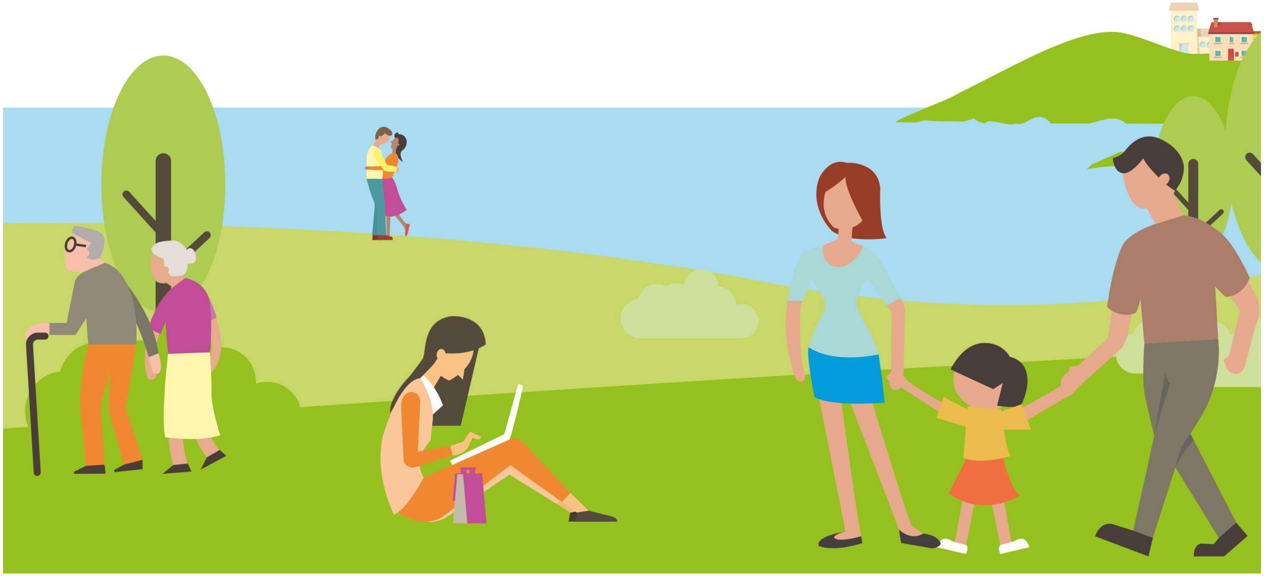
MY LIFE A FULL LIFE
HEALTH AND CARE SYSTEM REDESIGN

Public Engagement Report



July 2016

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SECTION ONE – EXECUTIVE REVIEW

1.1 This report examines the public feedback and engagement captured as part of My Life a Full Life's Health and Care System Redesign.

1.2 The core purpose of the engagement was to involve as many people as possible in the health and care system redesign and fulfil three distinct purposes:

- To ensure that any future changes to services are developed with the awareness and involvement of the public.
- To ensure that the voice of service users is directly considered in any redesign.
- To ensure that services reflect the particular needs of the Island.

1.3 The methodology behind the public engagement fell into four main phases:

- Programme introduction and raising awareness (Feb-Mar)
- 'Case for Change' launch, start of co-production and the pre-consultation phase (Mar-June)
- Launch of main consultation phase (expected 2016)
- Summary of consultation findings and the launch of roadmap (TBC)

1.4 This report covers the first two phases. Co-production played a core part of the methodology, with the ambition to involve as much of the Island as possible. This included active engagement with the general public, health professionals, protected groups, and a variety of community organisations.

1.5 This was conducted through a publicly open online and paper survey, public meetings around the Island, as well as through working groups on focus areas. A defined approach to protected groups and those seldom heard/hard-to-reach was put in place which involved mapping key organisations, and raising awareness and engagement. Publicity for these activities was raised through various means which included paid advertising, earned media, direct mail, posters, as well as digital media and associated content.

1.6 Reception to the Health and Care System Redesign engagement was mostly positive. The general public as well as media and healthcare staff welcomed a chance to discuss the pressure on services and suggest ideas for the future.

1.7 There was some scepticism from a minority of participants who voiced 'consultation fatigue' or 'change fatigue'. There was also some limited awareness of the My Life a Full Life programme among the general public, and some council staff expressed concerns about being marginalised from the organisations' activities.

1.8 A number of recommendations emerged about how health and social care services can be improved on the Island. Some of the topics of focus included the availability of GPs, transport and accessibility, the 111 service, and the role technology and improved communication could play in the future of the Island’s health and social care services.

SECTION TWO – INTRODUCTION

2.1 Overview of section

2.1.1 This section sets out the reasons for and the objectives of public engagement within the redesign context.

2.2.1 Context

2.2.2 The following document captures public feedback and engagement undertaken as part of the Health and Care System Redesign currently underway on the Isle of Wight.

2.2.3 The programme is being run as part of the My Life a Full Life (MLAFL) partnership. MLAFL is a collaboration of health, care, and voluntary sector organisations which has been working with the Island community to develop initiatives that enable people to be more in control of their own health, wellbeing, and care needs.

2.2.4 The health and care redesign, which is supported by national Vanguard funding from the NHS, is working with the Isle of Wight community to reshape health and care services on the Island, with My Life a Full Life partners driving the process.

2.2.5 The focus on working directly with the community of the Isle of Wight is a core aspect of the health and care redesign. This document details the engagement activity undertaken in the first phase. The first phase seeks to raise awareness of the challenges facing the Island and then to encourage the population to participate in developing solutions to these challenges.

2.2.6 It also sets out the extent of co-production used to involve service users and lay people directly in helping to redesign specific services on the Island, grouped around a series of focus areas – a process that is still on-going.

2.2.7 The programme is being driven by a consortium led by KPMG, but organisations in health and care services from across the Island involved in health and care services have helped to shape and drive engagement in this first phase.

2.3 Purpose of engagement

2.3.1 The core purpose of the engagement is to involve as many people as possible in the redesign of health and care services on the Isle of Wight. This is seen as fulfilling three distinct purposes:

- To ensure that any future changes to services are developed with the awareness and involvement of the public.
- To ensure that the voice of service users is directly considered in any redesign.

- To ensure that services reflect the particular needs of the Island.

2.3.2 This first phase of engagement was to raise awareness of the challenges facing the Island’s health and care system – set out in the *Caring for our Island: Time to Act* leaflet, detailed below – and then involve the public in developing solutions to these challenges.

2.3.3 The feedback from this phase – captured in the summary document below, along with the appendices – is now being fed into the redesign process with all public suggestions being considered through both the redesign and co-production process detailed below.

2.3.4 This feedback will be presented back to the public, with the health and care redesign setting out key themes and ideas developed as a result of public involvement, before then setting out a formal options consultation on redesign later in 2016.

SECTION THREE – METHOD AND APPROACH

3.1. Overview of section

3.1.1 This section looks at the approach taken to engagement, including:

- The different phases of public engagement which have been undertaken
- The rationale for the approach taken
- The approach to reaching groups which are under-represented and/or have protected characteristics
- The approach to capturing feedback from public engagement

3.2 Strategy aims and approach

3.2.1 As outlined in the strategy, the objective was to deliver two overlapping core outcomes:

- Ensuring wide and meaningful engagement from the Island's population to help shape potential changes to health and care services
- Deliver a robust and auditable foundation that meets best practice guidelines and includes members of the Island to help shape the future health and social care provision on the Island

3.2.2 The redesign communications and engagement programme was designed to fulfil statutory obligations and meet expectations on best practice. All partner organisations on the Island were keen to play a role. The team also looked to tap into local groups and a network of informed partners to amplify reach and broaden effective communication.

3.3 Phases of communication

3.3.1 The communications and engagement strategy fell into four main phases. These phases and the overall timeline were reviewed against the Critical Path redesign, and were in compliance with NHS England assurance processes and best practice.

- Programme introduction and awareness raising (Feb-Mar) – completed
- 'Case for Change' launch, start of co-production and pre/-consultation phase (Mar-June) – completed
- Launch of main consultation phase (expected 2016)
- Summary of consultation findings and launch of roadmap (tbc)

3.3.2 *Programme introduction and raising awareness (Feb-Mar):* Introducing the overall programme to the Island. This was delivered through a public press release setting out the terms of the programme, but particularly driven through engagement via the key partners on the Island and their communications networks. Care and residential homes, doctor surgeries and the hospital were engaged with, and public venues such as libraries and sports centres were provided with information on the programme.

3.3.3 The redesign team prepared communications material for these organisations to share with their networks. This material set out the aims of the programme, the proposed timeline and introduced the approach to co-production, while also setting out the opportunities to get involved.

3.3.4 This phase also included preparation for the subsequent pre-consultation and co-production phase; this included the preparation of materials and the ‘suggestion box’ survey.

3.3.5 *Case for Change’ launch, start of co-production and pre/-consultation phase (Mar-June):* The redesign programme launched a pamphlet which was also hosted online, which set out the need to review health and care services on the Island, and explain why doing nothing is not an option. As part of the pamphlet, the document had a freepost form that invited members of the public to send in their views responding to a small number of open-ended questions. In order to ensure accessibility, an ‘Easy Read’ version of the pamphlet was also produced with the support of community groups.

3.3.6 The launch also set out the wider programme timetable, confirming how input in the pre-consultation phase would feed in to the review and the development of the main consultation which will be launched later in the year.

3.3.7 An online portal for the public to feed in comments was also established on the My Life a Full Life website (www.mylifeafulllife.com), and, together with email and a contact phone number, was used as an additional resource to capture comments. This was supplemented through social media activity directed through partner channels, creating a comprehensive multi-media communications programme.

3.3.8 In parallel to the Case for Change launch and two initial public events, a co-production programme began in partnership with key organisations to seek public and professional views on potential changes to health and care services on the Island, which would inform specific redesign options ahead of a formal consultation.

3.4 Public survey

3.4.1 One of the ways to ensure the majority of residents could get involved was through a public survey, which was provided through the Case for Change launch. The Case for Change invited residents to participate in a ‘suggestion box’ survey asking open questions and welcoming their views around the current state of services, and what changes they would like to see.

3.4.2 In addition to this, the programme hosted several engagement events – including public events, events targeted at specific groups (both general public and staff and volunteers), and clinical engagement events to present the Case for Change, and encourage interaction with the survey.

3.4.3 An important commitment from the programme was that the contributions received through this survey phase, were to be fed into the detailed modelling and development of options which will be presented back to the Island for consultation.

3.5 Approach to co-production

3.5.1 The ambition of the programme was to involve as much of the Island as possible in helping to reshape health and care services. A number of focus areas were developed for particular focus. The six broad focus areas were developed in discussion with, and approved by, the redesign board. They were chosen based on an analysis, performance data, changing demographics, and public and professional stakeholder views. For each focus area, a working group was established to look at defining the issue, and developing a solution design.

3.5.2 In addition to this, these focus areas formed the core focus for co-production activity. The focus areas chosen were as follows:

- Urgent and Emergency Care
- Women, Young People & Families
- Planned Care
- Mental Health
- Frailty
- Long-term Conditions

3.5.3 For each focus area, and in each of the three geographical areas, the programme invited interested members of the public to take part in user focus groups to talk about how services could be improved.

3.5.4 These meetings were convened by members of the voluntary sector and were provided with a series of questions and a template to capture outputs from the group. Exceptions to this were the events related to Planned Care and Urgent and Emergency Care, which were not convened by the voluntary sector but by the My Life a Full Life team. The findings of the locality sessions reported into the area working groups to help identify the key issues being addressed.

3.6 Hard to reach / often overlooked groups

3.6.1 The approach to defining hard to reach groups followed the guidance in the 2010 Equality Act which establishes nine groups of people with protected characteristics against whom it is unlawful to discriminate, as follows:

- Age

- Disability
- Gender reassignment
- Pregnancy and maternity
- Marriage and civil partnership
- Race
- Religion or belief
- Gender
- Sexual orientation

3.6.2 These groupings were used to inform detailed mapping of organisations and communities displaying these characteristics on the Isle of Wight, and they were engaged with directly to first make them aware of the Case for Change, and then give them the opportunity to share their views should they decide to do so.

3.6.3 In addition, the project team worked with Community Action to establish a methodology to approach seldom heard/hard to reach groups on the Island – those who may be afforded protection under equalities legislation, but who also have a tendency not to engage with formal consultations. Community Action identified the following groups as representing the Island's 'hard to reach' community:

- Young adults
- Carers
- Homeless people
- People with drug and alcohol issues
- Offenders
- Unemployed people
- People with disabilities / long term conditions
- People with learning disabilities
- People with English as a second language
- Mainland workers
- Children
- Residents of residential homes

3.6.4 The following approach was taken to engage with protected groups:

- Mapping – identifying those organisations that can be used to make contact with hard to reach groups, or act as representatives on their behalf.
- Awareness-raising – targeting specific groups and communities with tailored Case for Change material, including an easy-to-read version of the 'Time to Act' leaflet, to raise awareness of the programme and what it might mean for them.
- Engagement – where appropriate, attendance at public events and community meetings, to engage directly with representatives or representative organisations from those groups.

3.7 Capturing outputs

3.7.1 Each presentation and engagement meeting was recorded in the same template as developed for public events as described above and recorded accordingly. Evaluation forms were also completed by attendees to gauge feedback and help improve effectiveness of future events.

SECTION FOUR – ENGAGEMENT ACTIVITY

4.1 Overview of section

4.1.1 This section outlines each element of public engagement with details of the activity undertaken, including public meetings, co-production events, stakeholder briefings, community meetings, professional engagement, engagement with people with protected characteristics, and an initial public survey.

4. 2 Public meetings

4.2.1 Two public events were held in Shanklin and Newport on 21 and 22 March 2016 to mark the start of an initial phase of public engagement to raise awareness of the redesign, well ahead of any planned formal public consultation. Approximately 65 people attended. The sessions heard from senior members of the WISR Board as they provided an overview of the redesign process and outlined why change would be needed. The sessions also included small-group discussions with members of the public about what they saw as some of the main challenges facing the Island, and what issues might potentially be priorities for action.

4.2.2 Information on the redesign was also made available at regular health and wellbeing ‘roadshows’ held by My Life a Full Life in public locations around the Island. Engagement also took place through attendance at external events: for example, International Nurses Day, Mental Health Fete and Adult Social Care meeting.

4.3 Community meetings

4.3.1 Members of the redesign team attended 17 community meetings and events, reaching 299 people directly, to raise awareness of the redesign throughout an initial period between March and June 2016. These included meetings hosted by voluntary sector organisations such as Barnardo’s and Age UK, a session at Isle of Wight College, and community events such as Riverfest. Community meetings overlapped with engagement with protected groups and a full list of community organisations can be found in Appendix 4i.

4.4 Online and paper survey

4.4.1 An explanatory pamphlet, entitled ‘Time to Act’, was published under the My Life a Full Life banner on 18 March 2016 setting out why change was needed on the Island, outlining the importance of the redesign, and encouraging people to take the opportunity to have their say. It also included a simple open-ended survey asking for initial public views on the services on the Island and what might need to change on the Island. A corresponding survey was available on the My Life a Full Life website until 27 May 2016. The responses were used to help communicate public views to the working groups involved in the redesign process itself. In total, 449 paper responses and 189 online responses were returned by the deadline.

4.4.2 20,000 copies of the Time to Act pamphlet were delivered to 100 key locations around the Island and put on display for people to take away, in places such as schools, leisure centres, NHS and council sites, residential homes, and GP surgeries. The pamphlet was also distributed to all 69,000 residential residences on the Island, to raise early awareness of the redesign process and the need for change, as well as to encourage additional responses to the initial survey.

4.4.3 A shorter, easy-to-read version of the leaflet was developed in discussion with Community Action Isle of Wight, Healthwatch Isle of Wight and People Matter – the Island's user-led organisation. Additional copies of the leaflet were made available to voluntary sector organisations and accessible on the website for download.

4.5 Engagement with protected groups

4.5.1 As well as distribution of the 'Time to Act' pamphlet and representation at community meetings, additional targeted activity was undertaken during the initial engagement phase up to June 2016 to write and telephone so-called hard-to-reach groups and those representing people with protected characteristics, to offer them the opportunity to raise any questions, and to ensure they required no further information at that stage. In total, 230 organisations on the Island were reached during this phase. A full list of community organisations can be found in Appendix 4i.

4.5.2 The redesign team engaged face-to-face with people from a number of protected groups on the Island, for example youth groups, women's organisations, and Older Voices.

4.6 Co-production events

4.6.1 Eighteen public co-production events were held across the three localities between 3 and 13 May including at Newport, Shanklin, Ryde, Freshwater and Ventnor to get the publics' view on how the Island might respond to a range of issues which will impact the future of services. A total of 186 people attended these events. These were focused on the six specific themes aligned to the working groups examining redesign options – Frailty, Planned Care, Mental Health, Urgent and Emergency Care, Long-Term conditions, Women, Young People & Families.

4.6.2 Members of the redesign team and voluntary sector facilitated the co-production events, but were also joined by representatives from the working groups to hear directly from members of the public. Specific questions on service redesign options were developed and tested during these events (included in Appendix 3iii). The views from these events were collated and fed into the working groups to ensure that public input was sought early in the process, and could play a meaningful role in shaping the specifics of the redesign itself.

4.7 Stakeholder briefings

4.7.1 As well as the community conversations, protected groups outreach, and professional engagement detailed above, four briefings for specific key stakeholders took place:

- Andrew Turner MP - 13th May
- Town and Parish Councillors - 20th April
- Youth Council - 26th April
- Council briefing - 18th May

4.7.2 All briefings were held as part of the initial phase of engagement between March and June, where members of the Health and Care System Resign Board, and My Life a Full Life team could talk to stakeholders about the redesign, seek their views, and respond to requests for additional information. This included, amongst others, a meeting hosted by the Isle of Wight Association of Local Councils (IWALC), a meeting with the local Member of Parliament, and a briefing for Isle of Wight Councillors. A wide range of stakeholders were also welcome to attend any public meetings.

4.8 Staff engagement

4.8.1 The Health and Care System Resign team scheduled a series of events and meetings as part of an initial phase of engagement with health and social care professionals on the Island. This included a kick-off meeting at Newport Football Club on 17 March, attended by a variety of professionals in the health and care including GPs, nurses, hospital staff and the voluntary sector. This meeting introduced the redesign process and sought early views on priorities for action.

4.8.2 Other events included bespoke briefing sessions for Clinical Business Units at NHS Isle of Wight, a presentation to the Practice Nurse Forum, a session for staff working in adult health and social care, and a meeting for voluntary staff. Drop-in sessions at both the council, the CCG, and NHS Trust locations also enabled staff to learn about the process and how they might have their say in small-groups or one-on-one discussions. Health and care professionals were also welcome to attend any public meetings.

SECTION FIVE – PUBLICITY ACTIVITY

5.1 Overview of section

5.1.1 In order to meet the objectives of ensuring wide and meaningful engagement from the Island's population and to delivering a robust and auditable consultation, a programme of publicity was built around the redesign consultation process. The aim of the publicity activity was to build awareness amongst residents of the Case for Change, and to encourage them to attend engagement events or have their say online / via post.

5.2 Paid advertising

5.2.1 Paid advertising opportunities were taken out in the Isle of Wight County Press and the monthly Beacon magazine over the course of the engagement period in order to publicise opportunities to engage with the survey.

5.2.2 Four full-page advertisements were taken out in the Isle of Wight County Press over the March – April period. The Isle of Wight County Press readership is estimated at 97,026 and is a weekly publication that is printed for a Friday distribution day.

- 11th March 2016, advertising public events dates and locations
- 8th April 2016, advertising general engagement in the survey
- 15th April 2016, advertising participation in the working groups
- 22nd April 2016, advertising locality events, topics and locations

5.2.3 A paid advertising opportunity was also taken out in the Isle of Wight's monthly Beacon magazine, which has an average circulation of 50,000.

- April 2016, advertising locality events, topics and locations

5.3 Digital and social media

5.3.1 A set of recommendations was developed to be used across My Life a Full Life's social media channels in order to raise publicity for the engagement opportunities. This involved content to share and posts for both Twitter and Facebook, with reach boosted via additional paid promotion. This led to a digital reach of 138,180 over the three month consultation with around two-thirds of this taking place during the four week period around the locality events.

5.4 Video

5.4.1 An important piece of material in building publicity for the Case for Change was the online video. The video provided an overview of the Case for Change, using key spokespeople to discuss the need for progress and highlight how residents can get involved.

5.4.2 The video was uploaded to the YouTube platform in order to be shared easily and was embedded in the My Life a Full Life website. It was also used in public engagement events, and as of 7th June 2016, the video has 169 views.

5.5 Earned media

5.5.1 The promotion of the redesign process and public engagement opportunities also took place through earned media. Three press releases were issued to all local media, and appeared in articles in the Isle of Wight County Press and the Island Echo throughout the March – April period. This included:

- 18th March 2016, Island Echo, with a case for change focus
- 18th March 2016, Isle of Wight County Press, with a case for change focus
- 1st April 2016, Island Echo, with a focus on forthcoming locality events
- 27th April 2016, Island Echo, with a focus on public event

5.5.2 Alongside this, an urgent and emergency care feature was developed with Isle of Wight County Press in order to draw attention to the pressure on emergency care services on the Island and the need for change. This appeared in the Isle of Wight County Press on 20th May 2016.

5.5.3 Isle of Wight Radio also conducted and aired an interview with health and care redesign representatives.

5.6 Direct mail to households and community groups

5.6.1 20,000 copies of the Time to Act leaflet were delivered to 100 key locations around the Island, and put on display for people to take away, in places such as schools, leisure centres, NHS and council sites, residential homes and GP surgeries.

5.6.2 A leaflet was also distributed to all 69,000 residential households on the Island, to raise early awareness of the redesign process and the need for change, as well as to encourage additional responses to the initial survey.

5.6.3 Additionally, a pack of 15 leaflets alongside a letter explaining the redesign was delivered to 230 community groups.

5.7 Mailing lists

5.7.1 Mailing lists were also used to promote the redesign. Information promoting the opportunities to get involved in the redesign was placed in the newsletters, distributed to My Life a Full Life, Community Action and NHS Trust mailing lists. In total, five separate items during the March – May period were placed in newsletters going to mailing lists promoting the public engagement events, locality events, working groups and general involvement in the redesign. Weekly news alerts were also sent out to staff and volunteers.

5.8 Posters

5.8.1 Posters were also used as part of the publicity activity. 380 posters were developed to build awareness around the co-production events and distributed to partnership organisations, such as Community Action, the Isle of Wight Hospice and Age UK. They were then distributed with a cover note requesting the recipient’s assistance in publicising the events. Bespoke copies of the poster were also created for each of the locality events, and a PDF copy was mailed to different community groups to further promote the events.

5.8.2 Another poster was created to promote staff engagement events and these posters were circulated via partnership organisations in order to drive awareness and attendance to these events.

SECTION SIX – KEY THEMES AND FINDINGS

6.1 Overview of section

6.1.1 This section summarises the results of the programme's engagement activities, and it provides a brief summary of response themes.

6.2 Public meetings

6.2.1 Public engagement events were held on 21st and 22nd March 2016. As the first events of the engagement period, these focused on presenting the Case for Change and inviting participants to share their experiences around the current healthcare system. Both of these events involved two breakout sessions; the first, focusing on identifying and agreeing on the strengths and future challenges to the Island's health and social care, while the second session focused on identifying the focus areas participants believed required the most urgent attention for change. Although there was a broad range of issues in these discussions, there were key themes and topics that participants regularly prioritised.

6.2.2 *Breakout session 1: Agreeing the strengths and future challenges - Strengths*

- Many spoke of positive experiences at St Mary's hospital, saying that they had been kept well-informed and that the Intensive Care Unit was particularly good.
- Many commented that the ageing population has led to a thriving community of volunteers who have ownership of the Island and its issues.
- It was generally agreed that dementia care was a strong point for the Island, and volunteer initiatives like Age UK and the Alzheimer's Café stepped in when services couldn't provide.
- Many spoke of positive experiences with the Beacon Centre, mentioning that it was particularly good for less severe emergencies.
- Although it wasn't universal, the gastroenterology unit and the role of pharmacists were mentioned as enabling independence and management of conditions.

