = less cost

Lots of people are more comfortable with care at home and their own GP who knows their situation

Make more time for them, instead of "yes we have 1/2hr or 1hr to work with you", it’s all about time

Mobility would enable a more flexible service, and less inconvenience for very disabled clients

More community nursing would free up a lot of hospital beds
More contact for people in the community builds confidence in service

More convenient for patient and less worry

Most patients are happier at home and especially older persons who find change disturbing

My experience has been that we have had excellent care in the home

My nephew has MS – he receives care at home. Easier for his mum who not have to keep visiting him at hospital

Often problems can be resolved with advice/community care - no need for buildings

Old people like to live in their own homes as long as possible

Old people would not have to go to James Cook hospital as I have experience of this

Patients would be much happier receiving treatment at home when possible

People are better in their own homes if possible

People cannot always travel to the hospital easily nor visitors especially from East Cleveland

People much happier in their own homes

People need care and of course a place to care but it could sometimes be at home

Recovery at home is a lot faster, safer in your own home, less bugs

Short term hospital stay, and when ready would be better served at home

The more community nursing the better it could be

To deliver care at home, where patients want it and when they want it

Very much so if it keeps patients in their homes and hours are allowed for doctors appointments not just telephone consultation

We need to increase the number of community nurses as it is more important than location

We want to stay in our HOME for the rest of our lives with our own things around us. We want to eat our own food, sleep in our own bed etc

Yes most people would like to be helped in the home they would feel better

Yes to reduce the difficulty of travelling
As long as services are maintained (36)

As long as East Cleveland maintains one of its hospitals

As long as sufficient time is allocated to each patient!

As long as there is some community hospital provision as this also prevents patients being admitted to James Cook and supports community nursing & therapy services

As long as they can provide the same services and cover. Will they have all the necessary equipment?

As long as this happens + elderly + vulnerable get the support at home they need

As long as this will not overload the proposed locations

Bring services up to date

But existing buildings/infrastructure should not be overloaded to a point where they become less effective (N.B) car parking at Guisborough PCH

but some aging buildings need replacement

But we still need hospitals

But will there be enough staff?

Definitely a good idea as long as this service can be funded adequately

For all patients the important issue is to receive the best care no matter where

Having the right number of nurses

However I think it would be difficult to employ sufficient staff

Human resources development is important for any improvement of services

Human Resources development is key for any improved medical services

Human resources is vital for health service and I highly endorse your plan

I agree but my observation of how resources are managed must improve too much wastage and i.e. time

I feel this is a fantastic idea, but have my reservations if this will work
If properly organized and staff don't spend a large amount of time travelling or doing not much work

More money needs to be spent on the stroke sufferers etc;

More mobile options too e.g. OT events at other community venues - raising awareness of services etc

Only if comprehensive and joined up

Only if that is what expert evidence tells you to do.

Regular visits/checks on patient’s health & mental wellbeing, not as a direct response to a GP/hospital appointment. Reassurance for patients and carers alike

The more trained nurse, less place and practices are needed

There must be better organisation of nursing services!! I have experienced community matron service - EXCELLENT. District Nurses - understaffed and erratic

We need to go back to the old fashioned traditional approach of the district nurses etc. People who are vulnerable and are unable to access medical centre’s would benefit from this type of care, and the confidence of seeing the same people who help with anxiety and worry

Yes better to have quality medications and good services

Yes but not if it means closing Guisborough Hospital. People in this town need local facilities

Yes but with PROFESSIONALLY trained staff

Yes good idea as more & more pressure on James Cook Uni Hospital - who do sterling work

Yes it makes sense, but it will be very sad to see Guisborough lose yet another service.

Yes providing the above assurances can be given (Minor injuries may be minor but require urgent attention, this will not be available if only available at a single location)

Yes to increasing community service, but buildings must not be left to rot!

Maintaining buildings would be inefficient (23)

A lot of the buildings are not in any fit state for Dr's or treatment to go on

A lot of waste on buildings not reaching full potential

A much better use of finances
Ageing buildings are no longer fit for purpose. too much financial upkeep in line i/c health & safety

Ageing buildings are similar to anything becoming older. More resources are needed to keep them serviceable. Modern methods are therefore needed

Ageing buildings need to be upgraded and even demolished, so that it could be ready and fit to the new standard of living

Ageing buildings should not cost a lot of money

I am surprised the Guisborough Primary care Hospital is not considered a difficult to maintain ageing buildings site. Guisborough area needs a facility like the Linthorpe One Life Centre or the North Ormesby Health Village

If the buildings are nor providing the correct standard of care then the NHS should cease to spend money on them

Maintaining old buildings is too expensive & the money could be better spent

My experience of older buildings are very expensive to maintain

new buildings are designed-for-purpose, being more beneficial to both staff and patients

New buildings with better equipment + services

Newer buildings are cheaper to maintain, therefore money can be spent on patient care

No point maintaining ageing buildings that aren’t fit for purpose

no point maintaining an ageing building if the patient dies due to lack of care or funding

Of course some of the building are very old and waste of money and time to work on them

Old buildings need continuous maintenance so are expensive

Some building are simply wasting money which otherwise would have been used in more important services

Some hospitals too old to alter

Some of the hospitals are too old!

There comes a time when old buildings outlive their use

Too expensive to build more why close ‘Carter Bequest’ and others? use them instead of pulling them down
Agree (17)

Absolutely agree

Agree with it

agree with you

BUT this is a LOADED question anyway, suggesting that the only sensible, logical answer should be yes

Definitely yes

I definitely agree

It makes sense

It's a no brainer decision

It's obvious - but this is a leading question, isn't it?

Seems like common sense

Seems sensible

Sounds good to me

Spot on

The answer is in the question i.e. maintaining ageing buildings which are NOT ABLE

This is a very slanted question” how else could it be answered?

This is just plain common-sense, I can’t think of any reasons against this

When you phrase it that way most would say yes. But you’re not saying what extra stuff these nurses will be doing. They've always been few on the ground and overstretched in Guisborough area

Other (28)

All available funds to focus as is possible to maintain points of interest (Don’t get side tracked)

All patients care should be excellent services and treatment no matter where

Answers in your question
Are there any old buildings left?

Are there cheaper options for office/admin accommodation than those used at present?

Because, having good buildings and infrastructure has its role in healing

But stop GIVING the land to developers, then paying astronomic rents

Ditto

Don’t get enough care

Hopefully lead to better care

I have a vested interest regarding the closure of Carter Bequest hospital. My mother received totally inadequate treatment at that unsuitable building masquerading as a hospital. CLOSE IT

It’s important for the elderly to have access to the doctors surgery, people on Ings farm have 2 buses to get to Redcar hospital or get a taxi

It’s important to think how to look after them then where?

It’s more pleasant for people to have to go to instead of sitting in old cold places

More nurses means better care and welfare for the individual person

No comment

Ok. We need good buildings too

Overlooking building is not wise, some buildings need updating

Please see the responses to other questions

Provided that the care is made available. My husband and myself have been on hospital 3 times since Oct 12, we both made certain (James Cook + Darlington Memorial) that people knew that we could not cope at home on several occasions but no help was given

Spending on?

The elderly/vulnerable require extensive care from nurses

The trend to centralisation is not satisfactory for many elderly people and their relatives

There would be more centralised care
This for people to benefit from these services and if you offer it could help patients

To carry out treatment buildings are needed but this could be done anywhere

Yes I just worry its only talk

We have to consider priority as both are important

No

Buildings are important to delivering care (12)

Both of them looks of equal importance to me

Buildings are important

buildings maintaining is very important to prevent any infections

Hospital standards are vital

Hospitals > Nursing

Hospitals need to be improved to provide better care

I think it is better if it is giving equal

Maintaining ageing buildings are more important

Maintaining ageing buildings is more important in my opinion

maintaining buildings and having the right equipment is equally as important

These are not mutually exclusive alternatives

Why not do both?

Other (36)

?? existing buildings or replace or renew over a period until available in every location

Money spent on the community

A hospital is needed in the town (Guisborough)
As this is often service lead focus, rather than person lead care

Because any care is better than none

Buildings are secondary however if you have the extra resource to do it then fine

Carter Bequest wouldn’t matter as James Cook is in Middleborough but Guisborough has no other facility

Community nursing is an excellent idea but should be ‘as well as’ + not ‘instead of’ - closing local buildings for therapy means any specialized nursing or equipment used will mean, again, the elderly having to travel

Rehabilitation services are suffering because of this proposal

Don’t do away with smaller units, James Cook is too full already, better personal care at smaller units

Good quality buildings are also important for the psychology of the patients and their carers

Guisborough in the East Cleveland area is an old hospital Redcar & Brotton are not see question 7 (Minor injury support at Guisborough should be left there)

I believe due to an ageing population, the younger population should be cared for more

I do not think enough services can be given, too big area not enough staff, would need too much

I think we should improve community facilities at Redcar & Guisborough & Brotton

In practice doesn’t work - sounds good in theory!

Investing in old buildings is rather timely in our area, neglecting them for any longer will further increase future costs

It depends on which buildings you are thinking of destroying

It seems your questions are worded to ‘encourage’ people to agree with your statements. How much in the 30 year period of paying for Redcar will it cost in comparison to the maintenance of Carter Bequest Hospital

It’s about people and caring not money and buildings

Local communities will have to leave their area where either the client of the family will have to travel, which they may not afford

Maintenance of ageing buildings is one time investment and hence it should be given priority in this year’s budget
Maintaining ageing building equally as important as increasing community nursing

Money is better spent on new hospitals

My experience of community nursing was variable. The care at Guisborough General could not be bettered

Not everybody wants to be treated in their own home they feel more safe in hospital

Nursing is very important

Once centers close never replaced

Services need to be local to those using them even if it means new builds

The buildings are there why not use them for the good of the "local" population. I agree care in the community should be given more resources but who will provide it NHS staff or private companies who need to make a profit at the expense of the taxpayer and patients. Carers with limited time slots under pressure to perform does not bode well for quality healthcare

The buildings should have been maintained, it’s just an excuse to close community hospitals. The kind of care given in small hospitals should be duplicated not crushed.

This is just an excuse to close building and centralize services

We have been told previously the cost of the NHS is staff - not buildings - which is why Redcar PCH is underused. Paying nursing services to travel to patients homes is not cost effective

What is needed is a new/different approach, not what is suggested, perhaps using hidden resources within communities

Will anyone tick the box advocating buildings not nurses??!
Q.5 How else do you think we could increase and improve community based services for people who are elderly, vulnerable or who have long-term conditions? This would include, for example, occupational therapy and physiotherapy services.

More/longer Home visits/home care (49)

Any service needs to have comprehensive out of hours services - to deal with problems 24/7 ideally in the persons own home - not all incidents require or need hospital admission

At home people would not be waiting too long for therapy

Bring more nurses to visit patient at home

Bring more nurses to visit patient at home

By providing home visiting and taking them out

By providing some of the services at their home such as blood test

By sending trained nurse to their home

By sending trained nurse to their home

Care in the home (support)

Checkups on elderly should be more often for the housebound

Definitely physio at home is essential, in our case for my husband who is paraplegic

Expansion of day hospital facilities, and day centres for more social problems including loneliness and dementia. Rapid response to social needs, walking aids commodes etc. * Better home care support (banish the 15 min appointments) Ensure carers are dementia aware. Allow them time for flexibility. If an old person is off legs one day they may need a bit longer!

extra care at home services podiatry in more locations

Feel many elderly would appreciate home visits rather than attending outpatient clinics

Going back to when I was looking after my elderly mother the only thing I wanted help with was someone to sit with her whilst I went out. It was impossible to get any help with this and I had to beg friends and neighbours who, quite frankly, I would rather not have asked. However, it was also quite a problem getting her to go to hospital appointments so both the examples would be of help I would imagine when people are frail.

Hold house to house services
home service

Home visit

home visits where possible

I believe in care, wherever possible going to people in their homes

I think a visit from a doctor or nurse once a month means they have not been forgotten

I think is best to take care of the elderly, the vulnerable in their own homes, with their relatives being paid and working for them

if its suitable and can be done at home do it, old people would like to be at home

if possible, to treat then in their own homes

If you could provide some of these services at their place. Could help a lot to both patients and providers

Improvement would be good if therapy of any kind could be done at home (under supervision & advice & shorter waiting at hospitals)

It would be easier at home, but for some services it is better to go out to venue, due to equipment/machinery

It would help if GPs visited patients at home as well, as they always used to visit the elderly as part of their job! And then there was only one doctor, not group practices!

It would help if some of these services could be available in their homes for housebound patients

Just providing a personalised service in the home

Making arrangements for the elderly to get periodic physiotherapy services at home if possible would be helpful

Maybe more home visits would improve patients care

More home care

More home visits and not just for elderly there are much younger people housebound which require these services

More home visits from nurses and doctors

More provision of home-delivered services would be a distinct improvement
more trained staff (and volunteers) to provide care in the home money saved by closing old, out of date buildings should be made available to provide more home and community care

More treatment at home

More visits to people who are lonely, and need to talk to someone, maybe join a day centre

Perhaps the treatment could be done in people’s homes

PLEASE improve community podiatry services - elderly people can’t always get to the clinics, however ‘local’ a better home visiting service, especially for those with diabetes, would prevent problems getting ‘worse’ and ultimately save money in hospital admissions!

Simple regular routine health visits/checks in the patients home

Some of these services can be done by nurse at patients place to save both patient and NHS time and costs

Some of these services can be done by nurse at patients place to save both patient and NHS time and costs

Some of these services can be done in locals surgery or even patients home

The obvious is to increase staffing levels and the allocation of a particular carer for the elderly who would do at least a monthly visit even when patient is not specifically ill

There is a need for more staff possibly to visit homes and/or even nursing homes to keep people at home. Possibly increase facilities in community hospitals

Visit at least one a week to help a little. Caring is important!

Yes more home help

More local facilities (42)

A lot of people live close to the main hospital. This could be the best location for care close to home.

As you so rightly say, these services will become more necessary with the increasing number of us living longer. It will therefore mean an increasing number of qualified staff. They have LOCAL ‘call in’ centres must be better use of their time - otherwise they spend much of their precious time travelling to see individuals!!

Bring more services to Redcar hospital to save long journey to James Cook
By establishing these community in different locations to have easy access

By increase the number of local surgery which carry some of services that before was done at hospital

By providing more centre close by

I am in favour of keeping the services in the community saving the elderly from going to hospital. In my experience it would be preferred as visits to the hospital can be traumatic

I believe local services is essential closest to the community that it services

I go to James Cook for reiki and aromatherapy every month and it would be handier if I could go to Redcar Primary Trust because it is nearer and saves an hour’s time

I think there should be more services provided locally than at present - centralisation is not the best answer

If we can have more practice with better quality close to different area

If we could have a community based service in every town and one centre rehab service is useful

If we could some of treatment @ local surgery such as therapy, physio could save time

If you used local hospitals for more services, it is easier to get to for older people; James Cook is such a massive place very intimidating for older people. It would give the large hospitals less work for minor ailments the nearer to home locations the better

Increase local community service

Increase the services provided at local hospitals. The physiotherapy services at East Cleveland hospital are very important. Having had physiotherapy at East Cleveland, it was a great help being local

Keep the clients & treat them within their own community without them having to go to James Cook or Redcar Primary Care hospital that way the client will be familiar with the surrounding area and people

Local community based services can do most of these tasks

Local community based services can do most of these tasks

Make these easier to access

More near to the people in need
More outpatient facilities to avoid lengthy journey to JCUH

patients don't need to go to hospital for every service such as physio if it is provided in local community services

Provide more local amenities in Guisborough/Loftus areas not just Redcar/Middlesbrough

Provide some of the services which they have to do at hospital close to their home

Providing more services locally

Reduce the waiting times, ease transport access by providing facilities across the area, increase trained staff, keep appointment times

Some of the treatment can be done locally and no need for hospital treatment

Some of the treatment can be done locally and no need for hospital treatment

Therapy services should be offered in local GP surgeries where possible or outreach centres. Getting to these services is usually a problem for the elderly and infirm.

There are too many therapists-based clinics centralised at the JCUH, these clinics should be moved into the community hospitals and managers should focus on making JCUH purely an inpatient acute service and as soon as patients are ready to be discharged all clinics should be held at the community centres. If this model were taken forward it would release therapists to outreach to those who cannot attend a community centre.

They would need to be in easy distance to get to

To increase the number of local community-based services

To increase the number of local surgery where patients can receive some of this service

to provide easy access to services such as therapy through locals

To provide more small centre in different location

To provide most of the services locally

To provide most of the services locally

To provide some of the hospital treatment in the local practice which is easy to access

To provide some of the services which already received at hospital close to their home @ local practice or centre instead of hospital
use local pharmacy premises/care homes more use of 'life coaches' - improving care pathways

Where possible at home or nearest centre. Plans formulated in Hosp. for continuing physio should be carried out

Occupational therapy & physiotherapy (30)

Agree more occupational health & Physiotherapy services should be at peoples own homes – this does not mean people in both acute or community hospitals should have their need of these services reduced

Any increase in OT or physio would be helpful

Definitely more occupational therapy services. Could be done more in patients home

Expand a mobile occupational therapy and physiotherapy service to treat patients in their own homes as much as possible

Give as much care, occupational therapy - physiotherapy at home or collect people & take them to local hospital, especially in the winter. Carers Together do a wonderful job with cookery class, sing-along’s, luncheon club maybe an idea, they do meet for lunch but if you haven’t your own transport for SOME it may be difficult, let people pay for their help if they can afford to

I have a disabled daughter and would not have been able to look after here now had I not had about 12 weeks physiotherapy

I have had reason to complain about the lack of physiotherapy for my son who has deteriorated in his ability to walk in the last year. I have received an apology for this, but no action has been forthcoming to remedy the situation! i.e. increase the number of physiotherapists from 1 for the whole area for learning disability

In my experience occupational therapy make sure you have facilities at home. When leaving hospital the physiotherapist should be more hands on, more caring. It’s how the patient feels after an operation, and talk to the patient instead of talking between themselves which party they are going to etc;

Local physio services

Long waiting list need more occupational and physiotherapy

Making arrangements for the elderly to get periodic physiotherapy services at home if possible would be helpful

Maybe have a physiotherapy and occupational therapy unit in each local hospital depending on
costing and use of units

More physiotherapy services and more help from occupational therapies

More trained staff, and maybe group sessions for occupational therapy

Occupational therapy & Physiotherapy would be extremely good for the patient

Of course increase OT's and physio's makes sense. NHS ought to be moving forward not decreasing services'.

OT and physio services in the home, in the long run save money and give patients security for their health problems

OTs and physiotherapy are essential for the elderly vulnerable and those with long-term conditions because they advise on exercises equipment etc. that can make a real difference to people's lives, which is all about quality

People with long term conditions would benefit from occupational therapy, dementia needs lots of stimulation being at home all day doesn't help them

Physio & OT mobile supporting discharge team like intermediate care at the Barn North Tees

physiotherapy

Physiotherapy

Physiotherapy

Physiotherapy and occupational therapy in patients own home is an excellent idea and will be beneficial to families and will eliminate the need for transport to and from departments

physiotherapy at home for the disabled

Re-introduction of the above services would be useful! At present in Guisborough there are no occupational therapy or physiotherapy services as far as I am aware. After my stroke I did not receive occupational therapy apart from an assessment for home adaptations and my physiotherapy was cancelled.

Therapists to help elderly & Vulnerable people with isolation. Not all need acute bed - just need TLC and care & compassion. ? Staffing issues however!

This is a difficult problem which is often left by authorities because no new ideas are coming forward; often it comes down to throwing money at it, which causes more harm. It needs discussion, costing and courage within our community. Ask, how many old people are currently
receiving occupational therapy/physiotherapy

We now don't get a physiotherapist visit or any physiotherapy, which is not good as being a quadriplegic I get no exercise and my joints are getting very stiff. Current system is that after 6 weeks it stops

Would like more physiotherapy

Train patients/carer (29)

By increasing knowledge of patient Training carers Training more nurses

By providing training + financial help to family members

By training more nurse and also provide some training for elderly so in some simple cases they can look after themselves

By training staff and also in some cases training carers and patient themselves for simple treatment to save time

By training staff and also in some cases training carers and patient themselves for simple treatment to save time

Caring service is essential but the carers should be better trained, better paid. They can continue if they are taught with physio on a daily basis therefore giving the trained people more time to spend with others. Plus the patient is often happier with one of his or her carers, once the diagnosis has been given by an expert. Then the carer i.e. family one cares coming in can continue with the treatment

Educate patient and carer to do some of the easy tasks themselves

For long term patient you could train them for some task or train their carers to save time and costs

If I (as a patient or carer) be trained to do something like blood pressure and some physio exercise, it save my time to go and see my GP

It is better to train the family members as patient is comfortable with them. With providing financial help and training
Most patient and carer can be trained to make things easier

People with long term condition should be trained so more time and cost will be saved and they will be less dependent

Providing training and encourage family members as they are the best carers with bit of financial help

teach them how to look after themselves better, able them to do some of the nursing at home

To bring more community nurse in, and educate patients to do simple task

to increase knowledge and also practical side of some simple task for patient

Train elderly for some task which they can manage themselves to increase their confidence, and save the time and cost for nurse

Train some of those elderly who can learn to be independent

Training carer and patients to reduce the number of visits by nurse

Training more nurses Some training for carer Some training for patient

Training patient to look after themselves in a simple way. Training carer to save time for nurse’s visit

More staff (19)

By having more people working for you

Central government funding would help to increase staff
Employ more staff

Employ more to speed up waiting times

More funding required to provide additional staff so they can provide & cope with increased workload to meet demand for elderly care

More money on increase for community nursing

More staff

More staff at the local surgeries (Doctors)

More trained staff (and volunteers) to provide care in the home money saved by closing old, out of date buildings should be made available to provide more home and community care

More trained staff, and maybe group sessions for occupational therapy

Reduce the waiting times, ease transport access by providing facilities across the area, increase trained staff, keep appointment times

Sufficient staff to run community based services - not run on deadlines (timing etc)

The obvious is to increase staffing levels and the allocation of a particular carer for the elderly who would do at least a monthly visit even when patient is not specifically ill

There are already waiting times for these services, unless more staff are employed waiting times will increase

There is a need for more staff possibly to visit homes and/or even nursing homes to keep people at home. Possibly increase facilities in community hospitals

There is not sufficient money or people to address this

There needs to be the right amount of staff so people don’t have to wait long and are seen very regularly

These are governed by finance with not the staff to cover

You need. More people, some clients only need 1 person some need 2 or more you need more people for one to one

Multi-agencies working together (18)

By giving more specialist training and promoting more multiagency working so they can share
specialist knowledge on a care of service user which will enable person centred care to the service user

Community based services need to run alongside social service GP practice etc, all needs to well organised and all parties must co-operate with each other. I think your aim is to use the two newer facilities but think of patients and visitors, their well being is important

Contact between various services necessary to provide comprehensive care

Development of partnership work with LA & social services. Possibly voluntary organisations

G.P. practices are too insular. more integration of for example 'health visitors' for a geographic area rather than attaches to a practice

maintain and enhance inter-disciplinary communication e.g. between physiotherapy and OT

Needs to be central with everyone in one place and working together

One way would be to make sure people can cope/and/or/ that all services involved speak to each other to implement the care

Provide local specialist appointments, all services to work as a team, ensure patients information is known prior to any appointment i.e. if suffer from dementia

The government should work together with the community to increase and improve community based services

Better access to community physio. better co-ordination between health & social care providers

By more communication within all services and more staff. Also more use of Redcar Primary Care Hospital

Communicate better with GP surgeries

More communication between the various agencies, more use of volunteers for social aspects of homecare, as much care in home as possible, adaptation of homes if necessary

Need to register all elderly, vulnerable and long term sufferers on a central register so that as a minimum every incumbent receives regular visits depending upon requirements and available resources

Older people with long-term conditions need to have regular re-assurance and information on their condition. A system of regular communication, perhaps through GP practice, or local clinic, could be an additional service which could help to improve their health and well-being

Tap into voluntary organisations & avoid duplication of services. Info hub should help with this if
managed and maintained correctly. Need to improve communications between wards & rapid response, Are often left waiting e.g. pharmacy not open, medication not ready with patient

You will need a lot more district nurses and health care assistants. Better communication between all health professionals and care providers, The ability to organise and prioritise emergency visits when needed especially for palliative patients who may need breakthrough pain medication, it is not fair to make them wait.

**More district/community nurses (17)**

*Bring back District nurse back, MATRONS and number 7, They were stacked, but you got the job done and learnt how to respect people, and make them feel important, and spend time talking to the patient*

*Bring back district nurse who go out and visit patients to find out what is wrong through discussion*

*Bring in more trained nurses*

*By increasing knowledge of patient Training carers Training more nurses*

*By training more community nurses, by increasing the number of local surgery with all facility*

*District nurses SRNs not those who are university trained but those trained on the ward hands on will show more empathy and care more*

*Dramatically increase the number of district/local nurses. My 90 year old mother has had 2/3 visits in over last 5 years. We could reduce or disband the communications and engagement team and employ some district nurses*

*Increase care and nurses throughout the community to help the elderly and vulnerable*

**More community nursing staff**

*More district nurses who have the same client group. So they can provide holistic care for elderly & vulnerable patients & provide a liaison between agents, so care is more joined up*

*More money on increase for community nursing*

*To bring more community nurse in, and educate patients to do simple task*

*Training more nurses Some training for carer Some training for patient*

*Training more qualified nurses to visit patient can be big help*
We could do with more community nurses, less money should be spent on Quango’s

We should have more community nursing staff they are very stretched at the moment and some don’t occupy or physio anyway

You will need a lot more district nurses and health care assistants. Better communication between all health professionals and care providers. The ability to organise and prioritise emergency visits when needed especially for palliative patients who may need breakthrough pain medication, it is not fair to make them wait.

**Improve transport (14)**

Better transport

Better transport arrangements to get from A - B Also value more use of village/community halls for social interaction

Community based services are vital due to the poor transport links in East Cleveland

Distances to travel, and transport, particularly for the disabled

Fine if adequate transport is provided

Have buses on to enable people to get there. Improve monitoring of conditions where patients are invited in for regular review. Get rid of telephone consultations. Bring back district nurse who go out and visit patients to find out what is wrong through discussion

Help get people out of the houses to these venues

James Cook difficult to get to without own transport

More day centres should be provided which offer OT and physiotherapy. No meeting places in Guisborough/Skelton or Brotton at present. And transport is needed to these centres at a reasonable cost

provide transport to help them attend

Reduce travelling & parking which is more stressful than your ailment

Transport

Transport to these places

What transport would be provided
Hold events/groups (14)

A lot of elderly people are lonely + would be pleased to be invited to lunch club, coffee mornings or someone visiting for a chat

any stimulation is beneficial, being sat in front of a TV (often switched off) or playing bingo is not enough

By increasing the number of community based services for local people

By providing seminar sessions for the elderly, for example

Establishing a medical centre which brings the elderly together for chat and communication

Group support for people who live alone for physio and therapy. Lunch groups exercise clubs, diabetic groups for elderly and groups who need support

I think you need to create more day centre groups for care along with homes care. This would help to provide a service of social enhancement for the ISOLATED

More day centre services, also to include partners/families in activities

More day centres should be provided which offer OT and physiotherapy. No meeting places in Guisborough/Skelton or Brotton at present. And transport is needed to these centres at a reasonable cost

More day centres where elderly and lonely can go advice/care could be available there. It would get people out of their homes and into company which is vital to their well being

People need to meet people so within the unit maybe a coffee shop

Social services and socialising

The more HOME input or day centres to allow people to stay in their own homes is so important, some day centres where the individual could attend to give the carer a break is so important & allows an aged person to stay within the family home (perhaps two days a week) & prevent the person going into care. Perhaps someone to call on that family occasionally - just a social call to see how they're coping - would stop them feeling isolated

Would this be possible for some clients to be transported to a centre for care therapy for a shorter period of time as in day care setting

Better use of existing facilities (14)
Better use of East Cleveland hospital

Bring specialist from James Cook hospital out to see patients as this could free up car parking spaces at James Cook hospital and it will be better for patients who live in East Cleveland

By more communication within all services and more staff. Also more use of Redcar Primary Care Hospital

Could increase & improve services more if more staff and use local clinics in towns more instead of them in disuse

Could open one of the wards at the Redcar Primary Care Hospital, as a renal unit for dialysis patients

Ensure care professionals are not constrained by time slots and have time to give care and support. Where will you get extra staff from? You have already quoted you could not find staff to man minor injuries. Why is Challoner ward closed? Surely it could be used for some services rather the stand empty.

Have more of the services available at the care trust hospital in West Dyke Road Redcar, instead of having to go to James Cook in Middlesbrough

Hope that Brotton Hospital will continue to provide services

Some of these services can be done in locals surgery or even patients home

Use Brotton hospital more

We should properly use the facilities we already have. Brotton hospital has a long waiting time for OT or physio - WHY?? It has the facilities but not the staff

With particular respect to stroke, I struggle to see how community professionals will be able to replicate the physiotherapy facilities currently available at Guisborough Hospital. In ‘peoples’ homes (which is what the new strategy is proposing) remember that in hospital these facilities are available. ‘On top’ on a daily basis. If the assumption is that patients will go from their home up to the physiotherapy unit at Redcar Hospital each day then that is simply not practical.

Make people aware of services

A greater awareness (e.g. publicity) of the services made available + what they specifically entail and can offer, and it not be assumed that people are aware of which services are available to them within the community In my (previous working) experience, people still lack knowledge of what is available
Awareness of services often GPs don’t refer to community based services if acute settings available

By opening training centres, so that people could be aware and use the services

Check if they have ‘carers’ and ensure they are aware of services. People often need reassurances or minor treatment

It should be made clear what services are available and have a single contact point for help & advice

It would be helpful if ONE person was able to tell the patient all the help that is available to them instead of patient having to get information in dribs and drabs when no one can point them in the right direction to get the help they need instead of them having to go to so many different people to find out

make it clear where you can ask for these things and what help is available in the home

Make more people aware of what is available

Making people aware by giving courses, letting them say how they feel and how they want to be helped and taking action when their needs are clear

More visits to people who are lonely, and need to talk to someone, maybe join a day centre

Speaking for myself I’m happy with the service I’m receiving but we struggled initially to get the help we needed because we didn’t know how to go about it

you should make people aware about your services and give courses to the community about your plans and your services

You should make the community aware and should give the people the help they need

**Improve services in local community (11)**

Any services that can be carried out on a one to one basis should be carried out in the community

By increasing the number of community based services for local people

Community based care is better for the elderly and disabled

Community based services need to run alongside social service GP practice etc, all needs to well organised and all parties must co-operate with each other. I think your aim is to use the two newer facilities but think of patients and visitors, their well being is important

Occupational services, physiotherapy services, district nursing in attendance yes, but elderly do fall
in the home and can be depressed, they need for short periods in the confidence building which they do get in community hospitals; feeding, dressing, etc.

Services in community hubs are easier to get to

To improve services at local surgery and community based services

To improve services at local surgery and community based services

To increase the number of local community based service

To increase the number of local surgery or community based services which deliver some of these services such as physiotherapy

Working with the community to assist elderly

*Use volunteers (9)*

Development of partnership work with LA & social services. Possibly voluntary organisations

Everything should be done to keep these people moving. Please support the volunteer groups & charity groups (i.e. the heart/breathe easy etc.) to maintain their trained staffing levels

Listen to the nurses and people who look after these vulnerable patients - some have good ideas on what is needed for their patients. It’s not the same for all. Different patients have different needs. Volunteers who drive patients to hospital is a good scheme. Neighbours recruited to help - or buddies!

More communication between the various agencies, more use of volunteers for social aspects of homecare, as much care in home as possible, adaptation of homes if necessary

Should try & set up an elderly/vulnerable help unit in areas & volunteers may come forward to keep an eye on these ‘neighbours’

Tap into voluntary organisations & avoid duplication of services. Info hub should help with this if managed and maintained correctly. Need to improve communications between wards & rapid response, Are often left waiting e.g. pharmacy not open, medication not ready with patient train volunteers and young people to do a few hours per week care at the elderly peoples home as a work experience, also make use of the medically educated refugees, you will find them very helpful

Volunteer visitors on a social basis would help if they could report any concerns+ changes they observe. These could then be picked up by the professionals
Volunteers are required? charities and the private sector seem to get them when required + an actual local estate community centre with health advice 12hrs a day

Social care (8)

Care - social care

Social care

Social care

Social care and deliver quick and fast care

Social care and deliver quick and fast care

Social care and leisure sports for elderly people

Social care and social service

Social care is very important for elderly

Nothing / already good (7)

Don't know how to improve, but yourselves + occupational therapist were good us

From experience I could not rate these services enough, professional, friendly, kind and always at the end of the phone when needed. Thank you to all

Happy with current services

I think you do a great job now

Recent experience of visiting physiotherapists has been proved more than satisfactory

Service is okay. My sister has a mobility car, she finds this very useful & helpful. Compared to the NHS & other countries, this country does a lot for all communities. I was in a wheelchair for 3 months – the service I received I cannot knock it

You do a good job now

General positive comments (7)

A family member had to use these facilities after a stroke; they were very important and certainly
aided recovery. An increase must be a positive

Any community based service that would improve lives for people who are elderly or vulnerable with long term conditions would be beneficial

Any of these services are fundamental solutions to those who have faced vulnerable getting dementia

Middlesbrough Council wish to support the ambition of the CCG through improved low level support for long-term conditions to improve compliance with medication and to reduce unplanned admissions. We are keen to develop community hubs as a way to co-develop and deliver such services, commissioning VCS organisations to deliver such a service based on the Wigan community model.

More personal care for patients can only be a good thing

Would approve the proposals

Yes, these two services are well used in Guisborough Hospital ask any ex-patient for their views

Involve families (6)

I think you need to involve families and maybe some sort of financial help to encourage them, families are the best carers and elderly people feel comfortable

Involve family members and encourage them to engage with financial help

More consulting with relatives. Discuss discharge more; ensure patients really can manage at home. Do not make promises of physiotherapy, which will not happen!

More day centre services, also to include partners/families in activities

We need to involve family members and encourage them to engage and maybe have a financial gain

We need to involve family members, they can provide the best care, and have some sort of financial gain

Better GP service (5)

A better service is needed from GPS the current arrangements whereby my GP has to "ring back" rather than being able to make an appointment is very unsuitable and distressing ESPECIALLY to vulnerable & elderly patients it SHOULD be possible to make an appointment on request
Book services via local GP

Communication with older folk probably @ GP level. Old folk don’t like asking but if someone could inform them of the help needed

Make the booking time easy and accessible 7/24 at the nearby GP. GPs in our community need more and extra help

Provide proper access to GP’s

Housing improvements (5)

I think we could increase & improve by preparing what is more important for them like housing

Make more care houses, put more effort to develop the services

More extra care housing schemes + villages instead of a choice between remaining at home or going into residential care. isolation is a big issue for the elderly and vulnerable

People without relatives nearby may do well in warden controlled housing, with a view to return to their own place on improving

Should improve the services for elderly and vulnerable by giving them or invest in education on the service that they get and on their lifestyle, for example housing improvements.

Better aftercare (5)

Aftercare, leaving hospital - carers, patients doctor to visit. For the elderly someone if no family or friend to ensure food, clean clothes washing for short period until patient can look after oneself

As carer for my husband have found that services during his first year post-stroke were wonderful. That has not continued. Have had very little medical support & advice as his condition deteriorates. Feel the ‘system’ has ‘left us in the dark’

For 7 weeks my husband attended group meetings at Guisborough hospital for people with Alzheimer’s. This provided a stimulating environment and new people to meet. Unfortunately, there is no follow up provision. Something to fill this gap would be helpful

I think clinical respite beds should also be available even if just for a couple of nights. After leaving hospital for up and not quite ready for home & even if elderly person has a spouse.

There should be more follow up when a stroke patient came home from hospital. There is none at the moment
**Invest in training (4)**

*Improve training for health visitors/community nurse in assessment of patient’s needs, not wait for the crisis situation to occur. Make possible prediction of future needs for chronic conditions or elderly patients, to aid budgeting & staffing. Increase awareness of these services & how to access them by providing more information for carers, patients & residents of sheltered housing and residential homes.*

*Invest in training – not carers, they leave – have a heart, take time with us, don’t be a business*  

*To spend money for training on nurses. to increase knowledge of carers*  

*Train nurses to cut toenails. Calling a podiatrist is a torturous business. IN a recent case at Guisborough it took three weeks*  

**Listen to patients(4)**

*By listening to the preferences of the users of this service*  

*Listen to the patients. Don’t brush over facts, knowing someone cares what your saying is a big help*  

*Listen to what people in the community are saying - they want to remain in their own homes!*  

*Listening and speaking with the elders and vulnerable in a programmed manner might help them feel looked after*  

**More care for dementia (3)**

*Expansion of day hospital facilities, and day centres for more social problems including loneliness and dementia. Rapid response to social needs, walking aids commodes etc. * Better home care support (banish the 15 min appointments) Ensure carers are dementia aware. Allow them time for flexibility. If an old person is off legs one day they may need a bit longer!*  

*I noticed when filling in this questionnaire, there is no mention of any extra care for people suffering from dementia, as I am a carer for my 89yr old mother*  

*More care for dementia would be good*  

**Having the right staff (3)**
Again I feel staffing could be a problem. Particularly, properly trained staff

Choosing personnel carefully is important you got to get the right person, naturally kind and happy to help people

Hiring the right man/woman who can do the helping work from deep down not just for money

Audiology/Podiatry (3)

Audiology

Audiology/podiatry

Audiology/podiatry/retinal screening

More/improved facilities (2)

If the cost can be met more facilities should suffice

Improving facilities locally is a good thing

Other (62)

1. Adequate supervision 2. Improved communication with informal carers, especially those living with patients 2a Establishing specific capacities support required for particular capacities from informal carer both in and out of hospital 2b Letting informal carer know who is to arrive, who to contact etc 3. People, carers, professionals not ‘misleading’ informal carer by saying my parent/grandparent has dementia - it can cause someone to be lulled into a false sense of security thinking they know what they are talking about when in fact the particular home & personality aspects have not been appropriately identified. Can lead to misidentification by professionals i.e. carers 4. Honesty from professional carers 5 professional carers being trained when to use honesty rather than just making up stories or asking questions just for the sake of it 6. Stopping people like opticians due to visit asking for ‘Mr Savage’ and other likewise names which can clearly upset very sensitive people who take things to heart rather than thinking it funny. get staff to record things ‘better’ or take extreme care when making notes - following examples are from memory a. I was taking an elderly man to his GP, but he went to the toilet again as we were leaving. I was concerned about being late at the appointment and didn’t want to face any difficulties when we arrived in order to avoid upset to the patient. The GP receptionist kept saying about me having difficulty getting him out of the toilet. I wasn’t having difficulty. The elderly man just needed more time. Recording something about difficulty could have caused people to think he was being awkward. b. An agency district nurse noted - photographed foot with help of daughter From memory I don’t think she really tried to take to the patient to tell him what she was going to do as
she went along. All the daughter did was to help lightly hold the foot. The note the nurse recorded could have suggested there had been difficulty and the daughter’s help was necessary.

1. Keep community hospitals open and provide services such as leg dressings, bed sores and all minor ailments that elderly suffer. Practice doctors complain they are too many elderly booked appointments for such ailments.

All these services should be provided using mobile staff.