6.2.3 *Breakout session 1: Agreeing the strengths and future challenges - Challenges*

- The lack of access to GPs was regularly referenced, with comments that GPs were not responsive enough, had huge queues and not enough appointments. Residents were concerned that lack of resources could especially affect the most vulnerable; with some commenting that there was a lack of interaction between social workers and GPs. Many conceded that it was a national issue too.
- Attendees commented that the 15 minute slots for carers were not long enough, and should be longer in order to prevent isolation and loneliness. There was also mention that care was not reaching people early enough and was not consistent across the Island.

- Attendees commented that better communication and co-ordination could support a more holistic approach to health and social care.
- Many attendees commented that they believed more knowledge of volunteer initiatives and greater awareness of services was necessary.
- Many stated that they believed there was not enough respect for urgent and emergency care services, and this was a cause of bed-blocking and similar problems.
- Many commented on transport and accessible services in connecting residents to the community and wider services, believing it has a role to play in loneliness in older people

6.2.4 *Breakout session 2: Emerging focus areas:* The second session focused on identifying the focus areas that participants regularly prioritised and felt required urgent attention, these were – frailty, urgent and emergency care, women and children, primary care and mental health. Participants were invited to discuss and examine these four focus areas in more depth and to identify the key factors and reasons behind these.

6.2.5 *Frailty*

- There was disagreement over whether services on the Island to reduce loneliness were working well, with some noting that knowledge and awareness of services was a particular issue.
- Some commented that tackling isolation and loneliness had an important role to play in preventative health, and had a role in improving the quality of life for those who have dementia.

6.2.6 *Urgent and Emergency Care*

- Almost all attendees agreed that an effective emergency care system was important, and the overloading of the system was a result of poor management and performance in other areas.
- Some groups noted that unnecessary admissions were an example of failure in other parts of the system, and discussed whether the system and referrals more widely were working effectively when compared with the past.
- An emphasis on education and prevention from an early point was raised regularly as a way to improve the emergency care system, especially if the resourcing and staffing situation will not improve. One group mentioned the current high standard of First Aid education in schools and the role it might be able to play in prioritisation

6.2.7 *Women and Children*

- Much of the conversation around Women, Young People & Families' Care focused on the importance of investing in young people as much as the older generation.
- Most groups agreed that the older generation on the Island were well looked-after and that it was important to look forward to fund prevention and education amongst young people.

- Attendees noted that spending on the older generation was worthwhile due to the benefits it brings to society in the form of the voluntary sector.

6.2.8 *Primary Care*

- In almost all groups, the role of the community was seen as an important part of primary care on the Island, with some mentioning that deteriorating networks and decreasing quality of life for the old putting it at risk.
- Communication was raised as an issue at a primary care level. Some commented that initial point of contacts do not listen or ask the right questions and problems are missed.
- Personal responsibility for lifestyle choices was raised regularly, with many agreeing that a greater emphasis on preventative education could help.

6.2.9 *Mental Health*

- Attendees commented that it should be a part of every pathway and it was important to tackle it in order to prevent hospitalisation and associated costs.
- Some thought the area had enough support already and commented on the difficulty of judging the severity of illnesses. Even those thinking it was a high focus area, argued that it was an area that should be tackled differently rather than increasing services.
- There was general agreement that societal stigma played a role in treatment, with some arguing that prevention should not be left to GPs, but started in schools

6.2.10 There was a consensus across most groups that some roles in the community could be utilised to make a greater contribution to the health and social care service. Community navigators were flagged as having particular potential. Some suggested that those over 65 should be encouraged to train for that role. Parish councillors were also seen as positions in the community that could be used better.

6.2.11 A ‘health plan in the community’ was mentioned as a way to use the community as an asset. Schools were emphasised as particularly important to include, with education seen to be an excellent way of ‘triaging in the community’.

6.2.12 Another consistent theme of discussions was the creation of a ‘culture of responsibility’, with the Island’s health and social care service providing tools to manage care, rather than being totally relied upon.

6.3 Co-production events

6.3.1 Eighteen public co-production events were held across the three localities between 3rd and 13th May. These were intended to get public views on how the Island might respond to a range of issues which will impact the future of services. Many suggestions were made during the course of the co-production events and we have provided a selection of those comments below. However, full notes of the events can be found in Appendix 3.

6.3.2 *Urgent and Emergency Care*

- Those that attended events focussing on urgent and emergency care mentioned the need for greater understanding of the difference between ‘urgent need’, and ‘urgent care’.
- It was felt that the community had huge potential to take more of a role in supporting vulnerable people, and preventing both the need for urgent care services and the inappropriate use of them.
- Attendees raised the importance of the role of volunteers, better coordination, and improved information-sharing as means of improving community support.
- Pharmacists were also seen as a potential alternative for those seeking advice, and it was said they could become a first point for contact in many instances which would relieve some pressure on other services.
- Participants discussed being seen by other professionals instead of GPs for out-of-hours care, but they wanted to be reassured of quality. Some attendees felt that pharmacists could be used more effectively, though some did not know what they were able to provide aside from prescriptions/medication. It was also discussed whether pharmacists could respond with regards to out of hours provision, especially in end of life care.
- Medical buses for Friday or Saturday nights were suggested, staffed by the voluntary sector, following the model in Liverpool which is jointly funded by the Police. Although medical buses already exist on the Island, awareness of these services were lacking.
- On the 111 call-back by GPs, some asked whether that there could be a target time for call-back response (such as one hour). This is an existing target, however, public contributions signalled this may not be effectively communicated.
- Education on health issues should be embedded within other ‘non-health’ lessons (like history, geography) in schools, and should be started from a young age. This would help educate people from a young age on the appropriate use of services.
- Health and safety checks could be used to prevent falls from happening. Teams could examine diet, their home and medicine to examine the risks. A ‘Home Start’ scheme for older people was also suggested, which could use volunteer’s time to get them out of the house, and notice any hazards within the home. There was discussion as to whether opticians, dentists and others could be able to pick up issues earlier also.
- Care in a crisis was discussed by one group, including volunteers that co-ordinate within streets or neighbourhood areas so that the community is more involved in supporting the vulnerable. Brading Town council was mentioned as an example that could be built upon.

6.3.3 *Women, Young People & Families*

- The biggest theme to emerge was the desire to see needs-based care and not solely care based on diagnosis, which may not always be appropriate.

- Methods of delivery in terms of the use of technology were also discussed but a difference of opinion was recorded as to when virtual appointments and other technological innovations would be appropriate.
- Travel was raised as an issue because patients are frustrated that, for some key services, there is a need to go to the mainland for planned hospital appointments as they are not provided on the Island, such as Radiotherapy. The main issues were around time and costs of travel.
- It was also said that the hospitals on the mainland are not accommodating for patients from the Island, as they are given appointments at unsuitable times. Changes by mainland hospitals to offer appointment times that better suit the patient would be welcomed.
- The role of education as part of the redesign was raised. It was remarked that education plays an important role and that it is part of the puzzle and should be given greater emphasis given the experience within the education system in dealing with children and parents.
- Recruitment and retention of NHS staff was raised as a wider problem within the system, especially with GPs.
- The quality of schooling was highlighted as a particular problem, with many on the Island, and those coming to work on the Island opting to send their children to private schools.
- Whilst many thought maternity care was brilliant, some wanted more flexibility for working mothers, at weekends or in the evening.
- Suggestions included a ‘virtual A&E’ for children. The use of Skype, for example, would mean people would able to send photos so that a specialist can see it and make a decision.
- In one session there was the recommendation for greater education on emotional resilience, as well as rights and responsibilities.

6.3.4 *Planned Care*

- Key themes included the need to expand and upskill the role of volunteers to support medical staff, as there was general agreement that volunteers could play a key role.
- In addition, it was also said that improving education around health management and people taking personal responsibility was important.
- It was commented that clearer preventative health targets should be given, rather than being lectured or instructed with vague advice, for example to eat more healthily.
- There was significant emphasis on raising awareness and understanding of the options available for general care support. For example, attendees expressed that they had little knowledge of the services that the Beacon, and the Health and Wellbeing Clinic could offer.
- To help people take control over their own care, the better management and streamlining of the voluntary sector was a theme, including bringing all volunteers and/or voluntary sector organisations together in a searchable database for both the public and professionals, e.g. GPs. The potential for the voluntary sector being added to a ‘choose and book’ system was suggested. It

was also proposed that volunteers could be utilised to facilitate the discharge process, albeit with support from nursing staff.

- An expert patient programme, providing real-life, practical tips was suggested. On a similar theme, it was discussed that practical information on independence aids should be provided by services - such as recommendations on the best wheelchair or disability access car with lower doors – along with medical information. It was also suggested that a central point of contact – via local area co-ordinators, sign-posting, Help Centre at the Library – could help people take control over their own care.
- The Podiatry service was identified as helping to keep people out of hospital and as a vital service for those with diabetes – it was felt by one group that a mobile physiotherapy, podiatry, dental 'truck' could work well.
- Information and communications technology (ICT) improvements were discussed by one meeting. Some patients would prefer receiving information via email, rather than hard-copy letters, and it was noted that information was still shared by fax/hard copy between health professionals, which can delay treatment.
- To support people when leaving hospital, a nurse-led step down facility was proposed that would support patients in the transition to home care. More than one group suggested that discharge planning should begin on admission and that more effort should be made at the start of the patient journey to give the 'whole life' information about a condition. It was noted that people often have a 'mind blank' when being informed of medical information, and that patients should leave with a paper care document. A question was also raised around whether hospital 'over-cares' for patients, and makes them less confident when they return home – and whether people should be encouraged to do more for themselves while still in hospital.
- The introduction of a 31-day target for cancer, between first treatment and discharge was raised as an idea that could be replicated – as apparently takes place in Northampton. Information and sign-posting services to help people stay active, like self-help groups, clubs to help people stay fit and healthy (allotment, walking etc) were also suggested.

6.3.5 *Mental Health*

- One of the central themes was that support for crisis needs to be 24/7. Charities were praised for offering good service, but many commented that waiting times in general were too long and speed was crucial for helping those in a crisis. In particular, the overall speed was seen as crucial for helping those going through a crisis, potentially supported by bringing together volunteers and Citizens Advice to resource telephone advice lines.
- There were also comments that the approach to medication needs refining, as some felt that prescriptions were given only because waiting times were long.

- Technology was seen as having potential in providing mental health services, however it was emphasised that accessibility was key - training would be needed as well as a recognition that digital services are not for everyone. Access to data via technology for NHS staff was seen as very important.
- The benefits of a holistic approach to mental health was emphasised, with any changes being based on experiences, and personal health care budgets were not seen as a positive solution, as it was widely seen that it would raise pressure on those with mental health issues.
- A ‘crisis house’ or recovery centre, that could provide an alternative to Seven Acres was suggested for respite care.
- Using Skype, online health forums and social media to contact services was considered a benefit, where volunteers could help manage phones/social media channels. However, concerns were raised with regards to accessibility and it was felt it would be necessary to hold training sessions to empower people to be able to use social media/new technologies.
- There was discussion on allowing access to buy private counselling, although some participants in sessions raised concerns about potentially unaccredited counsellors.
- Employment was also considered a factor in coming back after a crisis, with education of employers on mental health seen as helping to reduce stigma and support applicants.
- Greater localisation of support was seen as potentially beneficial, such as through Citizens Advice or drop-in centres which would benefit the wider community and not just those with mental health concerns.

6.3.6 *Frailty*

- The need for more coordinated approach between different services caring for the elderly was raised consistently throughout public engagement.
- There was significant discussion on the role of carers and how they could be better supported, and how this would in turn benefit those that receive their care.
- The role of volunteers was a key theme, and while the positive role and need for more volunteers was cited, there were concerns that the quality of care might not be consistent.
- There was willingness for neighbours and members of the community to help, and a desire for a greater role for voluntary organisations which are willing and able to assist.
- The idea of a ‘Carers Network’ was floated, although it was noted that it could be difficult to engage people with busy lives who are occupied with looking after someone. It was pointed out that notice should be given if carers need to change. It was also felt that paid carers were often too rushed. Attendees noted that people want healthcare but also companionship.
- It was suggested that more community events would be one way of addressing isolation, and that better advertisement of events, for example via newsletters, might encourage people to come out more. It was argued there should also be an emphasis on building resilience within the community, for example by creating resources such as gardening clubs. Participants suggested that shops and supermarkets could place leaflets focused on the benefits of volunteering in

deliveries and have them in-store. One idea raised was whether there could be a central directory or some way for everyone to know what is on offer. There was a feeling that more people would volunteer if they knew what was available.

- Better transport, for example community buses, would also be a way of ensuring that people were able to leave their home and meet people.
- A recurring suggestion was that the community should be used more to identify and support those who may be suffering from loneliness. The postal service and the fire brigade could be utilised; perhaps via awareness training, such as dementia friend training. It was asked whether postal workers or the post office, shopkeepers or others could help identify those that are isolated or lonely.
- The multiple benefits to volunteering were discussed and it was suggested that there should be greater focus on communicating those benefits.
- One group also asked whether schools should play more of a role. Some suggestions included buddying children with elderly people, and an idea around a 50-plus education project, where older people go into schools to listen to children read for example.
- The ability to keep learning in older age and better understanding the signs of dementia earlier in the community was mentioned. Another idea was ‘dementia nurses’ (which were envisaged as working in a similar way to Macmillan nurses). Education was again mentioned, and a free education centre for older people was proposed at one meeting.
- It was said that Dementia Awareness Reaching Communities (DARC) training should be expanded so more people recognise the signs of dementia, and possible routes to refer for help.
- Attendees at one meeting were receptive to the idea of GPs conducting more home visits. They also felt that nurse practitioners have sufficient knowledge to triage and refer onwards in many cases. To support this, health assessment training could be done. Attendees noted that nurses or community matrons are often preferred as practitioners, as they also have a more holistic approach. Examples of successful projects from the mainland cited by one group included Bedgrove, and Aylesbury. This includes a team of nurses for patients aged 75 and over who are living alone with health care needs. The nurses who keep an eye on the patients, are provided with their number to call instead of GPs, and are given call alarms and flashing door bells etc.
- It was noted that people in residential care implied that staff “don’t take care of them”, for example not cleaning spectacles, or helping them to clean their teeth. It was suggested that a person centred check list or timetable of care should be developed, alongside an individual plan for how to deal with difficulties for each person.

6.3.7 *Long-term conditions*

- It was said that medical staff needed to be more sensitive and recognise that patients want to understand their conditions better. Patients should also be given as much information as possible to enable them to understand their conditions better, doing this would aid their confidence and encourage them to take responsibility for their own health without having to contact medical staff with every concern or query. It was suggested that this could be done through leaflets, dialogue with medical staff or carers. In addition, information about what help is available needs to be better advertised so that people are aware, and know how and where to access it.

- The idea of using technology was embraced, with services such as Skype and other phone options supported to reduce pressure on the system, and in some cases, or for those with conditions like autism, it was said that it could be a benefit.
- Patients also want better communication and co-ordination between consultants and GPs, so that people with multiple conditions do not feel ‘batted from one to the other’.
- It was also said that improved communication and coordination was required in terms of medication to avoid waste, and to make sure that when people have several medications, the expected interactions between them were clearly explained.
- Improved access for prescriptions to improve self-management, with one person citing a case where they could not get a prescription for five days because it was too busy.
- It would be useful to have trained key workers to take responsibility for education and explain to patients what they should do or expect and ensure that they are properly informed.
- Regular appointments and monitoring are seen as effective ways to prevent a crisis, with the view that since GPs are busy their monitoring duties can be provided by nurses.
- Suggestions included ensuring that carers are receiving support and that their needs are being met too, and regular checking to determine any ‘downhill’ trends, and the ability to intervene in problems early.
- There were comments on improving the varying quality of ‘respite’ bed accommodation that better meet the needs for younger carers (under 60).
- Those with long term conditions commented that on hospital discharge, volunteers could meet a patient on the ward, and take them home on the day and stay for a while. There was also the need for better assessment before discharge which can be referred for support.

6.4 Stakeholder meetings

6.4.1 *Town and Parish Councillors:* A team from My Life a Full Life met with Town and Parish councillors on the Island to provide them with an update on the programme and invite their views. It became evident that some councillors had a somewhat negative perception of My Life a Full Life. It was said that they believed My Life a Full Life did not understand them and had thus far failed to engage effectively with them to seek their views. They had also mentioned that there was a degree of public apathy, as they were ‘fed-up’ with being asked for their views, but had not seen any outcomes to date. There was a feeling that My Life a Full Life could have drawn on the Councils’ expertise and community network more effectively as they felt they were closer to the people on the Island through their close relations with their communities. They also stressed that health was a matter of individual wellbeing and therefore, Town and Parish Councils in particular were not use to dealing with such issues, and recognised the need for them to improve in that regard. Overall this was a productive meeting and concluded on a key objective to build a closer working relationship and develop better mutual understanding. This would be achieved through ongoing and regular communication – with a further meeting in the pipeline; sharing messages and details of upcoming events; and welcoming further feedback from Councillors throughout pre-consultation on the redesign and beyond.

6.4.2 *Isle of Wight Council:* A team from My Life a Full Life met with councillors from the Isle of Wight Council. It was used as an opportunity to update them on the programme and answer questions. Councillors raised a number of points, one of which related to engagement with hard-to-reach groups. It was said that for those that are not able to complete the surveys, respond over email or go out to attend one of the co-production events, people were available to answer the phone and speak to them as an alternative. The team were also asked about carers and were was able to confirm that carer support was being looked at as part of the programme, and there was on-going engagement with carer groups, including a bespoke consultation event for carers run by Community Action IW. One of the biggest concerns from the group was losing services on the Island, and the associated travel issues for residents. In response, the team reassured the councillors that where they can, they will seek to provide services on the Island as it has been recognised that travel is an issue for many people. However, for some conditions, it may be necessary for people to travel to the mainland because there is better technology or expertise. Another concern was the issue of recruitment and retention of staff. It was acknowledged that this was a national problem and not one that was confined to the Isle of Wight. The redesign was taking place in an effort to protect the services, and GPs specifically, so as not to overload them with the sheer volume of work. A follow up meeting is currently planned for 27th July 2016.

6.4.3 *Andrew Turner MP:* The My Life a Full Life team met with the local MP to introduce him to the programme and further brief him on its purpose. He enquired as to the accountability of the programme, and it was confirmed that it was a coalition of organisations, but with a Board structure with a focus on transformation rather than delivery.

6.5 Staff engagement

6.5.1 The engagement programme included 17 staff events, including meetings with key business units within the hospital and the CCG. Feedback was collected through written forms which asked respondents for their views on current challenges, what they believe services should look like, and their thoughts on practical improvements that they think should be made.

6.5.2 From the responses, there was clear consensus that one of the key challenges faced by staff in the health and care service was a lack of, or poor, communication among the various services and departments to the detriment of patient care. One of the contributing factors to this was the computer systems used by staff which could be different depending on where staff worked, and that the procurement of such systems should be made based on effectiveness, and not necessarily on cost alone. Ineffective computer systems impact on the quality of service can, in turn, have knock-on cost implications, it was said.

6.5.3 The overwhelming request from staff was to see services more integrated to help with communication and service delivery. This would enable professionals and other services provided in health and social care to share knowledge for the best possible care for patients. Another prevalent suggestion was the use of locality teams all working in one place. These 'hubs' would be better able to provide care required by residents more quickly and easily, and reduce the strain and demand on other parts of the health system on the Island.

6.5.4 In terms of practical improvements, staff who were engaged suggested better computer systems and technology to assist them in their day-to-day activity, better communication between health services and various partner organisations (e.g. the Council and volunteer bodies), and also a need for increased recruitment to support them and reduce the stresses and strain placed on them currently.

6.5.5 Another key theme from the staff feedback was that prevention must be a key part of the future health and social care services on the Island. Participants felt that there was currently too much of a reliance on GPs with a shift in mind-set needed in order for people to manage health concerns proactively. Engagement with the education was seen as necessary in establishing this mind-set of self-care in children. Those involved did recognise that it may be a difficult task to change this behaviour.

> *"Most people don't want change. Everyone wants to have their favourite GP, their favourite hospital"*
>
> – Stakeholder, WISR Programme - Market Engagement Day – 14th April 2016

6.5.6 Staff strongly believed that there ought to be more focus on mental health services, that that is where more support is needed, and that there should be parity between mental and physical health. This is because some more physical health issues could be prevented if mental health issues are diagnosed and dealt with early. People have complex needs and in some cases have multiple diagnoses. Particularly children's mental health services were seen as in need of further resourcing. The second area staff felt needed to be focused on was urgent and emergency care, followed by long term conditions at a third place.

6.5.7 Following up with patents after discharge was something which was raised consistently during the sessions, with many emphasising that they would positively contribute towards improving services and improve health in the long term.

6.5.8 It was also suggested that there should be more integrated training made available for hospital staff, such as doctors and nurses, primary care providers, and the voluntary sector. It would create more consistency in care and it would address the current strain on resources. Participants mentioned particularly that the quality of GPs on the Island was variable, and commented that this often influences how well some of the primary care services engage and collaborate.

6.5.9 In terms of assessing need upon admittance, respondents suggested that nursing staff should to the best of their ability immediately try and assess possible further social care the patient might need in order to ensure that all health needs are met. It was further proposed that discharge planning ought to start from the moment of admission so that there are adequate strategies in place when the immediate needs are met.

6.5.10 Expanding the role of 111 was also raised by a few participants. Staff emphasised not just the need to increase awareness of the services, but also to enable them to triage more and be a primary access point for health advice.

6.5.11 The Professional Reference Group (PRG) session on the 18th May focused on how working groups can be braver in their thinking and focus on the bigger picture through the use of more progressive language and thinking beyond the current health system to include social care and circumstances. They also said that financial impact should be considered as well as the consequences of any changes. It was also recognised that behaviour and culture change needs to be different at all levels of the organisations.

6.5.12 The following PRG session, on 7th June again reiterated the need for a broader vision from the working groups, and recommended having a combined session to that effect. They also requested further detail on how cost savings would be made as well as how housing support and prevention and early intervention would be incorporated into plans. The PRG also requested specifics around how the 111 services can be upscaled and how the Trust can be supported in encouraging the self-management of long-term conditions.

6.5.13 In regards to particular focus areas there were various comments made. Recommendations included more clearly separating the topics of dementia and frailty, more explicit explanation of the term ‘urgent care’ and ensuring mental health was linked more across focus areas.

6.6 Community meetings

6.6.1 17 community meetings and events, reaching 299 people, took place through organisations within the community. These meetings had a focus on engagement with hard-to-reach and protected groups, which can be found in Appendix 4i, and a number of themes emerged.

6.6.2 *Urgent and Emergency Care:* In community conversations around urgent care and emergency services, a common theme was that generally people did not mind if they were seen at home or in hospital, but their main concern was being seen and treated within a reasonable time frame. In conversations, most participants expressed a preference to see their GP first, with many stating that they would like to see an extension in GP opening times.

6.6.3 The 111 service was seen as too risk averse by many, with residents commenting that it sent too many people to the Beacon. In a conversation with 38 people at the Beacon Centre on 24th May 2016, 4 people had called 111 and been sent to the Beacon, 9 had spoken to their GP and been sent to the Beacon and 7 had attended the Beacon without calling their GP or 111, because they felt that it was a waste of time.

6.6.4 During the carer's consultation, there was a general feeling amongst carers that they only accessed emergency treatment for their cared for person when it was a true emergency. However, it was suggested that 'Carers' Information Packs' could be created to signpost them to appropriate information and advice for relevant conditions. Carers' training courses, whether formal or informal, were also suggested to better prepare people for caring with regards to particular conditions.

6.6.5 *Planned Care:* In terms of GP surgeries, the appointment system was roundly criticised in most conversations. Most said that they were happy to see a nurse or nurse practitioner if appropriate. There were also suggestions about awareness of 111, with comments that the service should be promoted via social media, or it should be converted into an app. By doing so, the pressures on GP surgeries could be alleviated.

6.6.6 Technology was seen as a good option across the board, accessing help via phone, Skype or other online services. However, this was qualified with comments that it should not be the only option, with young people especially cautious that it should not replace physical examinations.

6.6.7 *Women, Young People & Families:* In discussions around maternity and children services, the ability for partners or family to stay overnight after the birth and for children's clinics to be held at family centres were popular recommended changes.

6.6.8 C-section support was mentioned by several as an area where improvements could be made. Women who have had C-sections felt that they did not have enough help on the ward after the procedure, and support was found wanting.

6.6.9 Some expressed concern over early discharge after having a baby. One mother recalled her experience of being sent home before she had been adequately taught how to properly breastfeed her child, and had to return within 6 hours to receive help. In doing this, it was felt like it took up more of services than needed. It was also suggested that more comprehensive support following birth was needed, as health visitors did not work weekends or evenings.

6.6.10 Children's centres were described positively, with those using the services saying that they would be happy to donate to keep the service going. There was also a suggestion that a mother and baby mental health unit was needed on the Island, as long stays on the mainland could separate mothers and children from their families.

6.6.11 Another concern raised was that infertility and fertility appointments were booked for, and held in the same place which meant a miscarriage is often treated alongside a pregnancy. There were suggestions that a barrier between appointment rooms could be helpful. A directory of minor illnesses was also recommended, with comments that the patient.co.uk site was good, but would have been more helpful if it had a symptom-search function.

6.6.12 *Mental Health:* When speaking to young people, it was widely felt that the transition to adult services was not smooth. It was suggested that more integration into services should happen at school, with the example of Barnardo's and Ryde School seen as a good example of services clustering around schools.

6.6.13 Teenage students recommended a lived-experience mental health volunteer to provide an on-call telephone service. A popular suggestion was also that practical workshops for parenting teenagers should be available to all parents, with wider health education in school recommended to include self-care of minor illnesses.

6.6.14 In community conversations with organisations dealing with homelessness, the central theme was accessibility. Many commented that they suffered stigma from professional bodies and applauded welcoming services that had been available at the Night Shelter, Downside.

6.6.15 Comments were made as to the need for regular checks with GPs or other medical professionals, in order to improve dementia diagnoses. Persons with a particular risk of developing dementia ought to be examined on a regular basis so that it could be detected early.

6.6.16 Technology was often considered as being particularly useful in helping people access mental health services, both prior, during and after episodes requiring treatment. The notion of having an app or a phone line was particularly popular, where people can connect with a 'buddy' who they can talk to when they are feeling down or in need of support. It was suggested this could be manned by volunteers. Some, however, noted that it would be vital to ensure that medical professionals manned the phones in order to give the best advice. Having services available 24/7 was also often highlighted, whether it be a telephone line or a centre.

6.6.17 Another note that was brought forward during community sessions was the need for greater improvement surrounding two diagnoses where patients have co-existing mental health and substance misuse issues. Some noted that health services were currently not equipped to deal with dual diagnosis, and some respondents said that a lot of the capacity at Seven Acres was taken up by those misusing substances. Others noted experiencing stigma associated with either alcohol, or substance abuse when seeking help for mental health, and expressed concern that it might impact their diagnosis. Some young people in particular felt they were not taken seriously when attending medical appointments alone, and would like the option of an advocate, particularly when discussing depression or contraceptives.

6.6.18 *Long-Term Conditions:* Themes in the community conversations focused on carers looking after people with long-term conditions. There were recommendations that bereavement counselling could take place further down the line, when the impact of a death set in.

6.6.19 The carers consultation, hosted by Community Action and attended by 65 carers, provided a number of suggestions for improvement. For example, in terms of signposting, it was said that more information could be provided on benefits, strokes, and volunteer organisations to support carers, especially young carers. An annual or bi-annual 'carers roadshow' was also suggested, which would bring together all the relevant agencies. There was a suggestion about awareness of services that will visit at home, introducing a 'chronically ill housebound directory' for example. A carer's discount card was also roundly welcomed. Another popular suggestion was the creation of a Carers' Information pack which would include information on benefits, self-help groups, and social and respite care services. It was suggested it could be made available at GP surgeries.

6.6.20 Respite arose as a key theme, especially for younger carers. At the carers' consultation, an increase in respite hours was recommended, as was the ability to book into 'respite', with suggestions that this could be more applicable to young people.

6.6.21 Conversations amongst those in the community with learning disabilities focused on accessibility, independence and communications. Most agreed that communication in hospitals could be improved, especially with staff explaining situations directly to the patient, rather than to just a carer. It was suggested that day services, domestic help, and support with bills would enable those with disabilities to stay independent and in their homes.

6.6.22 It was widely thought that the Island could be made a friendlier place for those with intellectual disabilities. Verbal announcements on buses and awareness bracelets that are recognised by retailers in case a person needs help were suggestions for improvement. Emergency passports with key information were also suggested.

6.6.23 Technology was also welcomed by those with disabilities, with the suggestion of a Skype call in a pharmacy, rather than travelling to the mainland for an appointment if no examinations were involved.

6.6.24 *Frailty:* Transport was seen as a key issue for the elderly during community conversations, especially in relation to travel to and from the hospital or the mainland. When discharged, wheelchair users have to rely on Red Jet staff members for additional transport support. It was suggested that a system should be in place with taxi companies and/or Red Jet to offer more support.

6.6.25 Support with transport to and from homes for the elderly or those with movement difficulties was also a central theme. Some suggested that isolation in the elderly could be overcome, if a volunteer was able to attend coffee mornings with a service user, pick them up for regular outings, and support them in attending day services.

6.6.26 With regards to care, many felt that they would prefer to live in homes with their families rather than in a staff-supported setting. For that to happen, there would have to be support with everyday things such as laundry, cooking, and budgeting. Exercise was also seen to be vital to keep the elderly mobile for as long as they were able, even if just chair-based exercise, and focus on mental stimulation.

6.6.27 Another theme which emerged from conversations with regards to elderly care was the need to ensure participation from the elderly in community activities. It was suggested that being active and engaging in physical activities would greatly improve the health of elderly people. Even if this was just a case of doing exercises from a chair, it would provide mental stimulation as well as improve their overall health. In achieving this, it was mentioned that more of these types of services ought to be made available.

6.6.28 It was mentioned at the carers consultation that a buddy system would be useful to prevent loneliness and isolation not only for those being cared for, but also for carers. The suggestion was that both carers and those being cared for could be matched by age groups or with those that share similar interests. Those in attendance at the meeting believed it would be particularly useful for those looking for companions to attend a group or activity for the first time.

6.7 Survey responses and public feedback

6.7.1 As part of the pre-consultation process, residents on the Island were invited to share their experiences and ideas as to how health and care services could be improved. This was possible through a paper feedback form, and also as an online survey. These were supplemented with feedback received through phone calls, emails and letters received by the My Life a Full Life team. In total 723 responses were received across all mediums. Understandably, there were various different experiences and suggestions shared. A review of all responses, however, reveals a number of common themes and ideas expressed.

Response type	Percentage of responses
Paper	60%
Online	26%
Emails	9%
Social media	0.5%
Phone calls	3%
Letters	1.5%

Fig.1. Type of responses and percentage of feedback

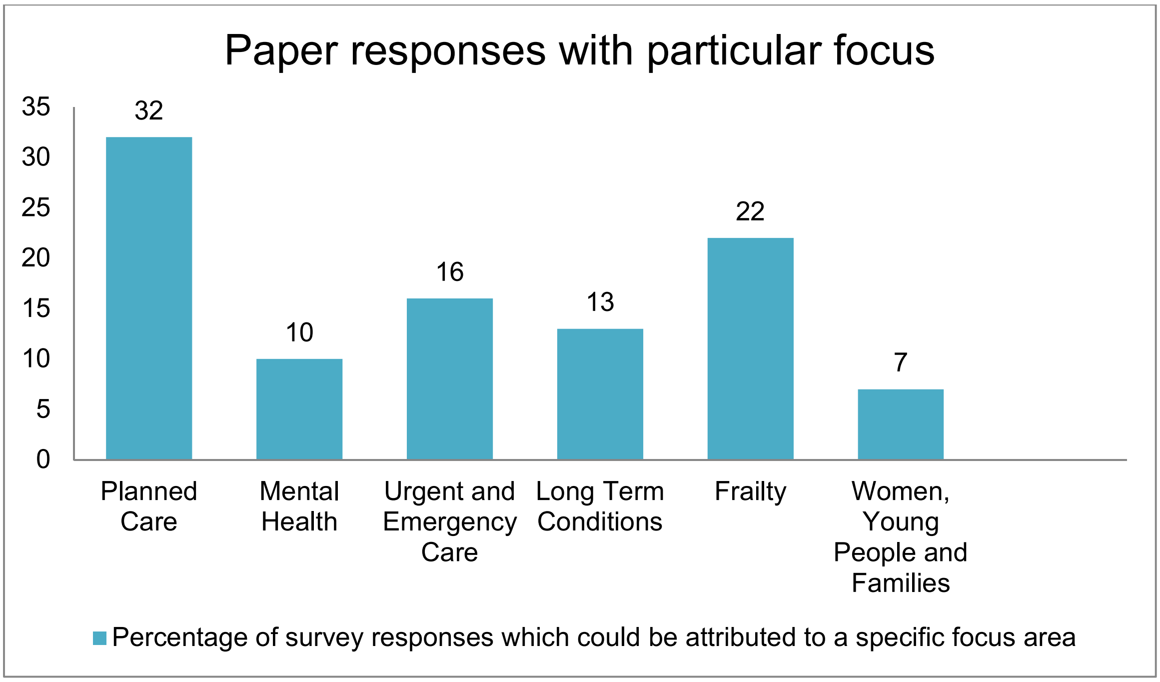


Fig.2. Chart of paper survey responses that could be attributed to a specific focus area

6.7.2 *Planned Care:* An issue that commonly arose was bed blocking, with 9 responses explicitly focusing on this area. It was felt that due to the lack of services which could be delivered at home for the elderly, hospital beds were, on a consistent basis, being taken by those that could and perhaps should be cared for at home or elsewhere.

> *"St Mary's is doing the best they can with reduced funds and bed blocking. We desperately need more money for care"*

6.7.3 There was some anger at the closure of cottage hospitals on the Island, and there was some appetite to see them reopen to help with freeing up beds at St Mary's as a result.

> *"To reduce bed blocking by patients unable to return home alone, bring back cottage hospitals for families to look after their sick"*

> *"A cottage hospital – where people would be moved out of hospital to recover – to free up beds at St Marys"*

6.7.4 As highlighted during other forms of public engagement, there was concern over services leaving the Island, and having to travel to the mainland for treatment. Associated with this is the concern with travel, particularly for those who did not have access to their own transport, and relied on public transport or support from others. It was mentioned that there was some capacity on the Island to support the services provided on the mainland, such as blood tests being taken on the Island ahead of planned care and appointments on the mainland. These solutions, however, were not always offered, with different technologies sometimes cited as obstacles.

> *“Generally happy about services on the Island but not about when referred to the mainland hospitals. They don’t seem to realise the difficulty”*
>
> *“Funding needed or help with funding to mainland appointments”*

Fig.3. Word cloud of the most common terms used in planned care focused responses

6.7.5 Through survey responses, there was another concern about the efficiency through which various branches of health services communicated. Limited communication between GPs, primary care services, hospital services and adult care services meant that information on a patient was perceived as being scattered across different providers, and not collated or comprehensive enough. This was a key area where respondents believed improvements could be made. . In fact, a key area where communication was highlighted was in the treatment of elderly persons. Many respondents felt that the various branches connected to their care, such as the hospital, residential home and GPs needed to improve their cooperation and communication with each other.

> *“I noticed very poor to non-existent communication between the hospital, [the] GP and care home. I feel strongly that this could have been easily improved without recruiting more staff.”*

6.7.6 *Women, Young People & Families:* A common theme in responses focused on children was a call for improvements to pastoral care and mental health work in schools. Many respondents felt this was a gap in the service which, if filled, could improve services and add to a more holistic approach to health care. Some commented that greater involvement from charities could improve the situation.

“Stretched and big gaps in service for child mental health and children in care”

6.7.7 There were calls from respondents to improve services for children with mental health issues. Suggestions for improvement included an internet chat as a way to provide counselling as well as calls for a centre for eating disorders to be introduced to the Island.

“Support and counselling via internet chat regularly would be good”

6.7.8 It was also noted that more general education and support for children in schools was needed, in order to educate students about mental health and remove the stigma of mental illnesses on the Island. Respondents believed if there was more understanding of mental health issues, and what might cause them, it would help foster a more caring environment for children to come forward and ask for help early. This would help prevent future problems, and help make students aware of the support available to them.

6.7.9 Alongside this, another idea that was regularly raised was better health education at schools in order to encourage a ‘culture of responsibility’ and drive the prevention effort. If more efforts were directed towards educating pupils on the various sections of the health service – what they do and when patients should go to see them – it was believed that it would greatly reduce pressures on primary care services and the healthcare system overall as many appointments at emergency rooms, for instance, were considered inappropriate for an A&E and more suited for a GP environment.

“Education on how to keep body protected from diseases”

Fig.4. Word cloud of the most common terms used in women, young people and families focused responses

6.7.10 Some respondents called for more creative thinking with campaigns that could reach children and the elderly alike, and encourage them to be healthier. Some younger residents returned forms requesting longer physical education lessons and greater education about common illnesses. In so doing, it was believed that it would be possible for many future illnesses to be prevented.

“More imaginative health activities which engage older people and younger people alike”

“Tackle before it becomes an issue.”

6.7.11 It became evident that 111 is not currently working for young children, with four responses detailing a common theme of parents calling the number and immediately being referred to the Beacon centre out of precaution. Parents noted that this cautiousness, while well-meaning, meant that they were often taking up services that were already stretched and that robust advice from 111 would have been sufficient without going to the Centre.

6.7.12 The consistency of care when it came to midwifery was also a regular theme, with women complaining that they had seen various different midwives during their pregnancy, and would have preferred a more one-to-one approach where a relationship could have been developed.

“During my maternity care, I was seen by a different midwife for each appointment”

6.7.13 Overall the feedback from surveys and public engagement was that the services on the Island for women, young people, and families are by and large very good and many parents felt properly looked after.

6.7.14 *Mental Health:* In the area of mental health, most public feedback called for significant improvement and improved access. Eight responses focused on that particular area. Whilst there were some responses relating good experiences with counselling, many comments were that services were hard to access and understaffed.

Fig.5. Word cloud of the most common terms used in mental health focused responses

6.7.15 A key theme within mental health which quickly emerged in public engagements was the need for better prevention and aftercare following a mental health crisis. Many noted that it was much easier to access services in a moment of crisis, but on occasions prior to a crisis, many services were unable to meet with patients due to resourcing pressures. Similar were the experiences surrounding aftercare, where it was felt that little support was made available, which could potentially lead to a relapse.

> *"Generally the health care is very good on the Island, but I have noticed a downturn in what is available, for rehabilitation and aftercare services"*

> *"From personal experience emergency care is excellent. However, aftercare is the complete opposite and is appalling."*

> *"Timely follow up for all patients with a proper service for mental health and a choice of Psychiatrist for adolescence"*

6.7.16 The need for more coherent support across the Island was further noted, as provision was considered patchy. In particular, a respondent noted the need to develop Community Health Hubs further.

"If the solution is to keep persons out of hospital and de-medicalise conditions and self-care in the community then there needs to be expansion of community mental health facilities in key geographical areas - Ryde, Sandown/Shanklin, West/East Cowes, Newport and Freshwater with additional smaller scale provision in Bembridge, Ventnor, Brightstone."

6.7.17 There was an emphasis, in responses, on creating an information-sharing atmosphere for mentally ill patients. The idea of having a named social worker, who would know the patient, build a relationship and understand their problems, was a notable suggestion.

"People feel safe when carers/health professionals are known, regular and consistent."

6.7.18 Alternative therapies, such as exercise and music stimulation were suggested as ways to deal with dementia. There were also comments that residents would support experimentation on the Island for creative ways to tackle this issue.

"Isle of Wight is an ideal community to pilot projects for dementia sufferers…community transport, accessible lunch clubs…dementia buddies"

6.7.19 *Frailty:* Quality of care, and the location of it, was a central theme to public feedback around frailty. Many called for more residential homes for the elderly, and more care in homes, seeing them as a key problem in hospital bed-blocking. One respondent particularly noted that there ought to be care provided in specialised homes as it would enable more hospital beds to be freed up without losing the quality of care.

"Many older folk could be looked after in their own homes"

"My mother was in hospital for weeks because it took that long for her to be looked at by the community care manager"

"Build a 150 bed interim unit on prison site for bed blocking elderly"

6.7.20 Many felt that better care could occur after the elderly were discharged, and that improved care in the right places, whether that was in a residential care home or at home, was cheaper in the long run and better for the patient.

"No one wants to die in hospital"

"Too many difficult agencies involved in care"

6.7.21 There were various individual ideas for improving care for the elderly that came through in the public feedback. This included a personal independence budget for over 75s, vouchers for over 60s to be used at the gym, a mobile chemotherapy unit and creative ways to educate on fall prevention.

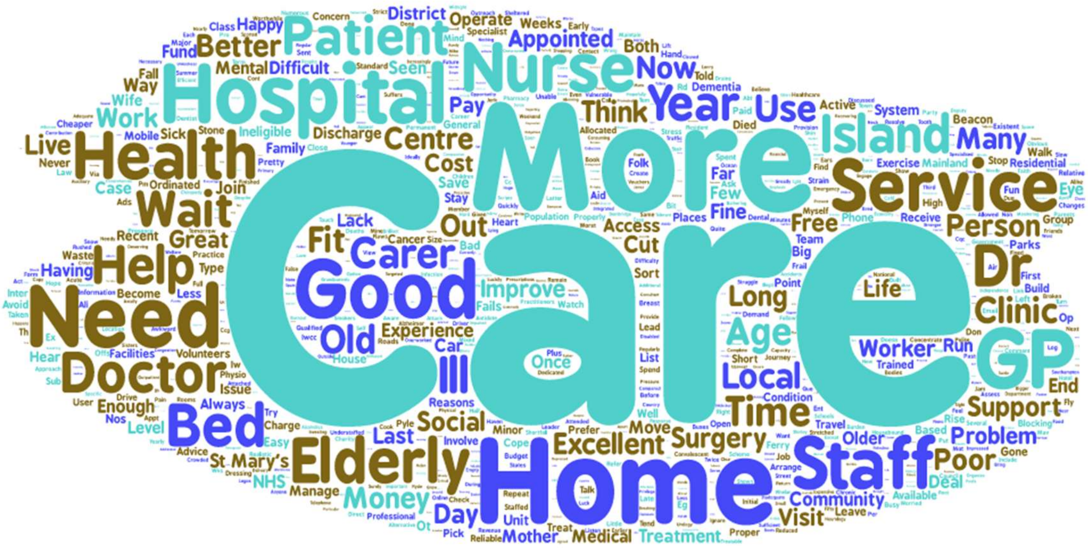


Fig.6. Word cloud of the most common terms used in frailty focused responses

6.7.22 Continuity of care was a central theme that came across in the feedback. It was felt that trained carers should not have to ‘watch the clock’ when caring for the, often lonely, elderly. A central information hub was also raised as an idea that could support unpaid carers.

“My husband has a twice weekly visit from a district nurse over the last two years we have seen over 30 different district nurses”

6.7.23 It was also widely felt that families could take a greater role in care, with one respondent stating that free mainland links could connect family to elderly in need of care.

6.7.24 *Long-Term Conditions:* A central theme around long-term condition care was the call for more provision to those who were housebound, more specialised homecare and better use of home help. The theme of people becoming more independent in their own care of their long-term conditions was seen throughout responses. Transport is seen as a problem, with calls for improved accessibility of volunteer and health services for those with mobility issues.

“An Island-wide service for disabled people – buses or taxi set up to take people in wheelchairs to social events, shopping or to day centres”

6.7.25 Access to mobility support, such as wheelchairs, was noted as insufficient by respondents as it would often mean long waiting hours and hinder their ability to move around and lead their lives. One respondent noted in particular that currently it takes between 6 and 12 months to receive a wheelchair.

6.7.26 Alongside this, many residents felt that a more joined-up approach between services was critical, with better communication, awareness of options, and an improved approach to planning. One respondent commented on the jargon they felt was prevalent when talking to health professionals about managing their condition. Another asked for better crisis sign-posting. Many comments focused on poor experiences with receiving diagnosis which seemed to either take time to receive or wasn't accurate the first time.

6.7.27 Another key point that was brought forward in both surveys and public engagements was the need for effective prevention in order to avoid future healthcare concerns. One particular area that stood out was the issue of obesity and food education. With obesity on the rise, respondents felt it was necessary to improve public education around food and obesity more generally.

"More preventative care for preventable conditions such as obesity and diabetes"

"Most people, adults and kids, on the IOW are hugely obese and this is going to cause such problems to the health service. I see this far more here than on the mainland or in Europe. Help with educating people not to eat processed food and sugary drinks."

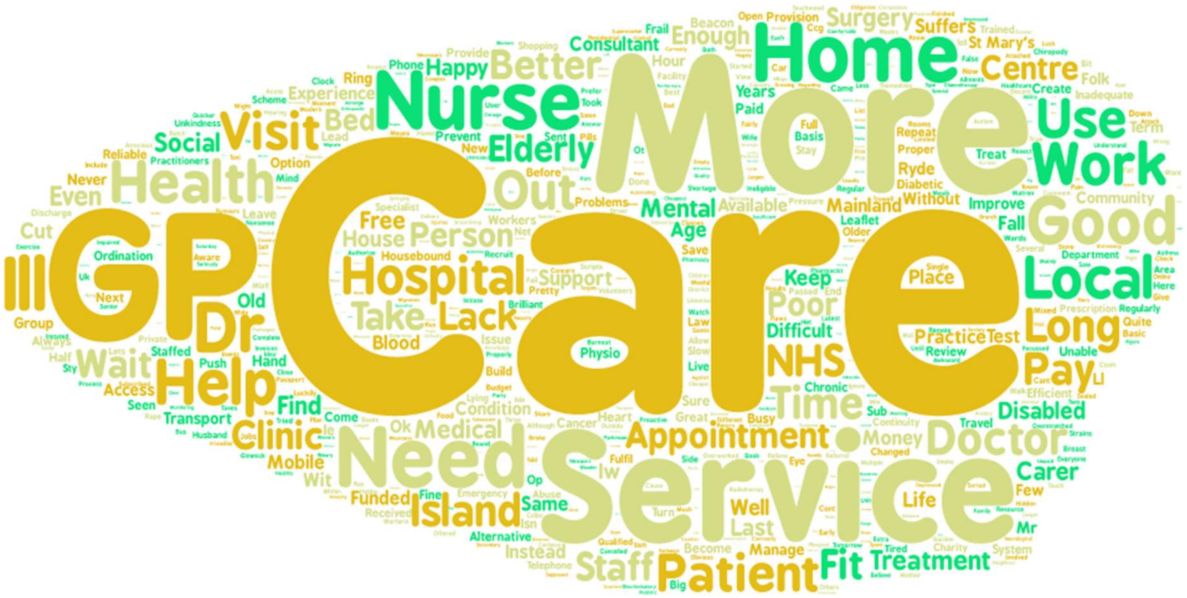


Fig.7. Word cloud of the most common terms used in long term conditions focused responses

6.7.28 *Urgent and Emergency Care:* Emergency care was generally seen to be 'ok' or 'good', though some residents felt the service was overstretched and involved long waits to be seen.