Apart from being capable, an appreciation of the patients limitations. i.e. if little or no sense of touch having to manipulate small/awkward pieces of equipment is not a practical solution.

Arrange for carers to discuss their relative’s health with the Medical Care Team without the patient. There could be limits, but dietary & care advice would be appreciated.

As long as sufficient time is allocated to each patient.

As long as there is no additional cost to the service user travel wise.

Awareness of specific needs provide specific alerts from surgeries to include most vulnerable, complex needs patients (Not all elderly are those categories) and allow special circumstances for these types. In emergencies e.g. when asking for doctor’s appointments in hospitals when setting appointments (time for example in areas such as day patient procedures) Sounds as if more trained professional staff will be needed care assistants even the best are not enough cover for lots of clients!

better mental health care in Redcar & Cleveland

By preparing for them what is necessary.

By promoting more quality and high standard of training it will enable the service user and the family to have a good trust and relationship with professionals which means co-operation and response to treatment.

Care needed 24hrs. to provide all levels of care throughout the day.

Could residential homes be incorporated into the mix?

Do not put people in homes just because they refuse to wear walking aids and other equipment that they may have used all of their lives. This would make room for those people who really need the homes.

Easy use of a gymnasium following knee & hip replacements - broken bones.

Elderly are so vulnerable and it is for the best if we could provide a comfortable environment for
them

Enable them to live in their own homes as far as possible with support services as above and practical help to remain at home

Far too many different people. In six weeks my grandfather has met 40+ professionals, none of which had any information about him

Have PROFESSIONALLY trained staff also GP ATTACHED

Have a local phone contact 24hrs instead of 111 service having fast and reliable service

I don’t agree with the proposals to take patients out of hospitals/rehab services and having them community based. My point of view is based on a personal as well as a professional level

I think GPs should ask all their elderly patients if they are managing alone, some of them don’t like to ask for help

I think when it comes to death, a room should be provided not shoving the person from pillar to post as in my father in law’s death

I would say by helping people psychologically morally and financially

If possible make more easily available and known people, not complete strangers (where practical)

If there one centre in different area so it’s easy to access them

Important to know we are still valued and make us feel CARED ABOUT

Improve organisations such as carers. Possibly users of these organisations could be on an audit panel. I think the role should be semi-professional and more accountable

Increase local community service

Is there a guarantee for patients that they will receive the service they are offered i.e. what happens with absence of staff at short notice? Who would pick up their calls/visits? How is this factored in? Would patients be left waiting for someone who doesn’t come?

It is vital to provide adequate day-care facilities for all disabled people requiring it, not just those who are mobile enough. Also for combined conditions such as wheelchair bound dementia sufferers also RESpite CARE There is never enough

Just do something
Local contacts for equipment supply – long + short term

look after them with a closer watch

Look where we were, even 10 years ago, how far can we improve in the future? Patients to as if 1 t 1 contact exists

Looking at the really big picture the question regarding chronic illness is how do we incentivise drug companies to develop cures and not treatments? To take an example – probably not current and not a good example but the one that comes to mind. Trigeminal neuralgia. Pain killers for life or a nerve re-section? Drug companies like GPs not surgeons.

Make sure PTS services are maintained then it doesn’t matter where the care is given

Make sure that they are checked upon every hour, as anything can happen within a short time

Maybe having a care book to fill in and therefore having a recent report on last time. Seen and recent talks just in case regular visitor can read whets going on and up to date

More accessible one to one care is needed, rather than telephone conversations & handouts which may not be fully understood. By enabling the individual to manage longer at home it reduces the rates and costs of inpatient care & is better for the individuals sense of well being & security

More respite care new buildings to provide this

Not everyone appreciates a host of people tramping in and out of their home. It can add to the difficulties of other house occupants, and the visiting times may not be convenient or fit in with normal running of the household

Once a service is established, and an efficient visiting programme developed, the service will prove economics with repeated patterns of treatment

Patients’ needs are upper most in all thoughts, but strive to improve, never stand still

Probably the availability of 24/7 cover for elderly and vulnerable people will be a big help

Programme replacement over a period of time to work to a pattern to suit local requirements

providing accommodation with all facilities near to them

Show more understanding with people who do not feel able to help themselves

Some of these smaller hospitals could be used to accommodate the elderly who have long term conditions, instead of in larger hospitals catering for post operative short term patients

Specialist service available in the community. Palliative & end of life care service available at home
& to have input and beds available in community hospitals as this gives patients the choice of where they want to be cared for near to family.

The community from the younger to elder should work together with NHS.

There is long waiting list and delays which affect patients and drive them either to hospitals or early death.

This would certainly help against loneliness, a terrible curse generally.

To meet their individual needs.

Try to have shorter waiting times.

Visiting the elderly, so a point of contact as many are lost in a broken system.

We have too many people now living in England, so it is very hard for the community services to cope.

We need all the money spent on the above to live in our own homes. Maintain our equipment that’s needed not maintaining buildings.

When you think of all the money spent moving patients long distances by ambulance surely the cost will outweigh the advantages.

You could improve by searching what is their need. What they want in their life.
Q.6. Do you agree with our vision to improve prevention and deliver more care in the community, closer to where people live, i.e., more consultant out-patient clinics, diagnostics and treatments in the community?

**YES**

*General agreement (69)*

Absolutely spot-on!

Any addition for the quality and quantity of the existing services is welcome

Any movement targeted toward helping people is well blessed

Anything is better than nothing

Because community’s health and safety could be guaranteed this way

Better service all round

Definitely x5

Good idea x5

Hooray!

I agree with improving prevention and local diagnostics & treatments

I agree with the proposed plan for more care in the community and closer to where people live. I am sure a lot of elderly and frail patients find accessing services in a large facility like James Cook Hospital intimidating and stressful

I agree x11

I am aware already prevention programme started

I think a lot of people would appreciate this

I’d be a fool not to

Improvement is vital to the evolving process

Improves healthcare

It brings a huge difference
It makes sense x2

It would help a great number of people

It’s already started with success

It’s always worth it and works well

It’s vital

Long overdue

Make it happen

More people visible for healthcare

More reassuring

No comments, it would be perfect

People need more personal care & attention

Positive x2

Sounds good if we need it

Surely. Where are GPs in all this?

The availability of short-term 'cottage hospital' beds would enhance this

The existing ones are very much appreciated as easier to attend and more personal

The more help and support the better x2

This has to be more beneficial to people

This is a good idea and if its implemented it would help more people

This is a good idea but disabled are not always provided for, no hoists etc

This means access to treatments by all

This with Q5 would be a big step forward

Though I do understand the cost implications of this, it would be beneficial to providers and users

Very good for the elderly
Would be a great help

Yes as long as the standard is the same, will they have the equipment

Yes I do agree with, deliver services to achieve the plan

Yes it is very important for the community

Yes its good idea and wish you good luck!!

Yes please

Transport (33)

Again - transport problems out of the area

As earlier, it is often difficult to get the old people to the cities, also often old people are looking after the cared for one who is also old

Because some older people are unable to travel far

Because the logistics of the most vulnerable/disabled/less mobile travelling is often enormous

Certainly in winter people need transport, if they fall they are creating more work for hospitals

Community based treatment can lead to savings on transport costs

East Cleveland is a difficult area to access clinics + doctors because of the terrain

Elderly patients & vulnerable patients find it difficult to get across to JCUH from the outlying communities

For convenience, also travel costs, especially for visitors, extended families to be close

Help will be needed to help the elderly with transport

James Cook is difficult to get to for a lot of people and the hospital is possibly overwhelming for vulnerable people

Less distance to travel

Less pressure and less travelling time for the sufferers and carers

Most patients do not have transport to travel out of their home area
Much better than having to travel to busy units or hospitals

Not every person has their own transport nearby units would be good for communities

Older people increasingly value less travelling

People who are without transport need care in community

Provided more and easier transport is provided

Providing non drivers are considered

Remember travel constrictions

Save travel costs and patient happier in own surroundings

Save travelling and moving elderly

Some people find it hard travelling to and from hospitals and getting to appointments on time

The elderly would be a lot happier and not having to travel

To avoid travelling long distances from home

Will benefit people who have difficulty arranging transport from their area

Yes as it will be easier for people who can’t travel much, to get treatment quicker without any problems

Yes elderly people cannot travel for treatment

Yes it saves them for time and transport

Yes, many elderly patients don’t have the support/ability to get to JCUH and this can put them off getting help

More local (26)

About time hospital based consultants looked at their local communities!

Again small + local professionals building relationships with patients and families

Clinics and investigations close to home are an excellent idea

Community care, closer to home is often more personable, easier to access + more likely to avoid
missed appointments rising

Consultants need to be persuaded to hold some outpatient clinics in outreach locations if numbers of patients justify this

Elderly and vulnerable patients would be much happier being treated locally

I think having treatment or after are delivered locally would make everyone concerned happier

If these services could be provided near where people, they would get help easily

If they could get the services near where they live they can get the help they need easily

Is moving to Redcar keeping people closer to home - who live in Middlesbrough

It could make the service effective and if it’s is located where people live people would be motivated to go there in times of need

It will enable service users to get treatment closer to home

Links to family + friends = less upset for patients

Local services would be better for the community (x2)

More clinics in the community near where we live

More consultant out-patient clinics in Redcar + Cleveland

More Consultant out-patient clinics PLEASE and less travelling to James Cook. More at East Cleveland hospital

Only if this means in the town where the person lives

The closer to home the services the better (x4)

Vulnerable people need help near to hand

We need more care in the community - our facilities are too far away

We need to be treated as close to home or in the home. We are all individuals not ‘groups’

Yes agree services should be close to where people live but how does disbanding services at Guisborough help this?

Your vision is very good, people need to be closer
Preventative (22)

Always prevention is the best option (x10)

Prevention can save lives. Money. Time (x3)

Prevention costs less than support for long term

Prevention is always better than cure, but education is a stumbling block

Prevention is easier and safer

Prevention, save time and costs in the future (x2)

Sometimes e.g. physio can prevent surgery

Sure it’s like dentist check every 6 month to prevent

This can help save costs in the long run and help with early diagnosis of any possible illness

Yes I have enrolled in an activity to help prevent diabetes (Father had it)

Move away from central location (22)

Because it is good to have more consultant outpatients

Better use of buildings, relieve pressure on James Cook hospital

By not having community going to hospitals outside their area this will happen anyway

Could also target specific community groups/centres to identify/prevention

Far too much is done at James Cook, access which is not easy for too many

If it helps in any way to avoid long frustration time in James Cook hospital

If it is at Redcar

If these services could be provided near where people, they would get help easily

Invaluable to have out-patient clinics for more care in the community

It benefits the elderly to meet people at their house

Most of outpatients can be carried out in community hospitals i.e. Redcar to reduce waiting and pressure on James Cook
Not enough only two more

Please see previous comments. I believe that all clinics should be moved out of the JCUH. Managers need to concentrate on changing the JCUH to only deliver an acute inpatient service and all clinics should be moved to the community centres.

Separate clinics for birth control or small ops. This is a good thing. Major ones this for the main hospitals

The clinics are to serve the community and I think they are helpful

There is a need to provide off the James Cook site the place is a nightmare

These outpatient clinics could be a regular routine say once a year (for everybody) not just vulnerable

We need more outpatient clinics

Would ease pressure on A&E hospital?

Would these be provided at the 'One Life Centre' Middlesbrough?

Yes but where are you going to provide the clinics? And you will need to recruit staff to man them as all Guisborough staff are going to leave due to the shoddy way they have been treated.

Yes, but not if by in the community you mean only Redcar Hospital

Makes it easier (18)

Anything that makes it easier for the patient + their carers

Anything to reduce travel for old people would benefit

As earlier, it is often difficult to get the old people to the cities, also often old people are looking after the cared for one who is also old

Because people can’t get the services easily

Because some older people are unable to travel far

Because the logistics of the most vulnerable/disabled/less mobile travelling is often enormous

Care closer to where patients live must be more beneficial

Certainly in winter people need transport, if they fall they are creating more work for hospitals
Close to where people live would be ideal

Convenience

Easier for patients, but less time for consultants to meet patients

Easy access

For convenience, also travel costs, especially for visitors, extended families to be close

I would agree with this vision with the proviso that clinics are easily accessible

If something happens it will be easy to call someone near you

It might be easier for some people

Much easier for patient and carer

Very convenient and very helpful we all lead busy lives - mums with children - old - infirm - it could benefit all young and old

Increase speed (16)

Access is easy and fast

Allows for faster access to healthcare

Anything that cuts down waiting and travel for the old

Anything to speed the recovery of patients

Better for patients. Less time consuming and would avoid the traffic jams and waits at James Cook

Help at home is best, saves time and money (x2)

I feel this has been long awaited the need for outpatient clinics + particular diagnostics + treatment, the length of time for a patient to see a consultant + have treatment could take several months I am sure this option would reduce waiting times

If the services were more readily available, may improve waiting times appoint

It’s less stressful & more time efficient for the person cared for and the carer if local services are available

More convenient and less time wasted
Save time and money (x4)

Yes it save them for time and transport

**Health checks/early tests (9)**

Follow up on screening and more testing needed e.g. Bowel cancer etc. should be prompted rather than left to chance

I have seen it in the surgery such as healthy heart check

I myself didn't know I have risk of heart disease until I had test

If in first place they get diagnosed no further treatment needed

Investment in health improving/prevention services desperately required

It's very good programme such as healthy heart check

It's worth always to do some test to early diagnosis

Like new programme for healthy heart check

Make people more aware of reasons for strokes etc;

**Will it actually happen? (7)**

As a vision it is fabulous but realistically speaking it is not easy

I just don't believe it will happen

Promised for years - wish it happen this time?

Provided we don’t lose other services

Visions are all very well, but is there the proper finance available to back it up

With suitable facilities and staff, Guisborough clinics are currently understaffed

Yes, but at what cost to our community?

**Less stress (6)**

Hospital visits and parking are very difficult for the elderly
I agree with the proposed plan for more care in the community and closer to where people live. I am sure a lot of elderly and frail patients find accessing services in a large facility like James Cook Hospital intimidating and stressful.

It’s less stressful & more time efficient for the person cared for and the carer if local services are available.

Less pressure and less travelling time for the sufferers and carers.

Often difficult to get to JCUH, will reduce stress at a time when you are frightened.

This will obviously take the pressure off JCUH and much, much easier for pts stress levels i.e. parking.

Other (28)

A nurse to answer the phone to discuss problems & advise the need to see a doctor or attend A&E.

Absolutely – it is vital to encourage more responsibility for managing one’s own health matters by having informed patients.

Action depends on speed and expert staff.

All services need serious improvement.

Almost a self-fulfilling prophecy.

But like everything, it needs costing and ask, what are the major needs of our old?

But see my comment on question 2 (Provided that the ‘investment’ does not demand a high degree of monetary expenditure which would drain resources required for their development).

But these services need to be co-ordinated to maintain efficiency and consistency. Communication between services is important.

But will consultants use local hospitals more? or is there increased costs to the trust.

But, surgeries are already over stretched - could the buildings accommodate.

Everyone is accountable - no cover ups!

Hospitals are degrading places.

No comment (x2)

Obviously - a leading question.
Personal experience

Please avoid multiple visits of groups of people in one day. E.g. Third day out of hospital for ill patient. Patient confronted by two carers morning, 2 OT’s plus student OT. District nurse doing assessment, nurse from private company doing assessment, carers etc.

See previous comments (x8)

There is a great need to increase provisions at local hospitals and doctors surgeries. Not centralise

Use Redcar hospital for more things instead of going - Middlesbrough - Norton - Northallerton

Would help find some people who does not know where to go

NO

No difference (7)

As long as there is good service for those people

Go to hospital

If surgical consultants are carrying out more out-patients clinics how can this happen, without destabilising hospital services

It does not make a difference

It is just a waste of money

This seems to be mostly about closing down existing facilities, which don’t add up to the VISION that you have spelt out

Too vague, not practicable

Not closer (4)

“Two questions here: I agree with improving prevention. Remember that James Cook hospital is part of the community and close to where many people live. Having outreach clinics etc for those with more limited access to the main hospital is not bad thing per se, but don’t force people to drive past the hospital to get to ‘closer to home’ services that are anything but.”

But you are not proposing to provide facilities closer to where people live, just the opposite. Carter
Bequest closing, Guisborough minor injuries closing. East Cleveland minor injuries closing.

Centralising services to Redcar is the OPPOSITE of this

Want a hospital near me

Other (2)

Care in the community for mentally ill worked, didn’t it!!

Some elderly people have no relatives so the best thing for them is to get specialist care in hospital
Q.7 We want to get your views on our proposed plans for change and understand any concerns you may have about these proposed changes to services, and how they would be implemented.

The change will be beneficial (51)

Agree with your proposals. Guisborough needs modernising similar to work at N Ormesby perhaps. Carter bequest is also too far away for some people & is an old building requiring change

All changes you have mentioned are for the better – which is a first for the NHS, wherever services are centralised, the service becomes 3rd class

Any action that make it easy to access for elderly can help

Any change which would streamline the systems in place now would help!

Any changes are good and needed and having feedback to help

As this a great aim, I’m sure it will be very useful

Better use of Redcar hospital will benefit a lot of people

Changes to any service are beneficial to all the community (x7)

Everything has been explained to me by GP Dr Nandah and it sounds like a good idea

Hopefully the proposed plan will improve services all round (x2)

I agree with the proposals as it keep the care close to the community it serves

I agree with the proposed plans & hope they come off

I agree with your plans and visions and this would be implemented if some charities or rich people could work together with you

I agree with your proposal and I will be following your plans

I am sure that everyone get the best of this programme

I am sure that his will improve the care for patient (x2)

I am sure that these new services brings more positive impact on patients treatment (x4)

I believe these changes will greatly benefit care in South Tees

I hope NHS can deliver what is promised
I think if it is implemented carefully I don’t think it will have a negative effect

I think it is a good idea to centralise these things for easier access and patient care

I think it will be effective

I think these plans sound wonderful - provided that they can be maintained long-term - don't get hit by cutbacks - resulting in staff cutbacks and yet another NHS or community blunder

I think your proposal good because it will bring services closer to people and will make it better

I think your proposals are a big step forward. Also follow ups once the patient is back to “normal” health

Improvements to current service would be welcome

Increasing community nurses will benefit more patients that need the care

It is a good idea to improve existing hospitals

It’s always good to develop and improve the service and will benefit all those who needs it

It’s good to change and improve the service always

Just want more help for any elderly person who may struggle with everyday life

My view is your proposed plans for change are good, I totally agree with that

These are an excellent proposed plans for change - it will improve health care for Middlesbrough - especially for elderly and vulnerable

These are excellent proposed plans for change. It will be good for people i.e. who are vulnerable and elderly

These are excellent proposed plans for change. it will improve health care for Middlesbrough

We agree with any changes you propose to help elderly

Would be beneficial for older patients

Would hope if implemented services would continue & not 'fizzle out' through lack of funding

You are doing a just class service and whatever changes you decide to implement will be taken with those that need it in mind

Your proposals are good. It is good to have consultations
No Concerns (46)

According the proposed plans in changing services they would be committed (x2)

Any changes at all must be for the better (x4)

As long as changes are needed

As long as my husband is well taken care of I don't mind

As you can all see from my previous answers I am in agreement with most of your proposed plans

From the leaflet all the ideas are sensible

I fully agree with reducing expenditure on old buildings and centralising minor injury in Redcar

I have no concern and I think when people get used to it, it has lots of benefit

I have no concerns but I do know that it will enable service users to get the care they deserve without any hassle

I have no concerns but I understand for elderly it is not easy to get one with changes

Implementing needs commitment so keep on committing to it

It all seems wonderful on paper, better care for the same money. Only time will tell

My view is I totally agree with the proposed plans and it can be implemented if you work hard on what you have proposed

My view is the proposed change is great and it could be implemented by discussing the proposed changes with the community

No Concerns (x12)

No concerns, a little help to each other helps. GP's a long way

One must move with the times as long as it's in the right direction

Provided service changes are handled sensitively, and the feedback is taken into account, I have no concerns

Start it and see how it goes

The plans are very good (x9)
Their implementation is fine

They seem sensible, we can only see what happens when they are implemented

You seemed to have thought about these things very carefully. So long as you go with the plan - not rushed, it should work. Iron out problems when you come to them

Transport concerns (43)

Access to facilities should be studied in the light of reduced or re-routed bus services

As question 1 (Redcar is too far for visitors from Guisborough to travel. Also, GPs will no longer visit their patients) People from Guisborough with a minor injury will go to A&E thus blocking A&E, rather than go to Redcar or Brotton

as question 3 (James Cook difficult to get to without own transport (Taxi’s expensive)) rehabilitation for all surgery would be better for local people

Brotton although a modern facility is well away from the major centres of population in the South Tees area and without good public transport links. From TSS it would take a minimum of 1hr 30 minutes using public transport and 30 minutes by car. In winter Brotton has been known to be cut off

Changes are for the better, but sustainable funding is necessary for staff/transport/facilities. It is a financial issue

Concerns about the position of the services especially Brotton. It is too far east for people to travel especially in winter - weather can be severe. Visitors could be elderly 1 1/2 hr bus journey each way! Are there buses in the evening?

Distance to travel for those who have no family and no transport

For some patient not easy to access single centre and may worry them

Hospital visits and hospital stays are very difficult for elderly and disabled and this?? If these can be local it is so much easier

I am only concerned if it’s not easy to access regards distance

I feel this is all about closing buildings & employing less people with already inadequate transport

I have only one concern that is, the minor injury service at a single location (I think it’s better to have services at least in two locations)

I think it is unreasonable to expect someone with an injury to get 2 buses to Redcar hospital. I also wonder why James Cook has so many bad crises and cancelled operations if their beds are really
underused!

I worry that the care for people in the own homes is going to be private and not all people will be able to afford this. Also the ease or lack of it to attend urgent care with children etc. when there is only public transport. Ambulances will be called for the wrong reasons.

If minor injuries are based at Redcar it means two bus journeys to get there as I don’t drive

In a rural community nurses travelling from home to home to deliver care in the winter with bad weather conditions is not feasible - patients will suffer.

Middlesbrough residents will be concerned that the only locations of community beds are at Redcar or Brotton. How should Middlesbrough residents be deterred from using JCUH A&E, even for minor injuries? Alternatives need publicity!

More transport to local hospital (Redcar)

My main concern is how patients are going to reach the proposed 'centres' from outlying areas

My major concern is that the elderly in areas such as Guisborough will become more isolated. Those Guisborough residents reliant on public transport will migrate to JCUH and not Redcar - if using public transport it is easier to get to Middlesbrough than it is to Redcar!!!!

Need point of access close to home! Drop in centres would be useful as trying to get appointment with GPs is very difficult and can take several days making patients conditions worse and sometimes causing hospital admissions

Older disabled or ill patients often do not have transport and having only one central facility could cause problems

Please use local hospitals more - it is easier for patients to have local services, rather than travelling long distances. Appointments at hospitals are sometimes too early for people in outlying areas

Public like to have somewhere local they can attend and trying to get GP appointments may take several days. Need drop in sessions somewhere local

Public transport / patient transport are a major concern for those of us without cars. Poorly people should not have to travel far

See Q3 (More convenient to reach reduces pressure on James Cook)

See Q5 (As long as there is no additional cost to the service user travel wise)

Services based in locations i.e. Redcar + Guisborough are vital for those without transport
Some patients are concerned in the future as they can’t access services easily

Some places are hard to get to as it costs money getting taxis all the time

The bulk of services seem to be based in East Cleveland. There is a geographical imbalance. Middlesbrough fares badly in these plans.

The report states that everyone lives within 30 minutes of a minor injuries unit or A&E. My biggest concern is transport for those who are unable to drive or have no access to a car. Sometimes it takes up to two hours to get to James Cook on two buses. Public transport links need to be improved especially on weekends. It will be horrendous to have to get 2 buses with a hysterical child with a possible broken arm or a cut. Minor injuries units are there to take the load off A&E but unless this is addressed there will be more ambulance call outs and more people will just go to A&E.

They seem reasonable but some people may have difficulty in travelling to centralised centres

Transport (x2)

Transport concerns me if services are planned in outlying areas

Travel costs and appropriateness for centralised service. If location is far – won’t have many visitors

Travel to and from venues may be difficult a well funded volunteer driver programme might be one solution

Travelling and getting to places. May not be convenient. Would prefer one standardised approach

Very concerned about losing Carter Bequest for Middlesbrough patients, they will end up staying longer in hospital. Redcar is 10 miles away

When one is younger & relatively healthy it is not too difficult to hop on a bus or use one’s car. I may have got this documents meaning wrong but it seems to me that you feel that radically centralising many treatments you overlook the fact that the very people you want to help will find it more difficult to reach that help!

Working within the community, the majority of our beneficiaries always have concerns re visits to hospitals for various reasons including: Transport (they do not want to go by Hospital Transport it takes too long as does Public Transport). James Cook Hospital - they find it ‘overwhelming’ too big, too far to walk. Services based more locally in the community at smaller venues were seen as non-threatening

You must think of the impact of the people - patient/carers as the hospital must be within bus area

Changes to services (38)
All services are geared to get people in and out as quickly as possible no one takes time to actually listen & understand what the problem is. You treat a symptom you see such as high BP without realising the cause is the stress of looking after my husband with dementia

At the moment, there doesn’t seem to be much available for elderly and/or dementia sufferers. One or two routine checks, such as bowel screening is all

Availability of e.g. x-ray services fully integrated with the hospitals computer system and able to do full spinal x-rays has been desired in conversation with a Consultant at JCUH because of the need to reduce congestion at main x-ray and resulting patient waiting time

Caring for people in their homes when possible is positive, but it’s important to ensure beds are available to those who need them in the community

Concerned that health care facilities in Guisborough will be cut. Elderly care beds, terminal care beds and minor injuries

Crossley unit is underutilised at RPCH would be better suited if adapted to accommodate the stroke patients

First port of call for minor injuries should be local e.g. GP surgeries (using practice nurses) and drop-in centres. Any concerns could be referred to the central point of Redcar for X-rays etc.

Fully equipped local hospital and medical centres are in place. They are under-used and residents of East Cleveland are having to travel far too much for routine tests and advice. Proposing to bring services to them is the news we’ve waited to hear

Get back to cottage hospitals no trekking down ‘long’ corridors (like James Cook has)

Guisborough’s population is increasing rapidly - 6 primary schools, a large comprehensive, a variety of Sports activities. We need more services not fewer

I am originally from Darlington area, I now live in Middlesbrough. I would just like to say I am appalled with the hygiene & service received at James Cook, it was so different at Darlington

I believe Brotton hospital should be utilised to its full potential. It’s a modern building which can serve East Cleveland well

I have particular experience of stroke and believe that whilst the aim of increased rehabilitation at home is laudable it is fraught with practical difficulties. I foresee a greater percentage of people going straight from Ward 28 at JCUH into a care home because of effective elimination of the rehabilitation period in hospital which in many cases would otherwise make them fit to go home. Of the people who go straight from Ward 28 to home it will inevitably put increased pressure on their carers-in effect these carers will be providing the cost savings as they will be doing the work that
nurses would have done had there been a rehabilitation period in hospital.

I hope there would be enough local services or nurses to visit patients at home.

I think it is unreasonable to expect someone with an injury to get 2 buses to Redcar hospital. I also wonder why James Cook has so many bad crises and cancelled operations if their beds are really underused!

I think more services could be located in Redcar Primary Care hospital.

I think that one should have stroke units in each area (Brotton hospital for surrounding areas, Redcar town area) Guisborough.

I think that they could be a good idea, but please remember that it is not always the old who need care, it can also be younger people i.e. blind, deaf diabetic, Alzheimer’s.

If Guisborough hospital minor injuries unit closes this will place more pressure on JCUH A&E which is already being monitored – plus parking at JCUH is a nightmare currently.

It doesn’t matter how many wonderful facilities for treatment you provide centrally or in the community, if you omit day-care & respite Carers need the breaks desperately.

It’s vital stroke services need to be maintained both inpatient and rehab.

James Cook is too big, people expect to get MRSA when they go in, after recent visiting relative more prevention is needed. JC main passageway hasn’t even got a bottle of hand gel.

Making access to services simple and straight forward - a single switchboard.

Mental health in this area still left wanting always the speciality left out of any improvements.

Middlesbrough residents will be concerned that the only locations of community beds are at Redcar or Brotton. How should Middlesbrough residents be deterred from using JCUH A&E, even for minor injuries. Alternatives need publicity!

Minor injury support at Guisborough should be left there.

More care in community needed, people would rather be treated at home if can.

Need stroke/elderly liaison people so the carers have a good help and back up.

Parking at Chaloner building Guisborough is very limited. Not enough for staff+ patients/visitors – access poor. Staff will fill car park without having patients cars as well.

People are worried that NHS couldn’t provide enough Nurse or services that promised.
Putting elderly people who have had strokes or other life threatening illnesses, especially palliative care in open wards such as those at James Cook is heartbreaking and inhumane. I have seen elderly women on mattresses on the floor with a rail around her like a cage, no way to treat a human being. Dignity is a basic right which doesn’t seem to be provided in large units. If you want to see good practice, people treated with dignity, respect and compassion, palliative care at its best then visit Carter Bequest and the duplicate it. For God’s sake don’t close it.

These services proposal would be most welcomed, if the staffing for these improvements are in place

To get more services at Redcar Primary care hospital

To have palliative care beds & specialist services available in community hospitals

Very concerned about losing Carter Bequest for Middlesbrough patients, they will end up staying longer in hospital. Redcar is 10 miles away

We just need a service we can rely on & trust & stop all the changes & excuses of not having staff

We need as much care in the community as possible. Many stroke victims don’t need to be in hospital but need care

We need more professional domiciliary care services – a hasty 15 minutes for each visit is not enough time for more than rushed and cursory contact. This is bad for both sides – pressurising care services & Inadequate for patients

General concerns (29)

Change for changes sake is never a good policy. Therefore see my comments in answer Q2 and 5 implementation requires a full understanding of all the services involved and their problems before it can be carried out

Change is vital but my concern is that is it real change which can help people?

Concerns as already raised

Elderly may not cope quickly

How does this affect GP service?

I am concerned are there enough local centre or nurse to provide good services

I am not sure it’s a good idea especially for elderly

I am worried the standard will go down and waiting times could get longer
I don’t agree with all the changes you propose

I hope patients will have a choice of where they are treated

Implementation of these are not for me

Implementations is not easy but you do it if you have a good feedback of it

It is a process that should have been and needs to be more transparent, it has been very obvious to many of us that this has been in the plans have been for quite a few years and the services at those community hospitals you are no talking about closing have been purposefully run down to ensure you had the data to close them

It needs to improve

More information

My concern is any change in service has side effect, hope you could see it beforehand

My only concern is putting things in one place

My only concern is the number of centres are not enough

My only concern is, if by any reason I don’t receive the care that I should after a while

One assumes that you have fully considered any pitfalls that may be considered by the public at large

Only worried if those things that now are promised won’t be delivered as it should

Only worried that closer care might make people lazy and not making any effort to get out

Some people feel safer in hospital. If a patient had no one at home, would they be allowed to choose to stay as an inpatient?

The only concern I have is waiting list as when only one centre there would always be waiting list

The plans shown tonight are too vague, not specific enough and we believe already a done deal

The proposals seem broadly positive, but the wording of your documentation and this questionnaire is poor. What exactly does “in the community” mean? Do you mean in people’s homes? If so you should say so, more clarity us needed in your information e.g. “The quality accessibility and sustainability of our current community estate - that is just long-winded jargon isn’t it. This approach does not encourage confidence in your ability to deliver these proposals

Will it make patients more vulnerable at home?
Will this improve waiting times for treatment?

Worse

**Communication (25)**

Adequate supervision needed to ensure effective communication. E.g. professional carers suggesting supplementary diet drinks etc, and the patient/informal carer/ GP surgery and dietician going along with it without the overall dietary requirements being assessed and the kind of carer support required.

Ask the patients more about the above

By sharing ideas with governmental agencies and with the community

Communication is a big factor travel time for old people

Communication is the biggest factor with GPs and patients/carers involving them in decision making

Contact MPs + Councillors (It’s local election next May 2015)

Good communication will ease our concerns and help us understand what effect changes will do to improve services

I realise we have more elderly people, some who have difficulty getting about, so an integrated system and co-ordinated appointments would be good

I would say first you should advertise your service and let people in the community know about it. Like make on event and invite people to that event and introduce them with your service

Improve the services and emphasise what people need

Information to all on new venues & services available there & access to them e.g. GP only referral etc use of the sire around GP service at Carters e.g. more care parking, increased hospice provision

Just keep people informed as to contacting services, make things accessible

Keep & update where possible, ALL property that is in use now, and spend any money on worthwhile new project to save lives

Leaflets in GP surgeries Posters. Answer phone messages - contact detail TV adverts - radio

Middlesbrough residents will be concerned that the only locations of community beds are at Redcar or Bratton How should Middlesbrough residents be deterred from using JCUH A&E, even for minor injuries. Alternatives need publicity!
More contact at home for the elderly from nurses & doctors. My mother is 90, deaf and partially sighted and had no contact from NHS

People need to be kept fully informed and consulted at every stage

Provided that there is still good access to James Cook hospital + local support + care is properly tested + implemented, it would relieve the pressure on hospital wards + give patients the option as to where + how they would prefer to be treated

Provided the changes are well advertised in a timely manner using all kinds of communication skills e.g. Facebook, posters in community buildings etc, then there should be limited teething problems

Relatives + carers need to be made aware on an individual basis + helped to adjust to any changes

Should make people aware of these changes in advance by providing more information

Talk to people not just reams of forms to fill in

The medical community should work together with the community in order these changes to be implemented

The services need to be co-ordinated amongst practitioners, communication needs to be effective; treatment need to be of a high standard

This consultation is important

Cost (22)

Agree with proposed plans, but where is money coming from?

Are you able to provide the staff required bearing in mind the costs where will the finding come from surely not just from question4

Ask the people responsible for finance to give you more help

Changes are for the better, but sustainable funding is necessary for staff/transport/facilities. It is a financial issue

Core incentives ideas are very expensive to get them

I am most concerned about the proposed changes to the services provided at Brotton hospital. I do not see how centralising services is of any benefit other than cost saving and actually reducing local community services!!

I do not object to change but not change for changes sake when it will cost a lot of money to do so
I think change is necessary. I would be hopeful that the proposal would be successful. My reservations lie with funding.

I think it is disgusting you are even considering closing carter bequest hospital. My uncle got exceptional care there which he would not have got at home. You’re closing hospitals to save money not to help people. It’s all about money. Also where are all these extra people coming from to look after people in their own homes?

I worry that the care for people in the own homes is going to be private and not all people will be able to afford this. Also the ease or lack of it to attend urgent care with children etc. when there is only public transport. Ambulances will be called for the wrong reasons.

It’s all about money and shortfall in budgets plain and simple. If you were honest and admitted this you would maybe get more public support. You state that nothing would be removed or changed until the new services are proven to work, yet you have placed an end date on the whole initiative. This puts undue strain on all involved and inevitably leads to cutting corners purely to meet time constraints that are arbitrary in the extreme.

Money is the common denominator of all change. Everything is a compromise, just do your best for old people.

much better idea for more community based services, but money must be made available, no short cuts, must be closely monitored.

My concern would be funding, bearing in mind that we are always being told that there is no money available.

My concerns would be that it would be more about all exercise to save money than providing services in a more enlightened positive way, however you dress it up with convenient jargon.

My only concerns would be the cost implications for providing a viable community service, especially in the height of the difficulties the groups I attend (health through activity. Exercise referral programme. At Southlands leisure centre) are having in obtaining funding to keep it going.

Please do close Guisborough hospital. It cannot be cost effective and concerns around safety and care standard. Staff to not appear motivated/committed or caring.

see attached: A few points on the public consultation; - the booklet issued is too ‘woolly’ - cash only mentioned 2x p.12/14 - has no relevance -no detail of resources - cash, personnel or other - no intermediate time lines - additional investment p.16 how much? From which budget? - How dependent on local authority contribution? - You need to give us more detail on overall budget - how is it raised? -49 G.P practices - which best performing etc - I notice sign at Redcar District Hospital @property services’ is this best use for hospital building? You are on the right track with integration and proactive, I do hope you succeed, all the very best.
Why are you moving services into Chaloner? The building is old, not fit for any purpose except offices. The car parking is appalling; the bank to the car park is very steep and will be a problem in the winter. How much of my money are you planning to spend re-building x-ray over there? What are your plans for Guisborough hospital site redevelopment space?

Would hope if implemented services would continue & not 'fizzle out' through lack of funding

Your plans for change seem ok, but my concern is cost will you get the money?

Yours plans seem ok as long as you keep within your budget

Some find change difficult (16)

Always changes first not easy to be accepted but when they realises the benefit they get used to it

Always changes need time to get used to, but the important thing is to get most out of it

As still we have time and there are still plans, so we have time to get used to them

As with any change, not many people embrace it and I feel particular the vulnerable etc need things to change slowly and respect their views, they are after all individuals with medical problems but are people who have feelings and are aware of what is still happening to them

Change is often disruptive and this would have to be a smooth transition which did not interfere with healthcare

I am concerned about elderly as it is not easy to cope with new changes

It may look strange first but people get used to it

It may not be easy to start but will be ok

It takes time but after that patient can see clearly the benefit

People may get nervous about new changes but get used to it

Some patients can't cope easily with radical changes

Some people accept changes with difficulty

Take times to get used to new services (x4)

The only concern is for elderly who can't accept changes and need their normal routine

They are good changes although it take time to get familiar with new services
To get the best of services can sometimes take a long time to get used to new service

Transport Positives (8)

Agree with your proposals. Guisborough needs modernising similar to work at N Ormesby perhaps. Carter bequest is also too far away for some people & is an old building requiring change

Closer to people in need the better

Considering I have hearing difficulties, tremors, heart conditions; I would appreciate facilities being available locally

I feel smaller clinics and local is important for elderly folk

It is good to have consultant out-patient clinics close to where people live

It is good to know that at last our healthcare is going to be dealt with in our own area

Local access to health professionals is the way forward

Local hospitals used more

Centralisation (8)

Centralising services do not work. Look at the ambulance service. Local hospitals should be used more. Closing minor injuries at local hospitals is disastrous thinking

I think you are trying to centralise services and that will not be helpful

I would like to see more services all inter-linked, based perhaps in RPC

It doesn’t matter how many wonderful facilities for treatment you provide centrally or in the community, if you omit day-care & respite Carers need the breaks desperately

My concerns are always based around people being lost in the system with the trend towards large centralised services so my support would always lean towards localised community based services

Stroke facilities in one place sounds ideal, more useful facilities in Brotton likewise /Guisborough sounds a bit chaotic Carter Bequest good solution. Redcar PC hosp put to full use is best news of all a new facility underused - uneconomic

While this is on the whole a good idea, I feel that it is imperative that hospital beds are not lost for those people who still required hospital stay. Also I’m not sure centralising minor injuries in Redcar will help the outlying communities
With many hospital merged into James Cook hospital it seems that patient care is not as good as what it was when they had local hospital & specialist hospital

**Needs to happen quickly (6)**

As quick and effective as possible (x3)

As soon as possible but not to the disadvantage of existing services

Sooner put into practice the better for our age group

Why not just doing it? Don’t mess about - 2016 a long way off

**Staff need to be trained appropriately (5)**

My concerns are not enough staff, equipment timing, (nurses having time to spend with patients and patients are not rushed)

My only concerns would be that care in the community would have adequate staff to provide a good level of service, and that staff would have a good level of skill in their particular field

Staff should be trained

The ideas are great, but the increase work load for the teams will require a lot of study, training & resources and an increase in dedication/calling to say nothing about well administered budget

The press state that District Nursing is losing staff etc. Can enough staff be trained / employed to fulfil requirements?