"When an ambulance was called it took six hours for it to come"

“Emergency plan for everyone with a life-threatening condition”

6.7.29 One of the most common views shared by residents was frustration and disappointment with regards to booking GP appointments when planning their care pathway. For example, 92 responses focused on GPs and related themes. There was dissatisfaction about waiting times for an appointment (which in most cases took between 1-2 weeks); concerns over the appointment system and only being able to book in the morning to see a GP that day, and in some cases not being able to pre-book an appointment in advance.

“It looks like there are not enough GPs / Doctors to keep the Island healthy”

“Hard to get GPs appointments”

6.7.30 There were a number of suggested solutions to this problem, with some respondents proposing alternative staff such as nurses or pharmacists. Others called for better awareness of options available, as one respondent was not aware of telephone appointments until his GP mentioned it, and many were open to the idea of using technology like Skype to ease pressure on GPs. Generally, technology was seen as a positive measure to help relieve some of the pressure GPs face.

“On-line booking by patients of appointments and repeat prescriptions.”

“Greater use of telephone consultations with GP to reduce patients' attendance at practice.”

6.7.32 A central theme was around the education of patients, with some respondents feeling that if residents were better educated on illnesses and afflictions and where they were best treated, pressure on emergency services would reduce.

6.7.33 Communication was also a consistent theme, with respondents suggesting that it could be improved. One suggestion was that a copy of an admission form should be made out on arrival to A&E and given to patients or their accompanying person.

6.7.34 *Additional comments:* More broadly, there is a feeling of worry for the future of the health and care services and resources on the Island. This is primarily being driven by two factors; firstly a growing concern that housing developments on the Island would increase demand for health and care services on the Island, adding to the pressure these services are currently under. Secondly, by the perceived failure to attract and retain health care staff on the Island.

6.7.35 Making appointments ahead of time was brought to the fore by several respondents. If residents are aware of requiring a future appointment which is not urgent, there are no ways for them to make an advance appointment at their GP. Having IT systems which would enable this function was deemed crucial as it would not only help patients plan their care much easier, but also aid hospital staff.

“Better computer system Islandwide for doctors/hospital. At the moment I cannot make an appointment for more than two weeks ahead.”

Fig.8. Word cloud of the most common terms used in urgent care focused responses

Fig.9 A summary word cloud of the most common terms used in the survey responses:

SECTION SEVEN – CONCLUSION AND NEXT STEPS

7.1 Overview of section

7.1.1 With a formal consultation not expected until later in 2016, the main objective of engaging early on the redesign has been met. The objectives were to both raise general awareness of the process, and to seek meaningful input from the public and professionals alike. This was met through the multifaceted communications strategy undertaken by My Life a Full Life, including printed media, digital media, medical professional engagement, and public engagement.

7.1.2 Additional work has been undertaken to begin a dialogue with groups representing people with protected characteristics. Any existing and future engagement activity will be catalogued for future reference.

7.1.3 This section sets out what the report has found and outlines the observations and lessons from this work, which can help inform future engagement on the redesign.

7.2 General reception

7.2.1 The general reception to discussions on the process has been positive, with the public debate on the Island demonstrating an awareness of pressure on services and the need for change. As with any change, there has been some scepticism in the minority and an element of ‘consultation fatigue’, but the message from local leaders on the urgent need for radical thinking has been communicated both in engagement events, staff briefings, and in the local media.

7.2.2 Feedback has shown there is perhaps limited awareness of the My Life a Full Life programme among the general public, so in future communications and content, it will be important to highlight its link with the participating organisations which are well-recognised on the Island.

7.2.3 Local campaigning for additional public funding has meant that the future of services is a running issue in the local media, although in public discourse, the Health and Care System Redesign team has largely managed to draw a distinction between short-term pressures and longer-term change.

7.3 Media response

7.3.1 Initial engagement with local media has generally been positive. Local media has particularly expressed an interest in covering the topic more once the Health and Social Care Redesign enters the next phase and a concrete proposal is on the table.

7.4 Staff engagement

7.4.1 Engagement with staff has been generally positive, with some groups, such as those working in Adult Social Care, being keen to work more closely with the redesign team to help communicate with frontline workers.

7.4.2 Engagement was also seen by staff as an opportunity to re-engage with the My Life a Full Life programme, where there may have been little contact since it was first launched. However, it became evident there are also significant in-year changes facing staff. This pre-existing sense of 'change fatigue' may have either reduced the willingness among some quarters to engage in the early phase of the redesign or contributed to a degree of scepticism.

7.4.3 It was observed that council staff was more likely to express concerns about being seemingly marginalised within My Life a Full Life. Other concerns related to more immediate pressures and a perception of limited communication from Council leaders to staff about the direction of the programme.

7.4.4 The My Life a Full Life team has conducted a number of staff and volunteer events and briefings at both Council and NHS Trust and CCG locations, which nonetheless aimed at addressing these comment and providing a foundation for further engagement. Briefings were created and made available to attendees. Such briefings were made available not just centrally but also via partner organisations.

7.5 Events

7.5.1 During the public engagement it was decided to expand the number of events the My Life a Full Life team attend and highlight the ongoing communications consultation. Public attendance at the initial events in Shanklin and Newport was good, supported by a social media push, press advertising and information shared via partner organisations.

7.5.2 One of the lessons learned from this process was that having 18 public co-production events may have needed reconsideration. They presented a great opportunity for members of the public to engage with the redesign project, as it covered all geographical localities and focus areas. Yet there was considerable variation in numbers of attendees, where some events only had a handful of attendees. Conversely, some events were attended by a great number of people. For example, there were 36 people that attended the 9th May Mental Health event but no attendees came to the Urgent and Emergency Care event on the 10th May. Another lesson from these was that it helped the events to have more senior clinicians attend, and to not schedule events in the evening time as these events attracted fewer attendees. Partnerships with the voluntary sector were also key. Mental Health events were supported and heavily promoted by voluntary sector organisations whereas Urgent and Emergency Care events were not and subsequently had considerably lower turnout.

7.5.3 The support of a partner organisation for events on a given focus area, generally led to improved attendance, and this should be taken into consideration for future events.

Attendance at local events could also be boosted by further advance notice or posters in public spaces around the locality in the preceding month. Further ensuring that events do not clash with existing events on the Island would also go towards increasing attendance at public engagement events.

7.5.4 As with any series of public events, there was at times conflicting feedback from people unable to attend about making them more accessible by holding them on different days of the week or at different times. The My Life a Full Life team attended Health and Wellbeing Roadshows to help reach a wide range of members of the public. Plans for a public exhibition during the early phase of engagement were put on hold, but should be revisited as part of further communications activity. This could perhaps be combined with additional activity at high footfall public spaces to reach people in everyday situations, such as local supermarkets, and existing public events.

7.6 Publicity and channels

7.6.1 Additional activity on social media may have contributed to boosting attendance at key events. Future engagement might be better informed by the data analytics generated by digital communication strategies to date, such as information on demographics, to target specific groups, including people with protected characteristics.

7.6.2 The locality co-production events showed that direct mail remains an effective way of reaching a broader audience on the Island. Some attendees who had received a copy of the ‘Time to Act’ leaflet had previously been unaware of My Life a Full Life or seen adverts in the local press.

7.6.3 While there are challenges on data protection involved in working with a range of partner organisations, the variety of email distribution lists and lack of data on engagement (such as tracking via analytics) make it problematic to assess to effectiveness of email for communication with the public.

7.6.4 Discussions with staff showed that they receive several different email bulletins, both internal and external, and as a result, many of them go unread. It is clear from feedback from staff that further consideration on this point is needed.

7.7 Next steps

7.7.1 A key decision for the redesign will be the timings of any formal consultation, following the NHS England assurance process, and this will inform the activity in the next phase. This time ahead of consultation could be used in a number of ways, including:

- For the Health and Care System Resign Board and OMG to consider conclusions and observations from the initial phase of engagement and agree priorities for the coming period

- Updating organisations on the Island in both professional and voluntary sectors, as well as members of the public who attended event, on direction of travel of the redesign and next steps
- Developing case studies on issues identified by the working groups
- Additional direct engagement with so-called ‘hard-to-reach’ communities and groups representing people with protected characteristics
- Planning of consultation activity to reach maximum audience, including identifying public spaces for posters or exhibitions

APPENDIX – TABLE OF CONTENTS

APPENDIX ONE – FULL RESPONSES TO SURVEY

i) **Table of response numbers**

Response type	Number of responses
Paper	434
Online	189 (average)
Emails	63
Social media	4
Phone calls	22
Letters`	11

ii) **Feedback letters**

Feedback via letters	
Date	15th May 2016

Key summary points

Respondent identifies good and poor services as well as proposed changes, as follows:

Good

Hospital

- Hygiene improved, infection rates down
- Hospital nurse specialists are excellent
- Ambulance staff are well trained, efficient and kind

Community

- Phlebotomy and pharmacy services are excellent

Poor

Hospital

- Outpatient waiting time too long
- Some communication levels could be improved

Community

- GP levels
- Long hold times on telephones sometimes

Changes

- Cottage hospitals for short term GP care, short term convalescence and rehabilitation.
- Day centres with clinic amenities
- Saturday surgeries

Hospital

- NHS nurse banks (as opposed to using agencies)
- Better management of nurse staffing levels on wards

Feedback via letters	
Date	NA

Key summary points

Respondent wrote in about their personal experience and changes they would recommend to specific areas of the health and care system.

Care Services

- Respondent had poor experience with carers who were tasked with looking after the individual's mother who had dementia but who did not provide adequate care. Examples included not checking up properly, administering the wrong medication and lack of understanding of a patient's condition (e.g. asking them if they were hungry when patient had dementia).
- When challenged by the patient they abruptly cut off contact and terminated the contract.

Social Services

- Respondent criticises the social services, arguing that most lack understanding and experience of patients with certain conditions and rely too much on textbook knowledge. The individual argues that in reality a 'one size fits all' approach does not work and patients need personalised care tailored to their condition.
- As a remedy, the respondent suggests that textbook knowledge should only ever be used as a guide and that social services need to cooperate with the patient's carers and/or family.

Care Homes

- The individual's mother was admitted into a care home on the recommendation of the Social Services. Though the care home was pleasant and friendly and took care of the patient's social needs, they let her down on health care. Respondent reports that their mother suffered from weight loss whereas she previously had a healthy appetite. In addition the patient suffered from injuries and bruises which were not explained. The respondent also states that she requested care home staff to provide a check-up for a breathing problem. This went ignored and the patient subsequently developed pneumonia.
- There were too many part time, irregular staff who have no connection with the care home patients or have enough knowledge about their condition.
- Not enough regular full time staff to be able to spot differences in mood and health.
- There is a culture that people enter care homes to die therefore the quality of their health is not important to staff.

- A useful remedy would be to employ more full time staff who recognise changes, are invested on their jobs and cooperate with the patient's family.

CCG

- Respondent deeply unhappy about the organisation and felt victimised after her complaints went unheeded.
- Respondent feels there could be more transparency and integrity in the organisation so that patients didn't feel exploited.

A&E

- Hospital nurses need a better understanding of some conditions, such as dementia and be aware of when it is appropriate to ask a patient to make a decision.

Feedback via letters	
Date	19TH May 2016

Key summary points

Respondent wrote in to say they had a very disappointing experience with the ITCCS Physiotherapy service (Integrated Care Clinics?). Though they initially had a successful keyhole operation for their knee they did not receive adequate after care or physiotherapy after having been late for an initial appointment on the mainland.

- There was miscommunication and lack of signposting with the result that the patient had his first physiotherapy 12 weeks after his surgery.
- Facilities were not adequate, instead of specialist equipment to measure the strength and mobility of the knee it was simply a converted office with a curtain divider so that two patients could be seen at the same time. There was no privacy and the staff members had no access to an IT system so his details were handwritten. It was clear to the patient that the staff had no access to his GP records or medical history.
- Patient felt he was not given adequate care or assessment. This did not improve on his subsequent visit; the staff did not measure his progress (there were no devices or equipment available to measure his strength, improvement, mobility, etc.) or provide a further appointment.
- It emerged that the staff were not actually NHS as the service had been sold off and they were doing what they could. They also mentioned that the facilities at another location were no better as it was a converted store room.

Feedback via letters (re Mental Health Consultation, Riverside Centre)	
Date	9th May 2016

Key summary points

The redesign should aim to:

- Maintain the highest quality in the NHS professional 'acute' / crisis services – to sue them to their maximum clinical effectiveness whilst in parallel there should be some actions to reduce demand for these services.
- Maintain the highest quality professional 'primary care' services, especially early intervention psychosis, linking into partnerships with other NHS teams, specialist organisations in the community and patient groups that result in both prevention and recovery, and a consequent safe reduction in the level of demand for NHS services
- Redesign an approach / understanding across the Island to mental health that achieves thee aims.

    - Training for all staff in the NHS on how to identify and how to respond effectively and in a timely manner to mental health issues. In particular this needs to be addressed to those groups for whom mental health is only a component of their work so that they can recognise the 'signals' and be able to redirect those patients to the right NHS professional. This is important for preventative provision from schools to nursing homes – school nurses, health visitors, dieticians, etc.

    - Building a 'Network of Community Organisations' skilled in being able to respond to mental health, so that patients can be referred before, during or after.

    - Trained / educated staff at private companies, schools and other public service organisations who can respond to mental health in an effective way.

    - Greater understanding about mental health on the island so that there is no stigma and that mental health episodes are treated as importantly as physical health episodes.

    - More support for specialist 'Third Sector Community Team' such as the Island-based 'My Team' who can assist with social, financial, housing advice and signposting to other services. These can appear daunting to an individual without support and if not addressed can impair recovery.

Feedback via letters (response to Long Term Health Conditions, Brookside)	
Date	10th May 2016

Key summary points

Respondent recommends the following changes in order to ensure effective NHS services for people with LTC:

- Specialist training for individuals with LTCs and their carer, partner and guardian which covers self-monitoring technology, guidance and knowledge about their condition from NHS professionals so that they can effectively self-manage. This would require NHS and Social Care Sector to develop training and set aside resources to train and appoint staff such as community matrons, school nurses, etc.
- An acknowledgement that mental ill-health may be a direct consequence of experiencing physical ill health by both patient and carer/parent/guardian. To train NHS staff to identify these and be able to refer to appropriate preventative programme.
- Long term health conditions should be considered and renamed as Life Time Health Conditions, especially where these conditions started at birth. The current care system is skewered markedly in favour of persons aged 50+
- It would be useful to have a Network of Community Organisations (similar to the one proposed in the Mental Health response). These would ensure that patients and their families can access support groups and would also help reduce demand on the NHS.
- Recognition of the contribution of the arts to treatment, prevention and effective self-management. He highlights several programmes in this area which Healing Arts provide.

Feedback via letters	
Date	

Key summary points

- Respondent writes that her experience with emergency services when she needed urgent surgery was fine, but that it was her experience of day surgery and going into her routine hospital appointments that left her disappointed.
- She found that waiting times were far too long with a shortage of nurses which left other hospital staff very stressed and rushed. As a result she felt she didn’t receive a good standard of care and left feeling inadequate as she didn’t get to communicate adequately with the nurses.
- Respondent suggests some key changes that are needed:

    - More attention and care needs to go to patients suffering from the early stages of dementia as they are often ignored
    - The NHS is underfunded and it is having a detrimental effect on the service it provides. This needs to be addresses by the Government
    - Nurses and medical staff need to be trained more to treat patients with kindness. This would have a positive effect on their quality of life.
    - More communication between hospitals on the mainland such as the one located in Southampton and Isle of Wight authorities who could work together to produce leaflets with key information about who to contact, services provided, etc. Isle of Wight residents often have to access mainland hospitals as some areas of surgery are not provided on the island. On discharge it would be helpful to ensure that patients understand their condition, what they

should expect, and who they contact if they need help. The level of care on these mainland hospitals need to improve to compensate for patients being separated from family and friends.

  - It would be helpful to have an assurance of care which can be provided by nurses so patients do not necessarily need to see a doctor.

Feedback via letters	
Date	21ST May 2016

Key summary points

- Respondent wrote in about their most recent experience of St Mary's Hospital where his 98 year old mother was admitted suffering from a chest infection. He writes that while there seemed to be plenty of staff there was very little management control so that everything appeared disorganised and haphazard. There was very little follow up to check that actions had been completed with the result that visitors had to request attention from staff repeatedly before tasks were undertaken. For example, his mother waited two days before a dressing was changed. On another occasion there was an oversight and menus were not distributed around the beds. The outcome was satisfactory but their experience of nurses was disappointing.
- It was obvious that in order to have good care patients at St Mary's need support from the outside, such as from their partner or carer, particularly elderly patients.
- In contrast the standard of care at Bournemouth General was very good and MLAFL need to work closely with them for best practice and advice.
- Respondent mentions anecdotal reference that staff at St Mary's is provided from agencies, and speculates that this may be why they seemed to lack direction or pride and care for their job with no visible good leadership.
- Respondent recommends decentralisation away from St Mary's which can be achieved through:
  - More responsibility being passed to pharmacies for minor attention to ailments, who can (if necessary) pass patients to the most appropriate department
  - Local clinics to be established around the Island, offering A&E services (particularly for cardiac arrest)
  - Weekend opening of GP practices – at least during day time hours
  - The above could be partly funded by a lottery on the island

Feedback via letters	
Date	12th May 2016

Key summary points

- Respondent criticises the perceived top heavy management in hospitals where there are too many senior executives and not enough staff who do the ground work. This is putting the whole hospital system under financial strain and putting patients at risk. As well cutting back on senior staff, the respondent suggests enlisting more volunteers to help hospital staff.
- There is low morale among patients which slows down their recovery and deepens the issue of hospital beds being blocked.
- Respondent feels all illnesses and health conditions need to be treated with the same level of importance, and that end of life care is just as important as maternity care.
- The individual is also very sceptical about the MLAFL survey, questioning whether it

will make any difference.

Feedback via letters

Date	19th May 2016

Key summary points

- The programme's aim to 'help people lead heathier lives' is very commendable but it also needs to stress that people should take more responsibility for their own health too, such as doing daily exercise especially when residents live in places like the Isle of Wight. Respondent mentions that within six months of moving to the Isle of Wight and taking regular walks, her medication for asthma was withdrawn by her GP as she no longer needed these.

- Respondent mentions that the Isle of Wight has many sports facilities which are reasonably priced and easy to access. In addition, most community services such as the Sandown library provide yoga, exercise and singing classes; the latter two are fee and well attended.

- Respondent also mentions that the doctors at the Lake (Beech Grove Lake in Sandown?) are very good and that there are plenty of "fantastic" things about the Isle of Wight to be proud of.

Feedback via letters

Date	-

Key summary points

- Respondent writes that she was very pleased at the standard of care she received from a Care Manager when her husband was diagnosed with Parkinsons and Dementia. The Care Manager arranged respite care as well as a sitter which allowedher some flexibility and opportunity to take a break. However, she never found about extra help in the form of Care Allowance or Disability Living Allowance which would've been helpful.
- On a personal note, the respondent mentions that after having received wonderful care at St Mary's Hospital for a broken arm and leg she was sent to Highfields Nursing Home in Ryde which was a big mistake. She writes that not only did she not receive care and medication, but she was put in a room with no toilet facilities and care staff had falsified her reports to say that she had been checked every two hours when this was not the case. After she left the care home there was no follow up and no care was offered.
- The writer provided a list of recommendations, including:

    - Training dedicated Care Liaison Managers, such as an ex hospital nursing staff, in multiple disciplines of care, so that they have knowledge and contacts in medical care, social services care and benefits. For example, her doctor never mentioned that she could apply for Care Allowance or Disability Living allowance. To have on point on contact with knowledge about these services would be very helpful.

Feedback via letters

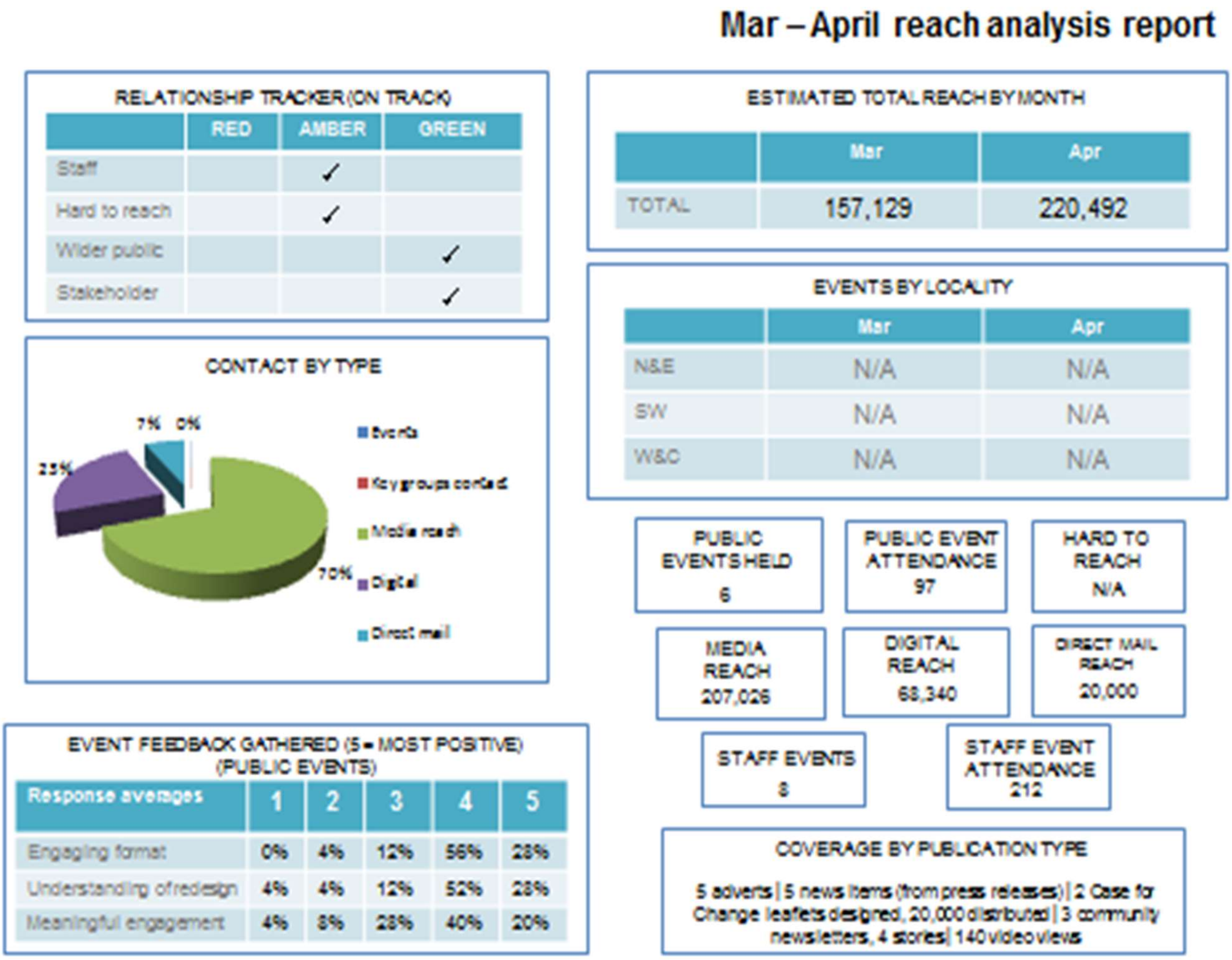
Date	13th May 2016

Key summary points

- Respondent states that her personal experience of health services within the past two years – especially of community services – is one of remoteness and total lack of communication. Since her previous GPO retired she doesn’t know who her new GP is or what the process or system is like to see a doctor or nurse.
- Positive experience of St Mary’s Hospital for a surgery that had been treated well 14 years ago.
- She suggests much more could be done with the elderly in the community through training in technology. She briefly mentions the Virtual Patient Participation Group which she was part of but has since disappeared without any sign or feedback. A similar system, if run well, would enable patients to use technology to communicate, obtain diagnosis, or referral and generally stay connected. This would be especially valuable for elderly people who live on their own and value their independence.
- Other significant improvements would be to see transport to appointments, regular / prearranged home visits by experienced staff. This type of personal visits would cut down on surgery or hospital visits.
- Overall, the Community Health Services on the Island seem remote and unable to provide adequate services or communication to patients – at least in West Wight.