**Very good staff (4)**

Redcar hospital is very good - clean easy parking - no traffic problems locally, good staff

The ideas sound good, I think the right type of staff who work for social services is extremely important courteous caring showing respect, just because people are old, ill or neglected they still need respect.

This week my disabled husband has encountered many of the problems envisaged - i.e. waited all night for an ambulance after 111 call due to excess 999 calls - staff very good in keeping contact

Why has Teddington hospital closed for A&E when they offered an excellent service and very caring efficient staff
Other (37)

A comprehensive list of the services available would help

Already given views

Change is what is needed, true, but why not look at the potential of willing thousands of cheap labour in our communities and plan accordingly

Close down old buildings and give people who lose their jobs work in looking after people in their own homes. Nobody wants people out of work!

Close Guisborough and Carter Bequest, use the revenue & capital to develop services. I think there will be a need to project services with review before full implementation

Comment when I know what you are going to do. Use Brotton Hospital more. It seems to be a white elephant

Do not employ people on high salaries - provide an appropriate service - that was provided 10 years ago - give people choice

Focus on delivery of promises, not as a politician, but as care of the community

Get rid of people in high places in NHS & provide more nurses & specialists both in the community & in hospitals & more consultation with the carer

I don’t feel qualified to comment on any other sections in this questionnaire - I have no experience of the services involved

I doubt medical and social assistant would co-operate

I think they have been confirmed in discussions with staff who have taken note

If you don’t know, how can I tell you?

Implementation is very hard, you need experts to involve such an area

In favour of proposed changes, but would like to see our local services stay

Instead of making buildings the focus it would be better if people - in surgeries or their homes?? the focus

It is alright for government to want to work in statistics but this does not take into fact early treatment means shorter stay in hospital and less stress on patients

Middlesbrough NOT just R + Cleveland should have a community hospital
More follow up care and less cost - it’s too expensive

My main concern would be that individuals involved would not be involved sufficiently in the service redesign, resulting in lost opportunities to make a positive, effective & well functioning service

My views should be obvious from previous answers reduce red tape

Need more information to make a decision and form conclusion

No comments (x14)

People get used to it

Praises the NHS for the help & assistance they do provide

Prevention a key factor with the elderly. If monitored regularly many long stays in hospital may be avoided

See my views above (Providing sufficient resources are invested in people who will provide the treatment)

See note below ...Ref Tom Blekinsop copy of response letter in Improve MP file

See previous answers.

Social care and social services are very important to look at

The health secretary said recently that better use should be made of local hospitals. I believe your cost reduction proposals will do the opposite

There is not enough space here to give my views and feel that this is deliberate. I feel that people are not being listened to and the overall decision has already been made!

These changes don’t include sending people home very late at night without any support. Assurance must be given to a person leaving hospital in ambulance there will be a carer there to make that person a cup of tea, washed and put in bed, the same person will follow this up the following morning (if necessary stay the night) until that person is settled. The team should have a nurse, someone to give them their meals and a cleaner which is very important the place is kept clean

This change has to be good for people - there should be facilities for elderly respite so that carers could have a worry free break & in turn keep loved ones at home

This consultation seems to be being told what is happening, and will happen regardless of the opinions of local people. Decision has been made
To take all facilities from a town the size of Guisborough (which is still growing) would be disastrous

Would you please stop employing groups of people at God knows what expense to arrive at a stupid improve
Q.8. How do you think our plans could have an impact on specific groups or individuals within our community? For example people from black and ethnic minority backgrounds, males/females, those with disabilities, carers.

**Positive (182)**

**Affect everyone/demographics irrelevant (69)**

Access to help should be easily availability to all, locally (4)

I consider the proposed changes should improve the public’s care, after-care and hopefully, well-being. All buildings should be fully functional and occupied

I think the plans will affect everyone the same

I think the proposals are welcome and a positive move in the right direction. Sure to help all the categories mentioned

I would say it is very important for them. It would have good affect on them

It is very good for them, because other minorities rather than citizens are more vulnerable to different problems

It should be positive as ‘all’ groups should be catered

It will impact on all of the above groups by closing their local hospital, and making the same mistakes as they have done with the James Cook hospital

It would be more helpful to these groups of people

Most of your proposed plans can only be of help to these people

No special are plans needed. There should be availability for all!

Plans and changes are always good and will benefit all minorities and backgrounds, as long as it used correctly

The plans could only benefit all individuals, regardless of colour and background etc. The plans could only enhance all lives. People with disabilities and carers would have such a better life, with fewer problems

This would help everyone, from any background (9)

**Positive (General) (32)**
Form a special team of highly qualified people, to cover all of these problems

Hopefully for the better

I cannot see a problem

I can only speak from a personal point of view but accessing regular care and advice for my husband nearer to home would have a great impact. There would be less physical stress on me and my family, fighting with wheelchairs and dementia at James Cook Hospital

I think it’s good for them (3)

I think your plans are quite good on specific groups or individuals

I would hope it would make life easier

I would hope that the plans would be helpful for everybody

It can change patients routines in a good way

It is very good for them

It should make life easier

It will definitely have a positive impact on the disabled and elderly

It will enable the service user to get the care they deserve quicker and in a higher standard

It will especially be more convenient for the elderly and disabled

It will have a good impact on patient’s daily treatment, especially for those who need frequent treatment

It will make a big impact, you have young and old, coloured and white some severely disabled, some who are capable

It would not seem so. If it helps the total eliminations of mixed sex wards this would be a bonus

Make life easy for both patient and carers

Positive impact on mostly elderly and disabled

Should be lots better

The plans are fair
They are good

Very good (2)

Well thought out future plans should help everybody

Yes, it will help minority backgrounds (3)

Your plans could work if you are able to get the money

Community (16)

Any plans to bring services back into the community can only have a very positive impact for all concerned

As above, (much better idea for more community based services, but money must be made available, no short cuts, must be closely monitored)

Help with integration of communities

Hopefully these plans will suit all members of the community

If things were based more locally - it would be beneficial for people with disabilities and carers

It will help the minority integrate within their community more easily

It would improve access to community care

Minority backgrounds feel isolated most of the time and that will help them, having the service they need

Socially, it is important

The whole community would be better when changes are made. It would improve the prevention and health promotion in area (4)

They will be able to integrate better and make friends with other people with the same difficulties

Yes, of course it will impact, if you know something is going on in your place you will give attention

Your plan will have a good impact on the health of white ethnic groups because they are the majority in the area and part do good

Quality of help (12)
As above, any improvement for the elderly is so helpful to those who are carers, I am the daughter of a man who needs the care so will fill in as if, I’m my father

Better support for families with dementia

I can see where improvements have been made, but still a long way to go

I hope it improves communication with responsible, informal carers and that responsible carers are identified as such accurately. One GP always got someone to tell the informal carer when he was sending the district nurse but, others didn’t. This meant the possibility for the patient to believe the informal carer wasn’t telling him what was happening and why. This increases feeling of vulnerability. Informal carers can be suddenly confronted with a new situation in car this needs to be supported.

I think that if you don’t improve services in hospitals as well as in the community, the NHS is going to have a lot more fatalities

It makes treatment easier for people who struggle with carers

It will have a good impact because all you have planned or proposed is very good for them

It will improve care and quality of life

It will improve the way that they receive help

Service will improve the quality provided

They can only improve services (2)

Effect on those with disabilities (11)

All plans would help disabled (severely) people with some or very little mobility

Big impact on disabled people

Definitely for disabled people, it is more convenient

I am sure for disabled and elderly that it’s more convenient

I have no knowledge of bi-ethnic communities, but as long as their cultural needs are met, I can’t find fault. Separation of areas for male/female and those with disabilities must impact well, if accessible, carers may benefit if some services and more local or at home

I think the group that would have more advantages are those who have disabilities
If there were respite beds for home carers to use for those they look after, there wouldn't be so many people in care homes as carers would have a stress-free break. And they would be able to cope much better.

It will enable people with disability and lack of mobility to get healthcare quicker without any delay in their care.

It would appear that the plans would be beneficial to those with disabilities and their carers. I am unaware of the impact on black and ethnic minorities.

No problem for us, providing that the disabled are provided for and staff are trained for the needs of the disabled.

The more disabled, the better your plans are.

**Help for carers (9)**

Carers don’t need to spend time going to hospital, and patients can be more confident (3).

I can’t speak except as a carer for an elderly disabled man. I think it could make care easier but I am grateful for the care already in place.

I think it could help the carers, but I do think more consideration should be given to the carers is the community; better training, maybe some specialised in caring for certain illnesses. Keeping carers on a rota, the same few for each patient as old and young people find it very distressing to keep having a change of carer and having to explain their disability over and over again, especially if there is a language difficulty.

 Might reduce the pressure on carers (4).

**Travel (7)**

For those patient who don’t have a regular carer and have difficulty going to their appointment, will be a very positive help.

Help the elderly and disabled to save them a journey to the hospital.

If things are centralised; travel and communication, things could possibly work better.

It could save time and money for those patients with regards to not having to travel to James Cook hospital; except for any specialist needs they may have.

Not having to travel to James Cook University Hospital will be appreciated by many people.
Simply by not having to travel too far, that has to help

Surely. Save time and money for transport and further treatment at hospital

Time (7)

As black and minority people are from different cultures, these plans have a positive impact on them as they don’t have to spend lots of time in hospital

For those who don’t have a regular carer, it will save lots of time and concern going to hospital

Increases people’s confidence, saves time and costs

It definitely saves time for patients (and carers) (4)

Confidence (5)

For people with disabilities, it will provide them with more confidence to receive part of treatment close to home

It gives more confidence to both males and females, and a more positive view towards the future (2)

It is obvious, there is anxiety, whether present available local services are replaced by inconvenience/lack of professionalism

Some elderly think that they receive better services at hospital and lose their confidence

Elderly patients (5)

Elderly people in the community regardless of colour or race should all have opportunity to receive necessary care as required. All medical staff display the highest of caring. The troubles are all government finance

Elderly receive a lot of care

I think it will be effective, in our culture we care for our elderly and we know how to care for them. It is a good plan

It will have huge positive impact for the elderly and the vulnerable people if it is implemented

The impact would be immense. Any help/care for the elderly would have a profound effect. Social groups are such a benefit
Other (9)

As long as the people are aware of the services

By raising awareness

Empowering choice, informing attitudes and responses is important for all groups. Ethnic/generational/gender approaches differ and need to be addressed carefully.

Everyone's the same, look after each other then it won't impact other comments. They should link all services up, it will give us reassurance. You needed more publicity, mind I don't read papers

It will affect these people the same way, it will affect those outside the people listed above

Must help the vulnerable

My husband is 90, with severe Alzheimer's, the minor injury facility at Brotton is a great help

Patients don't need to go to hospital for everything

Try anything to help the current situation; making people aware of any help offered and of any changes

Negative (167)

Travel (32)

Accessibility is difficult for disabled patients and carers in general, due to lack of transport

As both myself and wife are disabled, one of us is not always well enough to travel a long distance and have to rely on others; friends or extended family aren't always available. This causes more stress and relying on short notice to get ambulance is a no, no

As I have mentioned before; elderly patients, children and patients with poor mobility might have to get two buses to get treatment, if they have no transport.

Disability access services are further away

For some people, getting to a single place like Redcar is difficult, in regards to distance

For those of us who live in East Cleveland, Redcar hospital is not very accessible unless you have a car. So transport links are a different consideration, as the vulnerable people you are trying to help will be disadvantaged
For those who don't have a carer, it's difficult to access the services

From the TS5 area, an elderly spouse would have great difficulty visiting an inpatient. In my opinion, the basis of this proposal is to utilise a modern facility which was built in the wrong area

Hopefully none; as any form of discrimination goes against the 1995 Discrimination Act. Low income families will be hit due to parking charges at James Cook University Hospital and cost of petrol or public transport

I believe the residents of Guisborough will not benefit from the proposed changes and this is entirely due to the very poor transport infrastructure. Travelling to Redcar is much harder than it is to jump on a bus to Middlesbrough

If places are reachable then fine, but everywhere is two buses from where I live and the buses never follow without a long wait

Immobile patients need a local point of contact. Wheelchair taxis can be expensive and journeys are very tiring. They can often then be sent elsewhere

It is much harder for those with disabilities and the elderly, due to further travel. There are several buses to Redcar

It seems you want to increase travel, which will put a greater strain on GP practices. They will need more staff to carry out plans due to increased travelling and ambulance requirements

It will have impact on elderly visitors from Middlesbrough. Also have you considered families travelling via A19? This would add half an hour more to their journey, will it stop them visiting so often. Families are now more widespread

It will involve more travel, which may be a challenge for some people

Local bus services aren't always appropriate to centralise services.

Maybe inpatients would receive fewer visitors due to location of Redcar and Cleveland hospitals

My wife is unable to visit doctors or hospitals without the necessity of ambulances or relatives who will transport her

Non-drivers will find travel difficult. Patients in local homes using our urgent care facilities would need ambulance or taxi transfers to Redcar, or more likely James Cook

Patients in local homes and those who have no transport can be seen in local urgent care clinic. They may need ambulances to transfer elsewhere and they may put pressure on ambulance services

Patients with disabilities will have a lot more travelling to do for physiotherapy
People living in smaller towns will have a reduced service, especially if they don’t drive. Care times will increase, as less people seen a day

Perception by locals around venues due for closure - they wouldn’t walk to the site in any circumstances and most people visit by car or bus anyway. Mobility of community based services needs to be well prompted as this is the major thing that will appeal to residents. Most don’t care about budgets - it’s too remote

There might be problems getting from A to B for those without transport and no family support

They will have to travel further, as will relatives from Middlesbrough, which could mean less visitors. People may not know the area they are being sent to

Transport is difficult for the disabled and elderly (2)

Travel mainly, this is still a low car usage area, with very poor public transport

Travel to receive healthcare in the community is the main reason people are unhappy, about the distance and stress to access help at James Cook

We need to make sure all is cared for without too much travel and waiting time. This is a problem at most hospitals for the elderly and vulnerable

When using one area for treatments, travel costs are outlying areas - it may be too expensive

Home (21)

All people should be able to access care as close to home as possible

All should be treated the same, but it would be helpful if extra help at home be available on rare occasions

For foreign people, getting some help at home is more convenient

For some people it’s better to stay at their home, rather than go to hospital

For specific patients, such as disabled, it is more comfortable to have some of the nursing services at their home

For those who don’t speak English, hospital is a scary place, so receiving some treatment at home is peace of mind

Generally, specific groups will welcome the greater emphasis on treating people in their own homes
Getting more care into the home will help many groups, there will be no trekking to the hospital

Help the elderly to stay safe at their home

Home care for disabled people would be advantageous

I approve of the idea of home care

It may cost people more to go to a centralised unit. However if people will be employed to come to people’s homes, it should not make a difference

It’s more comfortable for elderly to be visited at their home

More support for people in their own homes would be a big help for family members who are carers. Carers need more support too

People who are physically ill, sometimes get depressed, so it’s better to stay close to home

People would appreciate a visit to the house by someone of the same sex as them

Some people are scared of hospital and prefer home

There is a possibility people could feel isolated in their own home, especially if they are alone and if families are not in the area. A lot of issues may be transferred to family, they should provide carers

They would be worse off with fewer services near to home

Yet again, carers are expected to take on another role. Home nursing is 24/7, instead of the NHS. We will have to pay for care in the home. The rich can buy hospital services - the poor can stay at home

Negative (general) (19)

As a carer, having a disabled son, it is essential that we use one of our nearest hospital such as West Mid, which saved my life and were very accommodating to my son

As NHS/hospitals do not disseminate on any of the above grounds, I cannot see how the plans set out will impact negatively on those groups, as long as there is reasonable access to all services in the community

Could cause a lot of stress for families

I do not think ethnic groups would accept this

I feel that these proposals are a disgrace and, again people are not being listened to

I think it will be more accessible for carers and those with disabilities. Will need to have translations
services for BME and speakers of other languages

I think the idea of centralising services would be a disaster to East Cleveland

I think the very young and elderly are always the ones who will suffer

If we go to Spain or another foreign country, everyone has insurance, sometimes costing £500 for two pensioners. Why is it not the same here? For the immigrants or visitors using the hospitals all over Britain (it cost £3,000 for 2 1/2 days when I had acute bronchitis in Jan 2014)

Lack of understanding of what is available and how to access it through social and communication barriers, which will always be an issue

Mental health has a very poor service in Redcar and Cleveland

Obviously the more centre's of care, the easier patient access, but in balance the plans should work for everyone

Only the obvious fear that local elderly and vulnerable people will have about hospital closures

Selfish/ideological interests will have to be curbed, the true intent appreciated and agreed

The impact would be that vulnerable people will not get the specialist care they need. Some people don't have family. Who tends to their needs when the community carers aren't there

The provision must be real, not token. The elderly still retain some provision for single sex (appropriate) cover in sensitive areas

This is Britain, maybe ethnic people should adapt to British culture if they choose to reside here

To keep changing things is expensive and destroys trust and relationships built up existing services and individuals

Use Brotton hospital more

No difference (15)

I don’t think it will have an impact (9)

I don’t think it would have an impact

I don’t think it would make any impact on ethnic minority people or other characteristics

Shouldn’t make any difference, all changes and plans will make services more local (2)

The plans as suggested are only going to cause minor changes, because the plans are not of a major
nature, we need more
Without effective local transport, it will make little difference. Unless, you employ staff with effective communications skills there will be little impact

**Disabilities/carers (12)**

As a 68 year old carer I am concerned that this will increase my ‘workload’

As an elderly carer with a badly disabled wife (from a stroke 8 years ago), I’d appreciate more of a pro-active effort from the professionals

Carers are some of the people who have great difficulties leaving their loved one alone. I take my husband’s hearing aid for repair at the local hospital and have to wait for a long time in a queue, sometimes two hours, only to be told I have to leave it to go to James Cook. Something I knew in the first place, only they would not let me leave it

Carers will have more of a burden placed on them.

Disabled people, as well as elderly are more catered to

I think carers have a tough enough job without making things any worse

**More emphasis on ‘caring for the carer’ (2)**

Moving facilities would make things very difficult for disabled people and their carers

People with severe sensory loss must be properly accommodated

They will result in more pressure on carers as professionals retreat into central facilities

With day-care places closing and no alternatives available, more elderly/disabled people are being left isolated and carers are struggling to cope

**Language barriers (12)**

Ethnic minority people might have language barriers and travel problems (5)

Have a well experienced medically trained interpreter (4)

I cannot see any groups should have problems with changes, except non English speakers who would require a translator

The main issue with minorities is language and culture, so you need to address this point now and
then

There will be big impact on people with no English language who might find it difficult to get to hospital

Demographics not important (9)

Carers need much more support generally, especially for short-term relief. All people should be treated equally so ethnicity is not important

Having lost a brother recently, I would not care what colour or creed was adding to the success of care delivered to patients

Hopefully they won't, as I said earlier - local is best. Why even mention specific groups; people are people

I don't think it affects minority people

Stop segregating people and treat everyone as equal patients

There should be no discrimination (3)

You shouldn't have to worry about the colour of the people that have to attend

Elderly patients (8)

As I said, the elderly could have difficulty coping with a new programme

As this is often service lead focus, rather than person led care, this often leads to those nearing pensionable age looking after elderly parents; when they really need support themselves. Thus resulting in an increase in poor mental health within the community

Elderly people don't need to go to hospital

It is difficult for elderly to get used to these changes

Older people prefer smaller units with more personal care, many dread going into James Cook Hospital. They should provide better prevention, go back to the old ways of nursing, too many nurses are in it for the money, but don't care anymore. Forget the doctors stations, too much chatter goes on

Some people struggle with changes, but surely it will make life easier for most, such as, the elderly

There are very few ethnic minority people in our area. Especially in winter people need to meet to
have coffee, play cards, dominoes, scrabble (the UBA) type of thing, but for so many, transport is the main problem - especially in winter. Many are nervous to start something new but if friendly caring volunteers could at least be their contact to start with, older people like myself would be able to welcome people when they arrived, but in bad weather I couldn’t as I’d possibly have no one to care for me

We need less travel

Unsure (27)

Ask the black and ethnic minority backgrounds about the above

Cannot comment really as my experience has been since my husband was diagnosed with vascular dementia, three years ago

Cannot say what impact your plans could have

I do not know but I am worried it could get worse

I don’t know (4)

I think that time and new practices will tell if new measures help the community

N/A (2)

No comment (3)

Not enough information to know on all groups

Not sure (9)

This question requires feedback from each of your specified groups in our community (plus many others unspecified) before you can estimate or qualify the impact of your plan

Until the services are actually in place, it would be hard to say. Also, this questionnaire presumes some prior knowledge of services and how they do or do not work. In my role in a previous job, I constantly came across people who had a fatal lack of awareness of specific services available to them

You can only please some of the people some of the time, but never everyone all the time

Other (12)

They say that in life the two certainties are death and taxes. Strange how these are the two things
that pay no regard to trendy compartmentalisation. The NHS is paid for by taxes and taxes are levied without regard to minority status. The NHS help stave off mortality and morbidity and mortality and morbidity pay no heed to minority status – except in respect of inherited disease. Cut finger... no special treatment. One of these fancy Jewish genetic disorders, African sickle cell disease, got to have regard to ‘expert patient’ status.

Difficult to say as there is insufficient detail. On the whole they don’t appear discriminatory.

Employ both ethnic people to help

Having had a stroke, once discharged from hospital, both my wife and I felt we had been abandoned as far as follow up services were concerned, or information on what services might be available. Fortunately my wife saw an article in the local newspaper and a contact number for the group health through activity/exercise referral programme. I now attend the group each week which has been a lifeline and we feel continued funding is vital for this programme

How would the care be audited - people with disabilities probably don’t like to make a fuss

I am white and abide by this countries rules and regulations, why should it bother anybody whom is doing the same

I feel that if everything is centralised then the elderly and carers

I’m not sure. As a carer may help has been through Ashwood at Guisborough and carers together

Information needs to be given, and be available at all levels

It is essential to establish the various constraints that these groups or individuals may be limited by; stamina, diet, communication, family/customary constraints. Full knowledge is essential

Redcar has single bed rooms which could be a safety issue for patients after a stroke

That won’t become apparent until you implement your plans.
Committed to creating insightful and dynamic partnerships that deliver powerful and intelligent results.
Appendix 5. Carers Together Vulnerable Groups Survey
IMProVE

Vulnerable Groups Survey

December 2013

In partnership with Carers Together
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Background

The ImProve Project

NHS South Tees Clinical Commissioning Group (CCG) has started talking to the public about services for the vulnerable and elderly and those living with long-term health conditions such as diabetes, heart disease or chronic obstructive pulmonary disease (COPD).

Over the past year, we have been working with GPs, hospital doctors, managers and local authority partners to consider the challenges we face in meeting the needs of a growing population of older patients with long-term conditions and other health and social care requirements. We now want to listen to the views of local people, stakeholders and professionals and encourage as many as possible to get involved and have their say about this important issue.

About the survey – a joint project between the CCG and Carers Together

With the Improve project, NHS South Tees Clinical Commissioning Group is aiming to move the focus of the current model of care for particular groups of patients from a reactive model to one which is proactive and designed to prevent a deterioration into ill health and hospital admission. The CCG is very committed to involving local people in its decision making.

Those patients that are elderly and vulnerable, who are often admitted to hospital, who are frail, elderly or live with long-term conditions, and who may also be in receipt of other community or home-based services are specific groups of patients identified in the project. Best practice is that any strategy for engagement should include seeking the views from all those affected by any change in services, in order to meet the Duty to Involve placed on commissioners of health care services.

A targeted piece of work has been undertaken in partnership with Carers Togetehr, Redcar, to engage and obtain the views of those described in the Improve project briefing.

The aim was for 50-100 people aged 65 plus in Redcar, Eston, Brotton, Middlesbrough and Guisborough to complete questionnaires. It was intended that these responses would be from the elderly and vulnerable people in those areas, that is those who are housebound, have limited mobility or living with significant long term conditions. Carers Together from Redcar undertook to deliver the survey, working with their own volunteers, clients and local groups to get the numbers required. The responses were then uploaded on line and a joint analysis of the findings was undertaken between Carers Together and the CCG, using Wordle, Survey Monkey and Excel software.

About Carers Together

Carers Together Foundation is a registered charity and a limited company and was established by a group of carers in 2004, who had identified the need for a local carers’ information and support
service that could also ensure that carers were recognized, listened to and valued. Since then
Carers Together has continued to be carer-led and has developed into an organization with a team
of staff and volunteers, who provide a range of services and a voice for carers in Redcar and
Cleveland. Over 4000 carers are registered with our services.

Our vision is “A better future for carers” and we work to achieve this by informing, supporting and
representing carers living in Redcar and Cleveland and the surrounding area.

Our aims are:

- To provide information and support to carers so that they are able to make informed
  choices about their lives
- To promote the health and wellbeing of carers
- To represent the views of carers and to positively influence policies and services, so that
  individuals and agencies understand, value and recognize carers and their caring roles.

Acknowledgements

Carers Together and NHS South Tees Clinical Commissioning Group would like to thank the
following organisations for their assistance with this project:

Royal Voluntary Service

The Older People’s Partnership for Redcar and Cleveland

Age UK Teesside

Redcar & Cleveland Visually Impaired group
Findings

What people said about help from local services

Question 4 - people were asked if they had received enough support from local services in the six months before completing the survey to help them manage their long term health condition(s).

Overall

Only 11 (3.4%) said they definitely had received enough support. The largest proportion of people said they had to some extent - 221 (69.1%). Forty three (13.4%) answered no to this question.

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<td>Yes, to some extent</td>
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<td>No</td>
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<td>Comments - what could be improved?</td>
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Answered question 320
Skipped question 28

There were many and varied comments about what could be improved:

A simple word analysis shows the most common words describing local services.

General themes are set out below.
**Appointments**
Generally people wanted to see more and better organisation of appointments and more information relating to appointments.

**Communications**
Comments about communications included improving communication between departments, liaison with carers, a more joined up approach, a holistic view of the family situation. ‘The different departments do not interact with each other which confuses everyone. No one department seem to have the full, up-to-date information.’

**Continence supplies**
‘Incontinence pads that are fit for purpose and not to have standard, cheaply bought ones.’

**Costs**
There were a number of comments about the cost of services/support, lack of information and difficulty obtaining information

**Duration and number of visits**
A number of comments made about the frequency and duration of paid carers visits. ‘Carers visits could have been longer than 15/20 minutes and some more helpful rather than filling in forms.’ ‘Receiving bathing help twice a week and respite care and daycare three times a week part days. No other help given.’

Regular visits from nurse or doctor would be an advantage, currently they ‘only attend when requested. ‘Longer time spent with district/community nurses, more contact from GP’, ‘District nurse visits can be erratic.’

**Equipment**
‘Speed at which equipment recommended is actually delivered’

**GP**
People would like an improved relationship, doctors who stay longer in the practice and understand their conditions, easier access to appointments. One comment was about worry about being able to explain problems over the phone which is why it would be ‘better to see a doctor’. ‘Easier access to GP as it costs me £7.00 to get there so I don’t go as often as I should.” GP should be more involved in monitoring situation’

**Lack of information**
‘We had carers for 6 weeks when changed over, no one would say what it was going to cost and how was going to pay for it, no good having a big bill, so the carers asked not to come.’

There were a number of comments made about lack of information, relating to help and support from different services – the council for mobility, more information because doctors not available, one comment about support from Parkinsons nurses, lack of support on discharge for a carer.
Medicines
Someone to identify medication and its specific use.

More services
This included osteopathy, chiropody and physiotherapy (more than one comment), also hydrotherapy. ‘Make better use of the endoscopy unit and hydrotherapy pool at Redcar.’ There was a comment about how difficult it was to get a wheelchair and also a comment about support to clean the house. In relation to caring responsibilities ‘More frequent calls from ‘HomeCare' would benefit us’

Other comments
There was a comment about the withdrawal of a blue badge.

Satisfaction with services
There were over twenty comments from people saying how much they appreciated/ are satisfied they are with their care from local services.

Support and understanding
More staff support for practical jobs such as shopping and housework and washing care. ‘I was told that I needed help in bathroom. I was put on the list for a walk in shower along with my wife-she can’t get into the bath due to her illness. I got a phone call yesterday saying we have to wait two years.’

More support was required for housebound people and there was a comment that the Young Onset Dementia Team should give more support.

There was one comment about ‘Appropriate support for coping with continually deteriorating physical condition which impacts on my mental health problems. Six sessions with Talking Therapies is like treating a broken leg with a band aid.’

There were a couple of comments about understanding old age pensioners – ‘tell people to be more patient and give me time to answer the door’.

Trained staff
There were comments about the need for more trained paid carers, social workers and occupational therapists and waiting times in relation to these.

Transport
Help with travel costs where patient transport cannot be arranged in time.

Waiting times
There was a comment about the time taken from assessment of and diagnosis of dementia and receiving care. There were a number of comments about waiting times being too long both for doctors’ appointments (4-5 weeks ‘not unusual’, social services assessments,
specialist assessments from OT and for installation of equipment and three months for a cataract operation.

**Feedback on integration of services**

Question 5 asked whether different people treating and caring for patients (such as doctors or nurses) work well together to give them the best possible care.

**Overall**

Whilst people were very positive about the efforts people have made to work together, they made comments about a number of areas that could be improved.

A simple word analysis of the comments shows communication to be most frequently mentioned in the comments section of this question, followed by GP and doctors’ appointments.

**Appointments**

People commented that appointments need to be easier to make, the appointment system needs to improve and it needs to be easy and understandable to the elderly. It is also difficult for people to get there.

‘You have to wait on the phone for ages’. ‘Easier to get appointments.’ ‘Good support from GP but follow up hospital appointment took too long to wait for.’

Waiting times for appointments was also mentioned again by people.

**Communication/ liaison**

This was a strong theme, with over 20 comments made about improving communication and liaison between professionals, hospitals and GPs, keeping each other informed of treatment and progress, patients knowing what is available.

‘Doctor rarely visits even when requested, often prescribes over phone. ‘Very little communication between doctor and nurses.’
‘Doctors don’t always recognise when the slight but chronic cough I have is changing in character and indentifying the increased shortness of breath without activity is leading to Pneumonia. I have twice now reached the stage where sepsis is occurring when admitted to hospital. Sometimes the district nurses delay dressing my skin condition on my legs according to the hospital Dr’s directions when it worsens and becomes very painful. I have recurring MRSA.’

‘The blind leading the blind. Information from doctors not relayed to family members.’

‘No link between departments. Different nurses for what used to be the same job. "District" nurse will not do simple task and quotes new rules as being the cause.’

‘Every unit works in a silo! There should be a one stop shop which coordinates and monitors progress’

**Costs**

One comment was about local GPs being reluctant to spend their budgets on drugs and services. ‘They act as managers rather than as doctors.’

**Follow up**

There were comments about there being no follow up by the doctor, nurse and hospital staff, that it is easier to access your own doctor and this would be easier, although having the same GP is important ‘who knows about your condition and not doctors who hardly know you.’

**Home Visit**

‘Maybe a home visit from a nurse twice a year would be a great help.’

**Impact of disabilities**

‘Appreciation of all aspects regarding how any one of the disabilities effects the other i.e. fitting a hearing aid if one has a magnifying glass (10x) to see it and little, if any, sense of touch.’

**Lack of information**

Comments about people knowing what services are available, when to contact them, how and what for.

‘Access to relevant information when doctors and nurses have a collective review. Results of tests and treatments explained’

**More physiotherapy**

**More staff**

‘I had a visit from a district nurse approx every two months. This stopped around April.’

‘More staff, or any system will not work correctly.’
Knowing who to contact

Question 6 asked whether people knew who to contact if they were worried about their condition or any treatment they were receiving.

Overall

There was a range of comments (47) from people regarding improvements or their experience of services, although these were also balanced by positive comments about current services. Most people 288 (90%) said they did – either they did know who to contact, or ‘yes, for some things’.

<table>
<thead>
<tr>
<th>Answer Options</th>
<th>Response Percent</th>
<th>Response Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes, I know who to contact</td>
<td>67.5%</td>
<td>216</td>
</tr>
<tr>
<td>Yes, for some things</td>
<td>22.5%</td>
<td>72</td>
</tr>
<tr>
<td>No, not really</td>
<td>10.0%</td>
<td>32</td>
</tr>
<tr>
<td>Comments?</td>
<td></td>
<td>47</td>
</tr>
</tbody>
</table>

A simple word analysis shows the most common words used in the comments:

The general themes arising in the comments are as follows.
First port of call is GP
Most people talked about the first port of call being their GP and how they rely on local doctors. They also commented on having a call button. ‘I telephone my surgery with a problem and the doctor always rings back.’

One person said they ‘Can contact Stroke Association, GP Surgery and can ask to be re-referred to community matron service.’

Some people said it was difficult to contact people as they didn’t know who to contact.

There was a comment about not having a computer.

There were also a number of comments about support from family members to contact services when something is wrong.

‘I tell my daughter and she passes on information to the staff.’

Two people talked about their homecall service.

More written information
‘A written list of contacts/conditions would be helpful’.

‘Have written documentation which helps’. ‘Totally confused and forgetful’. ‘Update info re staff, constant changing of staff is most confusing.’

Passed between clinicians
There were several comments about being passed between clinicians. ‘No one seems to know who does what. You are passed from one organisation to another.’

Positive role of secretarial staff
Secretaries ‘sign post’. ‘Reliable secretaries save time for all social workers - great at signposting’

Waiting times
There were a few comments about waiting times.

Is more information and/ or guidance needed?
Question 7 asked if people felt they needed more information or guidance to help them manage their condition or any treatment at home.

Overall
Just over half of the respondents – 158 (53%) – said they needed a little or a lot more information to help them manage their condition or any treatment at home. A further 47% said they didn’t need any more information or guidance.
A simple word analysis shows the following most frequently used words in the comments made.

However, unpicking these comments, people wanted to know more/ receive more services in the following areas:

**Arthritis / specialist associations**

**Better explained information**
‘*Explanations are brief and covered in professional language.*’

**Carer support**
‘*All the staff who have visited have been very thorough but I rely on my wife to understand what is said and if spoken to alone I can give wrong information.*’

When visited, assessed, asked for information.
Carer could possibly be involved – ‘informed of changes = medication and processes.’ And ‘carers could be given more information about when a condition worsens.’

**Carer (paid) training**
Carers employed to work with dementia patients should be given guidance on how to speak to and react with patients.

**Community matron**
‘I was well supported by a Community Matron but her services have now been withdrawn.’

**Consistent information**
Constant information from all departments, i.e. one says eat plenty of one thing another says don't eat the sort of thing each time it is eat this don't eat this.

**Counselling**
‘Perhaps some counselling for depression resulting from caring for my wife.’

**Dementia assessment**
‘An assessment in the house from someone who knows about dementia.’

**Drop in service**
‘Information and support is hit and miss. Need a local drop in service.’

**Follow-up**
‘Last year I missed my flu jab and ended up in hospital 26th December to January 6th. Could not get get to my doctors for it and was not phoned about it. Same up to now this year but at the moment I am in hospital with broken hip.’

**Information on tests**
‘Patients to be told about results of x-rays and scans and not to be kept waiting for information’

**Parkinsons’ support**
‘Parkinsons’ experts, we haven't seen or heard of one in 22 years.’

**Physiotherapy / advice**
‘After going home physio ceased and I had no idea what I should attempt. I felt it was a case of once going home that was the end of it.’

**Podiatry at home**

**Social Services / information**
This was a common theme. ‘We see the GP regularly and know how to contact the OT but have had no contact or help with/from social services. Most of the things we have in place to help us remain living at home has been sourced and supplied by our family. We have even organised 'Home Call' ourselves.’
Waiting Times

‘There is often frustration about the time spent waiting. Screens in each waiting room would relieve the frustration.’
Organising care

Question 8 asked people how well they thought health and social care staff organise the care and services for local people.

<table>
<thead>
<tr>
<th>Answer Options</th>
<th>Response Percent</th>
<th>Response Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very well</td>
<td>37.5%</td>
<td>120</td>
</tr>
<tr>
<td>Not very well</td>
<td>5.6%</td>
<td>18</td>
</tr>
<tr>
<td>Fairly well</td>
<td>38.1%</td>
<td>122</td>
</tr>
<tr>
<td>Not at all well</td>
<td>5.3%</td>
<td>17</td>
</tr>
<tr>
<td>No opinion</td>
<td>13.4%</td>
<td>43</td>
</tr>
</tbody>
</table>

What do you think could be improved? 82

Answered question 320

Skipped question 28

A simple word analysis shows the following:
Where people think the majority of care for long term conditions should be given

Question 9 asked where people think people should receive the majority of their care if they have a long-term condition(s). They were given the examples of stroke, frail elderly people, people with dementia and people with chronic chest problems or heart disease.

Generally, people thought a mixture of places for care would apply, depending on their condition.

<table>
<thead>
<tr>
<th>Answer Options</th>
<th>Response Percent</th>
<th>Response Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mostly from their GP practice and community nursing staff?</td>
<td>11.9%</td>
<td>39</td>
</tr>
<tr>
<td>In their own home?</td>
<td>23.4%</td>
<td>77</td>
</tr>
<tr>
<td>Mostly from their local hospital?</td>
<td>1.2%</td>
<td>4</td>
</tr>
<tr>
<td>A mixture of these?</td>
<td>63.5%</td>
<td>209</td>
</tr>
<tr>
<td>Comments?</td>
<td></td>
<td>73</td>
</tr>
</tbody>
</table>

Answered question: 329
Skipped question: 19

A simple word analysis shows the most frequent words respondents used in their comments.
About the mix of services
There was a range of comments about the mix of services which suggested that people thought it depends on what support is needed and what problems people have: ‘A mixture depending on the condition’; ‘as long as it’s possible to reach out to these subjects above when needed I will be satisfied.’ ‘It is impossible to make very standard rules.’

Care at home
There were a number of comments which related to having an efficient and reliable network of care and feeling secure, with contact numbers and regular visits from named workers. There were also comments in relation to transport (public or otherwise) being available when people needed it. Home visits were relied on – taxi journeys were described as expensive although ‘sometimes going into hospital/surgery is important’.

Transport, and mobility, was a factor in wanting more care in the home. ‘My husband, who is 90 years old, is my main carer. Without my own transport access to services is difficult or nearly impossible.’

There were comments that most people would prefer to be at home, provided there is support. There was also a comment about getting help from social services and having a handy man provided ‘by the council if no relatives in the neighbourhood it’s difficult to fix light bulbs, fasten curtains, etc.’

Staff also need to know the people they were caring for at home, and support from their GP and practices nurses was considered important.

There was also a comment about the need for ‘good’ care homes.

Caring / dementia
There was a comment that more day care should be available.

‘Towards the end of life it's not always easy for the carer.’

‘Those with dementia need special care from experience, the only alternative is nursing homes as family cannot cope eventually.’

‘People with Dementia can and often do wander off outside and forget where they live and where they were going so should not be at home if they live alone.’

Communication
The idea of being at home was supported by comments about the importance of communication so that there is continuity of care which could be co-ordinated by community nursing staff, especially as everyone has different needs.