APPENDIX TWO – EVALUATION FORMS FROM PUBLIC EVENTS

i) **Engagement reach analysis – March and April 2016**



Mar – April reach analysis report

RELATIONSHIP TRACKER (ON TRACK)

	RED	AMBER	GREEN
Staff		✓	
Hard to reach		✓	
Wider public			✓
Stakeholder			✓

ESTIMATED TOTAL REACH BY MONTH

	Mar	Apr
TOTAL	157,129	220,492

EVENTS BY LOCALITY

	Mar	Apr
N&E	N/A	N/A
SW	N/A	N/A
W&C	N/A	N/A

CONTACT BY TYPE

PUBLIC EVENTS HELD
6

PUBLIC EVENT ATTENDANCE
97

HARD TO REACH
N/A

MEDIA REACH
207,026

DIGITAL REACH
68,340

DIRECT MAIL REACH
20,000

STAFF EVENTS
8

STAFF EVENT ATTENDANCE
212

EVENT FEEDBACK GATHERED (5 = MOST POSITIVE) (PUBLIC EVENTS)

Response averages	1	2	3	4	5
Engaging format	0%	4%	12%	56%	28%
Understanding of redesign	4%	4%	12%	52%	28%
Meaningful engagement	4%	8%	28%	40%	20%

COVERAGE BY PUBLICATION TYPE

5 adverts | 5 news items (from press releases) | 2 Case for Change leaflets designed, 20,000 distributed | 3 community newsletters, 4 stories | 140 video views

March

Public Events

- 2 x Public Engagement Event (65 attendees)

Staff Events

- 1 x Professionals Event (estimate 35 attendees)
- 1 x Council Drop-In (3 attendees)

Media

- Case for Change leaflet designed and 20,000 distributed to 100 addresses
- 2 items distributed across 3 newsletters (My Life A Full Life, NHS Trust membership (5,000 distribution) and Community Action)
- 2 adverts (public events, general engagement) in the IOW County Press (estimated readership of 97,026)
- 2 press releases
  - Case for change launch (hard copy only) in the IOW County Press
  - Call for public views to shape the future of the health services in the Island Echo (55,000 monthly unique browsers)

April

Public Events

- 1 x Health and Well-being Roadshow (23 attendees)
- 1 x Youth Council (9 attendees)

Staff Events

- 1 x CBU: Urgent Care (estimate 10 attendees)
- 1 x Trust Executive Briefing (estimate 10 attendees)
- 1 x Town and Parish Councillors event (8 attendees)
- 1 x Medicine for Members (37 attendees)
- 1 x CBU: Cancer and Diagnosis (estimate 10 attendees)
- 1 x Staff and Volunteer event (estimate 15 attendees)
- 1 x Adult Social Care meeting (80 attendees)
- 1 x Council Drop-In (4 attendees)

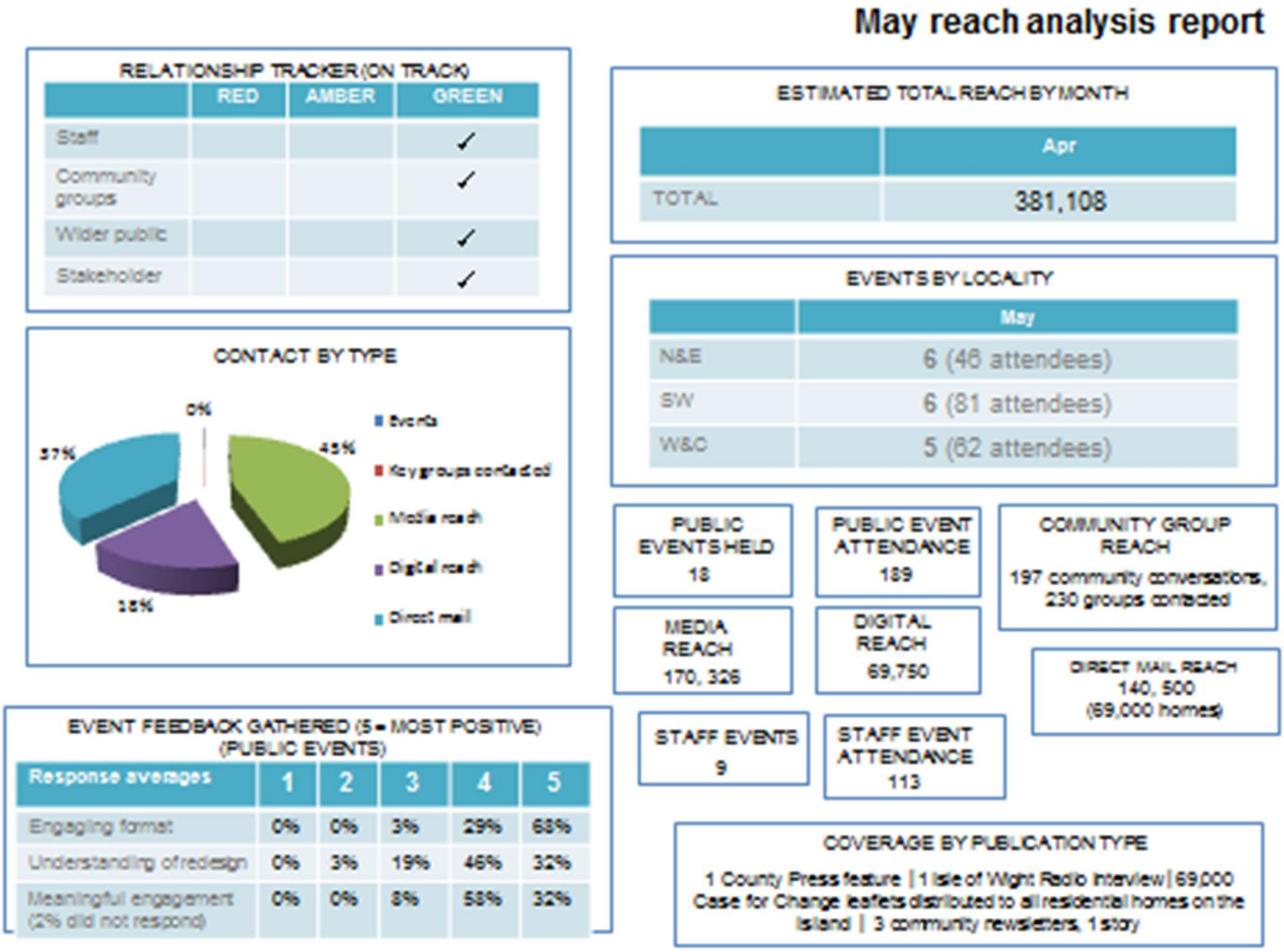
Media

- Case for Change: Easy to Read leaflet designed
- 2 items distributed across 3 newsletters (My Life A Full Life, NHS Trust membership and Community Action)
- 2 adverts (working groups, locality events) in the IOW County Press (estimated readership of 97,026) and the IOW Beacon (average circulation of 50,000)
- 1 video (currently 140 views on YouTube, used at public events)
- 2 press releases in the Island Echo (with 55,000 monthly unique browsers)
  - Write-up on public events in Shanklin and Newport
  - Forthcoming locality events (this week)

Digital

- £10 a week (reaching 950 - 2,500 people a week) for 1 week
- £300 a week (reaching 18,300 – 48000 people a week) for 2 weeks

ii) **Engagement reach analysis – May 2016**



May reach analysis report

RELATIONSHIP TRACKER (ON TRACK)

	RED	AMBER	GREEN
Staff			✓
Community groups			✓
Wider public			✓
Stakeholder			✓

CONTACT BY TYPE

EVENT FEEDBACK GATHERED (5 = MOST POSITIVE) (PUBLIC EVENTS)

Response averages	1	2	3	4	5
Engaging format	0%	0%	3%	29%	68%
Understanding of redesign	0%	3%	19%	46%	32%
Meaningful engagement (2% did not respond)	0%	0%	8%	58%	32%

ESTIMATED TOTAL REACH BY MONTH

	Apr
TOTAL	381,108

EVENTS BY LOCALITY

	May
N&E	6 (46 attendees)
SW	6 (81 attendees)
W&C	5 (62 attendees)

PUBLIC EVENTS HELD
18

PUBLIC EVENT ATTENDANCE
189

COMMUNITY GROUP REACH
197 community conversations, 230 groups contacted

MEDIA REACH
170, 326

DIGITAL REACH
69,750

DIRECT MAIL REACH
140, 500
(69,000 homes)

STAFF EVENTS
9

STAFF EVENT ATTENDANCE
113

COVERAGE BY PUBLICATION TYPE

1 County Press feature | 1 Isle of Wight Radio Interview | 69,000 Case for Change leaflets distributed to all residential homes on the Island | 3 community newsletters, 1 story

May

Public Events

- Frailty - 3rd May (12 attendees) (NE), 9th May (9 attendees) (WC), 11th May (6 attendees) (S)
- Planned Care - 3rd May (4 attendees) (NE), 11th May (3 attendees) (WC), 12th May (4 attendees) (S)
- Mental Health - 4th May (24 attendees) (NE), 9th May (36 attendees) (WC), 13th May (14 attendees) (S)
- Urgent Care - 4th May (13 attendees) (NE), 14th May (7 attendees) (S)
- LTC - 5th May (22 attendees) (NE), 10th May (8 attendees) (WC), 13th May (12 attendees) (S)
- Women and Children - 7th May (12 attendees) (NE / WC), 14th May (3 attendees) (S)

Stakeholders

Andrew Turner MP

Staff Events

- 1 x Staff and Volunteer Event (estimate 15 attendees)
- 2 x NHS Staff Event (estimate 20 attendees)
- 1 x CBU: Women's and Children's (estimate 8 attendees)
- 1 x CBU: Mental Health and Learning Disabilities (estimate 10 attendees)
- 1 x CBU: Medicine (15 attendees)
- 1 x International Nurses Day (estimate 15 attendees)

- 1 x Practice Nurse Forum (estimate 15 attendees)
- 1 x Mental Health Fete (estimate 15 attendees)

Media

- Case for Change leaflet mailed out island-wide (69,000 homes)
- 1 feature on urgent care in the County Press (estimated readership of 97,026) (print only)
- 1 feature on Isle of Wight radio (estimated listenership of 55,000)
- 1 item distributed across 3 newsletters (My Life A Full Life, NHS Trust membership and Community Action)

Digital

- £300 a week (reaching 18,300 – 48000 people a week) for 2 weeks
- £10 a week (reaching 950 - 2,500 people a week) for 2 weeks

Community groups / other

- 1 x councillor briefing (9 attendees)
- Hard to reach mailed out to 230 community groups
- Community conversations
    - Barnardo's - Stay and Play (9 attendees), Breastfeeding Support (9 attendees), Baby Club (6 attendees), Under 25's mum's group (4 attendees), Ventnor (8 attendees)
    - Salvation Army, homeless hostel (6 attendees)
    - Brading Youth Club (12 attendees)
    - Riverfest (18 attendees)
    - Beacon Centre (52 interviewees)
    - Active Living (32 attendees)
    - Way Forward (5 attendees)
    - Earl Mountbatten Hospice (1 attendee)
    - IW College (20 attendees)
    - St Mary's Hospital – Pharmacy / Lounge (15 attendees)
    - Carers' consultation (65 attendees)
    - Oddfellows (22 attendees)

APPENDIX THREE – DETAILED WRITE UPS FROM EVENTS AND MEETINGS

i) **Public engagement event – 21 March 2016**

Meeting summary note	
Meeting name	Public event
Date	21 March
Location	Landguard Manor, Shanklin
MLAFL team members present	Various team members – Elisha King table
Presentation method	Presentations from David Newton, John Rivers and Mike Bulpitt
Number of attendees	35

Issues discussed and outputs (continue over if required)

- The table convened included seven people covering a range of ages.

- Looking at priority areas, the group were particularly focused on:
    - Mental health
    - Managing long term conditions
    - End of life care
    - Support for young people

  There was some disagreement over the statistics provided for the teenage population, and some argued that the term ‘vulnerability’ needed clear definition.

In terms of strengths, the following were agreed upon:

- Wight Care, community alarm and telecare service
- Volunteering community, “without the volunteers, the island would sink”
- Services for diabetes
- GP appointments – if you are willing to be flexible
- Confidence in the community navigator roles
- Maternity services

In terms of challenges, the following were agreed upon:

- Underfunded services
- Not enough on the island, specifically around general practice
- Advocacy – nothing has happened in this area since 20 years ago when the initiative started. No joined up thinking
- GP appointments – inconsistent across the island, need one way to get an appointment
- Bed-blocking – behaviour needs to be challenged, step-up/step-down care needed and encouragement of independence needed. People need to be educated on the costs of hospital care
- Hospice care is limited by days
- More independent living needed with close support
- Dementia – no appropriate living conditions, close to family

The group has some conflicts around:

- Travel - whilst there was understanding that for some services you may have to travel off the island, it was seen as a major challenge for the island in terms of access
- Beacon centre – seen as a strength for the island, as an alternative, encourages skipping trying to make a GP appointment

The group focused on the potential of certain roles to make a greater contribution -

- Community navigator – the group had general confidence in their roles and raised question of whether they could also become educators. It was agreed that over 65s should be encouraged and trained to be community navigators.
- Parish councillors, could know who carers are but don't know yet. Improvements could be a better voluntary link with parish councils.

The group also voiced concerns over certain groups – particularly, those who don't shout the loudest, mental health users, vulnerable children and teenagers, carers who need more support. There was a general comment that one size care / treatment doesn't fit all.

Next steps

Information to be fed into modelling team.

Meeting summary note	
Meeting name	Public event
Date	21 March
Location	Landguard Manor, Shanklin
MLAFL team members present	Various team members – Gouljan Arslan table
Presentation method	Presentations from David Newton, John Rivers and Mike Bulpitt
Number of attendees	35

Issues discussed and outputs (continue over if required)

In terms of strengths, the following were agreed upon:

- Tailored, sensitive care
- Seven Acres, care for older people

In terms of challenges, the following were agreed upon:

- Aftercare could be better
- Bereavement counselling
- Care for carers
- Transport – better links, room for improvement
- Co-ordination between wards and departments
- Communication and education to raise awareness about certain services, as some people on the island are not always aware

Looking at the priority areas, the group prioritised:

- End of life care – something everyone will experience. Providing proficient care for carers, including bereavement counselling. Bed-blocking and ensuring the whole system works smoothly. Very important issue in light of the island's population.
- Mental illness / health – especially in young people, ensuring that problems don't escalate. The group also felt that people with mental health problems should be taken more seriously and not dismissed for their youth. Similarly it was felt that the issue of self-harm needed more attention together with deeper, more comprehensive care (i.e. care that goes beyond just therapy).
- Children and young people

Urgent care was seen as 'neutral' as the group though that a focus on education and prevention could solve many of the issues.

Next steps

Information to be fed into modelling team.

Meeting summary note	
Meeting name	Public event
Date	21 March
Location	Landguard Manor, Shanklin
MLAFL team members present	Various team members – John Lunny table
Presentation method	Presentations from David Newton, John Rivers and Mike Bulpitt

Number of attendees	35

Issues discussed and outputs (continue over if required)

- The table convened included six people of varying backgrounds and ages -Richard, who had previously worked in local authority and had undergone treatment both on the island and the mainland; Pat, from Ventnor an ex-nurse involved in a bowel cancer support group, she had orthopaedic surgery a few years ago (knees) where she had NHS appointments cancelled in the past so went private subsequently for later surgery; John his wife Pam have a niece with autism in Brighton; Liza, from Shanklin and Graeme from Southern Housing

- The group was very focused on the difficulties the island geographically faces in terms of services – in terms of mapping care, travel and staff shortages. Young adult care and a more joined up service were seen as the two areas for most significant improvement.

In terms of strengths, the following were agreed upon:

  - Support groups play an important role, but Pat mentioned that at times their interaction with clinicians and professionals was not so good, for example the bowel cancer support group initially started out to raise funds for a colonoscope
  - Professionalism of individuals working in the health and care service
  - Neighbours and communities looking after each other

In terms of challenges, the following were agreed upon:

  - Difficulty of mapping demand for services – for example one of the island’s strengths was the number of dedicated people working in learning disability areas on a 1-2-1 basis; a challenge was on funding challenge and how to address a complex group such as people with autism both in terms of health and accommodation
  - Cost of travel to the mainland for treatment. Island didn’t have the resources to deal with things on the island, eg. Radiotherapy
  - Signposting of services could be improved
  - Charities weren’t focused enough on young adults, for example, Autism Society. However, Aspire was mentioned as a charity that worked well with young adults
  - Better joining up of services was needed and information-sharing. Graeme argued that better communication was important, John claimed that his personal experience with diabetes clinics and communication was positive but 8 years ago while a quad bypass off the island went well the follow-up with support groups back on the island was less so. Graeme argued that better information-sharing between organisation was needed, citing the example that there was no formal agreement between Adult Services and Southern Housing.
  - Staff shortages - John argued that staff shortages seemed to undermine care, Pam noted GPs retiring earlier
  - Bed-blocking – Pat argued there were not enough care homes, noted that her family had difficulties releasing her father from hospital despite the fact they had a private care home being ready to receive him. John argued that more care homes should be provided through housing associations on a not-for-profit basis

Looking at the priority areas, the group prioritised:

  - End of life care (strongly agree). Earlier diagnosis of dementia was seen as a good thing, although many in the group argued that earlier diagnosis of most things would be beneficial. General agreement on the importance of people being able to die at home, and perhaps that carers should be given the confidence to take more responsibility rather than sending people to hospital

- Urgent care (strongly agree). Initially there were mixed views as to whether urgent care should be a priority concern, although it was later argued that it was important and needed to be effective

- Frailty – keeping people out of hospital (strongly agree), limited time for discussion

- Mental health (agree). The group believed that physical and mental health were linked, but that physical health issues were often more evident which may lead towards those being prioritised more. General view that joint working between local authorities and health should be better

- Vulnerability (agree). General view that issues such as obesity are a major problem but can perhaps be better treated through lifestyle choices than health services or medication, a view that is was often a 'social issue' such as binge drinking although some cases of more serious dependence would become medical. A discussion on the role of prevention versus treatment. One view that lifestyle should be most important given impact on other health issues, but the group decided on 'agree' with the statement

- Women & Children (neutral). One view that a well looked-after older population had wider benefits for society, noting older people had already contributed to society. General view that people needed to take more responsibility for their own health, looking after minor issues such as nosebleeds at home rather than using out-of-hours or urgent care services. However Graeme noted the important role of women's refuges

- Long-term conditions (agree). General view that management of long-term conditions was desirable (limited time for discussion)

Next steps

Information to be fed into modelling team.

Meeting summary note	
Meeting name	Public event
Date	21 March
Location	Landguard Manor, Shanklin
MLAFL team members present	Various team members – Liz Laurence table
Presentation method	Presentations from David Newton, John Rivers and Mike Bulpitt
Number of attendees	35

Issues discussed and outputs (continue over if required)

- The table convened included seven people – these included Jan and Barbara from the South Advocacy Services, Elizabeth who has recent experience of the gastroenterology services, Maggie, whose family had a history of mental illness, Dr John Rivers and James Seward and one other.

In terms of strengths, the following were agreed upon:

  - Dementia care – facilities and resources, including the Alzheimer's Café
  - Type 2 Diabetes research was thought to be especially good
  - Hospital – good facilities and patients kept well-informed
  - Experience with gastroenterology unit, specialist nurses and knowledge-sharing had allowed Elizabeth to take ownership of condition and self-manage. The group agreed that this should be universal
  - Pharmacists – helpful in health 'empowerment and good at following up
  - Communities – seen as a strength, Ventnor as a good example

In terms of challenges, the following were agreed upon:

  - 'Package of care'. Social workers seemed to lack information or knowledge about who they were working with. Dr Rivers commented that this might be more a perception of support, rather than what was actually in place
  - Assessment – could be better, more co-ordinated
  - Knowledge of services – the group were impressed when Maggie shared information about the AgeUK programme on the island but questioned the access and availability of the scheme
  - Sharing information within communities

Looking at the priority areas, the group prioritised:

  - Frailty (strongly agree) – loneliness and isolation in older people, vs. their physical healthcare
  - Urgent care (strongly agree) – there was agreement that there was not enough respect for the hospital services. Some members of the group argued that more of a 'failure' culture was needed for admissions.
  - Long-term conditions (strongly agree) – the group asked whether mental health should be included in the category. It was agreed that management and control over your condition was key – demedicalisation.
  - Women and children's health (agree) – the group commented that there was a need for good transitional planning for children with disabilities into adulthood
  - Mental health (agree) – the group believe there was more that could be done to prevent the worsening of conditions and rising cost of mental health treatment, and that it should play a role in every pathway. Some members of the group did question whether there was enough support already
  - Dementia (neutral) – most of the group believed it was over diagnosed already
  - Vulnerability (strongly disagree) – the group agreed that there were more sophisticated ways to make decisions about funding

The group did focus quite considerably on the role the community could play in health and social care. The idea of a 'health plan in the community' was raised believing responsibility for care ultimately lay with the community.

Next steps Information to be fed into modelling team.

Meeting summary note	
Meeting name	Public event
Date	21 March
Location	Landguard Manor, Shanklin
MLAFL team members present	Various team members – Wendy Mitchell table
Presentation method	Presentations from David Newton, John Rivers and Mike Bulpitt
Number of attendees	35

Issues discussed and outputs (continue over if required)

In terms of strengths, the following were agreed upon:

- Beacon Centre – positive experiences with fall
- Voluntary sector - wealth of provision, but not co-ordinated
- People have a right to die where they choose, on the whole
- Provisions for learning disabilities - dedicated nurse in the hospital, learning disability team accessible when there are issues
- Small size of the island ensures people are connected

In terms of challenges, the following were agreed upon:

- Disjointed services, with many duplicating each other and residents not knowing where to go for services. The group agreed that there were lots of voluntary sectors services but sometimes they seemed to duplicate and were not always coordinated or talking to each other.
- Community support – the group believed that informal neighbourhood or community support was on the decline, shrinking network of support from friends, family and neighbours
- Care isn’t reaching people early enough, which can lead to other problems, especially in mental health
- Learning disabilities – cut backs on learning disability care managers, increasingly exclusive criteria for some learning disability services.
- GPs – don’t always take symptoms seriously from those with learning disabilities, increasing pressures on GP time. Self-referral awareness is low
- Discharge planning – for people who live alone and are coming out of hospital, discharge planning is too short-term focused
- Respite services require more investment; placements were seen to be hard to access meaning people stay at home for longer. The group asked whether it could be more based in the community, with residents offering placements?

Looking at the priority areas, the group prioritised:

- Children and young people – ensuring the right lifestyle behaviours are learned at an early age
- Mental health – prevention. GPs need more time, and to listen to parents and carers more, to ensure real concerns are felt.
- Frailty – loneliness and isolation

The group agreed that if the above were prioritised, it would remove significant pressure from urgent care services. There was a significant focus from the group on learning disabilities and the island’s provision for them. Concerns were raised around issues with judgment of ‘capacity’ as affecting care provision.
Next steps Information to be fed into modelling team.

ii) **Public engagement event – 22 March 2016**

Meeting summary note	
Meeting name	Public event
Date	22 March
Location	Quay Arts, Newport
MLAFL team members present	Various team members – Amy Milford table
Presentation method	Presentations from David Newton, John Rivers and Mike Bulpitt
Number of attendees	40

Issues discussed and outputs (continue over if required)

- The table convened included six people covering a range of ages that included three retirees, an Age UK professional, a volunteer and a councillor.

In terms of strengths, the following were agreed upon:

- Hospital and emergency services - professionals are respectful and work as quickly as they can to help you.
- Medical Assessment Unit – volunteers are a great help to the nurses
- GP in East Cowes – excellent service.
- Voluntary and community sector – Alzheimer's Café has become a network of support. Group members did comment that voluntary sector needed professional leadership.