Equipment
There was also a comment about more and better equipment would help.
A couple of people felt it would depend on the availability of family help.

**GP, practice nurse and community nursing support**
This and support from community and practice nurses for managing at home was considered important (there was also a comment that someone didn’t think they currently got support from their practice for this). There was also another comment ‘GP has a first class service. Nurses and community matron are superb and very helpful.’ More home visits wanted.

**Hospitals**
Where there were comments about hospitals, this should be local; there was a comment that the local hospital is not interested in caring for long term conditions because of cost to local doctors. There was also a comment about the bus being in the area of the patient for longer – ‘hospital pick up bus could be given more time in our area’.

**Vision**
‘The vision makes sense on paper but not in reality.’

**Services that people thought could be improved for earlier discharge and independence**
Question 10 asked people which services in the local community they thought could be improved to support people to leave hospital earlier and regain their independence. A simple word analysis shows the most frequently used words in the suggestions made.

**Care at home**
People generally wanted their care at home but feel they need more support including better provision of homecare services, ‘more support for carers who work 24/7 to care for loved ones.’ ‘More time for (paid) carers to do their job.’
Chiropody

Community and voluntary sector support
Visiting charities, neighbourhood watch, police etc

Day care centre
Again, perhaps a day care centre, at the CO-OP building where health professionals could be on hand. As well as providing advice on care, it could also provide a bit of physio and social interaction. Ensure they are not left alone for long periods

Discharge help
Communication and contact with GP when discharged and support at home for as long as needed. One comment was ‘No opinion, as I was sent home the day after my leg operation to a husband who I am his carer. No help offered.’

Discharge services
Improvement needs to be in place prior to person leaving hospital, i.e. social GP, OT community care worker, so as not to cause upset or problems once home.

Equipment and adaptations

GP practice and community staff / home visits
Help in their own homes, a daily nurse visit. More health visitor services for people in their homes, GP home visits, ‘doctors and community nurses based at Doctors’. ‘District nurses should be on call as they used to be.’ A call ‘for the district nurse to be involved more’.

Home help
Home help and elderly watch needs improvement. ‘Very poor when I left hospital.’ For shopping, lifts to appointments, hygiene, gardening. Positive comments about home care system were seen.

Home visits from primary care and community staff
More visits from GPs, nursing and community staff generally. ‘Visits by the community nurse, preferably the same face can help who knows about your condition and circumstances.’

Local hospitals

Physiotherapy
Shorter waiting times. ‘Local physiotherapy services-too long a wait.’

Joined up care Joined up working between doctors, nurses and social services.

More staff
Extra staff
Occupational therapy services
Occupational therapy including the local council with regards to adapting better access to housing, etc

Physiotherapy
‘More physios, nurses etc, to make home visits possible.’ ‘Post-hospital rehabilitation and physiotherapy-in home services ...’instead of waiting in a hospital bed. ‘Waiting times could also be improved. ‘More physiotherapy input/falls clinics/training for the care staff in residential homes.’ ‘Physio at home instead of waiting in a hospital bed.’ ‘Physiotherapy definitely! ’

Respite Care
More local beds available for recuperation/respite care.

Social services
Assessments, visits, organised events, more joined up thinking. ‘Social workers are not always the easiest people to contact and council telephone systems are a nightmare.’ ‘I think social services could visit them more and help them depending what’s wrong with them and also tell them what special groups can help them. I go to take heart class twice a week and I think there must be other groups that do the same.’

Transport
‘Council run help which I am sad to say had cut backs.’ ‘Dial a ride transport.’ Comments that transport needs to improve generally; also public transport.
How important different aspects of health services are to people

Question 11 asked people to compare what different aspects of services are important to them.

<table>
<thead>
<tr>
<th>Answer Options</th>
<th>Not important</th>
<th>Important</th>
<th>Very important</th>
<th>Don’t know</th>
<th>Response Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Services are easy to access</td>
<td>3</td>
<td>76</td>
<td>228</td>
<td>7</td>
<td>314</td>
</tr>
<tr>
<td>Services are available at weekends and in the evenings</td>
<td>6</td>
<td>90</td>
<td>202</td>
<td>10</td>
<td>308</td>
</tr>
<tr>
<td>There are good public transport links</td>
<td>26</td>
<td>112</td>
<td>141</td>
<td>23</td>
<td>302</td>
</tr>
<tr>
<td>Parking is easy</td>
<td>13</td>
<td>99</td>
<td>173</td>
<td>14</td>
<td>299</td>
</tr>
<tr>
<td>The service is close to where I live</td>
<td>10</td>
<td>131</td>
<td>153</td>
<td>9</td>
<td>303</td>
</tr>
<tr>
<td>The quality and safety of the service</td>
<td>2</td>
<td>62</td>
<td>228</td>
<td>8</td>
<td>300</td>
</tr>
<tr>
<td>Close to other health services eg GP surgery</td>
<td>16</td>
<td>112</td>
<td>175</td>
<td>7</td>
<td>310</td>
</tr>
<tr>
<td>Close to other amenities eg library, shops etc</td>
<td>66</td>
<td>117</td>
<td>107</td>
<td>12</td>
<td>302</td>
</tr>
<tr>
<td>Answered question</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>328</td>
</tr>
<tr>
<td>Skipped question</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>20</td>
</tr>
</tbody>
</table>

Further analysis of the responses to the above, weighting* each number of responses against important at all, important or very important allows a more definitive ranking of importance for this group of older, less mobile, people:

1. Services are easy to access
2. The quality and safety of the service
3. Services are available at weekends and in the evenings
4. Close to other health services eg GP surgery
5. Parking is easy
6. The service is close to where I live
7. There are good public transport links
8. Close to other amenities eg library, shops etc

(*not at all important x 5, important x 10 and very important x 15)
Services/ suggestions for improvement were similar to question 10:

<table>
<thead>
<tr>
<th>Care at Home</th>
<th>Health visitors</th>
<th>Rehabilitation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care Homes</td>
<td>Home visits</td>
<td>Respite Care</td>
</tr>
<tr>
<td>Communication</td>
<td>Joined up care</td>
<td>Shorter waiting times</td>
</tr>
<tr>
<td>Community care</td>
<td>More staff</td>
<td>Social services</td>
</tr>
<tr>
<td>Day care support / activities</td>
<td>Paid carers</td>
<td>Transport</td>
</tr>
<tr>
<td>GP / community staff visits</td>
<td>Physiotherapy</td>
<td></td>
</tr>
</tbody>
</table>

There was also a comment that Redcar Primary Care hospital should have more varied clinics.

**What do this group of people think about not needing as many hospital beds in the area?**

Question 12 asked what people thought if, by providing more care outside of hospital, not as many hospital beds across the South Tees area would be needed. A simple text analysis shows that 175 people responded to this – 50% of whom made comments about not enough hospital beds, which is a substantial proportion for this type of question.
Other comments people made

Question 13 - those answering the survey were asked if they would like to make any other comments about the vision.

In contrast, there were 150 (43%) of people responding to the survey made positive comments about the vision outlined by the CCG, with the caveat that there should be good home care to support it.

About the people who responded

In all, 348 people responded to the survey.

There were 122 (40.9%) of people had help to fill in the survey document. Note: some responses will total more than the total number of surveys returned and percentage of responses as people could tick more than one option for some questions.

People living with a long term condition at the time of the survey

Question 2 asked if the person had any long term conditions. 191 (61.2%) said that they had a long standing illness or condition which affects their day to day activities.

125 (40.1%) of people said they had a long-standing physical condition.

Only 27 (8.7%) said they did not have a long term condition, nor cared for someone with a long term condition.
105 (33.7%) of those who answered said they did not have a long term condition.

People were asked, if they had a long term condition, what these were. They also had the opportunity to identify conditions other than those listed.

The question also allowed people to say what other problems they suffered from – they mainly described conditions such as arthritis, Type 2 diabetes, Parkinson’s disease, back, mobility and other heart problems. A simple word analysis shows arthritis (and other musculoskeletal problems) to be the most commonly described condition.
Male/ Female split

<table>
<thead>
<tr>
<th>Answer Options</th>
<th>Response Percent</th>
<th>Response Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>43.1%</td>
<td>141</td>
</tr>
<tr>
<td>Female</td>
<td>56.9%</td>
<td>186</td>
</tr>
</tbody>
</table>

Answered question | 327  
Skipped question | 21

Age range

<table>
<thead>
<tr>
<th>Answer Options</th>
<th>Response Percent</th>
<th>Response Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>66-70 years</td>
<td>15.2%</td>
<td>50</td>
</tr>
<tr>
<td>71-75 years</td>
<td>23.7%</td>
<td>78</td>
</tr>
<tr>
<td>76-80 years</td>
<td>24.9%</td>
<td>82</td>
</tr>
<tr>
<td>Over 81</td>
<td>36.2%</td>
<td>119</td>
</tr>
</tbody>
</table>

Answered question | 329  
Skipped question | 19

Ethnicity
317 (98.8%) people described themselves as white (one respondent did not wish to disclose their ethnicity and seven people skipped this question).

Living at home
(263 (87.4%) of people responding lived at home at the time of the survey. Ten (3.3%) lived in a relative’s or friend’s home, 14 (4.7%) in a nursing or residential home, and a further 14 (4.7%) in warden controlled (sheltered) accommodation.
Most people were living in their own home at the time of the survey, and were living in rented accommodation.

<table>
<thead>
<tr>
<th>Answer Options</th>
<th>Response Percent</th>
<th>Response Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>My own home</td>
<td>87.8%</td>
<td>280</td>
</tr>
<tr>
<td>Relative or friend's home</td>
<td>3.1%</td>
<td>10</td>
</tr>
<tr>
<td>Care home (residential / nursing)</td>
<td>4.4%</td>
<td>14</td>
</tr>
<tr>
<td>Rehabilitation unit</td>
<td>0.0%</td>
<td>0</td>
</tr>
<tr>
<td>Warden controlled accommodation (sheltered)</td>
<td>4.7%</td>
<td>15</td>
</tr>
<tr>
<td>Other (please say where)</td>
<td></td>
<td>23</td>
</tr>
</tbody>
</table>

Answered question 319
Skipped question 29

Older people caring

(Question 18) Over half (198 - 56.8%) of those who answered the survey said they provided some form of care for someone.

(Question 19) Many who answered the survey in their own right were living with someone who had a long term illness or condition with 81 (23.3% of all respondents providing care for people with dementia. (There were people who cared for others with multiple conditions for this question).
<table>
<thead>
<tr>
<th>Answer Options</th>
<th>Response Percent</th>
<th>Response Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>I care for someone who has had a stroke</td>
<td>29.3%</td>
<td>44</td>
</tr>
<tr>
<td>I care for a frail elderly relative or friend</td>
<td>24.0%</td>
<td>36</td>
</tr>
<tr>
<td>I care for someone with dementia</td>
<td>54.0%</td>
<td>81</td>
</tr>
<tr>
<td>I care for someone with a chronic chest problem</td>
<td>17.3%</td>
<td>26</td>
</tr>
<tr>
<td>I care for someone with a chronic heart problem</td>
<td>20.0%</td>
<td>30</td>
</tr>
<tr>
<td>Other - please say what</td>
<td></td>
<td>108</td>
</tr>
</tbody>
</table>

Answered question: 150
Skipped question: 198

Other conditions mentioned included Parkinson’s disease and arthritis:

See appendix 2 for the full list.
Where people lived

Conclusions

The aim of including at least 50 people in the target areas was achieved, with a range of different long term conditions, illnesses and other mobility problems being included.

All were also over 65, with as many as 36% over the age of 81.

There is a wealth of information and feedback about each service.

In most questions, there was a proportion of people answering the survey skipped that particular question. There is no evidence that this was not consistent and it is likely this is down to the length of the survey, people missing the odd question and people feeling there was some similarity between questions, and had already expressed their view.
Conclusions - overall themes

There have been some strongly consistent themes:

‘Appointments’ is an area that people strongly thought could be improved, including access and 1. waiting times.

Many people had arthritis and mobility problems, find it difficult to either give or receive information and worry about whether it’s accurate, whether they are listened to. See appendix 2 for a list of other conditions people said affected their day to day life.

People want to see more information, they want more communication and integration between services and they want more visits and continuity from the people who come to their home, such as the GP and practice/ community staff. There were also comments about involving carers more. See appendix 3 for the many comments made in relation to each question.

There were a number of services suggested that people felt they either wanted more of, or wanted delivered in the home. Examples include physiotherapy, occupational therapy, day care, GP and practice/ community nursing home visits.

There is support for a mix of services venues and for more services in the home, but this requires more staff, networks and information to do this.

Transport was mentioned as an issue, and lack of public transport.

There are some very elderly carers who are getting a variable level of support from health and social services in the community. Some people advised they had no information, out of date information or didn’t know where to go, although the GP usually was a ‘first port of call’.

Next Steps

The feedback from this survey will be used to help put together plans for the future shape of health services across South Tees, with the input of key partners and stakeholders, patients and the public. These options will be presented to the public as part of a formal consultation process during 2014.
Appendix 1
Survey questions and answer options

1. Are you completing this questionnaire on behalf of someone else? Yes / No

2. Do you have any of the following long term conditions? (please tick all that apply)
   - Deafness or severe hearing impairment
   - Blindness or partially sighted
   - A longstanding physical condition
   - A learning disability
   - A mental health condition
   - A long standing illness or condition which affects your day to day activities
   - No, but I care for someone with a long term condition
   - No I do not have a long term condition

3. If you have a long term illness or condition, please say which of the following apply
   - I have had a stroke
   - I am generally frail (e.g. I often fall)
   - I live with dementia
   - I live with a chronic chest problem
   - I live with a chronic heart problem
   - Other please say what

4. In the last six months, have you had enough support from local services to help you manage your long term health condition(s)?
   - Yes, definitely
   - Yes, to some extent
   - No, I don't have a long term condition
   - Comments – what could be improved?

5. Do the different people treating and caring for you (such as doctors or nurses) work well together to give you the best possible care?
   - Yes, always
   - Yes, sometimes
   - No
   - Comments - what could be improved?

6. Do you know who to contact if you are worried about your condition or any treatment you are receiving?
   - Yes, I know who to contact
   - Yes, for some things
   - No
   - Comments?

7. Do you feel you could be given more information or guidance to help you manage your condition or any treatment at home?
   - Yes, a lot more
   - Yes, a little
   - No, I don't need any more information or guidance
   - Comments – is there a person or organisation you should receive more information from?

8. How well do health and social care staff organise the care and services for local people?
   - Very well
   - Not very well
   - Fairly well
   - Not at all well
   - No opinion
   - What do you think could be improved?
9. Where do YOU think people should receive the majority of their care if they have a longterm condition(s)? For example, people who have had a stroke, frail elderly people, people with dementia and people with chronic chest problems or heart disease.

Mostly from their GP practice and community nursing staff? In their own home? Mostly from their local hospital? A mixture of these? Comments?

10. Which services in the local community could be improved to support people to leave hospital earlier and regain their independence?

11. In relation to health services, how important are the following?

(not important, important, very important, don’t know)

<table>
<thead>
<tr>
<th>Services are easy to access</th>
<th>The service is close to where I live</th>
</tr>
</thead>
<tbody>
<tr>
<td>Services are available at weekends and in the evenings</td>
<td>The quality and safety of the service</td>
</tr>
<tr>
<td>There are good public transport links</td>
<td>Close to other health services eg GP surgery</td>
</tr>
<tr>
<td>Parking is easy</td>
<td>Close to other amenities eg library, shops etc</td>
</tr>
</tbody>
</table>

12. By providing more care outside of hospital, we may not need as many hospital beds across the South Tees area. Do you have any views about this?

Our vision for South Tees means that more people will be treated in the community and those who need a stay in hospital will be supported to return home earlier.

13. Would you like to make any other comments about our vision?

14. Are you male or female?

15. Age – please tick the category which best describes you:

66 – 70 years, 71- 75 years, 76 – 80 years, Over 81

16. Ethnicity – please tick the category which best describes you:

White, Mixed, Asian/Asian British, Black/Black British, Chinese, Other ethnic group, I do not wish to declare my ethnicity

17. Where do you live? My own home, Relative or friend's home, Care home (residential / nursing), Rehabilitation unit, Warden controlled accommodation (sheltered), Other (please say where)

18. Carer – do you provide care for someone who is elderly or living with a long term condition?

19. If you live with or care for someone with a long term illness or condition, please say which of the following apply (please tick all that apply):

20. Please tell us the first four characters of your postcode: (eg TS1, TS10, TS17 etc)
Appendix 2
Other long term conditions and illnesses described by people answering the survey

- 10 years suffering with arthritis, now with rheumatoid arthritis.
- A long standing skin condition that cannot be healed because ulceration can occur and I have MRSA.
- Acute myeloid leukaemia (breathlessness)
- After breaking my ankle both sides and leg I have trouble with some of my house and garden jobs.
- After effects of badly fractured hip in 2010. Tumour of the spine diagnosed 5 years ago. I have one kidney.
- All boxes ticked apply about my wife. I am a full time carer for her.
- Alzheimer’s disease
- Angina
- Angina which is under control, Arthritis in hands, Thyroid.
- Angina, high blood pressure, high cholesterol, underactive thyroid.
- Angina, Thyroid condition, Visual impaired.
- Angina. Gout
- Anxiety and migraine
- Arthritis
- Arthritis
- Arthritis (Osteoarthritis)
- Arthritis in both legs from knees to ankles. High blood pressure. Take aspirin.
- Arthritis of spine and knees. Have had two operations on front and back neck. Now waiting to see Mr * again about lower back and legs.
- Arthritis of spine. Both hips need replacing and knees.
- Arthritis with poor mobility.
- Arthritis worse in hands
- Arthritis, back pain
- Arthritis, osteoporosis
- Arthritis, osteoporosis, Type 2 Diabetes
- Arthritis, poor mobility
- Arthritis, Sjogren’s syndrome, hernia
- Arthritis.
- Asthma
- Asthma/breathing difficulties.
- Asthmatic
- Atrial Fibrillation - On Warfarin.
- Attends classes for very short term memory. Prostate removed, left with bladder trouble.
- Back problem
- Blindness. Mental disorder
- Bowel cancer
- Brain damage and lack of mobility
- Cancer of the rectum
- Car crash victim - impact damage, memory problems
- Cerebral palsy
- Chronic arthritis with high pain levels. Bad knees. Crumbling spine.
- Chronic bad back, walking problems
- Chronic Obstructive Pulmonary Disease
- Chronic Obstructive Pulmonary Disease, I have a colostomy bag fitted
- Chronic Obstructive Pulmonary Disease.
- Chronic osteoarthritis and ageism
- COPD, Lumbar left neck and right neck, poor blood circulation in feet, osteoarthritis, osteoporosis, vertebral fracture hip, wobble when walking.
- Crohn’s disease
- Crohn’s, thyroid, heart valve change twice, bronchitis, osteoporosis.
- Curvature of the spine
- Diabetes
- Diabetes type 2. High blood pressure
- Diabetes, hips, knee.
- Diabetes, prostate cancer.
- Diabetes, prostate condition, breathless and dizzy
- Dizziness, irregular heart beat
• Due to an accident, my daughter has difficulty walking.
• End stage kidney failure. Heart attack - stent implanted. Balance problems. Mental health issues (depression)
• Epilepsy since 2001
• Five back operations, two knee replacements, diabetes, thyroid, extreme arthritis, aneurism, cholesterol.
• Had a bleed within brain. Diagnosed as having vascular dementia.
• Heart condition, kidney problems, breathlessness, 2 knee replacements.
• Heart problems/breathing. Severe generalised arthritis in all of the body. Diagnosed in April with arthritis in my hand - still not completely moveable. Exceptionally large hernia as a result of delayed reversal after colon cancer 8 years ago. Bad circulation down left side result of melanoma operation in left leg - large graft taken 3 years ago.
• Hernia
• Husband has dementia.
• Hypertension.
• I also care for my wife following her strokes. She uses a wheelchair and crutches.
• I cannot get up and downstairs. This is slow work and walking getting down to cupboards and dropping things on the floor to pick them up.
• I care for my husband who has cancer
• I have a heart problem, but not chronic
• I have had a long term mental health problem. Also I have osteoarthritis, osteoporosis, and I suffer with parathyroidism.
• I have skin cancer and have just had a mastectomy for cancer. I am disabled, had hip and knee replacements, have arthritis in hands and arms and Osteoporosis in spine.
• I have spinal stenosis, severe arthritis of the shoulders, collapsed arch of foot, aerial fibrillation.
• I have type 2 diabetes.
• I have very bad Arthritis from my waist down.
• IBS and osteoarthritis.
• Incontinence.
• Intermittent claudication.
• Kidney transplant. Permanent pacemaker. Type 2 diabetes. Asthma
• Leukaemia
• Lung cancer and bladder problems.
• Lung condition.
• Lymphedema
• M.S and a quadriplegic as a result.
• Macular degeneration. Carpel tunnel operation a failure losing sense of touch plus difficult in gripping objects
• Major back surgery has left me unable to walk, but able to cope.
• Major spine illness.
• Medication for raised blood pressure.
• Mobility affected-can only weight bear with use of tripod-left hand side of body paralysed.
• Motor neurone disease
• MS
• MS
• Multiple sclerosis
• Multiple sclerosis
• My husband is 86 and has hypertension which causes him to be dizzy and unsteady. His mobility and ability to take care of himself is severely affected and I am his carer.
• My wife has a stroke in 2009 but is 90% ok
• My wife has dementia (Alzheimer’s)
• My wife has dementia and up until two months ago I cared for her.
• My wife suffers from COPD. I suffer from chronic back and leg pain.
• No but I care for someone who has had a stroke and is severely depressed.
• None of these. I have had both hip replacements and lower back pain.
• Osteoarthritis
• Osteoarthritis
• Osteoarthritis. Cardiovascular heart disease
• Osteoporosis
• Osteoporosis, Angina, Tremors in hands
• Osteoporosis, diabetes, arthritis, chronic obstructive airways disease
• Pacemaker
• Parkinson’s disease, Lewy Body Dementia, Anxiety, Depression, Low Mood, Enlarged Prostate.
• Parkinson’s disease. Paget’s disease. Pacemaker
• Parkinson’s
• Parkinson’s
• Parkinson’s
• Parkinson’s
• Parkinson’s
• Parkinson’s disease. Arthritis
• Parkinson’s, Dementia
• Parkinson’s, Mind problem, Breathing, Diabetes
• Parkinson’s. Type 2 diabetes. Serious prostate condition. Catheter
• Polymyalgia
• Polymyalgia Rheumatica and Gout. Enlarged Prostate.
• Poor mobility die to stroke/fall which broke hip.
• Psoriatic arthritis, enlarged heart (had 3 attacks), diabetes, pernicious anaemia, stomach cancer in 2011, amputated toe by pass veins in RT. leg 2013, some prostate problem, some (only little) confusion.
• Rheumatoid Arthritis
• Rheumatoid Arthritis.
• Rheumatoid factor RO4LA antibodies gout, type 2 Diabetes, hypertension, Sjogren’s syndrome.
• Sciatica
• Severe active Rheumatoid Arthritis which does not respond to any of the modern "wonder" drugs. Long term depression.
• Fibromyalgia. Chronic Fatigue Syndrome.
• Severe Arthritis and multiple joint replacements.
• Severe Arthritis in both knees and I'm unable to walk far
• Severe back problems
• Spinal injury.
• Osteoporosis. Scoliosis. Osteoporosis. Discitis (spinal infection)
• Thomsen's disease (linked with muscular dystrophy)
• Triple bypass and valve change.
• Type 2 diabetes
• Type 2 diabetes (medication and diet)
• Type 2 diabetes and angina
• Unable to walk far due to age related problems eg osteoporosis in knees, soon gets out of breath and also has type 2 diabetes.
• Unable to walk far, am using an electric scooter.
• Very very breathless
• Weak back due to slipped disc 20 years and also problems arising from an ankle injury.
Appendix 3 – individual comments

Comments about what could be improved (support)
Excellent support from medical services, stroke association and GP surgery.

At the moment I don’t need much help.

More frequent contact to keep an eye on me.

The organisation of appointments and information provided.

Local health and social care services seem short on trained carers, especially social workers/OTS. Timescale following assessments? Dementia care.

Understanding of OAP.

Communication between departments.

I am very pleased with the service I get from my doctor and nurse.

With previous council care I received, I felt that areas of help should have been more clearly identified, and that information was not forthcoming on what could be offered to assist my mobility, whether council provided or privately.

Help with shopping and housework.

Good support initially, then it disappears.

Waiting times too long

Relationship with GP

More frequent visits by wardens etc.

Had to pay for private care 6 hours a day after surgery left me unable to walk.

Only help from GP

Carers visits could have been longer than 15/20 minutes and some more helpful rather than filling in forms.

Just from the doctor.

More practical help in the home.

Need more knowledge on what is available to help. Everything to help seems to be a secret. Not even the doctors know what is available.

My care is excellent.
Social Non Caring Services visited some years ago-first and last question-"Do you have 23500 pounds including your house"-?? Answer:yes-"In that case cannot help you"

Liaison with carers is patchy.

Doctors who stay long enough at the practice to know and understand my condition and health problems. Our doctors keep changing. (Marske Medical Centre)

Haven't needed any.

Regular visits from nurse or doctor would be an advantage, only attend when requested.

Only get information from doctors.

Receiving bathing help twice a week and respite care and day care three times a week part days. No other help given.

All help good.

I was told that I needed help in bathroom. I was put on the list for a walk in shower along with my wife-she can't get into the bath due to her illness. I got a phone call yesterday saying we have to wait two years.

Please see Ralph Brown’s Report.

The different departments do not interact with each other which confuses everyone. No one department seem to have the full, up-to-date information. Long waiting time between problems being raised and an appointment being made.

No complaints regarding doctors. Memory Clinic and GP have been good.

Difficult to see the Dr you want to see. A wait of 4-5 weeks is not unusual.

To see a doctor you have to ring the reception, then you have a phone call from the doctor but sometimes you cannot explain what is wrong with you yourself. It would be better to see the doctor.

The waiting time for an OT assessment was 18 weeks which is too long when the need for more care suddenly changes. By the time professional help came we had ourselves installed a stair lift, wet room etc. We were lucky that our family was able to help us.

At the moment everything is stable.

The local doctors have been very helpful.

Parkinson’s nurse is a good support in James Cook hospital.

Availability of osteopathic and chiropody treatment on the NHS.
Longer time spent with district/community nurses, more contact from GP, incontinence pads that are fit for purpose and not to have standard, cheaply bought ones.

My wife receives visits from COPD matron, at this moment this seems to be sufficient.

I have had no reason for their help.

After a decade of being accepted for disabled driving, I have now had my blue badge discontinued.

I am satisfied.

Frequency and duration of visits from Social Services and medical services.

More joined up approach. Take a holistic view of family situation.

Speed at which equipment recommended is actually delivered

Not much support from specialist nurses for Parkinson’s

Better use of local hospitals ie. More physiotherapy staff. Make use of the endoscopy unit including the hydrotherapy pool at Redcar Hospital

Regular physiotherapy is missing

Clients not getting time which is paid for staff. Should have more time with clients.

Just finished a very good cognitive therapy group. Now looking for further group therapy

More frequent calls from 'Home Care' would benefit us

We are very happy with our doctor and the service he provides, he has telephoned us when needed and made sure we saw consultants quickly if needed. It is difficult to get an immediate appointment but he's so popular.

I try not to complain; I have given in and have help to clean the house once a week.

Now deceased.

Problems left knee. Also right shoulder. Had some treatment for shoulder but not effective.

It was dependant on person's motivation.

My husband has treatment at James Cook.

Less red tape. People in authority listening to experience.

All satisfactory.

Something to tell people to be more patient and give me time to answer the door
GP should be more involved in monitoring situation. Young Onset Dementia Team should give more support

Doctor is concentrating on supportive measures and seeing me in 6 months

I have only needed blood tests.

Some assistance in understanding modern technology, reducing waiting times, eg. I have waited over three months to have cataracts removed.

We had carers for 6 weeks when changed over, no one would say what it was going to cost and how was going to pay for it, no good having a big bill, so the carers asked not to come.

I could not cope if my wife was not with me but I have had a lot of equipment and some monitor jobs to the home and my wife gets 2hrs a week respite. I do feel as well supported as is possible for the moment. Thank you.

Local health service, particularly Teesside Hospice have provided excellent support.

Satisfactory.

More support needed for house bound people, say friends.

Appropriate support for coping with continually deteriorating physical condition which impacts on my mental health problems. Six sessions with Talking Therapies is like treating a broken leg with a band aid.

Doctors have been very good

Still awaiting physiotherapy. Family had to hire a wheelchair. Staff seem to waste hours and hours form filling.

Recent client of Carers - exploring flexibility - one size does not fit all!

District nurse visits can be erratic. If they could be better coordinated this would help.

Local GPs seem reluctant to refer patients to Outpatients for treatment

Could and should have had it earlier

At the moment quite good health

Easier access to GP as it costs me £7.00 to get there so I don't go as often as I should

Appointments

I manage to help myself
I have been in hospital for about 2 weeks but have been discharged. Took about 7 weeks to recoup and had carers in to see my wife. Now I am well enough to look after her and I have to do everything for her.

Don’t know, have had the problem for approx. 10 years

More staff

Nothing at the moment but could change soon

Quicker visits by Social Services. Assessments could be better managed

Reviews of care

Stephen Parry (Mental Health Nurse, Guisborough) is our life line. Invaluable help and kindness every time he visits.

Homecare assistants should have longer times in the home even if it’s just to talk to the person living on their own

More doctors’ appointments available. A person to identify medication and its specific use. Help with travel costs where patient transport cannot be arranged in time.

Nothing can be improved for us. We know that more help would be available if needed

Good question but no idea of the answer

Very helpful at the time of hand problem, but need the RIGHT people or services for my problems

Have had nothing at all. As they was nothing that could be done for me.

Comments about what could be improved (people working together)
Community matrons and GP Practice worked excellently together. CAN NOT fault GP Surgery, they have been wonderful.

Local GP Dr Scott is excellent, but feel we need a bit more from specialists.

How can I tell?

Getting an appointment with your doctor.

If all carers were aware of ALL conditions in the people they are dealing with, sharing information about different evaluation dealt with by various groups.

When I call doctor for a visit they don’t come out. I get a phone call from practice nurse.

They don’t see or contact me often enough to really know me.

Poor liaison between GP and hospital consultant at times.
Waiting to see staff. On occasions it is a straightforward experience but other times it is very frustrating.

Link up following assessment to communicate together in a care package and treatment review.

Communication.

I had a visit from a district nurse approx. every two months. This stopped around April.

More staff or any system will not work correctly.

Easier to get appointments.

Good support from GP but follow up hospital appointment took too long to wait for.

More communication needed

Communication between professionals

More communication between hospital and GP

Better communication between hospitals and GP.

More communication between each so that they are kept informed of treatment and progress.

Life could be made easier if everyone knew what is available, I could have been helped years ago before I became so ill.

Again, I receive excellent care-encouragement to do my best and with good communication between all medical staff and receptionists.

Ease of seeing above.

Again, carers do not always know about contact from Health Services.

N/A

Doctor rarely visits even when requested, often prescribes over phone. Very little communication between doctor and nurses.

Can't always get an appointment when you want it or get through on the phone for ages.

Excellent doctors.

Waiting time.

No link between departments. Different nurses for what used to be the same job. "District" nurse will not do simple task and quotes new rules as being the cause.

No follow up by Doctor, nurse and hospital staff.
It would be better if all departments communicated more.

Very difficult to get appointments with GP. Have to attend another surgery 3 miles away because I can’t see doctor.

Easier to get appointment with doctors.

Improve communication between hospital and surgery regarding changes in medication.

Waiting time for appointments.

I don’t go to the doctors regularly. My husband regularly goes and does get looked after when there.

Better appointment service.

Nothing. They are very helpful.

Left hand frequently does not know what right hand is doing.

Better communication.

I am very satisfied with the help I have received

More interaction

Very good service

Better communication between departments

Maybe a home visit from a nurse twice a year would be a great help

I look after someone with long term illness.

My wife looks after me.

Nurse comes every other day to dress my husband’s legs. At present he is in James Cook. I hope he will come back to Brotton hospital.

Appointments system made easy to make and understandable to the elderly.

Yes, recently decided to monitor diabetes 3 monthly. Everything else is done by nurses.

District nurses only contact through GP surgery. Not available.

Passing on of information

Every unit works in a silo! There should be a one stop shop which coordinates and monitors progress

Doctor’s telephone system is always satisfactory
Not enough communication between GPs and other staff.

More information about one lot of carers, changing over to other carers, more assistance wanted

A greater sharing of information between staff.

Answer not known but it is important

Doctors don’t always recognise when the slight but chronic cough I have is changing in character and identifying the increased shortness of breath without activity is leading to Pneumonia. I have twice now reached the stage where sepsis is occurring when admitted to hospital. Sometimes the district nurses delay dressing my skin condition on my legs according to the hospital Dr’s directions when it worsens and becomes very painful. I have recurring MRSA.

The blind leading the blind. Information from doctors not relayed to family members.

Timely communication needed between departments. Notes to be read thoroughly before procedures

McMillan nurse is very helpful

Local GPs are reluctant to spend their budgets on drugs and services. They act as managers rather than as doctors

Also help from Sanctuary Support Group and Woodside very helpful

Physio - My wife does not get any

More communication between the different people regarding the best possible care

Surgeries open longer

Communication with each other

Sometimes there is a lack of communication between care staff in homes and GPs - and also not enough feedback to family members

Could do with always having the same carers. Sometimes people turn up who have no idea of the person’s condition. Information has not been passed on e.g. where tablets are kept

Access to relevant information when doctors and nurses have a collective review. Results of tests and treatments explained

Doctors to be informed sooner with regards to x-rays and scans

Appreciation of all aspects regarding how any one of the disabilities effects the other i.e. fitting a hearing aid if one a magnifying glass (10x) to see it and little, if any, sense of touch.

Easier access to own doctor
As our doctors are always changing I look after my own condition.

Having the same GP who knows about your condition and not Doctors who hardly know you.

Comments about who people contact
Can contact Stroke Association, GP Surgery and can ask to be re-referred to community matron service.

Again, local GP surgery very good.

Yes, but that doesn’t relieve the frustration of waiting so long.

Family help by putting together a list of contacts I may need, remind me when appointments are due - talk with family who talk with GP.

We should be given appointments in less time than 2-3 weeks at doctors.

I have 4 chronic illnesses and my doctor make sure I know who to contact.

My wife sees to this.

I telephone my surgery with a problem and the doctor always rings back.

Don’t have computer so don’t know how to find out.

Consultants told me to go back through GP rather than contact them again.

Have written documentation which helps

My father cares for my mother who suffers from dementia. She relies on 24 hour supervision. This has been completed by their daughter.

Our GP practice is very helpful and vital.

No one seems to know who does what. You are passed from one organisation to another.

Person form is being completed for no longer has capacity to access any medical services independently-needs me the carer to do this. I am aware of who to contact.

My first call is to the GP practice where I am treated with respect and help always available.

I would contact my GP.

We contact via nurses who put us in touch with the correct people.

Probably GP

Cardiac Department. Thanks for their guidance.
I need to see someone about carpal tunnel. I was told over telephone I needed to make my own appointments.

Department rules change with no advice note being sent out to inform patients.

Have to go through doctors to get specialist.

There needs to be a better, integrated service.

Home call service

Our doctor will phone us if necessary to reassure us and now a consultant we saw contacted carers together they have been most helpful and the facilities offered to my husband, cookery is great.

See Dr Moira Royal, Manor House Surgery who is really helpful. I couldn't ask for more from her.

My husband and I have a button, or we would contact the doctor.

If I needed a Dr wait anywhere from 2-4 weeks. (Age being a barrier).

System complicated. Too much health and safety - Gone mad.

Unable to contact myself.

Daughter does know contacts etc.

Passing on of information

Rely on local doctors

All depends on what it is. One gets the impression that each individual is only interested in their patch!

Doctors are very helpful

More help wanted, more assisted wanted

Once you have been diagnosed with a chronic condition which affects your energy levels and general wellbeing, everything is put down to that. It took years before anyone considered treating my hay fever even though every spring I turned up at my GP saying I was feeling worse than ever.

I cannot recognise anyone be they staff or residents to always tell them is something is bothering me. I tell my daughter and she passes on information to the staff.

Constant changing of staff is most confusing.

Reliable secretaries save time for all social workers - great at signposting

I need help to do these things
I do not know the name of my social worker if I have one. It used to be Georgina Willoughby G.P> and staff, district nurses.

A written list of contacts/conditions would be helpful

Totally confused and forgetful

It can prove difficult to access the person you need to talk to

Comments about information and guidance that could help people manage their long term condition

Mental illness is a subject most people shy away from. There should be more information broadcast about this illness.

Note in container on unit in my lounge.

Yes, but I don't which person or organisation. That is the problem.

There is often frustration about the time spent waiting. Screens in each waiting room would relieve the frustration.

A people run information/guidance coffee morning sessions on specific medical conditions, especially dementia.

Who?

After going home physio ceased and I had no idea what I should attempt. I felt it was a case of once going home that was the end of it.

Carers could be given more information about when a condition worsens.

Not enough detail given to my problems, and no follow up from appointments.

Waiting to see the paint management specialist at James Cook.

Information and support is hit and miss. Need a local drop in service.

Dad might benefit from someone giving him more information as to the outlook of Mums dementia and what to expect.

I was well supported by a Community Matron but her services have now been withdrawn.

I would like to know more information on my Husbands condition, dementia.

It could be nice if regular "get togethers" for cup of tea and chat with people who have diabetes. Could pass on helpful ideas and encourage those newly diagnosed, who are frightened as I was.

Manage OK with help from wife and family.
Last year I missed my flu jab and ended up in hospital 26th December to January 6th. Could not get to my doctors for it and was not phoned about it. Same up to now this year but at the moment I am in hospital with broken hip.

HELP is needed—not more information.

From GP and community nurses.

My haematologist doesn't know what causes my conditions but is working well with me to help work this out.

We see the GP regularly and know how to contact the OT but have had no contact or help with/from social services. Most of the things we have in place to help us remain living at home has been sourced and supplied by our family. We have even organised 'Home Call' ourselves.

How do you know that? If you knew about them you would be in touch with them. Provision of information and advice is very poor.

Not for me.

I have had to use the DDD service for my wife as her condition can deteriorate suddenly. My greatest concern is that I will leave it too late. I need help to assess her condition before I require emergency services.

At this time I am managing with the help of GP and family.

Explanations are brief and covered in professional language.

NHS

The help offered after brain damage until in hospital approximately 10 months later

Parkinson’s Society

Perhaps some counselling for depression resulting from caring for my wife.

Most are too busy with more needy cases.

Constant information from all departments, i.e. one says eat plenty of one thing another says don’t eat the sort of thing each time it is eat this don’t eat this.

District nurses. Care homes. Nursing homes.

Passing on of information

Not that I am aware

An assessment in the house from someone who knows about dementia
Had a couple of falls at home and the Falls Team have been very helpful and supportive with their visits and exercise routines

Our Doctor is very good but I feel I could receive more information about my dealing with my wife’s problems. I feel that caring is affecting my health.

More information from care supporters what it’s going to cost, who will pay for it.

All the staff who have visited have been very thorough but I rely on my wife to understand what is said and if spoken to alone I can give wrong information.

Carer could possibly involved - informed of changes = medication and processes.

Social services

No

I rely completely for my care on the staff at the retirement home.

Sometimes I don’t understand medical terms and would like it explained in plain English

I would not understand. Too much dogma. The mind BOGGLES

Difficult to coordinate when there are several complex issues

Parkinson’s experts, we haven’t seen or heard of one in 22 years

Arthritis associations

Access to podiatry at home

No

Doctors and nurses

MND Clinic

Social Services

Would like more info re Alzheimer’s following diagnosis

Social services

Carers employed to work with dementia patients should be given guidance on how to speak to and react with patients

Totally confused and forgetful

We are just being given this information now.
Patients to be told about results of x-rays and scans and not to be kept waiting for information

Close watch kept on short memory loss by a specialist

Comments about what could be improved in the organisation of health and social care services

We live in Loftus. Accessing social care is difficult. There are facilities in the CO-OP building and a community bus for transport. A day centre would be marvellous here.

My impression is that the care arrangements are pretty good, but I don’t I am really in a position to judge.

More staff to cope with people's needs.

Fewer variety of people.

The availability of personal information about where and how to access care.

Dementia awareness training - more social workers.

Maybe a rare house call from doctor or nurse.

At the moment don’t know enough about this to comment.

There must be more well trained staff to allow people to do their jobs correctly and treat patients in less stressful atmosphere.

Longer times for home visits are required.

Social workers could be more helpful. They need more time.

I felt like a nuisance because I had to chase them up to find out things. The impression is that a lack of funds means they do as little as possible.

Patients stigmatised.

No help offered for some things.

Better understanding of the needs of the old required.

Coordination

Remittance of payment for care. Organisation won’t take payments from VISA Debit card, Cheques not convenient.

Services are disjointed. They do not communicate effectively. GPs are not consistent and vary between different practices.

GP Surgeries need to see people when patients need to be seen, not told you have to wait 2 weeks for an appointment.
More information for looking after someone with dementia.

More staff.

They need more staff and resources to enable them to give a better service.

The care is so poor, I sometimes feel isolated and don't know who to contact.

I have no knowledge of health and social care organisation. From my experience of care at my GP practice I would assume it is excellent.

Availability and speed.

Sorry not impressed at all. Can they even spell EMPATHY.

Difficult to comment. Our experience has generally been a positive one but we get the impression that access to services/support is often dependent on the degree of proactivity.

Not enough flexibility to deal with individual needs.

Not given any information except from doctor.

They do a very good job.

Have part-time social worker-unable to contact when needed.

Social Services more visits twice in one year. My eldest son at times struggles with his special need boy.

Social care staff extremely helpful.

Given a local visit. Both my wife and I are pensioners.

See Ralph Brown’s comments.

Interaction between departments. Long delays between appointments due to shortage of staff and department restructuring.

Time scale, things take so long to sort out.

Just a number when dealing with social services, especially the finance department. R&C are a joke.

We do not get any social care.

Better communication between staff about what is being done and what needs to be done.

I really think we need more staff.

Nobody tells us what is available so I do not know.
Communication between services.

We stopped carers’ attendance because the office administrators bungled the attendance times.

My husband and I care for my 3 batchelor brothers who all have long term health conditions and disability. All 5 of us are over 70 years old. I receive a one hour direct payment for help in the home, it is not enough.

More integration of services.

Have had no experience.

More communication

Communications information for people who are not knowledgeable about what is on offer

Services are often away from where people live

Staff should have more time to do their work properly by spending more time than 2 or 3 minutes with each client, some of whom are spending their whole life savings on services which are not being met.

I feel strongly people are better cared for in their own home than going into hospital as many become disoriented when out of their own surroundings as long as carers are given time to do the job when calling on patients living alone.

Due to being short staffed, too eager to refuse care at home.

Not closing the files on people with a social worker so early, if reopened you have to deal with someone new.

Some reject outside help. Some remain ignorant of services available.

GPs need to be more involved or Social Workers IF they have the right skills

District nurses and doctors are excellent but I don't have any contact with Social Care staff

Not enough time given to carers to carry out jobs needed.

Have never had social care people.

Access to day centres with health care access

We have had a lot of consideration. The main problem is the new appointment system for the GP.

In our case social care services have not been involved.

Over the past 30 years since my wife contracted this disease we have had the occasional help but have managed to cope pretty well between the two of us.
More money spent wisely. Short term economies frequently take a toll on extended families. In worst cases the carer dies before the family member they were caring for. More research is needed into the long term implications of caring for a relative.

More advice from social workers about the viability of individuals remaining in their own homes regarding finance, adaptations and care options.

Many health professionals don’t have time for you. Doctors have been good but I would have benefitted from more physio, occupational therapy, community nursing support

Staffing levels, information from homes, etc. Care Plans - compulsory family input

New to social services - difficult to find out what is available and no continuity

A better bus service from our area as it costs £7.00 for every visit

Quickness of physio appointments

More support for elderly at home

Social care services have been good

Maybe visit more often

At 90 I should get routine contact from doctors and nurses

Carers Together have been very helpful and put us in touch social care/telecare.

Communication between patients and professionals

Unfortunately, because of where we live - Easington near Staithes - we do get the best care possible.

Not enough recognition of needs of residents in care homes. Perhaps more unannounced inspections would help.

Communication between various organisations

We are just being given this information now.

In the past well, but they are so busy and have such a tight schedule that visits are VERY limited and ongoing problems keep ongoing

More nursing staff required at hospitals.

Comments about where people feel patients with long term conditions should receive the majority of their care

We have had care in our own home from GP practice and community matrons. The team at Skelton have been wonderful and have explained aspects of care and have put us in contact with other health care professionals.
Most people feel safe in their home.

You would recover better in your own home

Need support from all the above so that each one aware of their problems.

Various people can give access to various help or care. It would be good if there could be an average way of accessing all kinds of help.

Colin’s GP, and mine, are very good at co-ordinating our care. Colin’s GP has spoken to other agencies and nurses about his care.

I think it is difficult to decide where the majority of their care should be. Conditions such as dementia can be very complex.

I have had a fall in August. I have not had any one come from my surgery. I have been 3 times in a taxi which is very expensive.

Help from GP hospital so they can manage at home.

Everyone has different needs. The main thing should be continuity of care with someone that can be contacted when a problem arise whether in hospital or at home.

People would always prefer own home if care was good.

As long as there is efficient and reliable network of care most people would like to be at home. But there must be a feeling of security for the individual with contact numbers and regular visits from named workers.

I struggle to visit GP or hospital due to age and bad public transport.

Depends on family.

Obtaining GP appointment difficult. Waiting times very long.

Vital to help independence.

Hospitals need to be as close as possible to home.

My wife has had a stroke and is now in a care home.

I don’t think we get the support from GP practice.

People get better quicker if they are in familiar surroundings and family and friends can visit easier.

Most people would prefer care in their homes.

Preferable people are able to live at home with help available from as many sources as needed and available.
Each person needs different care so it’s impossible to make very standard rules.

We have had to rely mainly on the social workers.

At home if possible.

At home if possible.

It's good when GPs can visit us/me at home but sometimes going into hospital/surgery is important. It depends on how bad they are but I think most people prefer to stay in their own home providing there is ample support for them.

People must be supported to remain in their own homes. On the whole that would be most people's wishes.

I find my GP and community nurse work very well.

In the home if possible with the community support if possible and the understanding that staff have the knowledge of the patients they are taking care of.

My wife had a major stroke six years ago and I have looked after her ever since.

Primarily in their own home with support from GP practice and community nurses.

As long as it's possible to reach out to these subjects above when needed I will be satisfied.

Home care not sufficiently appropriate or frequent. Family often at a loss to know best treatment.

Too many examples to give a good answer. The individual case needs discussing and a program arranged - not always done at the moment.

I wish to say in my own bungalow if possible for the remainder of my life

More day care should be available

GP has a first class service. Nurses and community matron are superb and very helpful

Initially no help offered from either GP or Social Services although for some time prepared to carry on independently

I am told people receiving care in their home is not a practical proposition though

People with Dementia can and often do wander off outside and forget where they live and where they were going so should not be at home if they live alone.

Keep people in their own homes as long as possible providing they get help from social services and handy man provided by the council if no relatives in the neighbourhood it's difficult to fix light bulbs, fasten curtains, etc...
Those with dementia need special care from experience, the only alternative is nursing homes as family cannot cope eventually.

If GP carried out more patients care i.e. seeing more patients instead of making phone consultations. Then this would mean fewer people going to AE within minor complaints.

Local hospital not interested in caring for long term Diabetes, Lymphedema, Heart, Due to costs to patient’s doctors!

Hospital in emergencies.

GOOD care homes are a must.

In a nursing home for my condition.

Facing the outside is difficult.

Dependent on the availability of their own family to help

Most should be in care homes when they are incapable

Depends on the condition of the person. Towards the end of life it's not always easy for the carer

Getting hold of anybody at the weekend is the most difficult time, the doctors could be on duty at weekend

Better in home if partner can help them.

In my case as a day patient at Teesside hospice medical staff there are main decision makers.

The vision makes sense on paper but not in reality.

There is no simple solution as everyone is different. More and better equipment would help.

In own home if possible - otherwise a mixture is needed

Depends on the illness

More regular visits at home on a regular basis from GP for nursing staff who can spot changes when they happen

My husband, who is 90 years old, is my main carer. Without own transport access to services is difficult or nearly impossible.

If they have to go to hospital it should always be the local hospital

Depends what happens. I will get in touch with Dr and hospitals when transport required

Coordinated by community nursing staff
May be a need to attend clinics sometimes

At home if possible with sufficient caring support and time donated to them

Hospital pick up bus could be given more time in our area

At home for as long as it is safe for the individual.

As long as there is communication between them

Unless going into hospital is for the best

A mixture depending on the condition

A mixture depending on the condition

Comments about which services in the local community could be improved to support people to leave hospital earlier and regain their independence

Again, perhaps a day care centre at the CO-OP building where health professionals could be on hand. As well as providing advice on care, it could also provide a bit of physio and social interaction.

Physiotherapy definitely! More support for carers who work 24/7 to care for loved ones.

Care at home to get pulled back to do your own things.

Making their home to fit their needs.

Don't know.

More support in their homes so they can live in familiar environment.

If there could be a group of people who could point people in the right direction to get help on leaving hospital.

GP Services.

Welfare associations.

Day centres.

Social support and organised events with other elderly people.

Social services can do more joined up thinking in organising care at home.

Improvement needs to be in place prior to person leaving hospital, i.e. social GP, OT community care worker, so as not to cause upset or problems once home.

? Tell me.

Help in their own home.
Council run help which I am sad to say had cut backs. Dial a ride transport.

All services.

Extra staff

Visits by the community nurse, preferably the same face can help who knows about your condition and circumstances.

Help in their own homes.

A daily nurse visit

Local nursing staff and doctors

Home care system.

Home helps - for shopping, lifts to appointments, hygiene, gardening.

Public transport.

Doctors and community nurses based at Doctors.

Home help and elderly watch needs improvement. Very poor when I left hospital.

Visiting charities, neighbourhood watch, police etc.

Care at home services. Communication and contact with GP when discharged and support at home for as long as needed.

GPs and Community Nurses

Nursing/daily help care

Help when they get home.

All

Home care.

Sorry I cannot comment, I hope to keep my independence.

More health visitor services for people in their homes, GP home visits?

Visiting nurses or doctors.

Community Nursing.

Home nursing to provide longer visits to patients. Also, help with practical needs in the home, especially if the patient lives alone.
More Physios, nurses etc. to make home visits possible.

I cannot comment. I've had most support from Carers Together (Redcar)

From Community Nursing Staff.

More Physiotherapy Units.

Community nursing.

Local physiotherapy services-too long a wait.

Joined up working between doctors, nurses and social services.

Physio.

Social Service. I have good services from people when my wife was ill. Thank You.

Satisfied with our experience.

Post-hospital rehabilitation and physiotherapy-in home services.

Care homes to discharge patients into.

Never ask for people to come, I have managed on my own, I am 82 years, I don't know.

Carers. More community nurses.

In all areas.

Social workers are not always the easiest people to contact and council telephone systems are a nightmare.

I think social services could visit them more and help them depending what's wrong with them and also tell them what special groups can help them. I go to take heart class twice a week and I think there must be other groups that do the same.

Back up generally.

Care visitors.

Plenty of care when leaving hospital.

Specialist nurses to visit on a regular basis.

Have only been resident in this community for the last 5 months so cannot comment adequately on all services.

I find that care workers in the community have not had the training to take care of patients in the home with Dementia and stroke and heart problems.
Not enough information available to make a judgement.

As question 8 - Don't know what is available so cannot comment.

A free to use service for some support without recourse to means tested benefits.

Weekend visiting at GP, Saturday morning if needed.

Chiropody

More time for carers to do their job.

Home physios.

Depending on the individual requirements.

More local beds available for recuperation/respite care.

Visits from Social Services and community nurses. Hospitals decide on home care inappropriately to clear bed space (3 times in this case).

More respite care for people living alone with no carers.

Carers Together - More funding. Dedicated support workers/nurses.

Social services

Community nurses

Local district nurse

Social Services. Occupational Health. District nurses

Transport links to service express service

Occupational therapy services including the Local Council with regards to adapting better access to housing, etc.

More nursing care under the service of our GP

More time for home care staff and maybe voluntary people to help people who live alone.

More information about who to contact

Social Services.

GP Practice

Social Services After care.
Social Service carers should have more time for each elderly or disabled person paid by N.H.S. Then they could be cared for from home with extra help and care free of charge.

Nursing and social services.

Social care services.

More people to help to motivate and encourage.

Home help. Carers - Caring is based on the paid carers and what they are NOT able to do, not the person being cared for.

Social Services.

For the district nurse to be involved more.

District nurses should be on call as they used to be.

Dependent on the availability of their own family to help

Ensure they are not left alone for long periods

Short term care homes

Not enough time given to home care service.

The nursing staff could be improved.

More district nurses easily accessible to link with patients and surgery.

I don't know as I have 24 hours care from my wife so could return home promptly.

Social Services

No turfing people out of the hospital in the middle of the night. Especially if they rely on an ambulance.

Home visits of a more regular nature.

Social services

Local hospitals.

More physiotherapy input/falls clinics/training for the care staff in residential homes.

Physio at home instead of waiting in a hospital bed

More staff in all cases. 70-80 year old people are being exploited.

Short term respite with physio services to enable early return home
Didn’t receive adequate care when discharged to a small community hospital

Home Care. It is an excellent service

Social visits to patients and carers

Nursing

Just as long as the carers keep coming I am satisfied with this

Easier access by written information to caring services.

None available

Social Care Service

Community nursing staff numbers

Home carers

Respite care

More help from District Nurses. Better information about help that's available

It would depend individual's needs

Social Services. Health Authorities

Difficult to say for where we live. Carers Together do a good job but Redcar is a 45 minute drive from us.

Help for care at home

The Redcar Primary Care Hospital should have more varied clinics

Better provision of homecare services

More doctors and nurses

Total care

No opinion, as I was sent home the day after my leg operation to a husband who I am his carer. No help offered.

Comments about not needing as many hospital beds

An excellent idea to keep people in their own homes, but carers do need advice and help. As I am housebound looking after my husband, it is often difficult to travel to access all the help out there.
I agree, but we certainly need more help to keep these people at home.

I think reducing the number of beds would be a big mistake. What happens if there is, for instance, a flu epidemic or a spate of falls in icy weather?

Don’t know.

More staff could change this.

No

Still need beds in hospital but could cope probably with less.

Do not know how it could be improved.

As long as it's not at the cost of trained staff offering the services.

You will always need as many beds as possible in hospitals as a lot of people would be sent elsewhere because of this.

Yes. The concerns are that beds are not ready available. The worry is that some people are definitely better looked after in hospital. But people with good support at home do better.

Many cuts have had a negative impact on care in the community, especially learning disabilities care and support. Dementia care homes inadequate! (Staff trained)?

There should be enough beds still available for anyone who needs hospital care at all times.

Yes it's a good idea, providing that we can get proper care in our homes.

Indeed. Going by treatment in the last 12 months WE DON'T HAVE CARE.

Feel the number of beds should not be depleted too drastically.

As long as this does not mean people are sent home from hospital just to free up a bed.

We do need care outside of hospital - Independence make elderly happier.

The main point is to get services improved and enlarged and running more smoothly before this could happen.

Hospital beds are very important

I find it hard to accept if more home staff isn't provided.

Good

Good. Takes the strain off the hospital services.

Always prefer to stay in their home with familiar settings
Beds will still be needed for emergencies.

Number of beds should not be reduced. They will still be needed.

Would not be enough beds. People sent home too soon.

You don’t need more hospital beds, you need more convalescent beds. Once medical treatment has ceased people should have time to mentally recover and adapt. This is *not* a hospital responsibility.

You are still going to need the beds available.

Minor care units might help GPs and hospitals but they would need to have independent staff.

I fully agree that care in the home is more important.

Can’t see this happening due to cuts.

Not enough beds at moment, so more available is most desirable.

Hospital beds are very important.

I agree.

Care outside of hospital is ideal for some, but growing elderly population means beds will still be needed.

We need more hospital beds not less.

Due to aging population, this is unlikely to happen.

Don't agree. Never enough beds anyway.

All beds are needed due to long waiting lists at James Cook.

We should try to maintain the beds and improve the service.

More beds in South Tees area

Yes more beds are needed.

KEEP THE HOSPITAL BEDS.

Good idea providing there is DEFINITELY care in the community.

More care outside hospital, do not like hospitals.

By providing more care outside of hospital, waiting lists may be reduced and those who need to be in hospital can be there.
Community care would need vastly improving to take the place of care within hospital environment.

I think there should be as many hospital beds as possible. Is a tendency to discharge patients too soon at present. If day care surgery is possible that is the best. But more serious surgery patients knowing help is at the bedside in hospital can help recovery. It is frightening if alone at home not knowing what to do.

Agree fully but where is the EXTRA care to come from and the money to pay for the extra care and services.

No. I think as many beds as possible is priority.

May be true, but should not be used as a reason for reducing hospital beds till seen in practice.

People are better in their own homes as long as possible.

It is often difficult to get a bed at James Cook so if the number is cut, this will get worse.

Hospital beds must not be closed.

If care could be organised more quickly, this would free up hospital beds.

It is good to know hospital beds are available in an emergency but family and home is very important.

Care in the community is NOT WORKING-majority of care is left to wife/carer.

Do we have faith in nursing home after the recent publicity.

Use small local hospitals (ie-Brotton/Guisborough) for local/easy access treatment rather than James Cook.

We agree that there should be fewer inpatient beds at James Cook-but NOT at local community hospitals which provide absolutely CRUCIAL 'step down' care for elderly people prior to returning home-if you dispense with these, you are likely to end up with MORE pressure on James Cook-which is difficult to access for elderly and frail people.

Makes sense.

Depends on the care given-some areas will be better than others.

I think all the beds are needed in the South Tees area.

More care outside of hospital.

More care outside of hospital.
The number of available hospital beds should be proportionate to local population numbers. Increasing more care outside of hospitals should not affect bed numbers.

This argument has to relate to current conditions, but these are themselves variable e.g. is the present need for beds covered by the number available? If not, is there sufficient care outside available to repair the deficiency? Are there enough external resources—such as qualified staff, funding etc.

I think you do need more hospital beds. We have had to wait two and a half hours once for my wife to have a bed.

If doctor and hospital staff gave you more information.

If you have people in their own homes you could monitor them but I don't think you would need less hospital beds as you would have to provide more nurses to attend people at home.

I have received good care from hospital and community staff.

We need the hospitals we have. There is always a need for more beds than there is now.

The number of beds must not be reduced until the community resources are enough to provide safe and proper care.

We will always need more hospital beds.

Less time spent in hospital the better.

Local hospitals should be used more than they are now.

Beds should be there if needed.

Most patients consider recovering from illness at home is most beneficial. There are too many readmissions to hospital with people in too big a hurry. Take the best advice of the experts and do your best to comply with what they think best for you. Post hospital care is so valuable where necessary.

1. The number of hospital beds should not be reduced until the problem of beta-blocking is COMPLETELY eradicated. 2. More GP led local hospital places needed.

These need to be managed to fit with the demands winter brings but generally that is an excellent idea.

The need for beds in hospital are needed when patients are at their worst of an illness but I feel they are sent home without full support when needed.

This is an unknown quantity, any disaster calls for immediate hospital beds, therefore there should be beds in reservation.
More beds are definitely needed.

There are already shortages so why close more? Putting cost over care will let people down.

More care outside of hospital.

Need more beds and nurses.

Using home visits will ensure that as always useless bureaucrats will slash hospital beds too much causing delays, and inevitably deaths.

I have not had access to a hospital bed since the millennium.

Asking for care at home for long term health conditions does not absolve the NHS of the responsibility to provide beds for cases that require specialist emergency care.

No idea, as it depends on circumstances in each case I would think.

This may help bed shortages.

I would not like to lose our local hospital.

I agree if care could be given outside of hospital, it would ease pressure for hospital beds and visiting journeys.

Home care inefficient - used to clear bed space when patient not fully fit to leave hospital.

Probably OK, as long as the money remains in the NHS.

There are not enough hospital beds available at the moment so there should be no reduction

I agree

If we had more care in the community not as many beds would be needed

Experience shows that sometimes patients are bed-blocking when kept hospitalised; but receiving minimal medical treatment and rehabilitation efforts stopped if difficult under the ridiculous health and safety attitudes

There are not enough beds now

It makes sense for some but not for the very vulnerable

There is no reason that services more close to the people

There is still a need for beds in case of major accidents or an outbreak of flu

I understand that there is already a shortage of beds so why reduce further?
I don't think people who work as carers spend enough time at the cared for person's house. My parents pay for 4 x 15 minutes of care time but only receive 1 x 15 minutes and 3 x 2 minutes to dress, wash, toilet, etc. We're fobbed off with excuses.

You still need plenty of hospital beds

It would save money for the health service and make life pleasant for the elderly to be in their own homes just as it is sure the standard of care they receive at home is done with consideration and keeping the dignity of the patient.

I think more hospital beds are important.

It is important to have a number of beds for elderly who cannot be looked after at home.

Too many is better than too few.

There are too many beds, especially in A&E that are taken up with self-inflicted injuries and conditions such as drug addicts and drunks.

If at all possible, it is beneficial for the ill person to be looked after at home.

There should always be more beds to cater for emergencies.

More hospital beds are needed.

We need more hospital not less. At times patients really need hospital treatment.

Hospital beds should always be available for people who need them at all times.

Doesn't seem right as hospital is for sick people. They are needed.

Wrong, beds are vital and a lot are waiting for beds outside care helps for better treatment to emergency patients.

I do agree they should have care outside hospital.

Ensure you always have enough beds in case of an emergency.

Would need more varied help not the usual - we are not able to lift, can't put our foot on the walker etc.

Don't know.

In an ideal world it would be better to receive 24hr care at home where necessary even in the short term, but I doubt if this is financially viable even when patients pay for their own care.

No one could know as illness come quickly and beds would be needed.

Patients cared for at home will assist the NHS with bed shortages etc.
Home care must be reliable and easily accessible

Is this an excuse to save costs?

Only if there are social care homes

It sounds right from an accountancy point of view, but it's vital that support is first class - currently it's third class

Being at home is very important but hospital beds should be available when necessary

Beds should still be available, to cut waiting times for operations etc.

Numbers should not be reduced too much, ie beds should always be available.

Sounds correct

It's alright coming out of hospitals if you have more support at home.

Accidents can happen anytime or place. Would be better if you could know there would be always be an ambulance on call

Beds always seem in short supply as it is. More community help would be needed for people to manage their own homes more.

There is still a shortage of space on certain wards and moving patients is disruptive.

Fully agree with this policy

No

Provided help in available, home is best.

With an aging popular in an area of such high deprivation I consider we will need both the beds in James Cook together with all the beds in the local hospitals. Due to pressure on beds too many grail elderly people go in and out of hospitals repeatedly never staying long enough to get the treatment needed.

Patients with illnesses that have become critical and need oxygen or to be put on a drip to be treated quickly with antibiotics, need hospital care. Retirement homes are not equipped to provide this care, neither are the staff trained to use this kind of equipment. There are not enough care staff employed to monitor critically ill residents.

How would this be funded? Council care homes have all been sold off by our `Tory Masters'. It's all about money, NOT CARE. How do you link care with profit?

Through assessment seems to be lacking. And there are never enough beds
This is risky so needs to be done properly. "Chucking" people out of hospital to create empty beds overloads carers who have other responsibilities and may not be given the right support & information to care properly.

This is a good idea in most cases

Great idea

I think we would still need many hospital beds

It costs a lot more money to keep a patient in a hospital bed when you could be at home with support

There isn't enough hospital beds available as it stands without reducing them even further

I agree in general, but I firmly believe that good hospitals provide specialised treatment and/or services, not available in the community (eg GP practice)

Always think beds should be available

Better to be treated at home if possible

Availability of beds is very important. The number of beds should NOT be reduced for any reason.

Excellent. Good for patients and saving NHS money. Staff need to be well trained though.

This would help as there is always a shortage of hospital beds

There will always be a big need for hospital beds. Different factors need to be considered for elderly patients and those with special needs

I think this survey may be trying to close hospitals which would be a very bad thing. We don't have enough hospitals or staff as it is. Always trying to save money by putting more responsibility on families.

Will this affect waiting lists?

Rubbish! There will always be a need for more beds in hospitals; there are more people to cater for and more ailments to deal with.

Staff available to ensure patients’ needs met and people aren’t neglected

I know my husband is MUCH better at HOME. More visiting time for nurse *** would be really good.

I don't believe there are sufficient hospital beds available.

As long as the needs of the patients are put first and not performance targets.
There are not enough hospital beds now so by providing more care outside should reduce the
number required to a more acceptable level.

We need all the hospitals constantly offering services. We need a transplant unit on Teesside as a
matter of urgency

It depends how serious the case is, but really I don't think there should ever be a shortage of
hospital beds. However, if a person is well enough to be treated at home and they want to be at
home that's fair enough

The main reason for non admission is lack of beds and staff to attend to the patient. Small
hospitals/clinics within easy reach would be more helpful

I still think they need as many beds as possible

Beds are in short supply at present and many people are being treated at home now.

More care provided outside the hospital once discharged

In my case I have paid for most of my appliances including a stairlift which was serviced by Social
Services but now I have to pay for the servicing. I had to wait so long for a chair and now I've had to
buy that.

We need more beds across south tees badly

It is much better to treat people in their own home rather than at hospital.

**Comments about the vision**
Yes, treatment in the community is an excellent vision, but perhaps the community matron service
could be extended for those with permanent, life restricting conditions.

I think this is alright, so long as people are not discharged from hospital too early and then need to
return.

Don't know.

The health of the people is all about money and targets rather than people's health.

No

Makes sense to get people back to familiar environment.

This is the ideal solution but there needs to be a lot more help available after discharge from
hospital.

It is a good vision, but I am concerned as to how we get to that position. As a carer I can see many
problems in accessing relevant services. Some people with dementia must be in very vulnerable
positions.
I feel people, once diagnosed with dementia or visual impairment, could also play a part and any physical/other problems are not monitored.

Your vision? Is NIL. Come out into the real world.

Feel this would be acceptable to most people.

I agree, help to be independent.

Good idea but do you have the staff??

Good idea but more staff are required.

Excellent

I agree with what you are trying to do.

Whole heartedly agree with vision.

Sounds OK if it works.

I agree.

I fully agree.

I agree.

Jane Booth has been very helpful to us coping.

Depends on the quality of the support.

Whenever I needed help it was given quickly.

Its good idea providing other services such as transport and home care are in place and there is no extra pressure on carers.

A vision is no good without the services in the community. How are you going to provide services with all the cuts that the government are making.

Would be beneficial if support given.

More help needed in the community.

Good vision for the area

Agree

Hope your vision comes true.

A sensible and important concept.
With all the cut backs, due to lack of funds, it is impossible.

None. Seems good to me.

Good vision! When is it going to begin? How about help for the carers. They are elderly themselves but do the best they can, making themselves ill.

You have put exactly what I tried and failed to put into number 12.

Would say most people want to be at home but want to be confident they will get the help and care.

I agree with your vision.

Would support this view but as in 12, transition should be gradual...don't close wards/beds before need is clear.

Care in the home is far better than in hospital for us as we have been treated badly in hospital.

Vision is good-the practicality of it is harder. Hospital social workers (although busy) are really good, maybe let down by local authority, social services and private care providers.

The support should be at home and if possible by two people are qualified and one in training.

Returning home early would cause problems for wife/carer-not enough support supplied.

Must have! A backup of service.

Vision excellent-but do not close small local hospitals.

Fewer stays in James Cook for elderly people-but NOT at the expense of community hospitals-these provide a much better option for most frail/elderly people-specialist elderly services should be run from them, rather than concentrated in James Cook.

Fine if it works-you hear so many stories about how long people have to wait for treatment and also how many are discharged without proper treatment. A lot more community staff would be needed for this to happen effectively.

I would like this to happen. People going home from hospital need lots of support.

Question about carers: Would we be allowed someone to help cleaning etc. (We are receiving pension credits.)

See Ralph Brown's comments. Thank You.

A better social services department is needed to ensure ALL required services are fully in place before any patient is discharged from hospital. Social services leave a lot of tasks to the patients’ next of kin.
Your vision for the future appears worthy of every support towards achieving a successful conclusion. But see my comment in item 12 above! "Aim for the sky and you may hit the rooftops." Good luck in your effort! I wish you well.

I think some people are sent home far too quickly.

As I said if you have the money and the staff it might work but that depends on the care each individual will get.

It depends how often carers attend and for how long.

A good idea if the resources are sufficient.

I came home from having a hip replacement on 15/10/13. To date had my clips out at hospital seen nobody since.

Good vision.

Nothing wrong with your vision as long as there are the staff to maintain it.

Need more experienced people who really care about the illness and nursing the patient.

A THOROUGH home care assessment MUST be made before hospital discharge.

That must be a priority, with the proper resources this will be achievable and money will be saved in the long run.

It is nice to be treated at home with the support that is needed as long as the services are there when needed and know how to be contacted.

I think people prefer treatment at home but realise this is not always possible.

A good idea, but not optimistic that sufficient resources will be in place or available.

Treatment in the community is better.

More nurses.

Unless it can be guaranteed that home treatment will be of high quality, I fear that the service will be 2nd class with astronomical salaries for executives charged with carrying out this service.

Come off it! You are cutting back to save money.

Depends on the level of support for home recovery and whether family support is available as back up.

No, only try to help where and when.

I agree with your vision and hope it comes true.
I think your vision is right, the elderly like the comfort of home and not having lengthy stays in hospital.

Totally inappropriate. Home care used as an excuse to clear hospital beds!!!

A very commendable vision but a hard task to deliver.

We need a 24/7 NHS. Too many services finish lunchtime on Fridays.

I agree

In an ideal world this would be applicable but this is not an ideal world. Follow up appointments after discharge are continually cancelled

Make sure support is there ASAP

Sounds ok to me

I agree

Vision is admirable. Hospitalisation for other than acute conditions causes distress, patients wish to go home ASAP

Good in principal

Vision is good if the care factors are in place

The centralisation of services increases the time and effort

All departments throughout the NHS should talk to each other (communicate) to create better services for every patient

It is an admissible idea if the support will be forthcoming

The support and help must be carried out not just written down on a care plan and then not carried out properly

Need more support /advice for people who are self-funding, eg access to social workers.

When people go back home they should be very well supported and shouldn't be sent home too soon

I think it is a wonderful vision and workable as long as staff are well trained and selected in the first place for a caring nature.

We agree

Good vision.

I agree that after care from hospital is priority.
Not at the risk of relapse or infections occurring.

If GP surgeries made it easier to book appointments with the doctor this would relieve some of the stress taken up by people attending A&E for minor ailments that doctors are not seeing to.

I support the views expressed above.

You could try removing computer from nursing staff as they have little or no time to attend patients.

More care people need to be employed with adequate time to carry out all duties when visiting people in their own home.

A lot of support in the home will be required and not just dropped off.

GP’s should be more accessible to people, instead of telephone consultation.

New hospital at Redcar is totally useless. All they can do is put a plaster on and send you to James Cook hospital BUT TO FIND YOUR OWN WAY THERE.

Please make sure that once the patient is home, he gets sufficient care and attention, especially if he lives alone.

Would have to be very reliable and have to deal with all the problems i.e. lifting etc.

Good.

I believe this is the right option.

There should be more day care centres for wheelchair disabled so that they may meet friends and give their carers a chance to recharge batteries.

There should be more day care centres for physically disabled people to be able to integrate and have a social life away from their carers.

An ideal vision to work towards. I personally received adequate support after a lengthy stay in: teaching me to shower independently, information from the hospital and delivery of frozen meals.

Be aware that each patient has different needs

Seems reasonable

It's a good idea but requires more reliable staff which entails a lot more money invested in such a programme.

Sadly domestic care in the home is not very good yet this is an important link.

It's a good idea.
I think it is a good vision as long as enough staff are available to give their time and care in the community.

I agree with your vision but staff levels should be adequate and qualified. Home assistants should be well trained and have sufficient time with patients.

I agree

Longer nursing hours at home.

Frequent cuts in public services make it unlikely to work.

We do everything for the man concerned. I don't think he would have it any other way

*Local* recuperation hospitals make life so much easier for visitors and carers where elderly persons have friends of similar age and unable to drive. Travel and parking at James Cook is time consuming and expensive. It is too far from East Cleveland to return home between visiting hours and costs extra because of the long stay parking plus travel costs. Ambulance services are over stretched in East Cleveland.

Would be very good but health and welfare of the patient must come first.

Good "support" is vital.

Provided this is not just another political dream and that help in the home WILL be provided.

I agree.

My mother had a slight stroke resulting in 8 weeks in the hospital even though within 24hrs of admission all the effects of the stroke had disappeared. She is now in residential care for her debenture. It is now almost a year since she had her stroke. For the 2 years prior to that I had fought the health and social care system to get my Mother the care she needed. Immediately Nice authorised medication for middle stage dementia I tried to access this medication for my mother. I spent 2011 and 2012 plugging the gaps in the system caused by financial issues. This has had a massive negative ongoing effect on my health.

Some people need to be in hospital longer so as long as they get support it is ok

I could not cope on my own. Changes in format and new rules abound for what reason? NO ONE knows - management?

Return home is too quick for some patients which puts even more pressure on the carer

There's never any proper communication. We always have to ask all the questions.

As long as patient is looked after with same care at home as in hospital

Depends on individual needs and family or friend support
As long as the after care is good and not left just to the carer

No, I agree with treatment in the community and people staying at home

The vision sounds fine, but unless the envisaged outside support is actually in place, some departures from hospital may be premature.

I think your comments about this good and very important

It depends how bad the situation is

I hope this happens soon!

Support it - but depends on better facilities/manning in the community

Depends on what condition an individual has and how quickly they were recovering. Not everyone is the same

I agree

We are very fortunate we have each other and good family. Others are not so fortunate.

A very good idea to help people - it must succeed

We agree entirely

Not to be sent home until adequate care is put in place.

Timescales need to be improved e.g. 15 minutes is not acceptable

This would seem to be a way of saving money.

More care provided outside the hospital once discharged

As above. Care needed once out of hospital

Good if they do get support.
Appendix 6. Response from Durham, Darlington and Tees NHS England Area Team

Impact of proposed changes on Area Team-commissioned services

“Your proposed closure of Carters Bequest Community Hospital clearly impacts on Cambridge Road Medical Practice, which, as you know, is housed within the hospital building. We are clear that there remains a commissioning need for a practice of such a size to continue to be based in this area and appreciate the work that the CCG has undertaken with NHS Property Services to understand the feasibility of retaining the practice in situ.

“We understand from structural survey work completed that Carters Bequest Community Hospital can be demolished with the GP practice building retained, should the CCG proposals be approved and implemented. While further detail around the practicalities of this and whether or not the practice would need to temporarily relocate, are still awaited, we are sufficiently assured that your proposals pose no threat to the sustainability to the practice and that there is unlikely to be a need for any consultation over and above than local-level communications with registered patients.

“As you will be aware, your proposed partial closure of Guisborough Primary Care Hospital, affects North Tees and Hartlepool NHS Foundation Trust’s Community Dental Services (CDS) which operates out of the hospital’s Priory building. We are clear that there remains a commissioning need for this service to continue to be provided in this area and would seek assurances that suitable, accessible premises are available to accommodate this service locally.

“While the Area Team is supportive of the IMProVE proposals overall, further discussions are clearly required with NHS Property Services to fully understand the options for both of our affected providers, CDS specifically, if the planned changes go ahead. We therefore welcome your phased implementation plan for the proposed changes and acknowledge that this allows time for the further detail, options and discussions to be pursued. We would like to see the implementation plan aligned to any timescales that will ensure any changes for both Cambridge and CDS patients are negotiated, agreed and implemented in a planned and co-ordinated way, accommodating the need for any further consultation and/or needs that may arise in relation to changes to the services we commission.
“The primary care commissioning team remains keen to work with the CCG, our providers and NHS Property Services to fully understand any associated cost implications to the Area Team, be this in relation to rental costs, temporary relocations and/or communications and engagement resources. While we are fully prepared to review any costs incurred in the context of other potential local changes – such as those proposed in Eston - we will, understandably, be looking to minimise any financial impact on ourselves and our providers overall and will not be expecting to pick up any estate related costs.

“Our primary goal remains to ensure that disruption to patients is minimised throughout the implementation and we would seek assurances that our directly commissioned services are included in any planned communications and engagement as you bring your plans to life. This is particularly important given the specific, complex needs of CDS service users who include vulnerable groups such as people with learning disabilities. We would be happy to work with you and our providers to ensure sufficient support and information is made available if and as your proposals progress.

Assurance of proposed service changes

“As you are aware, the Area Team has undertaken two assessments of your proposed service changes throughout 2013/14-2014/15; the Strategic Sense Check in April 2013 and the Assurance Checkpoint in March 2014 to confirm fulfilment of assurance criteria in line with NHS England guidance.

“As you will be aware through our ongoing feedback at the IMProVE Project Group meetings, the majority assurance that remained outstanding at the assurance checkpoint in March, have now been fulfilled. We have been satisfied – through your business case, consultation documentation and outline outcome measures – that the clinical quality and patient experience benefits are clear, that your plans strategically align to broader urgent care and primary care strategy and that you have wide-ranging clinical sign up to the proposals.

“The outstanding elements of assurance, as depicted in the enclosed reconfiguration assurance grid, are reliant on further financial and workforce detail, to a) assure of sufficient and competent staff to support the shift away from a bed-based to home-based model of care and b) to outline financial costs, including staffing and transitional costs, beyond the estates redevelopment costs that your business case outlines. We fully acknowledge that such detail needs to be aligned to a final delivery model and therefore is expected to be incorporated into your
implementation planning, following your final decision. We therefore look forward to reviewing this at a later date as we continue to support you in taking the proposals forward.”