In terms of challenges:

- GPs - need to be more responsive, need more doctors, appointment booking was referred to as 'ridiculous'. Difficulty to access which was seen as a national and local issue.
- Care in the community – 15 minute carer slots leave people lonely, need to provide emotional support, 'elderly' health visitors, and better communication between nurses and social workers.
- No forward planning after hospital discharges.
- Volunteers need to be used more and activities should be publicised.

Looking at priority areas, the group prioritised:

- Dementia – more GP support needed, difficult to diagnose. The importance of ensuring wishes are met was also mentioned.
- Isolation and loneliness – the group linked this to urgent care, commenting that it exists until crisis then lots of people get involved and becomes a really expensive problem. The group noted its role in preventing dementia.
- Young people – role of education in preventing future problems.
- Long-term conditions – a good quality of life needs to be maintained so it doesn't become an emergency.

The group also commented on wider mental health – stating that it needs to be done differently, not more. Help should be provided earlier and treated as seriously as a physical injury. Some members of the group also commented that medication suppresses the

problem but does not address it and resources could be redirected to a more holistic approach. Prevention and hospitalisation was also discussed, with some members of the group commenting that hospitalisation should be preventing because people are healthy, or treated elsewhere – not because the hospital is understaffed or under-resourced.
Next steps Information to be fed into modelling team.

Meeting summary note	
Meeting name	Public event
Date	22 March
Location	Quay Arts, Newport
MLAFL team members present	Various team members – Bevan Boyle table
Presentation method	Presentations from David Newton, John Rivers and Mike Bulpitt
Number of attendees	40

Issues discussed and outputs (continue over if required)

- The group was very focused on
  - Prevention – through lifestyle education, early intervention key, should not be left to GPs but should happen through schools. A better response would reduce pressure on urgent care
  - Housing – mentioned more than once, inadequate housing supported unhealthy lifestyles leading to poor education and poverty

- Looking at priority areas, the group found it difficult to prioritise. However, when pushed, they were particularly focused on:
  - Young people –rated of self-harm
  - Mental health
  - Loneliness and isolation in older people

In terms of strengths, the following were agreed upon:

- Volunteers and charities work hard to plug a gap, volunteers step up where social care can't provide. Mental health volunteers were mentioned particularly as helping with less visible services like social clubs etc
- Group stated that they believe no services were believed to strong whatsoever
- Crisis team (111) have been good, but should be 24/7
- Beacon centre has been good at helping out with less severe emergencies

In terms of challenges:

- Some good practices that are expected on the mainland aren't carried out on the island
- Too many services require technology to access
- Unpaid adult carers make huge savings, need the right support. Don't get access to services until they reach a crisis point, need supporting during normal times
- Direct payments for children's services, there is not central list of carers to pick from
- GPs – over-reliance on GPs at present
- Adult mental health care – Chantry House is a disgrace, housing services related to mental health is terrible, hostels are awful
- Autism – currently invisible and not a priority.
- Young people – the group recognised that drinking in young people was a problem on the island, with some saying that they had seen children as young as ten drinking vodka at bus stations.

A comment was made around the potential of mixed generation living,reference to Sweden, solving social isolation for older people and young people benefited from guidance

Meeting summary note

Meeting name	Public event
Date	22 March
Location	Quay Arts, Newport
MLAFL team members present	Various team members – Chris Hogwood table
Presentation method	Presentations from David Newton, John Rivers and Mike Bulpitt
Number of attendees	40

Issues discussed and outputs (continue over if required)

- The table convened included nine people covering a range of ages, including several 70+ year olds and one 19 year old. The group was very focused in discussing prevention and self-empowerment as a means to deliver better healthcare for the Island. Almost every discussion came back to this main theme.

- Looking at priority areas, the group were particularly focused on:
  - Urgent/emergency care
  - Lifestyle choices – if greater emphasis on preventative measures
  - Children and young people – preventing self-harm.

- The group struggled to prioritise the majority of themes, except loneliness/isolation of old people which was seen as neutral.

- There was a broad discussion around the role of community – which was seen as an Island asset, although at risk of deteriorating.

- The Island was seen as a good place to be old – huge levels of activity for older people in the community.

In terms of strengths, the following were agreed upon:

- The size of the Island, which was an asset in terms of caring for a community
- Teamwork – various members of the table said that they had experienced good care and good collaboration between agencies
- Small teams that know each other – again linked to the Island point.

In terms of challenges:

- ‘turning the tanker around’ to focus less on medicalization and unnecessary medication to instead help people self-care and make more informed choices.
- The finances – everybody recognised and accepted the financial challenges.
- Communication – despite good experiences, people said services were bad at communicating with each other – the position was patchy – and with patients who aren’t always guided through the system.
- Growing needs – everyone recognise the pressure on services.

This group where particularly focused on education as a means to prevent poor health. They wanted to see more focus on prevention, better information on diet, healthy choices and signposting to reduce the burden on medical services.

Mental health and the role modern life plays was also a concern to many on the table who saw increased risks of mental health issues stemming from pressure on people working but also young people who needed more diversionary activities.

Meeting summary note	
Meeting name	Public event
Date	22 March
Location	Quay Arts, Newport
MLAFL team members present	Various team members – John Lunny table
Presentation method	Presentations from David Newton, John Rivers and Mike Bulpitt
Number of attendees	40

Issues discussed and outputs (continue over if required)

- The table convened included: Janice, retired teacher and daughter with learning difficulties; Diana, from Ryde, volunteer at Citizens Advice; Dave, lived independently, retired radar engineer and served in RAF during WW2, orphan in foster care since age of two; Fanny, a parish councillor and former nurse/carer; Mike Bulpitt, CEO Community Action IOW, and Councillor David Eccles

In terms of strengths, the following were agreed upon:

- Age UK and Care navigators
- Improvement in foster homes

In terms of challenges, the following were agreed upon:

- Carers – better central co-ordination needed.
- Primary care – lack of availability of GPs

Care navigators were discussed, with the group voicing confidence in their role, but believing more were needed

The group noted that services that have improved –

- STEM training in the college was now a strength, although remains a perceived lack of coordination in the past for transition to young adults for people with learning difficulties but that this had improved and that
- Foster homes, Dave commented on the improvement since he was in them

The group discussed the potential for more sheltered housing to help reduce bed blocking. There was also discussion that the island being a single area was perhaps a strength in terms of coordination with a single body such as the CCG, but that sometimes being an island was also a challenge

Looking at the priority areas, the group prioritised:

- Mental health (strongly, 1st) – the group agreed it was important to get people back on their feet, but discussion on how to prioritise resources.
  Mike noted the number of patients who had mental health issues and the need for more reablement services. One person noted her experience with someone on long-term sickness benefits, but questioned his claim of depression as a reasonable cause
- Women and children, self-harm in young people (agree, joint 2nd) Mike noted the important issue of self-harm among young women on the island
- Urgent care (agree, joint 2nd). Agreement that an effective urgent care system was important, but discussion about how well the system and referrals more widely were working now compared with in the past
- Managing long-term conditions (agree, 4th). Agreed, but noted the importance of prevention as well as management, such as through lifestyle changes
- Vulnerability, unhealthy lifestyle (agree/neutral). One strongly agreed that tackling lifestyle issues was important, but the group had mixed views and questioned how to *make* people take better decisions such as on alcohol
- End of life care, earlier dementia diagnosis (agree/neutral). While some questioned the benefits of earlier diagnosis, Janice noted her experience with her

father, while he was diagnosed early they should have prepared better but did not, and subsequent care arrangements should have been easier ○ Frailty, loneliness and isolation (neutral). Disagreement as to whether services on the island to reduce loneliness were working well, some views that reducing loneliness was important but others noted this could be managed within the community
Next steps Information to be fed into modelling team.

Meeting summary note	
Meeting name	Public event
Date	22 March
Location	Quay Arts, Newport
MLAFL team members present	Various team members – Liz Laurence table
Presentation method	Presentations from David Newton, John Rivers and Mike Bulpitt
Number of attendees	40

Issues discussed and outputs (continue over if required)

- The table convened included six people, mostly over 65 – including Dr John Rivers, Councillor Stephen Stubbings and a representative from 'Fight for the Wight'.

In terms of strengths, the following were agreed upon:

- Volunteers – experienced and a high number compared to the national average. Members of the group questioned the impact of raising the retirement age on the sector. It was agreed that the island's volunteer community have ownership of the island and its problems and stretch across a diverse set of sectors.
- Empowerment and independence – the quality of pharmacies were viewed to enable independence, whereas the doctors don't have enough time and are too prescription focused

In terms of challenges:

- Lack of network of support – seen to be an island and national problem
- Communication – not enough sharing of notes, could technology do it better?
- GPs – felt to be overloaded and the group questioned how work could be shared
- Schools – seen to be 'afraid' of healthcare, excluding children and creating unnecessary referrals. First Aid education was seen to be good at schools, especially at categorising 'big' and 'small' emergencies; the group asked how this could be incorporated into a bigger health plan.

The differences in experience was notable in this group, especially around note sharing and experiences with services on the mainland.

Looking at priority areas, the group prioritised:

- Women and children's care (strongly agreed) – group agreed that older generations were treated well and that costs shouldn't be imposed on the young. Prevention and education investment in the young could solve next generations need
- Vulnerability (agreed) – the group agreed that residents had to take responsibility for their actions within the community and that the NHS can't be everything to everybody. Some members of the group discussed the times before the NHS and asked whether it would be better to rely more heavily on community support
- Long-term conditions (agreed) – the group agreed on the importance of home care and management, thought it was closely related to creating a 'culture of responsibility'

The group touched on mental health, end of life care and out of hours services but there was little time to focus in detail.

iii) **Locality events**

A number of co-production events were held around the Island on themes and issues relating to each of the Focus Areas. The total attendees per focus area and the questions considered are listed below, before more detailed notes on each event.

Focus area	Total attendees
Planned Care	11
Women and Children's	15
Urgent and Emergency Care	20
Mental Health	74
Frailty	27
Long-term Conditions	42

Questions*

Planned Care

1. How can we encourage people to manage their own health better, and prevent problems occurring in the first place, to reduce demand on health services?
2. How can we support individuals to have control over decisions about their own care?
3. How can we support individuals who want to return home from hospital as soon as possible?
4. How can we in the community help people to lead happier lives whilst living with a long-term cancer diagnosis?

Urgent and Emergency Care

1. How do we increase awareness of The Emergency Hub (the Island's first point of call for emergency care) or 111 as a first point of call rather than choosing to go to A&E?
2. If you can't see a GP late at night and or early in the morning, for which services would you be happy to see a pharmacist or nurse or another suitable qualified health professional?
3. What would you like to use a local walk in centre for?
4. How can we step in earlier to prevent crises such as falls, mental health crisis, problem drug use, or severe asthma?

Frailty

1. How can we enable people to stay well and looked after in their own homes for as long as possible?
2. How can we support carers (both unpaid and professional) to understand how and when they should access emergency treatment?
3. How can we reduce loneliness and isolation?

4. How can we help to identify dementia earlier, including among socially isolated people or those who may not seek help?

Long-term Conditions

1. What could be done to enable people to manage their conditions themselves?
2. When people leave the hospital how can we make sure that they feel confident and able to manage their care?
3. How can we help those with long term conditions like asthma or diabetes avoid going to A&E when they have a crisis?
4. How can we better support carers to look after people with long term conditions?

Women and Children's

1. What do you most value about the way maternity and children's services are currently provided on the Island?
2. Can you tell us about an experience of hospital care that you feel would have met your needs better if it had been delivered nearer to home?
3. How can we support people to keep their children well and manage common childhood illnesses at home?
4. What changes do we need to make in mental health services for children and young people?

Mental Health

1. How do we better use technology to provide mental health services and allow people to look after themselves better? Have you seen it work well?
2. What support would you like to receive if you were in crisis and how should be this provided?
3. Do you think people would be open to having a personal health and care budget if they were eligible for one? How do you think this could improve things?
4. What should we be doing to improve services that offer relationship guidance, financial advice, employment and housing support?
5. How do we improve things for people after they have been in a mental health crisis?

* An open question was also asked in each session to allow attendees to raise other issues.

iv) **Locality events – Planned Care**

Meeting summary note	
Meeting name	Planned Care, Ryde
Date	4th May 2016
Location	Ryde Baptist Church, Ryde
MLAFL team members present	Amy Milford, Verena Stocker, Amy McEwan, Liz Laurence (WS), Signe Norberg (WS)
Presentation method	Small group discussions
Number of attendees	5

Issues discussed and outputs (continue over if required)

1. How can we encourage people to manage their own health better, and prevent problems occurring in the first place, to reduce demand on health services?

- Reduce specialist services in isolation.
- Education and facilitation – pre-op check and social workers, or individuals who can provide integrated needs assessment
- Difficulty of separating lifestyle factors (obesity) with the context of their lives

2. How can we support individuals to have control over decisions about their own care?

- Better knowledge and understanding of access / options available
  - Beacon – better understanding needed of what difference services are available (volunteers offering cups of tea, reassurance etc).
  - Health and Well-being Clinic (minimal cost, drop-in centre)
  - Bringing all volunteers together into a database
- Charities are redefining themselves to cater for providing new services
- A central point of contact – via local area co-ordinators, sign-posting, Help Centre at the Library

3. How can we support individuals who want to return home from hospital as soon as possible?

- Need to work with professionals to help them to make decisions about sending people home from hospital, including empowering junior members to take risks (for example, avoid admission) and nurse-led step down facility
- Unnecessary admissions are a problem; need better signposting, education in the community and service triage at the front door.
- Pooling NHS and Council budgets, which are different at the moment and a need to link needs assessment
- Discharge planning at admission - planning care before operation and feeding into the councils, via pre-set up meeting (monthly, weekly etc). Holistic pre-op assessment by hospital social workers
- Idea of a ‘Healthy Living Village’ was raised, with various levels of care, transitioning from one to the other, but comments that it would be a very expensive way of providing care.

4. How can we in the community help people to lead happier lives whilst living with a

long-term cancer diagnosis?

- Anxiety of cancer diagnosis – people need to be confident in the support they receive, idea of support groups was raised.
- Support to the immediate family, through respite care, is also key as additional issues can exasperate issues
- Northampton has a 31 day target for cancer, between first treatment and discharge - raised as an idea that we could follow.

5. What else could be changed that we haven't covered

- N/A

Meeting summary note	
Meeting name	Planned Care, Newport
Date	11th May 2016
Location	Riverside Centre, Newport
MLAFL team members present	John Lunny (WS), Amy Milford, Adrian Clarke, Steve Rowe, Mark Pugh
Presentation method	Small group discussions
Number of attendees	3

Issues discussed and outputs (continue over if required)

1. How can we encourage people to manage their own health better, and prevent problems occurring in the first place, to reduce demand on health services?

- Approaching people's family to ask them what might work better for treatment. Challenge that with retirees on the Island, family is often left on the mainland – so can the voluntary sector be used more?
- Feeling that the voluntary sector is underutilised, need for a better link up of services, more resources needed to raise profile of voluntary sector and a need for ideas of how we can boost it. These could include -
    - Streamlining volunteers if there is overlap
    - Questionnaire asking people if they want to be contacted by the voluntary sector
- More support needed at home and a better understanding of people's needs to support them staying at home, rather than going into a care home. (eg. Skype to help people).
- Reducing the fear among elderly of using technology to keep in touch with family
- Hearing – challenge to overcome patient sensitivity due to hearing loss, often takes a family member to help someone make a change. No referrals to hearing from adult social care currently
- Podiatry service helps keep people out of hospital and a vital service for those with diabetes – a mobile physiotherapy, podiatry, dental 'truck' could work well.
- Some patients would prefer getting information via email, rather than hard-copy letters.
    - Information still shared by fax/hard copy between health professionals which can delay treatment
    - IT issues where more than one form is created, but information is not passed on
    - Varying levels of knowledge among staff of IT

2. How can we support individuals to have control over decisions about their own care?

- New 'Paris' system, merging the NHS and Council system, should be able to tell GPs what voluntary sector services are available to a patient and also conforms to data protection. Could the voluntary sector be added to a 'choose and book' system?
- Could we diagnosis remotely, with consultants on the mainland? For example, an ECG result could be taken in a GP surgery and sent to the cardiologists.

3. How can we support individuals who want to return home from hospital as soon as possible?

- Could we replicated that British Red Cross example, a 'going home' pack? Age UK provides 'shopper's and Winter Packs (with checklist)
    - Can someone be sent home with volunteer support? And in the meantime, a council social care package put in place?
    - Could volunteers step back in after care package expires, instead of patients going into a private scheme
- Some people wait too long for transport
- Issues around access to care home and domiciliary care
    - End of life care requires more expertise than other care. More training for staff to support simple issues such as dehydration.
    - Boosting the prestige of carers will attract more people, they should also be paid travelling time.
    - Need to overcome cultural reluctance for staff to keep people in and not discharge them.
- Agreement on benefits of upskilling volunteer workforce to support quicker discharge, but

needs to be supported by clinicians / nurses for the approach.

4. How can we in the community help people to lead happier lives whilst living with a long-term cancer diagnosis?

- Helping people stay active and fulfilled, so people aren't considered differently by others. Information and sign-posting services to help people stay active, like self-help groups, clubs to help people stay fit and healthy (allotment, walking etc).
- Attendee told story about her husband's prostate cancer, that he worked all the way through until 6 weeks before he died
- Could we use Facebook? Asking patient if they would want an announcement put out, to their employees for example
- Could we screen for more than one cancer at a time?
- EMH – offers other support too, but not as well know
- Carers needs to be looked after, through respite care

5. What else could be changed that we haven't covered

- Difficulties in accessing hospital beds, attendee told one story of where patient was kept (in a chair in A and E, rather than a bed) in temporarily, when hospital was at 'breaking point', but then discharged at.
- 'Halfway house' between discharge to have and keep people in
- Attendee told story of asthma attacks in winter meant being kept in A and E for several hours before a final decision to admit. Patient could have managed at home with a nebulizer, although there are risks.
- Mixed response times with urgent care (999 number), but depends on geography. One attendee argued that ASC should be funded nationally and not through the council, given young people work on the mainland and then retire to the island. This point was challenged with the argument that although councils around the country are facing similar financial pressure
    - Attracting more industry to the Island to boost wealth and attract young people

Meeting summary note	
Meeting name	Planned Care, Ventnor
Date	12h May 2016
Location	Botanical Gardens, Ventnor
MLAFL team members present	Paul (CA); James Seward; Elaine Sharkey (council) ; Mark Pugh
Presentation method	Small group discussions
Number of attendees	[no sign-in sheet]

Issues discussed and outputs (continue over if required)

1. How can we encourage people to manage their own health better, and prevent problems occurring in the first place, to reduce demand on health services?

- Lack of discussion about your responsibilities to your health, all about the process.
- Clear targets needed – for example, ‘eat healthier’ is not very helpful. Daily Mail ‘8 week, less sugar’ diet delivers results
- Support groups need to be of use, not just ‘moaning sessions’. Earlier access to these groups is needed and education is key too – people need to know about them
- Expert patient programme, providing real-life, practical tips
- Joined up services – for example, advice on wheelchair, the best car with lower doors etc – as part of the medical information
- Generally, more effort at the start, when you find, to give you the whole life information on your condition
- Prevention was a key part of this conversation, topics covered included -
    - Refer earlier for home adaptions
    - Carers should take more time on assessments
    - Fire services or ‘trusted’ professionals to give advice on home safety
    - Using national tools on risk of falls that anyone can use
    - Question of whether we should screen everyone over 75? Where do people go if they have a high risk or family high risk
    - Database of voluntary groups available, but if no access to the internet – where can you find it? Improving ways of telling people about it.
    - Build support in mental health for young people to increase resilience, in schools, for example
- Lots of voluntary organisations competing for the same pot of money is not necessary a good thing. Need to be joined up and work together
- Need all in the community to understand how to alert professionals to health / care / social issues so people can get support earlier. Could we extend 111 to include this? Could we make people more aware of the Contact Centre and the ‘joined-up’ness of services?

2. How can we support individuals to have control over decisions about their own care?

- Advocacy is important to the process - especially amongst the young, old and those with mental health issues. This could be a role played by volunteers.
- Need to ensure people understand when they leave doctor’s surgery or hospital, what they need to do. Often have a ‘mind blank’ when you are being told something, you should leave with a paper care document. It was argued that the moment you enter hospital, it should be part of the ‘care’ that they should be sorting you to leave.
- Support once at home –

  - Should have a number that's not an emergency
  - Good neighbours scheme
  - Better use of town / parish councils to access volunteers in the community and tell people about services, support groups
  - Other 'connecting' people (hairdressers, milkmen, WI etc) – how do we get them involved to spread information and highlight issues?
- Notice should be given on discharge day to family and friends, often there is too little
- Information should be embedded across all services so wishes are adhered to – for example, DNR purple forms. Can we have these without a care plan and if so, how?

3. How can we support individuals who want to return home from hospital as soon as possible?

- More support to help people apply for continuing care money, so they can decide on home care
- Concern was raised that the system blocks people from being private carers. Access to training needs to be advertised, as well as PAYE / insurance information. Important part of care, if you want someone you know to support you and they are not live-in family
- Argument that it is less about sign-posting, and more about sitting and spending time with people.
- Volunteers have a limited role, commitment needed means must be paid roles. However, is there a role for volunteers at a lower level? They could support Care Navigators.
- Teams of 'trusted individuals' to assess homes for those going home to support. Needs to be balanced with control over decisions.
- Step-down facilities with a definite plan and timescale. The process at Amber Valleys, was commented on as a particularly good example.
- Question of whether hospital 'over-cares' for patients, and makes them less confident when they return home. Should you asked to do more for yourself in hospital?
- Group questioned whether there was a six week care plan to stabilise people at home.

4. How can we in the community help people to lead happier lives whilst living with a long-term cancer diagnosis?

- The term 'happier' was discussed, and it was agreed that this meant being able to continue with their 'normal' habits (for example, wheelchair access)
- Branding people with a diagnosis make them medicalised – can we stop this? Stigma amongst community and family – is there too much 'pity'?
- Hospice needs to be more about than end-of-life care, but people don't know or don't engage. Perhaps the word 'hospice' impacts confidence in the service?
- Social prescription – to support groups, gym, make-up consultant etc. It doesn't need to be at a cost, it could be a referral to the voluntary sector. Would make people happier and involve you in something that is not medical. Could be especially positive if you don't have a good support network.

5. What else could be changed that we haven't covered

- Medication issues
  - Drug interactions causing symptoms are not recognised often enough
  - Drugs reviews should be done by chemist, should be able to speak about your medication
  - Total medication review when you're leaving hospital. Often a confusing amount of drugs when you leave hospital, can lead to stockpiling
- Quality of communications needs to be improved – at the moment, often people can use

medical terms with no supporting information, referrals without talking about risk to allay fears, non-specific referrals to a consultant. A more friendly process is needed that is people driven, not process driven.

- Lack of private, affordable or sheltered accommodation on the island to give people a choice on how they manage their health and plan for their future.

v) Locality events – Urgent and Emergency Care

Meeting summary note	
Meeting name	Urgent Care, Ryde
Date	4th May 2016
Location	St. John's Church, Ryde
MLAFL team members present	Amy Milford; James Seward; Gulcan Telci; Elaine Sharkey (Council)
Presentation method	Small group discussions
Number of attendees	2

Issues discussed and outputs (continue over if required)

1. How do we increase awareness of The Emergency Hub (the Island's first point of call for emergency care) or 111 as a first point of call rather than choosing to go to A&E?

- It was felt by attendees that people sometimes feel the NHS is 'indestructible' and that they have a right to access – the perception is that because it is free they can use it whenever and however they decide.
- There was a discussion on how emergency access is paid for and how to communicate this – for example, by demonstrating how much it costs for a bed or an emergency GP visit. Ideas included posters in Beacon Centre, although balance would be needed to ensure people aren't put off by negative messages (including the elderly).

2. If you can't see a GP late at night and or early in the morning, for which services would you be happy to see a pharmacist or nurse or another suitable qualified health professional?

- The Beacon should be open in the evenings or weekend if you can't get a GP appointment. Some argued that the GP should be the default option, and some held the opinion that GPs are often better at the Beacon Centre than a local surgery.
- Some participants would be happy to see other professionals, but that 'depends how good they are' versus their GP.
- For pharmacists, people would want more information about what you can go to them for, when not just needing access to drugs and prescription fulfilment. Attendees did not all know about private rooms in Sainsbury's and Tesco, which may show that adverts are not yet working effectively.
- Medical buses for Friday or Saturday nights could be provided, staffed by St John's or Red Cross. There was a discussion on whether this would this reduce A&E / 999 calls. It was noted that Liverpool had one which was jointly funded by the Police and that the Island could learn from this.

3. What would you like to use a local walk-in centre for?

- Some said that it was needed at the weekend, ‘between six and nine’.
- However, others commented that they were happy with using another GP out of hours or instead of A&E, for non-life threatening conditions.

4. How can we step in earlier to prevent crises such as falls, mental health crisis, problem drug use, or severe asthma?

- Not enough health issues are discussed in schools – such as mental health, drugs and smoking. It should be embedded within other ‘non-health’ lessons (like history, geography), and should be started from a young age.
- Better advice over the phone is required when you call 111. For example, in a suspected drug overdose, the advice needs adapting to the actual situation.
- Some argued that since youth clubs are often church-run, there may be an issue with them giving information on drugs and sexual education. This should be further explored.
- On the 111 call-back by GP, some asked whether the call-back would be quick enough and suggested that there could be a target time for response (such as one hour) so that people knew when they would get a response. If a call-back was delayed, people need to know.
- Increasing the use of volunteers or other professionals was discussed.
- Medical staff currently find it ‘too risky’ to work outside the guidelines.

5. What else could be changed that we haven’t covered?

- One suggestion was staggered A&E admission depending on the need of patients presenting to the service.
- Care in a crisis was discussed, including:
    - Volunteers to co-ordinate within streets or neighbourhood areas so that the community is more involved in supporting the vulnerable. Brading Town council was mentioned as an example that could be built upon.
    - Crisis response is for 72 hours, but then people are passed back to ‘usual’ carers and this needs to be planned in advance with people who have existing conditions which are likely to get worse. Better handovers between teams is needed and better knowledge of services by professionals. It would also be beneficial to have better input to keep relatives and carers in the loop.

Meeting summary note	
Meeting name	Urgent Care, Newport
Date	14th May 2016
Location	YMCA Winchester House, Shanklin
MLAFL team members present	Phil Livingstone, Chris Smith, Matt McCarthy (WS), Mark Pugh
Presentation method	Small group discussions
Number of attendees	7

Issues discussed and outputs (continue over if required)

- With regards to workflow training and culture it was said that there is a need to ensure people with specific duties or skills are not performing generic roles that can be done by others. Those that have a particular passion should be allowed to upskill.
- There is also a need to better attract and rotate staff, explore how they can be better motivated and understand why people leave a role. Job satisfaction was highlighted as being very important; with some roles needing to be more diverse.

1. How do we increase awareness of The Emergency Hub (the Island's first point of call for emergency care) or 111 as a first point of call rather than choosing to go to A&E?

- The ambulance service was said to be 'abused' as people default to ambulances, but there was discussion on what action can be taken to change that.
- Institutions use the ambulance service inappropriately (for example, in nursing homes). Policies and procurement need to be in place to ensure 999 is not called by default.
- There was discussion on the need to help people understand what the ambulance service does, perhaps through improved education, potentially with council staff.
- Some believed that staff are unable to take risks, including anxiety about end of life care and staff worry about litigation and criticism from family members.
- Confidence in 111 service appears to be low, as people believe that the algorithm used in triage is not good. There is room for improvement in the way calls are handled and around transportation, it was said.
- There is also a fear of 'complaining', but discussion on whether the service should be actively asking for feedback to improve the process was had.
- Wider awareness is needed concerning 'urgent need', insofar as it doesn't always mean 'urgent care', and perhaps this can be delivered through an education programme.
- Elderly people often wait longer for services, and different people access urgent care services at different rates. Society and culture has changed.

2. If you can't see a GP late at night and or early in the morning, for which services would you be happy to see a pharmacist or nurse or another suitable qualified health professional?

- It was suggested that pharmacists could provide better sign-posting. They could also be used more in situations where you don't need a GP or for health prevention, according to attendees.
- It was also discussed whether pharmacists could respond with regards to out of hours provision, especially in end of life.

3. What would you like to use a local walk-in centre for?

- The group questioned what a ‘walk-in’ centre was and decided that it would be best used for minor injuries that cannot wait for GP treatment. There was an argument that a walk-in service could create demand, rather than relieving it.
- It was then asked whether it could be expanded to be used for other services (such as children’s services).
- Improvement is definitely needed in our out of hour’s centres, it was said. There was a question of whether current infrastructures could be used more effectively such as the Ryde Wellbeing Centres and Ambulance stations.
- Attendees commented that people in Ryde use the walk-in centre in Newport if they are unable to get a GP appointment.
- There was also a comment that the walk-in centre could be used as a place to signpost other services.

4. How can we step in earlier to prevent crises such as falls, mental health crisis, problem drug use, or severe asthma?

- Regarding falls:
    - They said health and safety checks could be used to prevent falls from happening. Teams could examine diet, their home and medicine to examine the risks.
    - A ‘Home start’ scheme for older people was discussed, which could use volunteer’s time to get them out of the house and notice any hazards within the home.
    - There was discussion as to whether opticians, dentists and others could be able to pick up issues earlier also.

- Regarding mental health and problem drug use:
    - Security risks mean the Police default to cells when dealing with mental health cases, and more can be done to turn people to the right services according to those in attendance.
    - Men in particular are seen as not using the services enough, it was commented.
    - Attendees agreed that education is key, and parents must be involved to pick up behaviour. It was said that My Life A Full Life should more fully integrate with those working in education too.
    - Help or support, rather than diagnosis, is sometimes all that is needed, it was said.

vi) **Locality events – Frailty**

Meeting summary note	
Meeting name	Frailty locality event – Ryde
Date	3rd May 2016
Location	Ryde
MLAFL team members present	[Missing sign-in form]
Presentation method	Small group discussions
Number of attendees	[Missing sign-in form]

Issues discussed and outputs (continue over if required)

1. **How can we enable people to stay well and looked after in their own homes for as long as possible?**

- It was suggested that one of the ways people can be supported to look after themselves at home is by providing information on nutrition.
- The issue of responsibility was discussed by participants and it was also emphasised that individuals needed to accept help when it was offered.
- Older people who are isolated also need local people to talk to, and the Island should look at how to facilitate these community connections.
- Another key issue was the need for follow-up when discharged from hospital – having someone to visit the person at home post-discharge would be useful.
- There was some confusion as to the follow-up care to which individuals are entitled when discharged. Participants felt that the criteria was not easy to understand, and did not understand the NHS ‘offer’.

2. **How can we support carers (both unpaid and professional) to understand how and when they should access emergency treatment?**

- The idea of a ‘Carers Network’ was floated, although it was noted that it could be difficult to engage people with busy lives who are occupied with looking after someone.
- Better education was also required according to those in attendance.

3. **How can we reduce loneliness and isolation?**

- More volunteers were requested and it was suggested that signposting could be better for volunteers, or members of the community, so that people felt confident in referring somebody they were concerned about. It was said that some people fear being labelled as nosey or intruding when it comes to helping, so therefore refrain. Ways of tackling this would be welcome.
- It was suggested that more community events would be one way of addressing isolation. Better transport, for example community buses, would also be a way of ensuring that people were able to leave their home and meet people.
- Volunteers were mentioned as being able to offer more time with those that are lonely, as paid carers have constraints on their time and can often only give care in 20 minute time slots. The Lions and Rotary were mentioned as examples of organisations to approach for volunteers.
- There was growing concern and frustration that doctors’ surgeries were closing. One participant had been sent to a GP surgery 1 ¾ miles away, which was not located on a bus route, and the journey had cost £8 each way in a taxi. The individual contacted Age UK and they were ‘fantastic’ and ‘couldn’t do enough for me.’
- A free education centre for older people was also suggested.

4. **How can we help to identify dementia earlier, including among socially isolated people or those who may not seek help?**

- As noted above, the ability to keep learning in older age and understanding signs of dementia earlier in the community was mentioned. Another idea was ‘dementia nurses’ (which were envisaged as working in a similar way to Macmillan nurses). Education was again mentioned, as some said that there was a need for education to dispel fears, share information about symptoms, diagnosis and treatment options, and to raise awareness.
- It was said that DARC training should be expanded so more people recognise the signs and possible routes to refer for help. It was felt that this could help people to recognise signs of dementia as opposed to “usual” or everyday forgetfulness.
- Finally, it was said that the community needs to be encouraged to come together in ways to help with dementia.

5. **What else could be changed that we haven’t covered? What are three practical changes we could make?**

- There was a suggestion that other venues such as churches should be utilised, as well as voluntary transport to get to them.
- According to attendees, some dementia groups such as Age UK cannot visit and offer help unless someone is ‘officially’ diagnosed.

Meeting summary note	
Meeting name	Frailty locality event – Newport
Date	9th May 2016
Location	Ryde
MLAFL team members present	Amy Milford
Presentation method	Small group discussions
Number of attendees	9

Issues discussed and outputs (continue over if required)

1. How can we enable people to stay well and looked after in their own homes for as long as possible?

- Attendees were receptive to the idea of GPs conducting more home visits. They also felt that nurse practitioners have sufficient knowledge to triage and refer onwards in many cases. To support this, health assessment training could be done. Attendees noted that nurses or community matrons are often preferred as practitioners as they have also a more holistic approach.
- People were positive about telephone appointments and skyping/use of technology if arranged in advance.
- Joined-up care was raised as a key issue, as some people see several different consultants who do not appear to communicate with each other effectively.
- It was highlighted that respiratory technicians already do remote monitoring and send information to other services (for example, the GP practice or respiratory nurse specialists). This was felt to be a good example of communication upon which other services could build.

2. How can we support carers (both unpaid and professional) to understand how and when they should access emergency treatment?

- It was felt that carers were particularly important and that if carers feel confident, people are able to stay in their own homes longer.
- Participants agreed that there was a need for respite breaks, and consistency in the quality of carers in order to increase trust and choice.
- It was pointed out that notice should be given if carers need to change.
- It was felt that paid carers were often too rushed. Attendees noted that people want healthcare but also companionship – for example, for some, it is more important to have a companion to sit with while they eat. This social element of caring needs to be better understood and supported.
- With residents who need care to eat or drink, it was felt to be a problem that people were not always given a choice but sometimes given prepared foods. This restricts intake and can have an impact on maintaining a healthy weight, so it was felt that choice of meals should be prioritised.

3. How can we reduce loneliness and isolation?

- Of all the areas discussed, loneliness and isolation was felt to be a priority issue.
- Participants raised the point that the fire service could be useful to help identify those who have no contact with other services and may be vulnerable.
- The postal service could also be utilised; perhaps via awareness training, such as

dementia friend training. The Brading residents social group was seen to be a good model, which meets once a month and has events, and works closely with care navigators to give information to people. The identification and use of more groups like this would be positive.

- It was felt by participants that people may be afraid to get themselves ‘out there’ in the community.
- Communication in general was felt to be an issue. Better advertisement of events, for example via newsletters, might encourage people to come out more. It was suggested that leaflets or information could be placed in local cinemas. A “Did You Know?” column in County Press / Beacon or local newsletters was also suggested.
- One issue identified was that there may be apathy on the Island – and that it was a challenge to get people engaged, particularly in volunteering opportunities which could help alleviate loneliness and isolation. Participants suggested that shops and supermarkets could place leaflets focused on the benefits of volunteering in deliveries and have them in-store. The multiple benefits to volunteering were discussed and it was suggested that there should be greater focus on communicating those benefits (for example, it can help people to improve own skills, and give a sense of satisfaction from helping others). Equally, the Island should get better at highlighting success stories. One participant used the example of an 8-year-old who volunteers with his mum to do gardening in older people’s gardens via Age UK. Another suggestion was to put something into estate agents’ packs about volunteering on the Island. Often people are moving to the Island and retiring so may have time to help.
- One idea raised was whether there could be a central directory or some way for everyone to know what is on offer. There was a feeling that more people would volunteer if they knew what was available.
- Using LACs and care navigators was discussed – those around table had previously not been aware of LACs and care navigators.
- Isle Help was not felt to be running well at the moment due to inadequate funding and it was suggested that volunteers could take a greater role in running this service.
- There is a lot of expertise on the Island but people may not want to get involved in certain sectors like frailty, dementia, and end of life.
- Attendees agreed that solutions need to be very local – and be based in locations other than Newport. Local communities could help identify local solutions, for example, helping in people’s gardens. There is a need to build on local community spirit.
- The value of the voluntary sector was discussed and it was felt that statutory services should be able to refer to the voluntary sector for support. It was suggested that the redesign should approach the Royal Artillery Association and British Legion in particular. It was suggested that there needed to be more partnerships between the health sector and voluntary sector, and that GPs and pharmacies need information to signpost to voluntary services. It was also felt that there needs to be mutual trust between health and voluntary sectors and there was a perception that there is some arrogance and lack of trust between the statutory and voluntary sectors. ‘Work together, don’t duplicate!’
- Attendees had mixed experience of reliability of volunteers and competition between [voluntary] organisations was felt to be an issue.

4. How can we help to identify dementia earlier, including among socially isolated people or those who may not seek help?

- Attendees felt that carers, especially in care homes, need to recognise symptoms and have better training in how to respond.
- Some staff were felt to be too inexperienced and unable to cope with challenging behaviour, which resulted in residents being moved on from the home.
- It was noted that people in residential care can struggle as staff don’t take care of them,

for example not cleaning spectacles, or helping them to clean their teeth. It was suggested that a person centred check list or timetable of care should be developed, alongside an individual plan for how to deal with difficulties for each person.

- It was felt that professional carers needed to be better trained, paid and respected by the community and that this should not be treated as a low level job; it was felt that they are not sufficiently valued and that the Island should consider how to address this.

5. What else could be changed that we haven't covered? What are three practical changes we could make?

- Keep services local and on the Island. The cost of getting to the mainland is too high. 'We need to fight to keep services here.'
- The County Press could do an 'Island Index' again – a list of all numbers for services on the Island.
- Participants felt that there was a need to change perceptions of older people.
- It was requested that the structure of the MLAFL office be circulated to voluntary sector as there have been recent changes to the people in MLAFL.
- Early appointments are difficult, especially with transport issues. Afternoon is therefore easier.
- Consultants have a habit of repeating stories. Answering the same questions time after time is frustrating.
- It was suggested that patient passports be rolled out to everyone: this way talking about a patient's history every time can be avoided.
- Transport for mainland appointments was also discussed. People seemed happy to go over when needed, e.g. for specialist scans, but should be able to get results on the Island.

Meeting summary note	
Meeting name	Frailty locality event
Date	11th May 2016
Location	Ventnor
MLAFL team members present	Amy Milford
Presentation method	Small group discussions
Number of attendees	7

Issues discussed and outputs (continue over if required)

How can we enable people to stay well and looked after in their own homes for as long as possible?

- It was said that there needs to be better advice for carers and a one-stop shops or a single point of contact to get information and advice on different services. Local Area Co-ordinators (LACs) will do it. A question was then raised as to how people find out about their LACs and access their services. It was agreed that information needs to be more easily distributed and communicated – GPs were suggested for this.
- Examples of successful projects from the mainland include Bedgrove, Aylesbury. This includes a team of nurses for patients aged 75 and over who are living alone with health care needs. The nurses keep an eye on the patients, are provided with their number to call instead of GPs, are given call alarms and flashing door bells etc. It is similar to care navigators and the signposting is considered very valuable.
- The attendees also said there was some confusion regarding roles in terms of statutory and voluntary provisions. It was said that preventing isolation improves

physical and mental wellbeing, and being part of the community makes people more willing and able to stay in their homes if supported. Therefore, there is not always a need to go straight to statutory services and use what already exists e.g. rambling clubs (are free, no tax payer cost, with mental health and physical benefits). These options should be marketed in the right places e.g. GP surgeries, pharmacies and shops.
- It was argued there should also be an emphasis on building resilience within the community where such services don't exist. By creating resources such as gardening clubs will enable older people to maintain their gardens and relieve pressures.

How can we support carers (both unpaid and professional) to understand how and when they should access emergency treatment?
- A wide range of conditions are covered for by carers. The attendees would like to see both paid and unpaid carers offered condition-specific training to improve knowledge and understanding so that people are not so risk averse. It was said that carers confidence in their own decision making needed to be increased e.g. know that emergency care is there if needed, and empowering people to deal with conditions themselves. It was also considered important to understand the natural or expected progression of an illness so it isn't a shock and identify when emergency care is needed.
- There was a desire to see third sector groups such as Carers IW to be funded to strengthen carers and provide support for this type of training.
- More broadly, it was said that there needs to be better support for carers who are in their opinion saving the NHS so much money.
- More peer-to-peer support was also suggested, with the possibility of a forum to share stories and ideas.
- It was aid that paid carers should have clinical supervision, which unpaid carers don't. They asked if this could be looked at, and suggested a rounded, holistic plan which covers both carers needs and the needs of those they care for, as they are interlinked and one's needs are often dependant on the others.
- Those attending the session said that the existing system does not sufficiently identify needs and take into considerations who or how they can fulfil those needs e.g. does it need to be a doctor or a nurse, or can it be a family member?
- They argued that there doesn't need to be statutory services undertaking this, as long as people are well trained. Carers themselves can be lonely or isolated under the circumstances so might prefer home visits to phone calls.

How can we reduce loneliness and isolation?
- One suggestion was to encourage extra-curricular activities (but not 'forcing' it on people) as some are isolated but not necessarily lonely. The key is to find out what they like and then identifying how community integration can be improved, although it was not clear who should do this. LACs could also accompany them to make the first steps, as well as care navigators, they claimed.
- Those that are 'hard to reach' and lonely and isolated need to be able to go where others are, for example shops or pubs.
- It was asked whether postman, shopkeepers or others could help identify those that are isolated or lonely.
- It was also mentioned that there needs to be less stigma around loneliness so people can self-refer and identify themselves as lonely, much in the same way stigma around mental health has been reduced recently.
- The group said LACs could map community assets and then share on Facebook

pages. Was also suggested that LACs upload information from their database on to Islefindit. More thought is also needed on how to share this information with people not online too. Age UK may look things up for those who phone in, for example. It was also said that versions go out of date very quickly, are there groups that could be paid to keep this information up-to-date such as library staff for example.
- Furthermore, it was said the internet does not suit everyone, but can help people feel more connected to others. Attendees said LACS would need to keep on top of person to person contact.
- The group also asked whether schools should play more of a role. Some suggestions included buddying children with elderly people, and an idea around a 50-plus education project, where older people go into schools to listen to children read for example.
- Others' ideas included an Age Festival, or making a film to raise the profile of older people so that younger people see them more as assets. They argued these kinds of projects would improve self-esteem and reduce isolation.

How can we help to identify dementia earlier, including among socially isolated people or those who may not seek help?

- It was mentioned that there are only three consultant psychiatrists on the Island who can diagnose dementia. There was a concern that there could be many on the Island that have dementia that have not been diagnosed accordingly.
- The group also mentioned that some people are accessing memory services with a diagnosis of mil cognitive impairment. The memory service is predominantly a short term input. It was said that GPs would only refer back to memory services is the developed plan was deemed insufficient, in which case the memory service will review the plan.
- The suggestion of those in shops helping to spot those struggling was again mentioned. It was said that some shops should be encouraged to become 'safe havens' for those out and about and distressed. It was mentioned that some shops already identify themselves as such, but not everyone in the room knew about it, so it was said that this should be better communicated.
- The next topic discussed was communication. It was said that the County Press is one option for reaching people; however it was acknowledged that not everyone reads it. The Beacon and Chronicle newsletters were also mentioned, as well as national segments on BBC Radio 4 for example. Other suggestions for better communication included posters, however these would need to be placed correctly, for example, in shops and GP surgeries. Other means included radio adverts, although it was agreed that these must be clearer.
- Where there is budget, adverts on social media could be considered.
- There was an acknowledgement that people consumed information differently. Other suggestions included building information into school curriculums, workplaces and trade unions, school governor's networks and other newsletters.

What else could be changed that we haven't covered? What are three practical changes we could make?

- The group discussed hospital discharges. They claimed that lots of people (nationally) are being sent home as soon as medically fit, regardless of whether there is support there for them or not. If there is a need to relieve pressure on beds, it was said that there needs to be an emphasis on making the support available and putting it in place to avoid people coming back. This can be done through nurse visits, or even by volunteers, the group said.
- According to the group, another reason for the increased pressure on hospital beds

is emergency admissions. Carers do not have the support they need at home and need emergency help, so are going to A&E as a means to receive care.

- It was also argued that weekend discharges shouldn’t happen unless a district nurse can care for them.

vii) **Locality events – Long Term Conditions**

Meeting summary note	
Meeting name	Long term conditions – Wootton
Date	5th May 2016
Location	Lakeside Park, Wootton
MLAFL team members present	Amy Milford, Paul Saville
Presentation method	Small group discussion
Number of attendees	10 (including one CCG & one facilitator)

Issues discussed and outputs (continue over if required)

1. **What could be done to enable people to manage their conditions themselves?**

- It was argued that there needs to be proper diagnosis as this has an effect on the patient’s ability to manage their condition. Patients also need a good relationship with their GP and ability to get GP appointments.

- Patients need more information and opportunity to understand their condition. This could be provided by nurses or trained volunteers to talk to patients so that they know what’s happening and what will happen next. This gives people confidence and encourages them to take responsibility for their own health and not rely on the state.

- There was discussion that not everyone has capacity to self-manage and therefore need support around them and easy/quick access to GPs. For instance at Tower House a patient couldn’t get prescription for five days because it was too busy. It was noted that most surgeries will give an emergency appointment but triage over the phone is difficult for some people.

- It was argued it is not always clear where or how to access advice and support. It would be useful to have trained key workers to take responsibility for education and explain to patients what they should do or expect and ensure that they are properly informed.

- For people to take more responsibility over their health there needs to be more education. This could be delivered through more support groups who can share information – what works for one person could work for another. It is also good for patients to know that they’re not alone. These could be delivered through well-trained volunteers.

- There needs to be correct / well-rounded information especially when given a leaflet. For example, Patient Line COPD leaflet said some conditions cause a short life expectancy, but this was not accurate. Where information is delivered through factsheets and leaflets they need to be supplemented or talked through with someone; people can't always take it in straight away and need to come back or discuss it with someone. A good way to understand a condition would be to talk it through with a nurse or trained personnel – this reinforces a message too.

- Regular appointments and monitoring are seen as effective ways to prevent a crisis, with the view that since GPs are busy their monitoring duties can be provided by nurses.

- It was argued that diagnosis of chronic condition can be 'a kind of bereavement' and patients need time to process and come to terms with this, such as having someone to talk to, even if just for a few minutes. This could be through a self-help group, phone line or a buddy system. The AA was seen as a good example – with groups and sponsors – and the model can be replicated across different issues.

- Other topics included:
    - Clear signposting to 111 services: clinical services need to signpost people to the appropriate support groups.
    - A user-friendly website to help people to find appropriate support group.
    - It was argued that since surgeries will not allow posters to be placed in their facilities, how should patients access information.

2. **<u>When people leave the hospital how can we make sure that they feel confident and able to manage their care?</u>**

- There was discussion that when it's a new diagnosis, medical staff need to ensure that patients are given information about their diagnosis and a forward care plan to enable them to know what is coming or what to expect. Follow up and regular monitoring is also important to reduce anxiety and also to check if the care plan is effective.