Ben Clark, Assistant Director of Clinical Strategy, NHS England
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• Proposals in line with clinical best practice nationally, regionally and/or locally  
• Projected and quantifiable clinical quality outcomes clearly articulated  
• Improvements to patient experience clearly articulated  
• Impact on patient safety clearly considered and actions in place to ensure safety                                                                                   | Fully                       |                             | Business case articulates broad benefits and objectives. Outline outcome measures have been made available |
| Clinical support             | • Support from GP commissioners and wider GP community  
• Wide-ranging clinical sign-up to proposed service model(s), across patient pathway                                                                                                                          | Fully                       |                             | Significant GP engagement undertaken at each stage of options appraisal and little opposition to date       |
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### Procurement
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| Procurement | • Development of proposals are consistent with rules for cooperation and competition | Fully | Evidence through project meetings and four tests’ evidence that choice has been thoroughly considered, specifically in relation to potential future service providers |
IMProVE – Integrated Management and Proactive Care for the Vulnerable and Elderly
Evaluation against the Four Tests
Introduction

NHS England has provided a framework to support organisations when developing plans for major service change (Planning and delivering service changes for patients, December 2013). This guidance outlines how NHS commissioners should work together with communities, providers and local authorities, to ensure that proposals and plans have effective preparation, robust evidence and are based on extensive engagement with staff, patients and the public. It states ‘major service changes should be evidence-based, and informed by how organisations can best meet the health and care needs of local populations within available resources’. In 2010, the Government introduced four clear tests for reconfigurations which schemes should be able to clearly demonstrate:

1) Support from GP commissioners;
2) Strengthened public and patient engagement;
3) Clarity on the clinical evidence base, and;
4) Consistency with current and prospective patient choice.

South Tees Clinical Commissioning Group (CCG) has been working collaboratively with key partners in health and social care over a period of two years to consider and address the challenges faced in meeting the needs of a growing population of older people with long-term conditions and other health and social care requirements. We have also gained the views of our patients and public in order to shape and develop a proposal for service change which culminated in a 13 week formal public consultation from April to July 2014.

This paper expands upon our existing IMProVE Outline Business Case, demonstrating and providing evidence of how our IMProVE proposal meets the four national tests outlined above. The paper is supplemented by an Evidence Log (EL), appendix 1. Individual items of evidence are stored at: I:\Collaborative Working\Improve Project\Four Tests

Test 1 – Support from GP Commissioners

South Tees CCG is made up of 49 general practices serving a population of around 280,000 people. The practices are represented by a CCG Governing Body which is made up of 8 elected clinicians, 6 of whom are elected from the member practices as well as a Chief Officer, a Chief Finance Officer and 2 lay members.

The CCG constitutes 3 ‘localities’, Eston, Langbaurgh and Middlesbrough and each locality have an appointed Locality Lead. The Locality Clinical Councils (LCC) meet 10 times a year and the Clinical Council of Members (CCOM) which is made up of a clinical representative from all practices, meets 4 times a year with a remit to hold the CCG Governing Body to account.

We have established 6 workstreams to support the development and delivery of CCG commissioning plans and priorities. Seen as a key component to ensure commissioning is clinically led, workstream membership is predominantly made up of GPs and supporting clinicians from primary care. The IMProVE workstream meets on a monthly basis and is overseen by an Executive Clinical Sponsor from the CCG with a GP lead. Sitting underneath the IMProVE workstream is an operational sub-
group which meets fortnightly. This group also invites participation from the wider GP membership, clinicians from provider organisations (Hospital Consultants and nursing and therapists from the community) as well as relevant local authority and voluntary sector colleagues. Workstream leads are responsible for ensuring the CCG locality councils are involved and kept informed of the work being taken forward through the workstreams. All CCG workstreams are intrinsically linked; in particular the IMPROVE programme ensures that it is aligned to projects and strategies developed by the Urgent Care Workstream.

The CCG Urgent Care Workstream has further evolved into a South Tees system resilience group to comply with national guidance around the need to involve all relevant stakeholders in collectively developing and overseeing local recovery/sustainability plans. The workstream’s membership was therefore extended to include representatives from both Local Authorities (including public health), North East Ambulance Service, South Tees Foundation Trust, Voluntary agencies, NHS England and the Local Medical Committee. As well as recovery planning the main focus of the group is to develop and implement a local urgent care strategy which is fit for the future. (E1)

As part of reviewing existing community estate against our proposed model of care, there was a need to consider other services delivered from community sites. In particular, future arrangements for minor injury services based at Guisborough and East Cleveland community hospitals needed to be taken into account, ensuring that our IMPROVE proposals are linked to our future urgent care strategy.

The CCG’s Clear and Credible Plan 2012 – 2017 (E2) developed by commissioners with input from the public, clearly describes the confusion caused by having multiple urgent care access points and how this has led to duplication across the whole system. The plan therefore advocates a streamlining of access points. Review of the minor injury services in Guisborough and Brotton has found both services to be poorly utilised with variable opening times and limited access to diagnostics. Our draft urgent care strategy currently being developed by the South Tees resilience group, outlines proposals to develop and commission Urgent Care Centres. Accessible through 111, it is proposed that these Centres would provide minor injury and ailment services to meet the urgent and immediate care needs of the South Tees population. The intention would be to commission a consolidated Urgent Care Centre in Redcar by April, 2015 in line with our IMPROVE proposal and a second Urgent Care Centre to be co-located at James Cook at a later stage. Redcar Urgent Care Centre would be available 8.00 a.m. to midnight seven days a week progressing from the current nurse-led service to one delivered by doctors supported by an advanced nursing team. During opening times the centre would also offer an x-ray and point of blood testing, providing patients with a seamless ‘one stop’ service for care and treatment.

The Urgent Care Centres would be available at times when they are most needed with the ability to treat a broader range of conditions than the current Minor Injury Units are able to do. This, in turn will help towards reducing demand for Accident and Emergency. It is envisaged that any patient seen, treated and discharged from the Urgent Care Centre with non-ambulant issues will be able to receive transport from the patient transport service.

In line with the above proposals, it was therefore agreed that consultation around the transfer of Guisborough and East Cleveland Minor Injury Services to Redcar Primary Care Hospital would be included as part of the IMPROVE proposals and timescales.

In April 2013 NHS South Tees CCG established the Integrated Management and Proactive Care for the Vulnerable and Elderly (IMPROVE) Advisory Group, a strategic multi-agency partnership comprising (E4):
The diagram below illustrates how the IMProVE Advisory Group fits into nationally recommended governance for determining evidence and proposals for major service change:

The group’s focus has been to address challenges outlined within our Joint Strategic Needs Analysis and Health and Wellbeing Strategies around our increasing elderly population, high disease prevalence and variation in outcomes. Collectively the group has sought to learn and build on areas of good practice from other areas in the UK, where fully integrated services for elderly patients and those with long term conditions have been successfully rolled out, creating economic and quality improvements across the whole system. In July, 2013 South Tees Foundation Trust hosted a half-day event, bringing clinicians and local authority commissioners together to discuss good practice (EL5). Clinical involvement in this group has driven a shared vision of moving away from the reactive care models that have developed over time, to models of care that are proactive in enabling a range of interventions to prevent deterioration in a person’s condition and an avoidable hospital admission. For example, clinicians recognised the need to identify early those patients at risk of future admission so that they could be supported to avoid their long term condition deteriorating; working with them and their carers or family to maintain their independence. As a result the CCG has successfully implemented a predictive risk tool and transformed the work of community teams in order to provide targeted supportive management.

Whilst clinical CCG Executive members have had the responsibility for reviewing the IMProVE programme, (EL6), we can clearly demonstrate involvement and support gained from our wider GP membership. The work and challenges of the IMProVE programme have been shared with member practices on regular occasions, both at locality meetings and the CCG’s Council of Members meetings, providing opportunities for practices to input and shape future services. Individual practice visits by senior members of the CCG team, including our CCG chair have also included IMProVE as an agenda item for discussion. (EL7) A fortnightly CCG bulletin is circulated to the entire membership summarising Executive and informal Operational meetings and our website features the IMProVE Programme.

There is a newly formed Clinical Professional Forum which included on its agenda on the 30th of January, 2014 an opportunity to discuss the IMProVE programme and there was very good support for our plans and vision. (EL8)

All of the above groups have played an active role in shaping future plans, evolving over time in response to clinical feedback.
Future Service Model – Option Development

Stage 1 – Development of quality criteria

In order to progress our vision and future service model, at scale and pace, it was recognised that reconfiguration of services and community estate across South Tees would be required. Clinicians and the public were asked to consider and agree criteria by which to appraise our current and future ability to deliver our proposed new model of care. Criteria were to be based upon delivering:

- A quality service which meets local and national standards
- A model of care which was sustainable into the future
- A model of care which was efficient and made best use of resources

Development of criteria was a main agenda item at the CCG’s CCOM meeting on the 16th of January, 2014 and repeated at two further meetings involving clinicians:

- an evening event at James Cook Hospital with representation from GPs and Acute and Community Clinicians from South Tees Trust on the 20th of January, 2014, and;
- a half day stakeholder event with clinical representation (GPs, consultants and other health professions) and representation from voluntary sector and local authority organisations on the 28th of January, 2014. (EL9)

The CCG Clinical Council of Members and the Trust meeting at James Cook followed a similar format. Our IMProVE sponsor, Dr Ali Tahmassebi presented the results and key messages from the recent public engagement programme around our vision for future services to support the vulnerable and elderly. He further described how our proposed model of care might impact upon service reconfiguration which included the requirement to centralise stroke rehabilitation, reduce beds and potentially close community hospitals. Attendees were asked to provide input into the development of quality criteria which could be used to appraise whether or not our current services and existing community estate could deliver our model of care. Clinicians were asked to weight the quality criteria as high, medium or low priority. During this exercise it became clear that clinicians preferred to categorise the criteria as essential or desirable which was duly adopted. Clinicians were also invited to give comments by e-mail on the criteria, a number of responses were received.

- At the Clinical Council of Members meeting on the 16th of January one of the GPs who is based in a practice in Guisborough expressed concern that patients should be fully consulted about any potential closure of Guisborough Hospital. Dr Ali Thamassebi, the lead sponsor for IMProVE re-iterated the need to formally consult and outlined the proposed time-table for this. He stated that all of the community hospitals needed to be reviewed and options would be developed once the agreed criteria had been applied. He also offered Guisborough and other practices an opportunity to discuss this further at individual practice meetings. (EL10)

- At the meeting at James Cook Hospital on the 20th of January, 2014, information was well received with clinicians taking an active part in the round table discussions and giving valuable input into the quality criteria. (EL11)

- The stakeholder event held on 28th of January, 2014 was mostly attended by the public but also had a clinical presence. The details of this meeting are discussed in the next section

- An e-mail received from a GP in Middlesbrough (EL12) asked us to ensure that Consultant 7 day working be factored in to any reconfiguration along with potential workforce requirements. To address this, the CCG is currently working with strategic partners through
the Better Care Fund and South Tees Unit of Planning to develop plans around 7 day working and potential workforce requirements and has recently commenced work to develop a Primary Care Strategy.

**Stage 2 – Agreement on final quality criteria**

Following collation and analysis of all feedback on the quality criteria, meetings were set up with the GP locality Councils to further present the case for change and the consensus view on the quality criteria. An additional stakeholder event was also held in James Cook Hospital where again, GPs, hospital and community clinicians were invited to attend. (EL13)

- **Eston locality group (18th February 2014)** were in agreement that things needed to change if we were to manage our elderly population and comments were received around why things hadn’t changed sooner. The group expressed concern at the amount of money void space and maintenance of buildings was costing.
- **The Middlesbrough locality group (24th February, 2014)** similarly acknowledged the need for change and to do something different. One GP expressed concern around provision in Middlesbrough if Carter Bequest Hospital was to close and to ensure that the same level of service was offered to patients across South Tees. This is being addressed by ensuring that plans are South Tees wide rather than locality based.
- **In Langbaurgh locality group (20th February, 2014)** questions were raised around bed occupancy in Guisborough and the fact that GPs were often told that beds were not available and that is why GPs are not using them. A discussion ensued around how there were often problems with staffing and maintenance of the building. It was suggested that it would be good to explore the use of nursing homes for palliative patients. The IMProVE proposal advocates the need to invest in community teams, in particular ensuring that palliative care teams are able to deliver as much care in patient’s homes but future proposals would accommodate patients who wanted to die in a hospital setting. A couple of GPs re-iterated that the Rapid Response Service needs to improve and that often they were not able to use service as criteria states that the patient needs to be safe overnight. It was agreed that the IMProVE programme would explore the potential to commission night sitting services.
- **At the stakeholder event (27th February, 2014)** there was general consensus around the presentation of the agreed quality criteria.

**Stage 3 – Agreement on option for consultation**

Before agreeing the formal consultation option, all GP practices were given the opportunity to input and provide feedback: (EL14)

- An engagement event held on the 31st of March, 2014 (consultant and community clinicians were also invited to this meeting)
- A Clinical Council of Members held on the 10th of April, 2014
- E-mail exchange or through an individual practice meeting

**Engagement Event 31st March, 2014**

- Good support for plans with comments around why we were not doing this sooner with concerns around our ability to retain staff whilst we progress. One of the Guisborough GPs who had expressed concerns previously at the locality council, brought up the difficulty of knowing how many step-up beds were potentially required for Guisborough patients given difficulties with staff shortages and maintenance of buildings. Whist it was acknowledged that staff may move on during the transition process, there was recognition that it was
important to have community services in place before proceeding to reducing beds as had been highlighted by the public.

Clinical Council of Members 10th April, 2014

- Good support. No questions or reservations were received from the floor.

E mail exchange

Only one e mail was received from the practice located at Carter Bequest, stating their anxieties around what will happen to their practice in the future. They also asked for clarification around the need for x-ray equipment for stroke patients. This was duly actioned and consensus with clinicians reached that if we were to ensure patient’s received the best possible stroke pathway, x-ray equipment would be required for patients requiring naso-gastric tube insertion without the need for further transfer to another site.

Individual Practice Meetings facilitated by a governing body GP and a CCG manager

Five individual meetings were requested, some of which were attended by more than one practice.

- East Cleveland – Very supportive of plans and wanted to be involved in service development for East Cleveland Primary Care Hospital. There were comments around the closure of minor injuries units stating that this may cause some concern with their population, however, the GPs agreed that this was the right thing to do and that low activity rates meant that this service was unsustainable.
- Cambridge Road (attached to Carter Bequest Hospital) – Very supportive of model of care. They are working with the Area Team on the future of their practice.
- Woodlands Surgery – This practice supports South Tees NHS Foundation Trust in looking after transferred patients in Carters Bequest. Practice very in favour of plans.
- Hemlington, Park End and Skelton – Very supportive of proposals.
- Guisborough (Springwood and Garth) – GPs keen to still have access to palliative care beds and be involved in end of life care. Feel there is a requirement for intermediate care beds with some medical cover and we should perhaps explore nursing homes for this. The CCG will continue to involve GPs in taking forward the palliative care provision across East Cleveland.

The IMProVE programme continued to be supported through GP locality and clinical council of member meetings, encouraging practices to get involved and to input to the actual consultation and final decision making process. (EL15)

CCG Governing Body members also meet regularly with lead consultants from South Tees NHS Foundation Trust via a Chiefs of Service Meeting. The proposed option was discussed at this meeting on the 2nd of April, 2014. (EL16) Questions were raised about a phased approach and the length of time it would take to implement the proposals, it was felt that this might not be quick enough but it was explained that it was important to be reassured that the necessary community services were in place to support the whole of the programme. It was also felt important that we concentrate on rehabilitation as a whole and not just focus on patients who have had stroke. To reassure the group that this would happen, the IMProVE work programme will include development of an enhanced therapy strategy across health and social care. There was definite support for transferring more treatments and out-patients from James Cook into the community, especially in relation to cancer therapies. Rapid access to diagnostics was also raised and will be addressed as part of the development of an assessment hub.
In Summary

The redesigning of pathways and service model for IMProVE has been a priority for the CCG and its members for the last two years. Involvement in workstreams and communications and feedback on redesign of patient pathways, particularly through GP locality meetings, has provided opportunities for our GP members to shape and agree our future model of care, ensuring they were an integral part of commissioning plans.

Wider GP members have developed quality criteria alongside consultant colleagues in order to support the development of a proposal for service change which has been well considered in various meetings and suggestions for improvement taken into consideration as plans evolved.

There is recognition that it is not always possible to gain unanimous support from all member practices. However, overall, the consultation option has received substantial support from clinical members of the CCGs whose patients are affected by the changes, both in their capacity as commissioners and as providers of GP services. Only small ‘pockets’ of reservation has been received around our consultation proposal, particularly around the location of beds rather than the model of care. This reservation was mostly expressed by GPs in the Guisborough area.

Test 2 – Strengthened public and patient engagement

South Tees CCG is committed to involving local people in setting healthcare priorities and making decisions about healthcare services. We have developed a range of ways in which the public can get involved in the work of the CCG and really make a difference to the health of local people. These include:

- Our website, in particular ‘My NHS’ section where people can sign-up as a member in order to be kept up to date about health services locally and opportunities to get involved in decision making.
- Public Events – The CCG, despite being a relatively new organisation has held a number of public events to gain the views of our public on what it is important to them and to share our future plans.
- Public Consultation – Before we make major changes to health services, we gather feedback from the public through various engagement opportunities, including public events and questionnaires.
- Patient participation groups – Most GP practices now have their own practice participation group.
- Healthwatch provides a way for local people to communicate, challenge and shape the decisions of commissioners and service providers in health and social care.

In order to ensure we fully engaged with our public around the IMProVE agenda, we carried out a number of engagement activities.

Call to Action Event

NHS England’s ‘Call to Action’ Programme launched in 2013 invited the public and staff to join in a discussion about the future of the NHS so it can plan how best to deliver services, now and in the years ahead. Call for action focuses on a number of challenges but specifically an ageing population and a rise in the number of people with long term conditions. The CCG sought views around these national and local challenges in a number of ways but in particular it held a ‘Call to Action’ event on the 11th of December, 2013. At the event, each table was asked to consider the following question: “Older people account for the majority of health care contacts. The proportion and numbers of older
people will grow in the coming decades. What should the NHS do to support older people to live with a better quality of life and reduce the need for a stay in hospital?” (EL17) Responses from the event were used to shape our proposals for the IMProVE programme. A number of themes emerged:

- More care at home - more equipment available, 24/7 services
- Carers - More support, education and information
- Discharge – safe discharge process with early discharge step down care
- Better information - hospitals/ professionals to give better information – this would include letters of discharge and out patient’s appointments.
- Integration - There were comments about community projects and the need for practical support and to see more integration between groups.
- Mental health - There was a general call for the need to improve social isolation and loneliness. Palliative care - Concerns were expressed that dignity needs to be a fundamental part of services and Care for the Dying.
- Self-management – The need to facilitate self-management in the community
- More care and services in the community - from all of the health, local authority and voluntary sector.
- Stroke services – people who are discharged from these services need more support in the community once discharged.
- More use of voluntary sector organisations
- Redcar Primary Care Hospital – Concerns about under-use

IMProVE Pre-Engagement Consultation

We also carried out a formal pre-engagement consultation from the 23rd of September to the 22nd of November 2013 with the specific aim of engaging a range of stakeholders, services users, carers and providers and the general public in a discussion around our vision for services for the vulnerable and elderly prior to our formal consultation in April, 2014. This was carried out with our partner organisations including representatives of Middlesbrough and Redcar and Cleveland Council and South Tees NHS Foundation Trust who were involved in developing the consultation document and associated questionnaire.

Questionnaires were further supported by an in-depth survey of patients and their carers carried out by the independent voluntary organisation Carers Together, particularly targeting the elderly and vulnerable. Five public drop-in events across South Tees were also held as part of the consultation designed to offer interested individuals, stakeholders, service users and carers the opportunity to contribute their views and opinions. We received around 100 replies to questionnaires with limited attendance at the drop in events (around 30 attendances). However, the in-depth survey gave us a wealth of information with over 400 respondents. (Full report E18) There was positivity around current services but a number of key themes emerged with suggestions for improvement:

- Co-ordination of services – The need for better collaboration and co-ordination between health and social care and different services
- GP access – Sometimes poor access to appointments, continuity of care and more home visits
- Access to information – Consistency and the importance of carers and families understanding information
- Care closer to home - There was considerable support for the suggestion that more care should be provided in the home or in a community setting. Respondents felt that this could aid recovery, prolong independence and keep hospital beds free for the seriously ill.
However, many commented that for this vision to become a reality, community-based care would need to improve significantly.

- **Quality of community provision** - The quality and extent of community-based services was a recurring theme. Respondents identified a number of areas for improvement including more frequent and longer home visits from both health professionals and home care providers, more rapid assessment of need and access to services and equipment, more practical support in the home, and on-call support available on weekends and in the evenings. There were a number of comments about hospital discharges being delayed because of lack of provision.

- **Hospital beds** - There was some confusion about the difference between community and acute beds with a number commenting that beds were needed in case of a flu epidemic or major incident. Opinions differed on the impact of closing community beds with some reflecting that it would take pressure off the hospital system and others claiming it would increase demand for acute beds. Around half supported the idea of closing beds and providing greater care in the community. Amongst other things, respondents felt that this would aid recuperation and promote independence. Many qualified their support for the closure of beds with the need to improve community health and social care services first. Some questioned whether there was sufficient budget/staff to develop and improve community services in line with the CCG’s vision.

- **Physiotherapy and Occupational Therapy services** - There were a number of comments about the length of time taken for assessments/access to services. Some commented that this was impacting upon recovery and hospital discharge.

- **Dementia services** - The need for improvement in services was mentioned by a number of people. This ranged from better information for patients and their carers through to the extent of the services available locally.

The results of this pre-engagement report and future actions were discussed and debated at a stakeholder event held on the 29th of January, 2104. This event had representation from a number of voluntary sector organisations as well as members of local councils and clinicians. In total, 52 people attended. The aim of the meeting was to give feedback on the pre-engagement consultation, engage with them around future consultation and their views on what makes a good consultation and to gain their input into the development of quality criteria to be used to appraise the delivery of our proposed model of care. (EL19) Similar to the clinician meetings, those who attended were invited to add/amend the criteria and state what was absolutely essential and desirable. There was general agreement amongst the clinicians in the room and the public on what was desirable and what was essential. Of particular note was that access to estate within 30 minutes’ drive and adequate parking was felt to be a desirable rather than an essential factor. Comments and concerns raised around patients with dementia have been taken forward as part of 2014/15 commissioning intentions and our Better Care Fund Plans with investment into dementia workshops aimed at identifying and implementing areas for improvement. (EL20)

Issues, concerns and suggestions for improvement from the public were taken into account in the development of our new model of care and option for formal consultation option around service reconfiguration. Changes to stroke services, working with partners to improve discharge through the development of a Single Point of Access and the requirement to improve community provision, particularly therapies, are all evidenced in our proposed changes. We have also noted public concerns about ensuring we have the necessary community services in place before we reduce the bed base significantly and this is reflected in our plan to introduce changes in a phased approach. Other issues, such as the need to improve carers and dementia services form part of our joint health and social care ‘Better Care Fund’ plan. (EL21)
Patient Participation Groups

GP practices, as part of our IMProVE pre-engagement work were encouraged to use IMProVE as an agenda item on their patient participation groups and encourage their groups to complete a questionnaire. As part of the formal IMProVE consultation, a joint patient participation group met to discuss the IMProVE programme as part of the consultation process on the 4th of June (EL22). GPs led the groups and gave further clarification to questions.

Healthwatch Engagement

The CCG has actively engaged with Healthwatch around the redesign and commissioning of services which included IMProVE and urgent care. On the 27th of January, 2014 Healthwatch members from Redcar & Cleveland and Middlesbrough were invited to a consultation event around the CCG’s commissioning intentions. The event led by Healthwatch aimed to provide members with the opportunity to contribute to and influence the way in which health services are developed. 34 members of Healthwatch Middlesbrough and Healthwatch Redcar and Cleveland attended the event along with 4 members of staff from South Tees Clinical Commissioning Group who supported the event in order to answer questions and provide a wider context to the commissioning intentions. (EL23)

Healthwatch has also supported in the CCG in an on-going advisory/critical friend capacity throughout the IMProVE pre-engagement and formal consultation process. They are also represented on the IMProVE Advisory Group and also an IMProVE Process Reference Group as detailed below. They have provided valuable input to production of consultation documents and circulation of materials. At a meeting on the 12th of June, 2014, they also gave useful further mid-stage feedback on further engagement activities and how we could improve ‘consultation language’ to further aid understanding. (EL24). This was duly adopted in further public communications.

IMProVE Programme Reference Group

As part of development of the IMProVE option for consultation and progression through the process, the CCG set up an IMProVE reference group. The purpose of this small group, with representation from Healthwatch, the Voluntary Sector and the Acute Trust, was to act as a critical friend or advisor on our processes and engagement plans. (EL25)

Engagement with Strategic Partners

An essential element of the IMProVE programme is the collective understanding that if we are to improve the outcomes for the people of South Tees we need to work together as a health community, providing integrated services which are co-ordinated and meet the holistic needs of the individual. Therefore our long-established multi-agency group, (IMProVE Advisory Group) has met frequently over the last 18 months to take forward our integrated agenda. This has been further enhanced by the nationally driven development of plans to commission and promote joint health and social care commissioning known as the Better Care Fund. This system wide group acts as a supportive forum to ensure the delivery of safe and effective services and also provides oversight for monitoring the progress of the IMProVE formal consultation process. (EL4)

Throughout the development of the IMProVE pre-engagement and formal consultations, the CCG Chief Officer has frequently met with Chief Officers and Leaders from both Local Authorities, both Acute Trusts (South Tees Foundation Trust and Tees and Esk and Wear Valley Foundation Trust), Health and Wellbeing Boards and its sub-groups to appraise and seek views on our IMProVE programme. (EL26)
Engagement with local Members of Parliament (MPs)

As IMProVE plans evolved, the CCG chief officer and some of our executive GPs have met with local MPs to appraise them on our need for change and the results of public pre-engagement around the vision for IMProVE. (EL27)

Overview and Scrutiny Committee

As part of our statutory public sector duties, the CCG have worked with South Tees Joint Health Overview and Scrutiny Committee, around our public IMProVE pre-engagement consultation and progression to the formal IMPRoVE consultation which began on the 30\textsuperscript{th} of April, 2014. OSC have been invaluable with their advice and support around the process, particularly in suggesting ways in which we could better engage with the public. Their suggestions were built in to our communication and engagement plans, particularly with regard to engaging BME communities. The Chair of the Scrutiny meeting did comment that we had presented a ‘compelling case for change’ at our meeting on the 27\textsuperscript{th} of February, 2014 prior to our formal consultation process. In the same month the CCG presented the IMProVe programme to North Yorkshire Joint Scrutiny Committee OSC; they were satisfied that the consultation process would receive appropriate consideration and simply asked to be kept informed. (EL28)

Engagement with the Voluntary Sector

The CCG has endeavoured to involve voluntary sector organisations in future plans. As previously demonstrated they were involved in our pre-engagement work around IMProVE and clinical members of the CCG governing body have also engaged with voluntary groups to keep them abreast of plans. (EL29)

Formal Consultation

The NHS Act 2006 (as amended by the Health and Social Care Act 2012) places legal duties on CCGs to make arrangements to involve service users in the development and consideration of proposals for change in commissioning arrangements where this will impact on how services are delivered or the range of service that will be available. Following development and agreement of our proposal for service change, we developed robust communication and engagement plans in order to formally engage with our public.

These plans were further informed by learning from our previous IMProVE pre-engagement consultation, guidance from the Joint Overview and Scrutiny Committee, Healthwatch and our feedback from our stakeholder meeting held on the 29\textsuperscript{th} of January.

A formal equality impact assessment was carried out on the consultation process, resulting in a significant amount of effort to target some of the more vulnerable groups, eg older people’s groups, stroke groups and those ‘hard to reach’ groups, such as the BME community. The Foundation Trust made sure staff were engaged in the process by allowing opportunities for them to talk to our executive GP members. (EL30) A list of service user groups engaged as part of this programme is as follows:

- **30th May**  Step out for Stroke – partnership event with service users
- **6th June**  Lifestore Middlesbrough MELA – engagement with general public
- **13th June**  Lifestore Middlesbrough – partnership work to engage with the general public around IMProVE to capture their responses to the Q & document
- **16th June**  Aapna (BME Communities) Organisation – engagement of service users including those with physical and learning disabilities to ensure they fully understood IMProVE and to support them in capturing their responses to the Q & A document
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<tr>
<td>2nd July</td>
<td>Grangetown Library – Over 50’s club - Service User Event</td>
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<td>3rd July</td>
<td>Redcar Library – public engagement</td>
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<td>4th July</td>
<td>Lifestore Middlesbrough – James Cook Hospital public and staff engagement around IMProVE</td>
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<td>7th July</td>
<td>Positive about Stroke – Service User Event</td>
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<td>8th July</td>
<td>Central Library – public engagement</td>
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<td>9 &amp; 10 July</td>
<td>Action for Blind People/Teesside Blind Society – Service User Events</td>
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<td>11th July</td>
<td>Ormesby Library – Service User Event</td>
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<td>14th July</td>
<td>Dormanstown Library – public engagement</td>
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<td>15th July</td>
<td>Roseberry Library – service user event</td>
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<td>22nd July</td>
<td>James Cook Hospital – AGM public and staff engagement</td>
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<td>23rd July</td>
<td>Guisborough Library – Service User Event</td>
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The consultation was extensively promoted and included:

- Copies of the consultation were sent to Care Homes, Libraries, Pharmacies, Opticians, Dentists, GP Practices
- An Event Flyer was distributed in Eston, Brotton, Guisborough, Middlesbrough and Redcar and public venues and businesses within these areas.
- Website copy to promote engagement and monitoring usage
- Full ‘rolling’ advert schedule placed within the Evening Gazette
- CCG promotion columns, Dr Henry Waters, within Evening Gazette
- In-house mail-outs promoting events to stakeholders, NHS Trusts, Hospitals, Local Authorities and Key Advisory Groups
- Managing and promotion of online questionnaire via the web
- Social Media – promotion via Twitter & Facebook
- Carers Together distributed 1,000 questionnaires to service users
- Everyday Language Solutions distributed 500 questionnaires

National learning around the format of public meetings was applied i.e. flexible market-style drop-in events were held in accessible community venues in each locality. Each of the event held took place outside of normal working hours (5.30-7.00pm) to support the general public’s attendance. Events were facilitated by NHS clinicians and managers along with colleagues from the Local Authorities. This provided the public with an opportunity to find out more about our vision, learn about our future plans and engage with members of the CCG, GPs, LA and hospital clinicians. Dedicated discussion tables were hosted by the team so that the public could give their views and have their questions answered. All feedback was captured by scribes that were present at each event. The events were held in Eston (4th June), Brotton (11th June), Guisborough (18th June), Middlesbrough (2nd July) and Redcar (9th July). 176 people attended these events and provided us with valuable feedback.

Additional events aimed at Councillors took place in Middlesbrough on the 3rd June and in Redcar and Cleveland on the 18th of June. Personal invitations were issued to all councillors resulting in 4 attending the Redcar and Cleveland event at Community Heart and 6 attending the Middlesbrough event at the Town Hall Crypt. In addition a presentation was delivered to the Redcar and Cleveland Health Overview and Scrutiny Committee on Tuesday 1st July. At the committee member were able to provide comment and raise questions which the CCG and its partners answered. We sought guidance from Healthwatch on the development of materials and information to try and ensure messages were clear and straightforward, developing a video to support this further. A project group which met weekly was in place before, during and after the formal consultation which was overseen by the IMProVE Advisory Group. The purpose of this group was to ensure the programme was on ‘track’ and that any highlighted issues were acted upon quickly.
On the 30th of April, 2014 a formal 13 week public consultation was launched ‘Better care for the vulnerable and elderly in South Tees: a public consultation on proposed changes to community services’. The engagement plan and final consultation report is included within our evidence log.

**Test 3 – Clarity on the clinical evidence base**

The CCG has clearly set out its clinical case for change, aligning it to the best available evidence and ensuring it has considered improvements that could deliver further benefits for patients. This is clearly outlined in our Case for Change Document, 2014 and our Outline Business Case.

Overseen by clinicians within the CCG Executive, the IMProVE case for change has been developed by and shared with wider GP members and clinicians within South Tees Foundation Trust. We have ensured that front-line clinicians affected by the proposals have been fully engaged, evidenced previously in Test 1.

**Local Challenges & Local Strategies**

South Tees ranks higher than the England average for almost all disease prevalence and is a national outlier for the number of unplanned admissions. Locally GPs and hospital clinicians are concerned that intermediate care and support services in the community that help people to remain well, manage crises and recover from acute episodes is hugely variable. Compared to other peer populations, South Tees has a heavy reliance on hospital based services with high levels of emergency admissions. Older people stay in hospital longer and are likely to experience more delays in transfer of care with a subsequent higher risk of deterioration. Local audits have shown that patients in community hospitals no longer have a need to be in a hospital bed and could be supported at home or in the community. An intermediate care review, commissioned by the IMProVE Advisory Group which included interviews with local clinicians revealed; concern about the variation and support patients receive within intermediate care settings, variation in levels of therapy and community hospitals being used for hospital transfers rather than step-up. We also have high numbers of people admitted to residential care. According to the National Adult Social Care Intelligence Service 2011-12 in Redcar and Cleveland there are 24 per cent more admissions of people over the age of 65 to residential care than authorities with similar populations and 59 per cent more than the England average.

Stroke rehabilitation services and rehabilitation services in general are also a major concern for our South Tees population. GPs have expressed concern that patients do not receive the same level of rehabilitation in community hospitals as they do in an acute setting which can lead to poorer outcomes. NICE stroke rehabilitation guidance recommends an early supported discharge team in order to achieve better outcomes and lower levels of disability and The National Clinical Guidelines for Stroke (Royal College of Physicians, fourth edition, 2012), a dedicated stroke unit. One of the North of England’s Coronary Heart Disease Network’s priorities is to reduce unnecessary variation in models of care (www.nesnc.nhs.uk/networks/cardiovascular-network/). South Tees currently has no early supported discharge team and has in-patient stroke rehabilitation delivered from a number of different sites.

In 2013, there was a national review of emergency and urgent care in England. Sir Bruce Keogh managed this review alongside NHS England. The review suggested that current service provision is fragmented and confusing. Following the guidance and recommendations from this report, South Tees CCG reviewed its current urgent care provision in December 2013. Similar to Sir Bruce Keogh’s
report we found that services in South Tees are complex and difficult to navigate, with multiple points of access for patients. These access points are often confusing and care is duplicated across services. Listed below are the many points of access to urgent care, both in hours and out of hours that provide face to face contact with clinicians:

- Walk in Centres
- GP led Health Centres
- Minor injury Units
- A&E – Major Trauma centre
- General Practice
- GP out of Hours service
- District Nursing service.

Patients can also access urgent care services through a non-face to face contact to receive advice and signposting and when required, access to clinical services e.g. home visits or paramedics; these are:

- Out of Hours
- GP
- 999
- 111

These points of access are not exhaustive and are not integrated with social care. Importantly many patients visit or contact one point of contact only to be told they need to go somewhere else. For example, 12% of patients attending the Urgent Care Centre at Redcar or one of the Minor Injury Units at Brotton and Guisbrough are sent to A&E at James Cook University Hospital.

One of the impacts of having multiple access points is that urgent care services are provided by a range of providers with different costs and contractual frameworks that don’t always integrate with each other; this can cause confusion and the need to access alternative NHS resources as opposed to a one stop attendance.

Nationally there is a drive for patients to be seen in the right place at the right time. The Minor Injury facilities do not allow for this. Services are delivered by experienced Nurse Practitioners working within agreed protocols with restricted access to diagnostics. This in turn limits the type of conditions that can be seen and treated at the Units and can result in patients being seen then referred to other NHS providers causing a delay in treatment, multiple attendance and higher costs to the health economy. The training needs and professional development of practitioners within Minor Injury Units is imperative and is dependent upon the resources from centralised NHS services. The demand for continuous professional development to be delivered at multiple points causes pressure on centralised resources. Within a centralised service this can be managed more proactively by a multi-disciplinary team, maximising the training and development of all practitioners.

Below shows the current access to Walk in Centres and Minor Injury Units, as can be seen there are many services with significant variation in availability of diagnostic facilities and times of opening.
<table>
<thead>
<tr>
<th>Name</th>
<th>Eston Grange Walk in Centre</th>
<th>Langbaurgh Walk in Centre</th>
<th>Resolution Walk in Centre</th>
<th>East Cleveland Minor injuries Unit</th>
<th>Guisborough Minor injuries Unit</th>
<th>Redcar Minor injuries Unit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Operating times</td>
<td>8am-8pm 7days a week</td>
<td>8am-7pm Monday to Friday 1.15pm-5pm weekends</td>
<td>8am-8pm 7days a week</td>
<td>9-5 Monday to Friday 8am-8pm weekends</td>
<td>9-5 Monday to Friday 8am-8pm weekends</td>
<td>24/7</td>
</tr>
<tr>
<td>Services provided</td>
<td>Pharmacy Opening times: 9am-10pm Mon-Sat 9am-9pm Sun</td>
<td>Does not have access to x-ray/blood testing or pharmacy</td>
<td>Pharmacy: Opening times: 9am-10pm Mon-Sat 9am-9pm Sun</td>
<td>X-ray: Opening times: 9am-1pm Mon-Fri (Wed 9am-5pm) Blood test: In opening time (Bloods sent to James Cook)</td>
<td>Blood test: Opening times: 9am-5pm Mon-Fri (bloods sent to James Cook)</td>
<td>Pharmacy: Opening times: 8am-10pm Mon-Fri X-ray: Opening times: 9am-5pm Mon-Fri Blood test: Opening times: 24/7 (Blood goes to James Cook)</td>
</tr>
<tr>
<td>Footfall</td>
<td>Year 12/13 23,227 Average per day 63.6</td>
<td>Year 12/13 1,341 Average per day 3.7</td>
<td>Year 12/13 43,775 Average per day 119.9</td>
<td>Year 12/13 2,965 Average per day 8.1</td>
<td>Year 12/13 2,451 Average per day 6.7</td>
<td>Year 12/13 20,802 Average per day 57</td>
</tr>
</tbody>
</table>

Quotes from Local Clinicians

‘Many of my patients were transferred from James Cook University Hospital to a community hospital, not because they had further medical need but because there was not the appropriate care and support available within the community to support them in their own home. Patients want to be in hospital when this is clinically appropriate, but want to be home when they are well. We must make the changes which are already in place in many other parts of the country and support our patients in their own home as much as possible rather than move them from hospital bed to hospital bed.’ Dr Ali Tahmassebi, GP, Redcar & Cleveland.

‘I applaud and fully support the endeavour of the CCG to transform community services within the IMProVE programme service model. Central to this work is the provision of an improved coordinated Rehabilitation service in the community where the patient’s needs for that stage in their recovery of
function and independence are best met, and the unit has the appropriate skills and facilities to manage them. I firmly believe that a stronger Rehabilitation Service can only be a force for good in supporting the patient and their family and carers to achieve their maximum potential for recovery of function, and quality of life.’ Colonel Michael Stewart CBE, Clinical Director in Orthopaedics, South Tees NHS Trust.

‘It is imperative that we continually improve urgent care services, maintain clinical safety and make the best use of our nursing staff. If we merge the resources of the three minor injury units to create one urgent care service in Redcar, we would be able to provide a more comprehensive service for our patients 7 days a week. This would achieve a much improved service for those patients residing in Redcar and Cleveland, facilitate further training of clinical staff and support the development of Redcar Primary Care Hospital.’ Dr Mike Milner, GP, Redcar and Cleveland.

Our proposal for change is clearly linked to our local joint strategic needs assessment addressing key priority areas, cardiovascular disease (including stroke), cancer, smoking related illness such as chronic obstructive airways disease and of course health inequalities which are exacerbating the situation outlined above. Both local authority strategies advocate supporting people to maximise their independence, remain safe in their own home and be part of the local community for as long as possible.

Partners have worked with us to contribute to our case for change, recognising that effective strategic commissioning can drive transformation in health outcomes. A suite of key performance indicators have been developed and agreed with the Health and Wellbeing Board in order to measure the success of our planned initiatives on the whole system. These indicators are included within our Case for Change Document (appendix C).

National Evidence & Strategies

We have aligned our proposals to national policy and with relevant national guidance and quality standards. NHS England’s planning guidance, ‘Everyone counts: Planning for patients 2014/15 to 2018/19’ calls for CCGs, working with key partners to lead the development and implementation of a ‘modern’ integrated model of care. The announcement of Integrated Care Funding in July 2013, now known as the ‘Better Care Fund’ aims to assist this integrated transformation, with a single pooled budget to support health and social care services to work more closely together in local areas. The five year planning guidance advocates a number of key ambitions which include:

- Improving the health related quality of life of the 15 million+ people with one or more long-term condition, including mental health conditions
- Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital
- Increasing the number of people with mental and physical health conditions having a positive experience of care outside hospital, in general practice and in the community.

This guidance also asks commissioners to consider six characteristics of major service change:

- A completely new approach to ensuring that citizens are fully included in all aspects of service design and change and that patients are fully empowered in their own care.
- Wider primary care, provided at scale.
- A modern model of integrated care.
- Access to the highest quality urgent and emergency care.
- A step-change in the productivity of elective care.
- Specialised services concentrated in centres of excellence.
In November 2013 NHS England’s national medical director, Sir Bruce Keogh, published the first stage of his review of urgent and emergency care in England. This was developed after an extensive engagement exercise and it proposed a new blueprint for local services across the country that aims to make services more responsive and personal for patients, as well as deliver even better clinical outcomes and enhanced safety.

He said the current system is under ‘intense, growing and unsustainable pressure’. This is driven by rising demand from a population that is getting older, a confusing and inconsistent array of services outside hospital, and high public trust in the A&E brand. For those people with urgent but non-life threatening needs there must be highly responsive, effective and personalised services outside of hospital. We believe our urgent care strategy is aligned to national thinking with the proposed consolidation and development of urgent care centres.

Since the production of our ‘Case for Change’ document, other national reports advocating the need to better support older people have been produced; Kings Fund ‘Making our health and care systems fit for an ageing population’, Kings Fund, 2014 and Delottie Centre for Health Solutions, ‘Better care for frail older people: Working differently to improve care, both provide a further clinical evidence base for improving services for older people. A NHS England update report (August 2014) to the Bruce Keogh paper on Transforming urgent and emergency care in England further describes the need to provide highly responsive urgent care services outside of hospital so people no longer choose to queue in A&E. (EL35)

**Summary**

Our vision for improving the way we deliver care for our vulnerable and elderly with supportive community urgent care services is aligned to our local and national strategies.

Our vision responds to the need to improve the lives of those people living with a long term condition and indeed our programme has already taken steps to do this by introducing a risk stratification tool with the development of an integrated community care team to support more patients to self-manage. Our proposals recognise the need to adopt a more modern, integrated way of delivering care, enabling people to receive care and support in their own homes or in the community, reducing the amount of time people spend in hospital which could be avoided. We want to improve our step-up and step-down processes by introducing a community wide health and social care single point of contact to help facilitate this. The proposal to centralise stroke rehabilitation into a centre of excellence fits with national guidance and the introduction of a community stroke team will enable us to meet NICE standards for stroke rehabilitation. We also want patients to receive the highest quality urgent and emergency care and by relocating under-used minor injury centres to a centre with enhanced urgent care cover will fulfil that need. We recognise that by developing a more enhanced urgent care service in the community, more patients can be treated effectively outside of The James Cook University Hospital.

**Test 4 – Consistency with current and prospective patient choice**

The Department of Health 2014/15 Choice Framework [EL36] provides a guide on the choices people have for NHS care and treatment. There are two particular elements of the choice framework which are pertinent to the IMProVE change programme:

- which organisation you can go to for your first appointment as an outpatient for physical or mental health conditions
- services provided in the community
The NHS Constitution states: “If your GP refers you to see a consultant you may have a choice of a number of hospitals. You might want to choose a hospital that has better results for your treatment, or one near your place of work.” This will not change with our new proposals. In fact it is expected that with plans to deliver more out-patient clinics and diagnostic services out in the community, the choice of localities available to patients will increase.

The Choice Framework states that choice of community services will depend upon where people live and will depend on what local clinical commissioning groups, GP practices and patients think are priorities for the community. It describes community services as services such as physical therapy, physiotherapy; adult hearing assessment services; psychological therapies, such as, counselling; or podiatry services. The person responsible for offering that choice is the GP or health professional who referred you to the service. Under our new proposals it is expected that choice of services such as rehabilitation therapies, day treatments, diagnostics and out-patients available in the community will increase.

Currently patients discharged to community hospitals are not guaranteed a choice of hospital site as beds are allocated on a clinical needs basis. This is in line with legal requirements. This arrangement will continue under new proposals with a focus on clinical need but with choice of site where capacity allows.

Changes to minor injuries units will mean that patients will have less choice of where they might attend across the South Tees community but they will have access to improved minor injury services. The proposed enhancement of services in Redcar, increasing diagnostic capacity and increasing the skills of staff working in those units, will hopefully improve the patient experience and potential outcome, enabling a broader range of conditions to be treated in minor injury units without the need for transfer to the A & E department at The James Cook University Hospital.

It should be noted that the NHS Constitution also points out that it is important that patients are involved in decisions about their treatment and are given information to help choose the right treatment. This will still be available to patients under the new arrangements.

It is also important to consider whether our IMProVE proposals also meet national regulations around choice and competition. The Principles and Rules of Cooperation and Competition (PRCC) issued by the Department of Health, form part of the NHS Operating Framework in establishing the system rules governing cooperation and competition in the commissioning and provision of NHS services in England. (EL37) It cites 10 principles for co-operation and competition:

1. Commissioners must commission services from the providers who are best placed to deliver the needs of their patients and populations.
2. Commissioning and procurement must be transparent and non-discriminatory and follow the Procurement Guide issued in July 2010.
3. Payment regimes and financial intervention in the system must be transparent and fair.
4. Commissioners and providers must cooperate to improve services and deliver seamless and sustainable care to patients.
5. Commissioners and providers should promote patient choice, including – where appropriate – choice of any willing provider, and ensure that patients have accurate and reliable information to exercise more choice and control over their healthcare.
6. Commissioners and providers should not reach agreements which restrict commissioner or patient choice against patients’ and taxpayers’ interests.
7. Providers must not refuse to accept services or to supply essential services to commissioners where this restricts commissioner or patient choice against patients’ and taxpayers’ interests.
8. Commissioners and providers must not discriminate unduly between patients and must promote equality.

9. Appropriate promotional activity is encouraged as long as it remains consistent with patients’ best interests and the brand and reputation of the NHS.

10. Mergers, including vertical integration, between providers are permissible when there remains sufficient choice and competition or where they are otherwise in patients’ and taxpayers’ interests, for example because they will deliver significant improvements in the quality of care.

It is important to state that our IMProVE proposals do not include any change to existing providers. We believe that we are currently commissioning services from providers who are best placed to deliver the needs of their patients and populations. We work collaboratively with our providers in order to try and deliver seamless and sustainable care to patients and are assured of their quality and their adherence to the patient choice agenda.

Commissioners are being encouraged to drive much more integrated care for patients and therefore there will be more emphasis on the future need for more collaboration amongst providers (Choice and Competition Delivering Real Choice: A report from the NHS Future Forum, 2011). We can therefore foresee that in the future we could potentially encourage collaboration amongst providers when it is in the best interests of patients, however, this will always be done in a transparent way, adhering to procurement regulations. Our model advocates the need to provide more home-based services and therefore there may be opportunities to increase choice through multiple providers, again this would be driven by what is in the best interests of our population and in accordance with procurement guidance.
<table>
<thead>
<tr>
<th>Item</th>
<th>Document</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Test 1 – Documents demonstrating engagement with CCG commissioners</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>EL1</strong></td>
<td>Terms of Reference for System Resilience Group</td>
<td>Demonstrates how wider stakeholders are now involved in the development of the urgent care strategy</td>
</tr>
<tr>
<td><strong>EL2</strong></td>
<td>South Tees CCG Clear &amp; Credible Plan</td>
<td>Demonstrates strategic direction for urgent care and delivering care closer to home</td>
</tr>
<tr>
<td><strong>EL3</strong></td>
<td>Urgent Care Strategy (Latest Draft)</td>
<td>Demonstrates development of the urgent care strategy and future direction of travel</td>
</tr>
<tr>
<td><strong>EL4</strong></td>
<td>Terms of Reference for IMProVE Advisory Group List of meeting dates Minutes of meetings</td>
<td>Demonstrates roles, remit, responsibilities and partnership working around the IMProVE project</td>
</tr>
<tr>
<td><strong>EL5</strong></td>
<td>Care of the Frail Elderly Person Event – July 2013 Themes and Goals from Event</td>
<td>Demonstrates partnership working in examining best practice and new models of care</td>
</tr>
<tr>
<td><strong>EL6</strong></td>
<td>Notes of Executive meetings &amp; Governing Body meetings relevant to IMProVE Programme</td>
<td>Demonstrates how the CCG Exec and Governing Body led the IMProVE Programme and the fact that this was a regular agenda item.</td>
</tr>
<tr>
<td><strong>EL7</strong></td>
<td>Notes from clinical council meetings and individual practice meetings IMProVE Workstream Action Notes</td>
<td>Demonstrates discussion around the IMProVE programme/workstream at Clinical Council and individual practice meetings.</td>
</tr>
<tr>
<td><strong>EL8</strong></td>
<td>Notes from Clinical Professional Forum – 30th January, 2014</td>
<td>Demonstrates wider clinical discussion</td>
</tr>
<tr>
<td><strong>EL9</strong></td>
<td>Attendance list for:  - CCG’s Council of Members meeting on the 16th of January, 2014.  - Stakeholder Event at James Cook Hospital on 20th January, 2014  - Stakeholder Event at Riverside Stadium on the 28th January, 2014</td>
<td>Demonstrates good attendance at meetings to discuss the development of future service development and configuration</td>
</tr>
<tr>
<td><strong>EL10</strong></td>
<td>Notes &amp; Presentation from Clinical Council of Members meeting on the 16th of January</td>
<td>Demonstrates how clinicians were asked to be involved in the development of quality criteria to</td>
</tr>
<tr>
<td>EL11</td>
<td>Email correspondence</td>
<td>inform a future option for service configuration</td>
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<tr>
<td>Notes &amp; Presentation from the Stakeholder Event at James Cook Hospital on the 20th of January, 2014</td>
<td>Demonstrates wider engagement with Consultants, GPs and Lead Community Staff</td>
<td></td>
</tr>
<tr>
<td>EL12</td>
<td>Locality group notes and presentations from:</td>
<td>Demonstrates how clinicians received more information around the case for change and the finalised quality criteria</td>
</tr>
<tr>
<td>- Eston - 13th February 2014</td>
<td></td>
<td></td>
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<tr>
<td>- Middlesbrough – 13th February, 2014</td>
<td></td>
<td></td>
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<tr>
<td>- Langbaurgh - 20th February, 2014</td>
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<tr>
<td>EL13</td>
<td>Notes and presentation from:</td>
<td>Demonstrates how clinicians were asked for their input and support for the proposed option and any comments received</td>
</tr>
<tr>
<td>Engagement event held on the 31st of March</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical Council of Members -10 April 2014</td>
<td></td>
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<tr>
<td>E-mail exchange</td>
<td></td>
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<tr>
<td>Individual practice meeting</td>
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<tr>
<td>EL14</td>
<td>GP locality notes during and after consultation period:</td>
<td>Demonstrates continued involvement of clinicians in the consultation and decision making process</td>
</tr>
<tr>
<td>- Eston – 1st May, 11 Sep, 2014</td>
<td></td>
<td></td>
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<tr>
<td>- Middlesbrough – 8th May, 11 Sep, 2014</td>
<td></td>
<td></td>
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<tr>
<td>- Langbaurgh 15th May, 11 Sep, 2014</td>
<td></td>
<td></td>
</tr>
<tr>
<td>EL15</td>
<td>Chiefs of Service Meeting 2nd April, 2014</td>
<td>Demonstrates commitment from GPs and consultants with regard to option and further ideas for improvement</td>
</tr>
<tr>
<td>EL16</td>
<td>Urgent Care Workstream minutes</td>
<td></td>
</tr>
</tbody>
</table>

**Test 2 – Documents demonstrating strengthened engagement with public and patients**

<table>
<thead>
<tr>
<th>EL17</th>
<th>Report of Call to Action Event held on the 11th December, 2013</th>
<th>Demonstrates engagement with the public around the national and local NHS agenda – in particular questions around our vulnerable and elderly populations.</th>
</tr>
</thead>
<tbody>
<tr>
<td>EL18</td>
<td>Report on pre-engagement consultation for IMProVE</td>
<td>Demonstrates engagement with the public on the IMProVE agenda illustrating support, key themes and concerns</td>
</tr>
<tr>
<td>EL19</td>
<td>Report from 29th January, 2014 stakeholder event &amp; Slides</td>
<td>Demonstrates feedback from the pre-engagement consultation – you said, we did, input on future</td>
</tr>
<tr>
<td>EL20</td>
<td>14/15 commissioning intentions (dementia collaborative Better Care Fund Plans)</td>
<td>Demonstrates CCGs commitment to improving Carers and Dementia services</td>
</tr>
<tr>
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</tr>
<tr>
<td>EL21</td>
<td>Patient Participating Group Redcar and Cleveland 4th June, 2014.</td>
<td>Demonstrates engagement with GP participating groups</td>
</tr>
<tr>
<td>EL22</td>
<td>Notes from Healthwatch meeting held on the 27th January, 2014</td>
<td>Demonstrates engagement with the public around commissioning intentions – includes IMProVE and urgent care</td>
</tr>
<tr>
<td>EL23</td>
<td>Notes from Healthwatch meeting on IMProVE consultation 12th June, 2014</td>
<td>Demonstrates positive feedback and advice around further improvements to consultation process</td>
</tr>
<tr>
<td>EL24</td>
<td>Notes from IMProVE Reference Group</td>
<td>Demonstrates wider engagement around the process for developing an option for consultation</td>
</tr>
<tr>
<td>EL25</td>
<td>List of meetings with Chief Officers Notes/presentations from relevant Health and Wellbeing Boards/Executives/Partnerships</td>
<td>Demonstrates involvement with strategic partners in the development of vision, model and option for consultation</td>
</tr>
<tr>
<td>EL26</td>
<td>List of meeting dates with MPs Letters to MPs</td>
<td>Demonstrates engagement with members of parliament</td>
</tr>
<tr>
<td>EL27</td>
<td>OSC Minutes for IMProVE</td>
<td>Demonstrates our legal duty to engage with local authority health scrutiny bodies and how we have actively sought their advice.</td>
</tr>
<tr>
<td>EL28</td>
<td>Presentation to Middlesbrough Voluntary Agency on IMProVE</td>
<td>Demonstrates engagement and awareness of plans with voluntary sector</td>
</tr>
<tr>
<td>EL29</td>
<td>List of Dates when CCG engaged with staff - minutes</td>
<td>Demonstrates communication and engagement staff activities as part of the formal consultation</td>
</tr>
<tr>
<td>EL30</td>
<td>Communications Engagement Plan</td>
<td>Demonstrates good communication and engagement with relevant stakeholders as part of the formal consultation process</td>
</tr>
<tr>
<td><strong>Test 3 – Documents demonstrating how the clinical evidence base has informed the programme and been tested by clinicians</strong></td>
<td></td>
<td></td>
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<tr>
<td>---</td>
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</tr>
</tbody>
</table>
| **EL31** | IMProVE Case for Change  
IMProVE Outline Business Case | Demonstrates consideration of clinical evidence for change |
| **EL32** | Medworxx Study | Demonstrates percentage of patients in community beds without a health need |
| **EL33** | South Tees Intermediate Care Review | Demonstrates clinical concerns about levels of therapy in community hospitals |
| **EL34** | Minor Injuries Case for Change | Demonstrates low activity levels for minor injuries |

<table>
<thead>
<tr>
<th><strong>Test 4 – Documents demonstrating consideration of patient choice</strong></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>EL36</strong></td>
<td>Department of Health 2014/15 Choice Framework</td>
<td>Demonstrates latest guidance around choice</td>
</tr>
<tr>
<td><strong>EL37</strong></td>
<td>Department of Health – Principles and Rules of Co-operation and Competition</td>
<td>Demonstrates latest guidance around competition and co-operation.</td>
</tr>
</tbody>
</table>
RESPONSE TO THE IMPROVE PROGRAMME PROPOSALS

PURPOSE OF THE REPORT

1. To present the South Tees Health Scrutiny Joint Committee’s response to the consultation in relation to the IMProVE proposals.

METHODS OF INVESTIGATION

2. Members of the Joint Committee met formally between 12 August 2013 and 17 September 2014 to discuss/receive evidence relating to these proposals and a detailed record of the topics discussed at those meetings are available from the Middlesbrough Council website.

3. A brief summary of the methods of investigation is outlined below:

   (a) Detailed presentations by senior officers and members of the Governing Body from the South Tees Clinical Commissioning Group (CCG) supplemented by verbal evidence.

   (b) Round table discussion with a wide range of organisations including Redcar and Cleveland Council, Middlesbrough Council, NHS England, Healthwatch, local MPs.

4. The report has been compiled on the basis of their evidence and other background information listed at the end of the report.

MEMBERSHIP OF THE JOINT COMMITTEE

5. The membership of the Joint Committee is as detailed below:

   2013/14 – Middlesbrough - Councillors E Dryden (Chair), Councillor L Junier, (Vice-Chair), Biswas, Cole and Mrs H Pearson, Redcar & Cleveland - W Wall (Vice Chair), Ayre, Goddard, Thomson and Wilson
6. 2014/15 – Redcar - Councillors Wall (Chair), Goddard (Vice Chair), Jeffries, Halton and Lanigan, Middlesbrough Councillors Dryden (Vice Chair), Biswas, Junier, Pearson and J Walker

SETTING THE SCENE

8. NHS bodies or providers of NHS health services have a legal duty to consult about the way that the NHS is operating and about any proposed substantial developments or variations (or changes) in the provision of the health service in the area. Any ‘substantial’ variations or changes to NHS provision should be subject to formal consultation. Where a proposed substantial change covers more than one local authority area, legislation requires that the respective local authorities appoint a joint health scrutiny committee. In these instances, it is only the joint committee that will respond to the consultation; exercise the power to require information to be provided about the proposal and exercise the power to require members/employees of the relevant body to attend before it to answer questions in connection with the consultation.

9. As the proposals covered facilities within Middlesbrough and Redcar & Cleveland Council the matter was dealt with through the South Tees Health Scrutiny Joint Committee.

BACKGROUND INFORMATION

10. The Joint Committee began in August 2013 by receiving a briefing paper which outlined the pre-consultation process as part of the IMProve programme and the Communications Plan that had been developed. Members had the opportunity to consider the plan and the questionnaire that had been designed and they made a number of comments as to the wording in the questionnaire and some suggestions for groups/organisations that the CCG may want to include in the consultation.

11. The Joint Committee was informed about the proposals for how the CCG would engage with the public, it involved disseminating information to a wide range of agencies and public events would be held in numerous locations around the South Tees area.

12. It was recognised by Members at an early stage that the opportunities being pursued, which included providing care outside of hospital in the community/GP practices and people’s homes, were likely to result in changes to the way community hospital beds were used.

13. On 27 January 2014, members of the Joint Committee received the results of the Carers Together survey which had received 400 responses from the public. There was considerable support for care closer to home to assist with the patient’s recovery process and prolong independence, as long as there was confidence that appropriate good quality community based care services were in place.

14. On 27 February the Joint Committee received an update on the proposed formal consultation process.
15. In April, the Joint Committee was presented with the draft case for change, proposals for change were being put forward when the formal consultation started on 30 April and which would run until 31 July.

16. At the meeting on 22 July, Members were presented with the Case for Change, which, in brief, outlined how 49% of patients in community beds did not have a medical need and would have been better supported by other services. That 33% of patients in an acute bed did not have an acute need. There were system wide financial pressures that needed to be addressed. The population is getting older, South Tees ranks as higher than the England average for almost all disease prevalence, both Local Authorities have higher admissions to residential care, an increasing number of unplanned admissions and a quarter of emergency admissions are from people aged 75 or over.

17. The information at that meeting also outlined the model of care, the clinical review, the estate review, the workforce review, the accessibility travel plan and the phased approach. The phased approach would involve putting new services in place and testing them before moving existing services, making step by step decisions about the changes that are being made and the impact they have on patients and that the introduction of these changes will happen over the next 2 years with all services in place by April 2016.

18. The Joint Committee was given a list of the community development work and re-investment that would take place between April 2014 and March 2016. Which would include, amongst other things, implementing the Community Stroke (Early Support Discharge) team, carrying out a resource review of therapy/capacity and demand, working with local authorities on reablement services, expansion of rapid response services, developing a Single Point of Access and Assessment Hub across the whole of the South Tees community and review current out-patient resource

19. At the meeting on 17 September 2014 the South Tees CCG outlined the responses they had received during the consultation process.

VIEWS ON THE COMMUNICATION/CONSULTATION PROCESS

20. Members were pleased to find that a large variety of communication/consultation mechanisms had been implemented as part of the process, including public meetings, road show events across Middlesbrough and Redcar and Cleveland. Other mediums had also been used to raise awareness and encourage participation in the process. The Joint Committee welcomed the opportunity to be involved in the early development of the consultation proposals.

21. The Joint Committee had made a number of suggestions about ensuring work was undertaken in order to reach the elderly, the housebound and people with long term conditions.

22. The Joint Committee heard that the consultation process had been independently verified and a mid-stage review had been undertaken by Healthwatch. Healthwatch had confirmed that throughout the consultation with their networks they had not received any negative comments or any major concerns from the public.
23. In general the Joint Committee was supportive of the consultation process that had been undertaken by the CCG. Members had the opportunity to contribute to the questionnaire and suggest people/organisations the CCG should include in their consultation.

24. Details of the proposals were outlined in the consultation document, however there was a concern that if someone had not read the proposals document thoroughly or went straight to the questionnaire, it was thought that people would tend to agree with some of the questions, for example the question ‘Do you think we should centralise stroke rehabilitation services in a single specialist unit in line with best practice?’ people could answer yes without realising that would mean that they would now have to travel to Redcar.

25. Dave Walsh, representing Tom Blenkinsop MP, made a number of comments regarding the consultation and the proposals which included, amongst others, the following:

- Concern about the consultation process, for example some people in the Brotton area had received details very close to the end of the consultation period. It was noted that the questionnaire could have been seen as leading people in to certain responses and that the implications of the proposals weren’t as explicit as they could have been.

- Concerns about re-provision of service through GPs when practices like Skelton walk in centre and Park End have closed and other practices like those in North Ormesby and Hemlington are being reviewed.

- Variable public transport between Guisborough, East Cleveland and Redcar

- No formal consultation with the Royal College of Nursing, Local Medical Council and unions.

26. The CCG agreed to take note of the above comments and work through them separately.

RESPONSE TO THE CONSULTATION

27. The Joint Committee heard that 586 survey responses had been analysed, 24 direction observations had been taken from events and responses had been noted from key stakeholders. Information from the consultation had ‘chimed’ with the results of the pre-consultation. The results were largely positive and where a mixed response had been received respondents had been mainly concerned about transport, waiting times and capacity.

28. The Joint Committee noted the consultation feedback which indicated that the significant majority of those responding to the consultation were in support of the proposals.

Transport
29. Transport was highlighted as an issue where people who had responded to the consultation had some concerns. When asked about whether community beds should be provided in 2 locations within the South Tees Area 15% of people were concerned about travel issues. 31% of people had concerns about travel and transport when asked about the proposal to provide a more comprehensive minor injury service in a single location (i.e. Redcar Primary Care Hospital). In discussing the proposed closure of the Minor Injuries Unit in Brotton there was a concern that people would not be able to access alternative services using public transport. The Joint Committee heard that there was no bus service to Redcar from the Guisborough area after 6pm. The CCG confirmed that they were taking this issue on board. There was a concern amongst the Joint Committee that people would then present to James Cook University Hospital (JCUH) however the clinical view presented at the meeting outlined that the bed base in Brotton Hospital will stay, services and diagnostic facilities would increase and that patients from Redcar/East Cleveland would go to Redcar Primary Care Hospital and not JCUH.

30. Members discussed the patient transport service that is available, it was noted by the CCG that the service was seen as a model for the North East, although members of the Joint Committee, with experience of the service, believed that the criteria for a person to qualify to access the service was too long, the process of a person having to answer a lengthy set of questions prior to being accepted for the service was too bureaucratic and this led to people being deterred from using the service.

31. Ian Swales MP called for a radical look at public transport, this was echoed by the Joint Committee who wanted to ensure that any changes would involve consideration as to how people who did not have their own transport could access the different services. It was noted that Redcar Primary Care Hospital could be a difficult place to get to even for people in Redcar area.

**Bringing Care Closer to Home**

32. It was noted that 96% of people agreed with the aim of improving prevention and delivering more care in the community. However, with regard to bringing care closer to home, people who completed the survey were concerned about the robustness of care plans, and people wanted reassurance that social care and health care services would be effectively joined up and that there would be the right level of trained professionals able to provide the service. The Joint Committee was reassured by the CCG that beds would not be removed until the CCG could demonstrate that the services were in place in order to cope with the changes.

**Financial Viability**

33. The Joint Committee was also concerned that the plans were financially viable. Whilst agreeing with the view that it was preferable that £2m was not used to fund void spaces in hospitals, and that it would be more effectively used for funding services in the community, Members stated that the right community services needed to be in the right place in place before any bed numbers were reduced.

34. The Joint Committee also welcomed the proposed community development and re-investment which would take place between April 2014 and March 2016 which included the recruitment of additional staff and ongoing appropriate training of current staff.
35. However there were concerns amongst Members that that there could be a ‘chicken and egg’ situation, in that facilities couldn’t be closed until new and improved community facilities were in place, but there was a concern that those facilities couldn’t be put in place until money was saved from the rationalisation of the buildings.

36. In discussing the issues above the CCG gave assurances that no community beds would be removed until the right community services were in place. The CCG had also told the committee (in the meeting on 22 July) that changes will be made in a phased way, putting new services in place and testing them before moving existing services, making step by step decisions about the changes that are being made and the impact that they have on patients and their health before continuing to the next step. Proposals will be introduced over the next two years with all services in place by April 2016. The committee were given a brief timetable for when the changes would take place which was as follows

| Development of community services which focus on improving pathways of care and discharge processes. Implement a community stroke team, increase reablement, rapid response and therapy services. Implement a single point of access and implement an assessment hub | April 14 – March 16 |
| Centralise stroke rehabilitation services to one specialist unit (Redcar Primary Care Hospital) Closure of Carter Bequest Hospital and re-provision of services within the community. Consolidation and enhancement of Minor Injuries services onto one single site (Redcar Primary Care Hospital) | By April 2015 |
| Redevelopment of Guisborough Primary Care Hospital (Chaloner Building) to provide increased range of community based services, closure of community bed base in Guisborough. | April 2015 – March 2016 |

37. The committee will be following the development of the proposals closely and will expect to receive periodic updates on its implementation.

The Right Thing for People in Redcar and Cleveland and Middlesbrough

38. Whilst the Joint Committee was broadly supportive of the improvements to community services, Members had questions about how the proposals would work in practice. Members agreed that the aspirations behind the proposals were good. Where Members felt that they needed more discussion and clarification was about whether the changes were in the best interests of the public. Members explored this issue in further detail with the clinicians present at the meeting in order to get beneath the detail on how the proposals would make improvements. The clinicians outlined how the proposals would improve services from a clinical perspective. For example, Members heard that prevention was a key factor, with regard to chronic conditions there was a need to prevent admissions and if people did have to go in to hospital it was important to ensure that they were discharged with adequate support at the right time and to ensure that people can maintain their independence in their own homes.

39. For patients with Chronic Obstructive Pulmonary Disease (COPD) Members heard that it is in the best interests of the patient to get them home with the right support in place
for them. They learnt of an initiative where community matrons have been put in place which had received excellent patient feedback.

40. In further exploring why these proposed changes were the best for people in the South Tees area it was outlined to the Joint Committee that the clinical view was that this was the best way forward. For example, stroke services were not currently meeting best practice. As Members had heard previously there were areas that needed to be improved in line with that best practice. The South Tees lagged behind other areas in the support that was offered to people to enable them to return home quickly, which aided a speedier recovery. The Stroke services that would be re-provided away from Carter Bequest and in Redcar Primary Care Hospital would be ‘second to none’. They will meet national best practice and ultimately provide better outcomes, better intervention and deliver a service that people presently do not receive. Members heard that a community stroke team was already being developed for people in the South Tees area.

41. The consultation document outlines brief proposals of how the CCG will meet national best practice guidelines by centralising all stroke rehabilitation and supporting services, e.g. physiotherapy, occupational therapy and dietetics at Redcar Primary Care Hospital. This will include 12 dedicated beds for stroke rehabilitation. The committee will have a keen interest in seeing how those services will develop.

42. There was a concern that the proposals had been developed as a ‘basket’ of measures designed to sustain Redcar Primary Care Hospital (a PFI Initiative). Whilst the CCG did not rebuff this suggestion, they explained that they had inherited the community hospitals and along with that the 35 year PFI lease. Ultimately the proposals were about quality, accessibility and affordability. The model of care that was developed had been the driver for change along with clinicians coming together with acute colleagues to develop the best model of care.

Staffing
43. The Joint Committee heard that an external workforce review had been established to ensure that there is suitable training and development provided to support staff in working differently. Members also had concerns about what would happen to staff as a result of any reconfiguration. The CCG acknowledged the concerns about plans for staff currently stationed at community hospitals.

RECOMMENDATIONS
44. The Joint Committee were broadly supportive of the proposals on the basis of the clinical improvements that will take place and the improvements to community services, however, have agreed that the following recommendations be made to the CCG.

45. Transport – The Joint Committee were very concerned about how people without access to a car and people on low incomes would be able to access services. Therefore Members would like to know what the CCG will propose to ensure accessibility is fair and equal for all. The committee are particularly interested in what plans will be put in place to help people in areas where car ownership is low and people have limited or low incomes. The Joint Committee understood that such an issue is not for the CCG to solve alone, although the CCG should take every opportunity to influence public transport design to ensure routes are planned which take in to account the predicted patient flows.
46. The system for accessing patient transport should be made easier and straightforward and that eligible people’s details are held by patient transport so that they don’t have to answer all of the questions each time they contact the service.

47. Referring to previous scrutiny reviews of Stroke Services, the Joint Committee welcomed the improvements to standards that the changes (as outlined in paragraph 40) to Stroke Rehabilitation would bring for patients – Members however, wanted a guarantee that the CCG would work with both Councils to ensure that the community stroke provision provides a sufficient level of support and care and ensure that services are in place before closing community beds currently provided for stroke rehabilitation.

48. Evidence of investment – The Joint Committee received information, at their meeting on 22 July 2014, about the examples of community development and reinvestment which will take place between April 2014 and March 2016. However Members would like to see specific evidence of how savings have been redistributed in order to provide the best community services for people across the South Tees area.

49. That the Joint Committee welcomed the opportunity to be involved in future stages which would involve regular updates to Members any implementation of the phased approach. Therefore the South Tees CCG are invited to future meetings of the Joint Committee on a regular basis in order to update Members on the implementation of the proposals.

COUNCILLOR WENDY WALL
CHAIR OF THE SOUTH TEES HEALTH SCRUTINY JOINT COMMITTEE

Date: 26 September 2014

Contact: Elise Pout, Scrutiny Support Officer, Telephone: 01642 728302 (direct line)

BACKGROUND PAPERS

The following background papers were consulted or referred to in the preparation of this report:
(a) Report on the outcome of IMPoVE Public Consultation – September 2014 – North of England Commissioning Support
(b) IMPoVE – A public consultation on proposed changes to community services May-July 2014
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<td>Implement community stroke (early supported discharge) team</td>
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<td>Present therapy capacity and demand outcomes to CCG to inform financial plan</td>
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<td>Recruit therapy staff</td>
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<td>Pilot and evaluate Redcar residential intermediate care / reablement service</td>
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<td>Implementation of a new social care model (reablement) in Middlesbrough</td>
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<td>Audit community hospital transfers</td>
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<td>Present results of audit to IMProVE advisory group and agree action plan</td>
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<td>Implement proposed actions from audit including revised community transfer pathway</td>
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<td>Monitor key performance indicators</td>
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<td>Further expansion and development of rapid response services across Middlesbrough and Redcar including commissioning of night sitting service (BCF)</td>
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<td>Implement SPA (phase 1)</td>
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<td>Review current outpatient capacity in existing estate</td>
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## Implementation Plan - IMProVe

### Appendix 4

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<th>Task</th>
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<tr>
<td>Develop plan to support increased outpatient and diagnostic provision in the community</td>
<td>South Tees Trust</td>
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<td>Market test redevelopment of void space in East Cleveland hospital</td>
<td>NHS Property Services</td>
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<td>Centralise stroke rehabilitation beds into Redcar</td>
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<td>Co-ordinate movement of services from Carter Bequet Hospital</td>
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<td>Develop and implement plan for disposal of Carter Bequest Hospital</td>
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<td>Close Carter Bequest Hospital</td>
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<td>Consolidate MIU into Redcar hospital</td>
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<td>Agree a public campaign to raise awareness around eligibility for the Patient Transport Service</td>
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<td>Develop a public communications plan to support understanding of what is urgent care and how to access services</td>
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<td>Pilot weekend district nursing service within East Cleveland</td>
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<td>Establish a group with stakeholders to explore the potential to influence travel plans</td>
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<td>Co-ordinate movement of services from Guisborough Hospital</td>
<td>South Tees CCG</td>
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<td>Partial disposal and redevelopment of community estate (Guisborough)</td>
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<td>Partial closure of Guisborough Primary Care Hospital</td>
<td>NHS Property Services</td>
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DH Healthcheck

Version number: Final Issued

Date of issue to SRO: 4th September 2014

SRO: Amanda Hume

Organisation: NHS South Tees Clinical Commissioning Group

DH Healthcheck dates: 21st to 22nd August 2014

Healthcheck Team Leader: Stephanie Finch

Healthcheck Team Members: Gerald Clemence and Aileen Moss
Background

The driving force for the Programme:
The intention is to transform community services with a focus on the integration of services across primary, community, acute and social care, moving away from a more traditional acute hospital-based model. The proposed changes are specifically aimed at older and vulnerable adults with one or more long term conditions. Currently, services are reactive and result in many older and vulnerable patients spending too much time in hospital when they do not need to. Emergency hospital admissions are significantly higher than the national average. It is believed this could be reduced if the right support was available in the community to help people when their health deteriorates.

Community hospitals are being used mainly as step down facilities rather than step up. The average length of stay for step down patients is 28 days. Almost half of the patients do not need to be in a hospital bed but were there mainly due to insufficient community based health and social care services.

In addition, with the right community services, fewer people would also need to go into residential care. In 2011-12, in Redcar and Cleveland there were 24 per cent more admissions of people over the age of 65 to residential care than authorities with similar populations and 59 per cent more than the England average.

The aims of the Programme

The model of care is based on the principles of “right care, right place, at the right time”, with the overall aim being to provide care as close to home as possible, wherever this can be done safely and cost effectively. Importantly, the vision is to move away from the reactive care model to one which is more proactive and responsive in delivering a range of interventions aimed at preventing deterioration in a person’s condition and an avoidable hospital admission.

The proposals aim to achieve a truly integrated model of care which spans the entire spectrum of health and social care, 24/7, to provide the most appropriate levels of support whenever and wherever service users require it. Commissioners aim to move towards providing services which are co-located, making best use of the estate, to make it easier for service users to access them, with an emphasis on prevention of disease and the promotion of healthy living. This is in line with the national vision for the integration and transformation of health and social care.

The procurement/delivery status:
At this stage of the Programme, no procurement is envisaged.

Current position regarding Health Gateway Reviews:
There have been no previous Gateway Reviews
**Purposes of a DH Healthcheck**
The purpose of a Healthcheck is to provide early and informal advice on the progress made by a programme before the use of full Gateway Reviews, as part of an ongoing external assurance process.

**Conduct of the Healthcheck**
This Health Gateway Review was carried out from 21st to 22nd August 2014 at South Tees CCG, North Ormesby Health Village, First Floor, 11 Trinity Mews, North Ormesby, Middlesbrough TS3 6AL. The team members are listed on the front cover.

The people interviewed are listed in Appendix B.

The Review Team would like to thank the IMProVE Programme Team for their support and openness, which contributed to the Review Team’s understanding of the Programme and the outcome of this Healthcheck.
Summary of Findings

The Consultation to date appears to be robust and thorough. There has been extensive pre-engagement and a wide range of consultation activities, with evidence of learning and iteration along the way. The messages overall are clear and coherent. The Review Team did not identify any problems with the process. A continuing communications process co-ordinated across all partner agencies will be required during the implementation phase to explain the decision, communicate progress and maintain support.

The CCG chose to develop an Outline Business Case (OBC). In its response, NHS England has asked for more detail to be developed covering implementation plans and workforce and financial implications. The CCG has assumed this will need to be submitted as part of a Full Business Case (FBC). The Review Team questions whether this is necessary. The CCG needs to clarify with NHS England whether it should focus on developing these specific plans, without completing an FBC.

Stakeholders interviewed were all supportive of the proposals and stated that most of the wider stakeholder groups are similarly in agreement. We were told the only significant opposition has come via a petition against a number of NHS changes/perceived cuts, only one of which was within the scope of the Programme.

The importance of strengthening the articulation of the clinical case for change at the Joint OSC was noted.

The process to arrive at a decision in October is being designed currently. The Consultation Report should be presented to the CCG Governing Body (CCGGB) alongside a covering report and recommendations which address any potential issues. This may include a set of criteria for decision-making and explain the broader implications of any amendments. Deferring or removing elements will not be without consequences and the Board should have clear information on what these might be, including any impact on other strategies and the sustainability of services.

Attention has understandably focussed so far on the consultation and the delivery of the decision making process, rather than developing a detailed Implementation Plan. This is partly to avoid accusations that the decision has already been made, but once this is, implementation will begin to what is considered to be a tight timescale. The Review Team believes it would be helpful to start developing a possible Implementation Plan now.

A number of organisations across the health and social care system will be key deliverers of the required changes and careful co-ordination and oversight should be established. The CCG and its partners will need to consider how all these changes will be managed across South Tees.

There is no Programme risk register, although there is evidence that risks have been considered. For the next phase, risks should be managed more formally, based on a detailed risk register. Similarly the Review Team believes that a Benefits Realisation Plan which identifies the desired benefits, measures, improvement targets and benefit owners will be an important tool in driving further change.
Findings and Recommendations

Progress to date

Consultation process

The IMProVE Programme is a key service transformation initiative for the South Tees area. The CCG has been working collaboratively with key partners in health and social care over the past two years to develop new ways of working that will bring health benefits to local people.

During this period the CCG has made significant efforts to involve patients, the public and representative bodies in ensuring that the new integrated health and social care models are appropriate and in the best interests of patients. It was clear to the Review Team that the CCG had used the information gained from this pre-consultation period to inform the preferred option outlined in the Consultation Document.

The public consultation period closed on 31st July 2014 and the consultation report is now being produced for the CCG. The Review Team was impressed with the determination that the CCG showed to ensure that the consultation involved as many stakeholders as possible and that the process was in line with the guidance provided by NHS England and legal advice.

Although some of the interviewees were concerned about the possibility of an IRP referral or judicial challenge, the Review Team felt that the consultation process undertaken by the CCG was of a very high standard and had minimised any grounds for challenge.

Business case and stakeholders

Business Case

The Review Team was shown the OBC, which had been presented to the local Area Team of NHS England, as required as part of its service change assurance role. We were shown the response from NHS England which confirmed that it was satisfied that the clinical quality and patient experience benefits are clear, that the Programme is in line with the urgent and primary care strategy and that there is wide-ranging clinical sign-up to the proposals. It identified three areas where it would like to see further details once implementation planning has commenced in earnest and these are:

- Workforce plan;
- Financial plan;
- Implementation plan.
It will also sign off the document on the evidence of compliance with the Four Tests, currently in draft form.

The CCG has assumed that an FBC is required by NHS England although the CCG does not have the internal capacity to develop this and will have to commission this externally. The Review Team questions whether an FBC is necessary for a series of changes which, although complex, were outlined fully in the OBC and will form part of the CCG’s commissioning role. It may be a better use of resources for the CCG to focus effort on developing the implementation plans, the workforce and financial implications, and the Four Tests, without the extra work required for an FBC.

**Recommendation**

Clarify with NHS England its expectations for additional information and whether an FBC is necessary.

**Stakeholders**

Although the Review Team was only able to speak to a limited range of stakeholders, it is clear from those interviews, and from the documentation provided, that this Programme is well supported. Whilst it is recognised that the proposed new ways of working will have some potentially unpopular consequences, including the closure of two Minor Injuries Units (MIU), we heard that the implementation of the new clinical models will deliver greater benefits across the whole health economy.

The public engagement and communications work undertaken by the CCG, including the details of the clinical benefits, has helped to underpin this level of support. It will be important to ensure that this level of engagement, with the public as well as key statutory partners, is maintained during the implementation phase of the Programme.

**Preparation for decision-making**

The Programme Team is now engaged in designing and preparing documentation to enable the CCG Governing Body (CCGGB) to take a decision on the outcomes of consultation. A timetable of activities and meetings has already been shared with the CCGGB and we have been reassured that members understand and support the outline process to be undertaken. This includes meetings with Health and Wellbeing Boards, Joint Overview and Scrutiny (JOSC) Board, IMProVE Advisory and Reference Groups, CCG Locality Groups, Chief Officers and Executive Teams.

Decision-making is currently scheduled for the CCGGB’s meeting on 8 October although we understand this may be deferred to 15 October to give the JOSC additional time to respond on the outcomes of the consultation process.

The Programme Team has been determined to observe the principle of objectivity in reflecting these outcomes and has consequently commissioned an independent
analysis of the Consultation responses. Equally to maintain objectivity, the Programme Team has not specifically defined the nature or content of the analysis report it requires.

Whilst the principle of objective analysis is understandable, it is important that the Programme Team and SRO’s requirements are clear not only on the factual analyses of responses, both in quantitative terms, but also the key themes emerging.

Also it is important that in order to assist the CCGGB in making a decision, an interpretation and overview of responses is also presented, together with a rationale for recommended action and underpinned by a clearly defined decision-making framework. The Programme and Executive Teams need to be explicit about exactly what, from the range of data/analyses available to them, will enable the CCGGB to come to an informed and defensible decision and how this should be presented. They also need to be clear about the framework for interpretation.

We believe it would help the CCGGB to come to a decision if this interpretation, overview and framework reflect on issues, such as:-

- Reinforcement and support for the initial principles and objectives underpinning the case for change;
- A clear framework of criteria and weighting of consultation responses;
- Analysis and description of modifications to the CCG’s strategic direction developed in response to pre-consultation processes;
- The potential implications and interdependencies for this programme of change and other programmes;
- The sustainability of existing NHS providers if the proposal set out in the Consultation Document and questionnaire is varied or modified in content or timescale;
- Proposed delivery of benefits in the short and medium term;
- Consistency with national policies and responding to the requirements of NHS England.

This overview should not detract from the greater level of detailed data available to the CCGGB, but create a clear and focussed context to enable decision-making to take place.

We understand that a creditable level of responses from interest groups and individuals was generated through the pre-consultation and formal consultation processes. In addition, we were told that a petition, with 1759 signatures, is due to be received. We understand the petition is opposed to a range of what are seen as cuts in health service provision in East Cleveland, only one of which is covered in the consultation.
It was not clear to the Review Team how this petition, which was outside the formal process, responds to or addresses the consultation proposals and how it should be interpreted. It is important that the SRO and Programme Team determine how the petition informs or detracts from the formal and rigorous consultation that has been undertaken.

**Recommendation:**
Review the format for the consultation report and interpretation, together with a process and criteria to facilitate informed decision-making by the CCG.

As indicated above, in preparation for the CCGGB’s decision-making, the Programme Team intends to present an initial consultation report to the JOSC, in order to have feedback to inform the CCGGB in October. It was unclear to us whether the JOSC has authority to object formally or challenge the consultation proposals or whether this authority lies with the two individual OSCs. We understand that the SRO has asked for clarification on this issue.

It is recognised that, despite general support and improved integrated working at officer level, there may be concerns amongst some elected members of the JOSC about the local impact of some the proposed changes. It will be important to clearly articulate the clinical benefits of the proposed changes and how any concerns will be mitigated.

In the context of both aiding the CCGGB’s ultimate decision-making and addressing known OSC concerns, it is important for the Programme Team and wider CCG staff to continue to work proactively with elected members and Local Authority officers. The Programme Team needs to determine the information and proposed response to the issues that have been raised that it intends to share with the JOSC (and other groups) to assist them in informing the CCGGB’s decision on the consultation process.

**Readiness for Next Phase**
Attention has understandably focussed so far on the consultation and the delivery of the decision making process. We have heard some wariness about developing too much detail on implementation ahead of the decision, in case the impression is given that the decision has already been made. However, once the decision is made in October 2014, implementation will begin to what is considered to be a tight timescale.

Programme delivery will be complicated by the need for the CCG, the Local Authorities, the Acute and Community Trust, the Mental Health Trust and NHS Property Services to work together to deliver a range of changes in a timely fashion.
There is also considerable overlap between the Programme and the changes proposed for the Better Care Fund and the emergent Urgent Care Strategy.

The CCG has appointed a Head of Programmes (due to commence in mid September). NHS Property Services has bid for a project management post to lead on delivery of the Programme.

The organisation and governance of the Programme in the implementation phase will require careful thought and planning in order to ensure that the resources are effectively brought together and managed. In addition, the CCG will be managing a number of similar programmes in the future that will need to be effectively aligned in both governance and programme management terms.

**Recommendation**

**Review and agree the governance and resourcing requirements of the Programme across all partner agencies during the implementation phase.**

**Risk and benefits management**

It was made clear to the Review Team that whilst there is a broad understanding of the risks associated specifically with the process of consultation and wider implementation of the IMPROVE Programme, there is no formal programme risk management process. There is a CCG risk register which we understand covers some of this Programme’s risks.

On the assumption of the proposed service changes going forward, in part or in totality, it is important that a formal programme risk and issues process is instituted that is clearly aligned with the organisation’s overall approach.

This will facilitate the recognition of programme risks, reconciling them with other change programmes across the wider health and social care system, and the identification of critical interdependencies.

**Recommendation**

**Develop a Programme Risk Register aligned to the CCG’s risk management approach.**

Work has started in relation to benefits realisation planning and delivery. There is an acknowledgement that this is still high level and there is significant further work to do to shape this process. The Programme Team is setting this further work within the context of NHS Outcomes Framework.
It is important to ensure that the early “wins” from the proposed service reconfigurations are delivered (e.g. delivery of estate utilisation standards and efficiencies). In addition, that the desire of the general public for the principles of more care delivered closer to home, in line with national policy imperatives, needs to be achieved throughout the whole care system. The Programme Team should start to define its expectations for benefits realisation in the short and medium-term to initiate wider debate across partner organisations.

Recommendation

Develop a Programme Benefits Realisation Plan.

The first Health Gateway Review is expected in late November or early December 2014 to review implementation plans.
## APPENDIX A

### Interviewees

<table>
<thead>
<tr>
<th>Name</th>
<th>Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Julie Stevens</td>
<td>Programme/Project Manager, Commissioning &amp; Delivery Manager for the CCG</td>
</tr>
<tr>
<td>Simon Gregory</td>
<td>Chief Finance Officer, South Tees CCG</td>
</tr>
<tr>
<td>Toni McHale</td>
<td>Participation Co-ordinator, Healthwatch</td>
</tr>
<tr>
<td>Craig Blair</td>
<td>Deputy SRO and Associate Director of Commissioning, Delivery and Operations</td>
</tr>
<tr>
<td>Susan Watson</td>
<td>Chief Operating Officer, South Tees Hospitals NHS Foundation Trust</td>
</tr>
<tr>
<td>Jill Simpson</td>
<td>Clinical Strategy, NHS England</td>
</tr>
<tr>
<td>Paul Parsons</td>
<td>Locality Communications &amp; Engagement Manager</td>
</tr>
<tr>
<td>Janet Evans</td>
<td>Partnership Lead, People Services, Redcar and Cleveland Borough Council</td>
</tr>
<tr>
<td>Janet Walker</td>
<td>GP and CCG Board Member</td>
</tr>
<tr>
<td>Amanda Hume</td>
<td>Senior Responsible Owner and Chief Officer of South Tees CCG</td>
</tr>
</tbody>
</table>
Equality Analysis Toolkit
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Step 3: Responsibility, Development, Aims and Purpose 4
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Step 11: Sign off 9
**Step 1 - Document Ownership**

<table>
<thead>
<tr>
<th>Name of document being analysed</th>
<th>Integrated Management and Proactive Care for the Vulnerable Elderly (IMProVE) - Pre Consultation phase</th>
</tr>
</thead>
<tbody>
<tr>
<td>Person completing analysis</td>
<td>Nicola Jones/Beth Ellett/Julie Stevens</td>
</tr>
<tr>
<td>Date of analysis</td>
<td>March 2014 - April 2016</td>
</tr>
<tr>
<td>Function Area</td>
<td>Reference</td>
</tr>
<tr>
<td>Is the document</td>
<td>Proposal of new service or pathway</td>
</tr>
<tr>
<td></td>
<td>Proposal for service transformation to implement newly designed model of care/Potential closure of community hospitals</td>
</tr>
<tr>
<td>Reference</td>
<td>YES</td>
</tr>
<tr>
<td></td>
<td>YES</td>
</tr>
</tbody>
</table>

**Step 2 - Establishing Relevance**

**Public Sector Equality Duties**

To ensure compliance with the Equality Act 2010, all strategies or policies, proposals for a new service or pathway, or changes to an existing service or pathway, should be assessed for their relevance to equality – for patients, the public, and for staff. The general equality duty requires that when exercising its functions that the NHS has due regard to the need to:

- Eliminate unlawful discrimination, harassment, victimisation and any other conduct prohibited by the Act;
- Advance equality of opportunity between people who share a protected characteristic and those who do not;
- Foster good relations between people who share a protected characteristic and those who do not.

**Protected Characteristics**

You need to analyse the effect on equality for all protected characteristics – namely: Age, Disability, Sex, Race, Gender reassignment, Sexual Orientation, Religion and Belief; Pregnancy and Maternity, Marriage and Civil Partnership. Please also consider other groups who are currently outside the scope of the Act, but who may have a significant relationship with NHS services (for example Carers, homeless people, travelling communities, sex-workers and migrant groups).

With reference to the Public Sector Equality Duties and the Protected Characteristics, is an Equality Analysis required? YES

Please summarise your conclusion if an equality analysis is not required:
If you have concluded that the document is relevant please continue with your equality analysis below; otherwise please send this part only to the Equality and Diversity Team together with a copy of your document.

**Step 3 - Responsibility, Development, Aims and Purpose**

| Who holds overall responsibility for the policy/strategy/service redesign etc.? | Amanda Hume - Chief Officer/Craig Blair - Head of Commissioning and Delivery |
| Who else has been involved in the development? | Local Authority Colleagues NHS South Tees Foundation Trust Patients and Public North of England Commissioning Support Unit (NECS) Area Team Communication and Engagement (NECS) Voluntary Services |

**Purpose and aims:** (briefly describe the overall purpose and aims of the service – for a new service – describe the rationale and need for the proposal, referring to evidence sources. For a change in service or pathway – specify exactly what will change and the rationale/evidence, including which CCG/NECS priority this will contribute to):

The number of people who are elderly, vulnerable and living with a long term condition in the South Tees locality is increasing. The aim of this project is to transform the current model of care to be delivered to this cohort of people and ensure that efficiencies within services contribute to financial sustainability and quality of care for South Tees CCG and the localities it serves. Many vulnerable patients end up in hospital. It is well recognised that with the appropriate health and social care support, many could have remained independent within their own homes.

There is a proposal to embed significant service transformation over a number of years, with full benefit realisation in April 2016. There will be four phases incorporated into this service change and this can be identified within (Equality Impact Appendix 1) which also highlights the community hospital sites where the proposed model of care will be functional. This Equality Impact Assessment will be an evolving document and will have several iterations between March 2014 and April 2016.

The newly devised model of care will allow patients to access care closer to home and concentrate on rehabilitation, centralisation of stroke services, expansion of outpatient services and an assessment hub within the community.

This project will also allow both services and estates to be reinvested within during March 2014 and April 2016.

The proposed model of care will ultimately allow nursing and therapy personnel to be
reconfigured to ensure they are fully utilised and offer optimal care to those patients accessing the model to be delivered. This change in clinical care will be of benefit to those patients entering this pathway. This will not only promote safety but will enhance the quality of care implemented to the patients of South Tees' localities.

There is intelligence to support that the current community hospitals are not fully utilised due to numerous reasons, inclusive of staffing issues. Therefore South Tees' CCG recognise that in conjunction with their changes to clinical models of care, there was a need to review the estate holistically.

Workforce modelling and bed modelling has been completed to ensure that the proposals are fit for purpose and that there will be no detrimental effects upon patient care within this locality. Estate and transport analysis has also been completed to ensure a holistic view can be obtained whilst in the pre-consultation phase.

**Who is intended to benefit from the implementation of this piece of work?**

South Tees comprises of two local authorities Middlesbrough Borough Council and Redcar and Cleveland Borough Council) and one Clinical Commissioning Group serving a population of approximately 273,742 (138,744 in Middlesbrough and 134,998 in Redcar and Cleveland).

Life expectancy is significantly lower than the national average and the gap is even more significant for those aged over 75.

IMProVE will benefit the frail, elderly and vulnerable patients throughout South Tees. However, a number of service changes which will be implemented as part of this policy will also benefit younger patients who may be living with a long term health condition.

There is the potential that a negative impact will be perceived within the Middlesbrough locality due to the cessation of services within Carters Bequest; however there will be a positive impact upon East Cleveland and Redcar. In addition to this, there will be reinvestment within services at Guisborough which will have a positive impact.

**What are the key outcomes/ benefits for the groups identified above?**

- Increase in patients who are able to remain independent and within their own homes due to the model of care to be implemented.

- Enhanced services providing improved provision of nursing and rehabilitation support in people’s homes and in the community, in particular for those people who have suffered a stroke.

- Improved access to services – providing 7 day working when appropriate.

- Co-ordinated care - Health and social care personnel
| Does it meet any statutory requirements, outcomes or targets? | This equality analysis has considered South Tees CCG’s equality objectives to ensure that any risks associated with breaching equality and employment legislation are mitigated. It also supports South Tees CCG’s requirement in meetings to its duties and legal requirements in regards to equality duties (Equality Act 2010) and its responsibility on, duty to consult the public, Section 242(1B) of the National Health Service Act 2006. This equality analysis and overall project will also take into consideration consultation guidance particularly around European and UK election processes, Safeguarding of vulnerable people, Procurement rules, Information governance and Data protection |
| Does it contribute to the Equality Delivery System Goals? (specify goals and related outcomes)* | **Equality Outcome 1** Work with key stakeholders to improve the safety and quality of commissioned services across Middlesbrough and Redcar and Cleveland **Equality Outcome 2** Ensure all patients and carers can be involved and that patient experience is captured and acted upon to inform service change and delivery where possible |

*Equality Delivery System goals are fully explained in the Equality analysis guidance notes*

**Step 4 - Protected Characteristics – analysis of impact**

Please provide analysis of both the positive and negative impacts of the proposal against each of the protected characteristics providing details on the evidence (both qualitative and quantitative) used. If the work is targeted towards a particular group(s) – provide justification e.g. women only services. Any gaps in evidence should be accounted for and included in your Action Plan.

**Age**

**Impact and evidence:**

Integrated Management and Proactive Care for the Vulnerable and Elderly (IMProVE)- due to the nature of the project will positively impact on all age ranges who are deemed vulnerable but more specifically at older frail people within the South Tees locality who access health and social care. However, the model of care will also impact upon younger patients should their clinical need dictate this.
Whilst, the health of people in Tees is generally improving, it is still worse than the England average. Historically, our local area has been highly dependent on heavy industry for employment which has left a legacy of industrial illness and long term conditions. This, coupled with a more recent history of high unemployment as the traditional industries have declined, has led to significant levels of deprivation and health inequalities that rank amongst the highest in the country.

Within South Tees itself there are inequalities with regard to life expectancy, access to services and deprivation. The inequalities in life expectancy are evident in the most disadvantaged areas of Middlesbrough, where men can expect to live 14.8 years and women 11.3 years less than people in the least disadvantaged areas.

The map below shows the levels of deprivation within the area covered by our CCG, based on the Index of Multiple Deprivation 2010 (IMD2010), which shows that a significant proportion of our population live in the most disadvantaged areas:
The total population of South Tees is 273,742 of which 48,689 are over the age of 65. This and the projected increase in the population are set out in the table below:

<table>
<thead>
<tr>
<th>Authority</th>
<th>Mid-2012 population estimate Number</th>
<th>No. (%) aged 65 +</th>
<th>No. (%) aged 85 +</th>
<th>2021 population projection Number</th>
<th>% aged 65 +</th>
<th>% aged 85 +</th>
</tr>
</thead>
<tbody>
<tr>
<td>Middlesbrough</td>
<td>138,744</td>
<td>21,293 (15.35%)</td>
<td>2,591 (1.87%)</td>
<td>144,275</td>
<td>24,997 (17.33%)</td>
<td>3,911 (2.71%)</td>
</tr>
<tr>
<td>Redcar &amp; Cleveland</td>
<td>134,998</td>
<td>27,396 (20.29%)</td>
<td>3,259 (2.41%)</td>
<td>135,466</td>
<td>31,782 (23.46%)</td>
<td>4,540 (3.35%)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>273,742</strong></td>
<td><strong>48,689 (17.7%)</strong></td>
<td><strong>5,850 (2.1%)</strong></td>
<td><strong>279,741</strong></td>
<td><strong>56,779 (20.2%)</strong></td>
<td><strong>8,451 (3.2%)</strong></td>
</tr>
</tbody>
</table>

Source: ONS mid-2012 population estimates and interim mid-2011 based population projection

This predicted increase in the number of retired people living in the area will have a major impact on health and care services.

In 2012/13 from the total number of James Cook University Hospital (JCUH) unplanned admissions, just over 43 per cent were over 61 years of age. The age split is as follows:

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-17</td>
<td>8638</td>
</tr>
<tr>
<td>18-30</td>
<td>7297</td>
</tr>
<tr>
<td>31-40</td>
<td>5194</td>
</tr>
<tr>
<td>41-60</td>
<td>13638</td>
</tr>
<tr>
<td>61-80</td>
<td>19407</td>
</tr>
<tr>
<td>81-100</td>
<td>6971</td>
</tr>
<tr>
<td>100+</td>
<td>18</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>61163</strong></td>
</tr>
</tbody>
</table>

Older people generally have greater health needs than young people, especially with regards to long term conditions so they tend to access health services more as they age. This is already having an impact on primary care (e.g. GPs), hospital services and social care. Too many of our elderly and vulnerable residents ultimately end up in hospital, which could have been avoided with appropriate community services being available.

Rates of non-elective admissions experienced across the locality are among the highest in the country and are growing. This growth, coupled with demographic factors is a real challenge in terms of our collective ability to plan the future health and social care requirements of our population.

Hospital admission is not always required for patients. For many people who are frail, elderly or have long-term conditions, a community or home-based service is more appropriate. Improving and enhancing the range and type of healthcare available close to home can help people to live independently for longer.

The demand for social care services, costs and expectations are rising and are predicted to continue to do so, at a time when the funding is decreasing. To continue to try to meet
service demand in the current way will have a significant impact on the sustainability of local authorities who will not be able to meet the needs of those requiring social care services. Local Authorities will also need to redirect resources for other universal services.

Traditionally there is a local culture of dependency on health and public services and a tendency that people usually seek support when they are in crisis. This adds additional pressure on the most costly acute services. This is further exacerbated by the lifestyle choices of many people.

The newly designed model of care and the potential to reconfigure community hospitals within the South Tees localities can only have a positive impact upon patients. There will be increased use of appropriate services to ensure optimal care for patients, in addition to improved utilisation of hospital sites, ultimately impacting upon financial sustainability. There has been analysis completed pertaining to transport to ensure all people have access to potential sites identified for the model of care to be implemented within.

**Disability**

**Impact and evidence:** Consider and detail impact and evidence on disability (this includes physical, sensory, learning, long-term conditions and mental health) and if any reasonable adjustments may be required to avoid a disabled patient, or member of staff, from being disadvantaged by the proposal.

The graph below, although taken from 2011, shows that long term health and disability problems are greater in our area than the rest of the North East and nationally.

![Long-term health problem or disability aged 65 and above, Middlesbrough and Redcar & Cleveland, 2011](image)

Patients aged 75+ have a disproportionate impact on acute hospitals: although only a quarter of patients with emergency admissions at James Cook University Hospital are aged 75 or over, these patients account for the majority of emergency bed days:
<table>
<thead>
<tr>
<th></th>
<th>0-74</th>
<th>75+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Patients</td>
<td>18,093</td>
<td>6,044</td>
</tr>
<tr>
<td>Number of Spells</td>
<td>25,480</td>
<td>9,867</td>
</tr>
<tr>
<td>Total Length of Stay</td>
<td>69,966</td>
<td>86,713</td>
</tr>
</tbody>
</table>

Numbers of deaths from COPD increase with age, as the lungs become more obstructed over time. In the UK, deaths from COPD are very low in the age range 0-40 (less than 500 per year) but much higher in the 75+ age range for both males and females (about 20,000 per year).

COPD is the second most common cause of emergency admission to hospital and one of the most costly inpatient conditions to be treated by the NHS. There are around 835,000 people currently diagnosed with COPD in the UK and an estimated 2,200,000 people with COPD who remain undiagnosed, which is equivalent to 13% of the population of England aged 35 and over. In South Tees the prevalence of COPD is much higher than the England average with 2.6% of the Tees population (2010/11) diagnosed with COPD.

Therefore a new model of care is imperative to supporting the older patient in remaining closer to home with promotion of independence as far as possible.

The project will not have any negative consequences for people with a disability. NHS South Tees CCG are a Two Tick disability award holder and would reflect the same equality standards when assessing potential community hospital sites to implement the model of care devised.

Any patient with a disability will have an individual care package appropriate to their required needs and this will be implemented accordingly.

All areas where the model of care is to be functional will be DDA assessed to ensure all of the defined requirements are met.

**Sex**

**Impact and evidence:** Consider and detail impact and evidence on both males and females

No restrictions on gender in relation to those who can access the model of care to be implemented.

**Race**

**Impact and evidence:** Consider and detail impact and evidence on ethnic groups

There are no foreseen negative consequences for people accessing the model of care or community hospital sites.

The wider IMProVE project will be reviewing all relevant data which will take into consideration equality analysis requirements such as the admissions data by ethnicity.

**Religion or Belief**
<table>
<thead>
<tr>
<th><strong>Impact and evidence:</strong></th>
<th>Consider and detail impact and evidence on people of different religions, beliefs (and those who may have no religion)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>There are no foreseen negative consequences for people accessing the model or community hospital sites. All patients regardless of race will have equitable services offered to them. In addition, any patients requiring specific needs, for example prayer rooms, this will be considered for every phase of the service transformation between March 2014 and April 2016.</td>
</tr>
</tbody>
</table>

**Sexual Orientation**

<table>
<thead>
<tr>
<th><strong>Impact and evidence:</strong></th>
<th>Consider and detail impact and evidence on people of different sexual orientations</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>There are no foreseen negative consequences for people accessing the model of care or community hospital sites.</td>
</tr>
</tbody>
</table>

**Gender Reassignment/Transgender**

<table>
<thead>
<tr>
<th><strong>Impact and evidence:</strong></th>
<th>Consider and detail impact and evidence on transgender people</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>There are no foreseen negative consequences for people accessing the model of care or community hospital sites.</td>
</tr>
</tbody>
</table>

**Pregnancy and Maternity**

<table>
<thead>
<tr>
<th><strong>Impact and evidence:</strong></th>
<th>Consider and detail impact and evidence on work arrangements, breastfeeding etc.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>There are no foreseen negative consequences for people accessing the model of care or community hospital sites. Specific needs will be addressed to ensure that the community hospital sites provide the required working arrangements for staffing, but more importantly address any patient needs.</td>
</tr>
</tbody>
</table>

**Marriage and Civil Partnership**

<table>
<thead>
<tr>
<th><strong>Impact and evidence:</strong></th>
<th>Consider and detail impact and evidence on employees who are married or in a civil partnership</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>There are no foreseen negative consequences for people accessing the model of care or potential community hospital sites.</td>
</tr>
</tbody>
</table>

**Other Excluded Groups/Multiple and social deprivation**

<table>
<thead>
<tr>
<th><strong>Impact and evidence:</strong></th>
<th>Consider and detail impact and evidence on groups that do not readily fall under the protected characteristics such as carers, transient communities, ex-offenders, asylum seekers, sex-workers, homeless people.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>All patients accessing the model of care and the potential hospital sites will be treated with respect and equitably</td>
</tr>
</tbody>
</table>
Public Sector Equality Duty (PSED)

Please provide detail on how the proposal contributes to:

- Eliminating unlawful discrimination, harassment and victimisation;
- Advancing equality of opportunity between people who share a protected characteristic and those who do not;
- Fostering good relations between people who share a protected characteristic and those who do not.

Cumulative impact of this and other proposals? (Please consider whether this proposal, when combined with other decisions made by the CCG/NECS, might have a contributory positive or negative impact on the Public Sector Equality Duty.)

NHS South Tees CCG are commitment to taking Equality and Human Rights into account in everything they do, whether that is commissioning services, employing people, developing policies, communicating, consulting or involving people in their work. We strongly support engagement with local people and listen to their views and will endeavour to make reasonable adjustments to enable access for our local carers, patients and members of the public.

Overall there are no significant risks identified, however, this equality analysis will be a live document and updated throughout the project, to take into account any changes to the project and to mitigate any potential issues/concerns.

Step 5 - NHS Constitution and Human Rights

Checklist – how does this proposal affect the rights of patients as set out in the NHS Constitution or their Human Rights?

<table>
<thead>
<tr>
<th>Constitutional Rights</th>
<th>Yes/No</th>
<th>Please explain</th>
</tr>
</thead>
<tbody>
<tr>
<td>a</td>
<td>Could this result in a person being treated in an inhuman or degrading way?</td>
<td>No</td>
</tr>
<tr>
<td>b</td>
<td>Does the proposal respect a patient’s dignity, confidentiality, and the requirement for their consent?</td>
<td>Yes</td>
</tr>
<tr>
<td>c</td>
<td>Do patients have the opportunity to be</td>
<td>Yes</td>
</tr>
<tr>
<td>Step 6 - Engagement and Involvement (Duty to involve – s242 NHS Act 2006) Francis Recommendation 135</td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td></td>
<td></td>
</tr>
<tr>
<td>How have you involved users, carers and community groups in developing this proposal? (Please give details of any research/consultation drawn on (desk reviews – including complaints, PALS, incidents, patient and community feedback, surveys etc)).</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
This equality analysis applies to the pre-consultation phase where service transformation will be imminent. The model of care will be implemented within the forthcoming year, in addition to working towards the closure of two community hospitals. This programme of transformation is included within Appendix 1. We have engaged with patients, carers, stakeholders and local people to obtain their views about the long term vision for improving services and ensuring that more elderly and vulnerable patients with long-term conditions are able to remain independent for longer.

**Also give details of any specific discussions or consultations you have carried out to develop this proposal** – with users, carers, protected characteristic groups and/or their representatives, other communities of interest (e.g. user groups, forums, workshops, focus groups, open days etc.).

There has been several public engagement events to allow views to be expressed on the proposed model of care and the potential closure of community hospitals.

There has been a key stakeholder event which allowed all multi-disciplinary personnel to have an opinion on the proposals and also representation from the voluntary sector organisations.

Engagement with the Acute Provider has been completed

Attendance at the local Overview and Scrutiny Committees to present the model of care and the proposals has been completed

A Reference Group has been formulated to allow members from all organisations the opportunity to review and assess the options identified within the engagement phase. This has allowed an impartial and objective view to be maintained at all times.

**How have you used this information to inform the proposal?**

The information that has been collated from the patient and public engagement exercise has been used to inform the CCGs plans for the vulnerable and elderly in South Tees' localities

- To underpin the delivery of the IMPRoVe agenda and support the development of a strategy for communicating the compelling vision around the need for change.
- To raise awareness and understanding of why it is important that the NHS has a plan to deliver sustainable and viable services for the next three to five years.
- To ensure that appropriate mechanisms are in place so that the public, key stakeholders and partners feel engaged and informed throughout the process.
- To contribute to shaping public, and health services’ staff, expectations of NHS services in Middlesbrough, Redcar and East Cleveland.
- To maintain credibility by being open, honest and transparent throughout the process.
• To monitor and gauge public and stakeholder perception throughout the process and respond appropriately.
• To be clear about what people can and cannot influence throughout the engagement and consultation phases.
• To achieve engagement that is meaningful and proportionate, building on existing intelligence and feedback such as previous engagement/consultation activities, complaints, compliments etc.
• To provide information and context about the proposals in clear and appropriate formats that is accessible and relevant to target audiences.
• To give opportunities to respond through a formal consultation process.
• To maintain trust between the NHS and the public that action is being taken to ensure high quality NHS services in their local area.
• To demonstrate the NHS is planning for the future.

Have you involved any other partner agencies (such as Local Authorities, Health and Wellbeing Boards, Health Scrutiny Committees, Local Healthwatch, Public Health, CCGs or NECS). Please give details of any involvement to date or planned

The CCG leads an IMProVE Advisory Group which meets monthly. This group has representatives from Local Authorities, Public Health, NECS and VCS organisations as well as clinicians from our 49 member practices.

In addition to the above, as part of this project there has been a Reference Group formulated to offer an impartial and objective view on the proposed options.

Step 7     -     Including people who need to know

Please consider the way in which the proposal will be explained to a wider audience. (Will translation or interpretation materials be required (audio, pictorial, Braille as well as alternative languages); are there any particular approaches required for different cultures using outreach or advocacy support; is some targeted marketing required?)

NHS South Tees CCG have promoted the service transformation and model of care to be implemented using a number of mechanisms including

Local media
Digital media
Stakeholder Events
Website updates
Press releases
Targeted awareness raising with local VCS groups
Partner dissemination of information

Step 8     -     Monitoring Arrangements
Please identify the monitoring arrangements that will be introduced to ensure that the effect of the proposal does not result in a disproportionate impact on any protected group (e.g., by creating an unintended barrier); For example, including contractual requirements to provide equality monitoring data on those accessing the service or making complaints.

This model of care and service transformation will not have any differing impact on patients/services to that of the current system. Therefore there will be no significant change to monitoring arrangements.

**Which committee or group will receive updates on the monitoring?** (Include details of how often reports will be presented).

No change to current system

### Step 9 - Decision Making

Taking the equality analysis and the engagement into consideration, and the duties around the Public Sector Equality Duty, you should now identify what your next step will be for the proposal:

<table>
<thead>
<tr>
<th>Decision steps available</th>
<th>Rationale for your decision</th>
</tr>
</thead>
<tbody>
<tr>
<td>Continue with phased approach of service transformation between March 2014 and April 2016</td>
<td>The service transformation will encompass two years of service change as per Appendix 1. This will result in closure of specific community hospitals but this has been derived via a methodological approach and will be supported by additional evidence.</td>
</tr>
<tr>
<td>Adjust the proposal (please detail the changes you will make in the Action Plan at <strong>Step 10</strong>)</td>
<td></td>
</tr>
<tr>
<td>Fundamental review of/stop the proposal</td>
<td></td>
</tr>
</tbody>
</table>

### Step 10 - Action Plan

Please reference all actions identified above and any additional actions required to ensure that this proposal can be implemented in compliance with Equality legislation, NHS Constitution and Human Rights requirements.

<table>
<thead>
<tr>
<th>Action</th>
<th>What will it achieve or address?</th>
<th>Lead Person</th>
<th>Timescale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Continue with phased approach of service transformation between March 2014 and April 2016</td>
<td>The service transformation will encompass two years of service change as per Appendix 1.</td>
<td>Julie Stevens</td>
<td>March 2014 - April 2016</td>
</tr>
</tbody>
</table>
**Review date for this equality analysis**  
(when actions above and impacts of the proposal will be considered)  
Continuous throughout the process - March 2014 - April 2016

<table>
<thead>
<tr>
<th>Step 11</th>
<th>Sign Off</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Senior Responsible Officer</strong></td>
<td>[ ]</td>
</tr>
<tr>
<td>Date signed</td>
<td>[ ]</td>
</tr>
<tr>
<td>Presented to</td>
<td>.......(insert)........... Committee</td>
</tr>
<tr>
<td>Publication date</td>
<td>[ ]</td>
</tr>
</tbody>
</table>

*as the Senior Responsible Officer you need to be assured that you have sufficient information about the likely effects of the policy in order to ensure proper consideration is given to the statutory equality duties.

1. Send the completed Equality Analysis with your document to necsu.equality@nhs.net
2. Make arrangements to have the EA put on an agenda for the appropriate Committee
3. Use the Action Plan to record the changes you are intending to make to the document and the review date.
4. Arrange for the Equality Analysis to be uploaded onto the website once it has been signed off.

**Advice, information and guidance is available from the NECS Equality and Diversity Team at necsu@equality.nhs.uk**

October 2013  
(produced by the Equality and Diversity Team, North of England Commissioning Support, email necsu@equality.nhs.uk)

**Equality Impact : Appendix 1, following page...**
<table>
<thead>
<tr>
<th>Timeline</th>
<th>Guisborough</th>
<th>Redcar</th>
<th>Carters</th>
<th>East Cleveland</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Current State</strong></td>
<td>Stroke (8 beds)</td>
<td>In-patients – Step-up/down (32 beds)</td>
<td>Stroke (10 beds)</td>
<td>In-patients –</td>
</tr>
<tr>
<td>April 2014</td>
<td>In-patients – Step-up/down (18 beds)</td>
<td>Theatres</td>
<td>In-patients – Step-up/down (34 beds)</td>
<td>Step-up/down (30 beds)</td>
</tr>
<tr>
<td><strong>Total bed base: 132</strong></td>
<td>Out-patients</td>
<td>Out-patients</td>
<td>General Practice</td>
<td>Out-patients</td>
</tr>
<tr>
<td>(Plus 20 Intermediate Care Beds across 5 Tees)</td>
<td>Diagnostics</td>
<td>Diagnostics</td>
<td>Stroke Association</td>
<td>Diagnostics</td>
</tr>
<tr>
<td></td>
<td>Minor Injuries</td>
<td>24/7 Walk-In/Minor Injuries</td>
<td>Occupational Therapy</td>
<td>Minor Injuries</td>
</tr>
<tr>
<td></td>
<td>Therapies</td>
<td>General Practice</td>
<td>Speech &amp; Language Therapy</td>
<td>General Practice</td>
</tr>
<tr>
<td>Community development</td>
<td>Further development of community services to include:</td>
<td>Tissue Viability Service</td>
<td>Tissue Viability Service</td>
<td>Tissue Viability Service</td>
</tr>
<tr>
<td>April 2014 – March 2016</td>
<td>Carry out resource review of therapy/capacity &amp; demand – recruit as necessary</td>
<td>Therapy</td>
<td>Therapy</td>
<td>Therapy</td>
</tr>
<tr>
<td></td>
<td>Increase capacity of reablement services</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Implement agreed CCG pathway for patient transfer of care</td>
<td></td>
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<tr>
<td></td>
<td>Continued improvement of discharge processes from James Cook Hospital into appropriate services</td>
<td></td>
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<tr>
<td></td>
<td>Continued development of pathways of care</td>
<td></td>
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<tr>
<td></td>
<td>Further expansion of rapid response services – potential for night sitting service</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Implementation of Single Point of Access and Assessment Hub</td>
<td></td>
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<tr>
<td></td>
<td>Review current out-patient resource and develop plan to support improved provision/re-provision across 5 Tees community estate</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Market test re-development of void space within Community Hospitals</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Review diagnostic provision and develop plan to support improved provision across 5 Tees community estate</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Centralisation of stroke to meet best practice – commissioning community stroke team</strong></td>
<td>In-patients – Step-up/down (18 beds)</td>
<td>Stroke (12 beds)</td>
<td>In-patients – Step-up/down (30 beds)</td>
<td></td>
</tr>
<tr>
<td><strong>Close Carters</strong></td>
<td>Out-patients</td>
<td>Community Stroke Team Base</td>
<td>Outpatients</td>
<td></td>
</tr>
<tr>
<td>By 1st April 2015</td>
<td>Diagnostics</td>
<td>Stroke Association</td>
<td>Diagnostics</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Therapies</td>
<td>Inpatients Step-up/down (20 beds)</td>
<td></td>
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</tr>
<tr>
<td></td>
<td></td>
<td>Theatres</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Out-patients</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td>Diagnostics</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>24/7 Walk-In</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>24/7 Minor Injuries (Enhance skills of staff to enable more treatments)</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>General Practice</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Increased Therapy Staff</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Redevelopment of estate</strong></td>
<td>Re-Development of void space – partial closure of hospital (retain Challoner Building only)</td>
<td>Re-Development of Void space</td>
<td>Re-Development of Void space</td>
<td></td>
</tr>
<tr>
<td>By 1st April 2016</td>
<td>Out-patients</td>
<td>Stroke (12 beds)</td>
<td>In-patients – Step-up/down and palliative care support (20 beds)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Diagnostics</td>
<td>Out-patients</td>
<td>Theatres</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Therapies</td>
<td>Diagnostics</td>
<td>Out-patients</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Walk-In/Minor Injuries</td>
<td>Diagnostics</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>General Practice</td>
<td>General Practice</td>
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<td></td>
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<td>Therapies</td>
<td>Therapies</td>
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<td></td>
<td></td>
<td></td>
<td>Assessment Hub &amp; Medical Day Unit</td>
<td></td>
</tr>
</tbody>
</table>