- Some people felt that communication between GPs and hospitals is insufficient – sometime there is no clear explanation of changes to treatment / medication and what the plan is post discharge.

3. **<u>How can we help those with long term conditions like asthma or diabetes avoid going to A&E when they have a crisis?</u>**

- Suggestions included access to a key worker, which might reduce re-admission rates, and the role of self-care management packages to support when approaching crisis (e.g. a rescue pack from a GP). It was noted this is something that British Lung Foundation provides currently.

- It was claimed that 111 sometimes find it hard to hear or process information from patients who may be too poorly to insist on support or attendance at A&E – and that 111 needed to recognise crisis better and be able to call ambulance for people.

- On pathways, it was noted that paramedics can make decisions about TIA symptoms and refer straight to TIA clinic rather than hospital having to do it. There was a question of if they could similarly refer to asthma clinic.

- People felt they need better education – to be able to recognise crises better rather than dismissing issues, or going in to see doctors unnecessarily.

- Some people feel that the ambulance is not sent out as readily as they should be, although if not always necessary this could be a paramedic on a motorbike or an out of hours GP in a car.

- The important role of lifelines was highlighted, such as through alarms via WightCare or Age UK – which can be useful way of getting help quickly, although there could be benefits of wider access.

- The issue of 'neighbourliness' was raised. While they may sometimes need professional support – paid or volunteer – people could help set up events such as on stroke care. The pastoral role of churches was also noted.

4. **<u>How can we better support carers to look after people with long term conditions?</u>**

- Suggestions included ensuring that carers are receiving support and that their needs are being met too, and regular checking to determine any 'downhill' trends and intervene in problems early.

- It was argued that the Government needs to be pressured to recognise the money saved by carers and should be prompted to look after them properly. There was recognition of the strain on wider family and partners and the role of flexible respite, according to need not availability. The role of care managers in offering reassurance was seen as important. Carers Assessment being done in plenty of time would also be beneficial.

- There was comment on the varying quality of 'respite' bed accommodation and that meeting needs for younger adults under 60 is harder.

- It was argued that carers need support to manage people's behaviour where necessary – for example, Lewy bodies dementia – and that such support needed to be advertised. For carers of patients with dementia / autism / learning disabilities – doctors should have and use their register of carers to check in regularly and see how they are getting on and provide signposts to support groups.

- On hospital discharge, it was suggested that volunteers could meet a patient on the ward and take them home on the day and stay for a while. There was also the need for better assessment before discharge so that can be referred for support.

5. **<u>What else can be changed that we haven't covered?</u>**

- Other comments included:
    - Allowing volunteers to meet patients to give them support (for example this is being done in a pain clinic).
    - Expanding the Pain Service and making it more accessible.
    - Considering 'whole-life' transition between services
    - A more speedy response to issues to allow self-support

  - Better choices for management of acute and chronic pain (probably most common issue for all with LTC)
  - Starting national campaigns, such as seatbelts to stopping smoking, to educate people to understand that their health is their responsibility and how to manage it better themselves.
  - There was a question whether there were other countries the NHS could learn from.
  - It was noted that nurses don't always appreciate reduced mobility (asking patients to walk up to desk unnecessarily).
  - Informing patients about pain management

Meeting summary note	
Meeting name	Long term conditions – West and Central
Date	10th May 2016
Location	West Wight Sports Centre
MLAFL team members present	Amy Milford, Philippa (Community Action), Verena Stocker and Gulcan Telci
Presentation method	Small group discussion
Number of attendees	9

Issues discussed and outputs (continue over if required)

1. **<u>What could be done to enable people to manage their conditions themselves?</u>**

- Suggestions included:
  - Sharing of information between consultants that treat the same patient
  - A single point of contact coordinating multiple consultants
  - Simple to use online facilities to get easy access to information
  - Use of technology
  - Better awareness and training of local community and family to support conditions

- There was one comment that some patients felt they were discharged after a day's procedure from QA with no information; not even a leaflet to explain what they could expect – everything that they knew was from their own research. The medical service at St-Mary's was seen as slightly better, but it was argued that lots of Islanders have to travel to the mainland so the services there needs to be good also and reflect the My Life A Full Life vision.

- It was argued that some patients felt they were discharged too quickly (it was decided on the day to discharge). However it takes time to sort out medication at the pharmacy. One patient felt they needed more thorough assessment before being discharged. On occasions when thorough assessment hasn't happened patients have been re-admitted to the hospital on the same day, such as around coping at home, equipment, or occupational therapy needs.

- It was argued that if patients have to be discharged the same day – then they need better communication. It would be helpful to have a discharge ward, waiting place, planning space, some staff support/supervision to help with toileting needs. It was noted there was no staff or carers at the day room to provide support. There is a discharge lounge but some patients are not referred there – the reasons for this were unclear, while some patients didn't know this existed. It was also argued that carers need appropriate reassurance and a way of contacting staff, such as via an alert.

- The pharmacy was not seen as efficient by some attendees – with patients potentially waiting hours, especially for complex medication and being discharged with a number of new treatments.

- Transport home was seen as an issue. It was argued that Queen Alexandra Hospital says it will discharge patients even if wife or carer is on the Island and not able to accompany the patients who can't travel alone. It was argued that if patients were told the night before (subject to re-assessment on the day) then it would give them enough time to arrange transport or care.

2. **<u>When people leave the hospital how can we make sure that they feel confident and able to manage their care?</u>**

- Suggestions included:
    - Better communication between GPs and consultants, with a single point of contact to coordinate between GPs and consultants and ongoing treatment.
    - Better information for ongoing treatment following discharge, such as a discharge care plan and case notes shared with medical staff.
    - The role of linking GPs, hospitals and pharmacists, with follow up phone call to patient from the hospital or care supporter/coordinator.
    - The use of technology to gain access to a specialist.

- It was argued that patients need to feel confident that they can manage their care. A community matron was seen as helpful and can assist patients apply for continuing healthcare funding, but numbers are limited. Specialist nurses such as on MS are also supportive, but while the MS Society might help with funding and social aspects there were questions on whether it advised on how to interact with services. Care navigators were seen as helpful but it was argued that they are only available to people over 50.

- The prostate urology cancer support group was cited as an example, and while it was good for information and comparing notes, it was less so for practical help. The nurse specialist for the area seen as supportive and responsive, helping to take pressure off GPs.

- Greater information and education about patients' conditions was seen as important, especially when first diagnosed so patients know what is normal, what is worrying, what needs medical attention. Many patients feel 'self-taught' and that information and understanding doesn't come from medical profession. The use of online and Facebook was seen as helpful, including signposting to information.

3. **<u>How can we help those with long term conditions like asthma or diabetes avoid going to A&E when they have a crisis?</u>**

- Suggestions included:
    - Better awareness and training, such as via expert patients.

  - Better use of social media as a source of information.
  - Schools education for pupils on asthma and diabetes.
  - GP surgeries/clinics monitoring inhaler usage (collating data).

- It was argued that a talking service should be made available for patients coming to terms with diagnosis. This is provided for cancer patients but not for other equally life-changing LTCs which can affect the whole family. Family therapy could have been beneficial. Otherwise patients are happy to receive support from charities or voluntary organisations.

4. **How can we better support carers to look after people with long term conditions?**

- Information is seen as just as important for carers as it is for patients. One individual recounted that when they gave up work to be a carer they initially really enjoyed it. But they had no additional support in terms of finding out about issues such as benefits or carer allowance.

- Information is not always in one place and patients have to look at separate websites. Sometimes carers had to complete carers registration form at GP surgery twice though it was never clear why.

- It was argued it would be of benefit if GPs also asked about carers' welfare and that seeing different GPs diminished continuity of care, although this also applied to carers and patients. The role of Carers IW with drop-in cafés was seen as positive.

- One cared-for person accessed respite together through firefighters' charity, although this was not always as good as care at home.

5. **What else could be changed that we haven't covered?**

- It was argued that private housing modifications can be difficult to make happen due to landlords and that landlord's handbook briefings on contract modifications might be helpful.

- A family approach to services (children's services and adult's services) was seen as important.

- It was noted that urologist specialist nurses are good and that it was reassuring to know they are there to speak to, even though patient did not access the service they find it helpful knowing the nurses are a good source of information and are perhaps more accessible and have better 'people skills' than consultants.

- The role of direct payments was also raised, which would enable people to buy cover and occasionally take the pressure off their carer, or take them out on day trips. There was a distinction drawn between a personal budget not continuing health care budget, which needs then to raise purchase orders.

viii) **Locality events – Women and Children**

Meeting summary note	
Meeting name	Women and Children's locality event – Shanklin
Date	7th May 2016
Location	YMCA, Winchester House, Shanklin
MLAFL team members present	Gouljan Arslan (WS), Sue Lightfoot, John Howard
Presentation method	Small group discussion
Number of attendees	8

Issues discussed and outputs (continue over if required)

What do you most value about the way maternity and children's services are currently provided on the Island?

- Services should be provided locally – health visits and nurses provide the option of visiting patients at their home but more flexible choices are needed (especially when mothers work).
- It was said the children's centre provides valuable support.
- Many thought maternity care was brilliant but more flexibility was needed for working groups. A lot of sessions are geared towards 'stay at home' parents – there should be more evening, weekend and holiday offerings.
- In terms of method of delivery, face to face is always better.
- What about parents who have unique issues of their own? Mental illness, substance abuse? There are specialist support social services but they are not tailored for working parents.
- Antenatal care support is not consistent, and is not being diagnosed properly. There is an apparent gap between hospital doctors and GPs. They communicate without keeping patients in the loop. Doctors can also be too rigid. Unless patients fall within certain brackets of conditions they won't look after them.

Can you tell us about an experience of hospital care that you feel would have met your needs better if it had been delivered nearer to home?

- Resources are stretched – patients would have preferred an ambulance rather than take a taxi to hospital to give birth.
- Issue with being able to offer a home birth is that you would need two midwives in each home where a birth is taking place. Lots of women may need the service at any one time.
- Support is not adequate for women who miscarry. Emotional support is not provided and women are told to come back for scans after pregnancy.
- GPs need to have easy read leaflets on difficult subject matters to give to patients with information. Great to have written information with things they can and can't do.
- Better communication needed so that patients are empowered to take care of themselves, especially after being discharged from hospital. They can take care and have greater input into their aftercare.
- Paediatric doctors are good but sometimes they are not experts at unique health issues and are not able to provide good, effective outcomes.

- Patients tend to go to the mainland for care but the car ferries fill up and people often end up queuing up for a long time. The ferry terminals don't have the facilities that would make travel smoother.
- Mainland hospitals are not that accommodating either – they often give appointments at times that don't suit patients.

How can we support people to keep their children well and manage common childhood illnesses at home?

- Suggestion of a 'virtual A&E'. The use of Skype, for example, would mean people would able to send photos so that a specialist can see it and make a decision.
- Providing parents with information can easily alleviate pressure, there are pilots with 'pharmacy first' approaches which are not communicated well to the general population.

How can we support people to keep their children well and manage common childhood illnesses at home?

- People felt that we are focussing too much on diagnosis. Unless it is severe they won't get adequate diagnosis and therefore care.
- It was suggested that children should be trained on emotional resilience at school. Should also train children as to what their rights and responsibilities are.
- Not waiting for someone to reach crisis point but having a framework in place from the start.

Meeting summary note	
Meeting name	Women and Children's locality event – Shanklin
Date	14th May 2016
Location	YMCA, Winchester House
MLAFL team members present	Matt McCarthy (WS)
Presentation method	Small group discussion
Number of attendees	5

Issues discussed and outputs (continue over if required)

What changes do we need to make in mental health services for children and young people?

- During a discussion on this topic, the group agreed that we should revert to the Health Visiting service we had 30 years ago so that health visitors get to know their case load and recognise issues at a really early age.

What else could be changed that we haven't covered?

- The group asked why education wasn't included within the 'system' to redesign health and social care on the Island. It was remarked that they are part of the puzzle and would have a valuable input.
    - "I would expect schools to play an important role"
- The idea of supported internships was also raised. The group were critical or unsure as to what the Council careers service offered young people, and believed a programme that was of greater benefit for both young people and employers was needed that reflected the child's interest.
- Recruitment and retention of NHS staff was raised, with the quality of schools mentioned as a dissuading factor. It was stated that most NHS staff now send their children to private school; some members of the group labelled this an 'education tax'.
- Other comments of note during discussions included a needs based, as opposed to diagnosis based approach, and the need for earlier intervention.
    - "People want to be listened to"
- Finally, the use of alliance contracts was mentioned, and the idea of an 'Island Pound' which sounded as though it has come up in previous discussions on health and care redesign. The idea would be organisations have an equal voice and would look to empower community's strengths.

ix) **Locality events – Mental Health**

Meeting summary note	
Meeting name	Mental Health locality event – Ryde
Date	4th May 2016
Location	St John's Church
MLAFL team members present	James Seward, Liz Laurence, Signe Norberg
Presentation method	Small group discussions
Number of attendees	24

Issues discussed and outputs (continue over if required)

How do we better use technology to provide mental health services and allow people to look after themselves better? Have you seen it work well?

Using Skype, online health forums and social media to contact services was considered a benefit. To manage the extra workload, volunteers could help manage phones/social media channels. However, concerns were raised with regards to accessibility. It is necessary to hold training sessions to empower people to be able to use social media/new technologies as it generates another option in accessing services. An example could be through Adult Learning services. The island has an aging population however – concern. Before starting to use technology, necessary to recognise who would struggle with it.

The biggest gap is that there are no current examples participants could think of that operate successfully in this way. Some examples were however mentioned of singular small-scale initiatives. For instance, a Facebook group for islanders who experience anxiety and depression, but this is not moderated. Closed Facebook groups could be used and provide good community support. However, one participant noted a concern with privacy with Facebook groups and so forth as they are not anonymous.

Need to work with innovators/entrepreneurs to provide support through partnership.

One participant highlighted the Silvercloud app – for body image/depression and so forth. The person wanted to publicise it so people can use it without going to a GP.

It was noted it is crucial to note that digital services are not for everyone and must be recognised in the redesign.

Using text services could also present potential challenges – texts could be heavily misinterpreted by the person experiencing a mental health crisis. Digital is most suitable when searching for information and doing research. All and all, mixed experiences of technology use were noted in this group.

Another group noted that telephone lines are good but even these have their limitations.

What support would you like to receive if you were in a crisis and how should this be provided?

The major challenges for when you are in a crisis was perceived as being the following;

- Not feeling listened to, getting enough feedback, or being able to provide feedback on the services they receive.
- Initial assessment can be made on misguided and be wrong if you are not actively suicidal, or have tried to take your life.
- No holistic approach is considered (relevant, for example, in the case of dual diagnosis). For instance, stigma when drug users seek help (considerable barrier). Need for those recovering to socialise and rebuild their self-esteem.
- Patient should be able to provide feedback on the services they have received in order to improve them.

Services need to be available 24/7 – no way of knowing when crisis will occur. Overall speed is crucial for helping those going through a crisis. Referrals must be faster. Some felt prescriptions were given only because the waiting times were so long.

Potential solution is somehow bring together volunteers and CAB to man telephone lines to give support.

It was also noted that most people do not go through a “crisis” but rather live with mental health issues for years but still need support despite not needing crisis response.

Do you think people would be open to having a personal health care budget if they were eligible for one? How do you think this could improve things?

For some, this was not considered a positive solution as it would just increase the pressure people with mental health issues face and money used to set up the new system could be better spent elsewhere. Seen as a good idea overall but it could cause self-destruction for those with mental health concerns.

Another group that this was a good idea as it would potentially allow access to buy private counselling. However they did raise concerns that individuals could be tricked into seeing unaccredited counsellors and people could be exploited.

What should we be doing to improve services that offer relationship guidance, financial advice, employment and housing support?

Problems in accessing accommodation (e.g. via Housing Associations) to ensure housing continuity for young people.

Serenity integrated monitoring (SIM) (e.g. for people with PD – housing, ASC, police, to provide joined-up offer to client. How do we develop local community support to replicate this joined-up support across the island? (SIM -> MLAFL) Possible role for local coordinators?

Statutory services are generally shrinking (e.g. housing or homelessness) but need to be more honest about the scale of the problem and empower voluntary sector to address them.

Upskilling/training for volunteers and community members who want to help.

Questions were raised about the degree to which minority groups can access support groups and services.

How do we improve things for people after they have been in a mental health crisis?

The key focus area should be on ensuring there is after care/follow up. The biggest gap of care is located after the crisis. Third sector could play a crucial role here as peer to peer support is not systemic. Suggested solutions:

- Contact person/mentor on release?
- Trial period after being discharged from hospital?
- Evening support groups for those who work 9-5?

Overall, more communication is essential – not just on the issue itself but also on the help that is available.

There is also a need to link services together more. Information ought to be shared between statutory partners to ensure that a joined up, consistent response based on good knowledge of the individual's needs.

Voluntary sector needs to be developed or expanded to provide priority services targeting and delivering communications based services to help prevent mental health crisis. Needs to include outcomes, qualitative and case study work.

Need to ensure more peer-led support is available and that they can support/services Likewise building effective interface with formal statutory services to ensure safety and that referral occurs when appropriate. Professionals could for instance attend support group sessions to provide advice.

More groups such as Seven Steps are needed. Support for finances and learning could be useful areas for consideration after a crisis.

A voluntary organisation should also coordinate resources that are already available – set up timetable for people to see when they can attend.

Employment was also considered a factor in coming back after a crisis. It is necessary to educate employers of mental health illnesses so they do not unjustly judge applicants who disclose any potential illnesses on application forms.

Some participants noted however that peer to peer support is not sufficient on its own.

What else could be changed that we haven’t covered?

Need for a recovery house, consider dual diagnosis, allow for only mental health treatment cost assessments, support for children with parents with mental health issues should receive extra pro-active support

Education particularly key.

Help should be localised (CAB outreach as example). Drop in would be good for everyone as well as those with mental health concerns.

x) **Health and Wellbeing Roadshow – 7th April 2016**

Meeting summary note	
Meeting name	Health and Wellbeing Roadshow (South)
Date	7th April 2016
Location	Sandown
MLAFL team members present	Amy Milford, Community Action
Presentation method	Banners and leaflets
Number of attendees	23

Issues discussed and outputs (continue overleaf if required)

Waiting times was brought up as an issue that needs particular attention in the redesign. That it takes so long – sometimes hours – to get to see your GP, despite making an appointment for a specific time slot, should not be the case.

Some members of the public expressed concern over the fact that the redesign is very top-heavy and despite being in the work for years, little has changed. Because it started as a conversation about what needed to change, it has now gone "full circle" and there has been little tangible change.

Another issue raised was in relation to financial pressures, in particular how people on the island may have unequal access to health and social care services due to their financial situation – if they are in-between jobs or working on an hourly rate.

Another participant also addressed the financial pressures of the healthcare services themselves, in broad terms.

Misc.

One member brought up alternative therapies as potentially part of the solution to alleviate the pressure on healthcare services.

Some questions were asked about the funding of the redesign. Are people on the island being sufficiently involved, vis-à-vis non-islanders?

Concerns

- Concerns about the timespan and funding of the redesign programme.
- Concerns about costs of healthcare long term – even if we change the entire system, will there be enough money in the future?
- Concerns about involvement of non-islanders vis-à-vis islanders.

xv) Staff events – Market Engagement Days - 14th April, 22nd April

Meeting summary note	
Meeting name	Market Engagement Day
Date	14h April 2016
Location	
MLAFL team members present	James Seward, Mike Bulpitt
Presentation method	Banners and leaflets
Number of attendees	15

Issues discussed and outputs (continue overleaf if required)

GP considerations that may impact on the redesign process

- Most people are reluctant to take responsibility of their own wellbeing and rely on 'spoon-feeding'. Hence in order for the new model to work there needs to be a change in the mind sets of the people. Most also tend to come to the GP for all issues even when other providers, e.g. social care providers, are better placed to assist them.
- Other stakeholders agreed that most see GPs as the first port of call.
- The discussion with the GP should not just be a remedy or medicine for current issues but should also focus on how they should manage their health concerns more broadly and proactively.
- The media plays a part in the current mind set of people as it encourages people to go to their GP, not the other providers that may be more suite to help them.

Provider's perceptions of the public view of the redesign

- There was a query as to whether any feedback was obtained from the public about their concerns and comments. James said that they did get a lot of feedback which may not be direct responses to the questions asked by them, but still highlighted the issues that the public faces in accessing services.
- In discussing the changes that may take place, a stakeholder commented that "Most people don't want change. Everyone wants to have their favourite GP, their favourite hospital"
- James agreed but said that they should make use of the current opportunity to redesign services.
- From a stakeholder: "It's not just about change, it's about improvement. It's about how you spin it".

Targeting the programme

- James explained the work done by KPMG and the findings when benchmarking the island's health system against similar populations. This has shown areas of potential outliers. KPMG has recommended 6 broad focus areas within this; i.e. Urgent care, planned care, mental health, frailty, women and children and long term conditions. Working groups have been set up for these areas who will meet 4 times over 3 months to design pathways. The key is how we design these services to keep the 3 themes of 'sustainability, safety and quality'.
- Stakeholders asked whether the programme will engage with the education sector as

the mind set of self-care starts with children. James agreed but mentioned that though it's been discussed before it hasn't kicked off as yet. As Age UK has already got volunteers working in schools in Hampshire it was discussed that James should pursue this further with Age UK representatives.

- The expectations from the public during the meetings were discussed. Age UK already has a care navigator with an extensive database of feedback from their day to day operations. It was discussed that it would be productive to utilise this and draw key themes. It was also highlighted that it's important that the public are given solutions during the engagement events as most have already been requested for their feedback and hence now are looking for responses to those concerns.

<u>Current collaboration and its impact on redesigning future services</u>

- A concern was raised about trying to obtain further information on an article in the My Life newsletter about a pilot programme for Phlebotomy. On enquiring with the provider about this programme, the provider was unaware of the programme and could not provide further information. There should be a better system for providers to obtain better information on such initiatives or connect them with relevant interested parties.
- An idea that was discussed between participants was of GP consortia. Primary care federations and ACOs are implemented elsewhere, even in most complex organisations such as North East Hampshire.
- The participants discussed transferring responsibilities from GPs to other sectors such as domiciliary care. The concerns were whether a shift of duties will help save cost within the overall system. Mike Bulpitt suggested that there are many things that can be done economically in for example the volunteer sector. The focus should be to invest in the right place, i.e. more towards preventative care rather than the acute sector.
- James inquired whether the participants would be interested in being a part of the working groups and Mike added that alternatively they could participate in the public meetings. It was highlighted that a family would not fall to one specific category and would touch upon all focus areas. It was discussed that the best way forward was to attend at least one meeting as convenient, but raise issues or comment across all focus areas. The organisers would need to be mindful about this during the meeting.

<u>Session feedback</u>

- Participants agreed that the meeting has been useful and that the smaller group encouraged discussion. It was suggested that the next meeting with a higher level of expected turn up should be conducted by breaking down the participants in to smaller working groups.

Meeting summary note	
Meeting name	Market Engagement Day
Date	27h April 2016
Location	
MLAFL team members present	N/A
Presentation method	
Number of attendees	N/A

Issues discussed and outputs (continue overleaf if required)

Current challenges

The quality of GPs in the area is variable. This influences how well some of the primary care services may engage, and how willing they might be to commit to providing care differently and collaborate with others.

An example was given of how services are not currently linking in together as best they could, through the experience of a participant's father in law who had a stroke and required care on the Island. It wasn't clear what needed to happen next (from the patient point of view) to progress care, or who which service was best placed to provide that care.

Concerns were raised that this process had all been done before – people wanted to know what was different this time. Essentially "it has to work" this time. There is also greater buy in across the island.

Although putting the person at the centre of the model to encourage patient choice for the services they receive was considered the right approach, there needs to be a recognition that there are limitations to the resources and services that can be provided to these individuals. Expectations need to be managed accordingly.

Involving the public in the redesign process

Vulnerable people should have an opportunity (and if necessary be facilitated) to participate in the public consultations on the island.

This also includes how best to involve individuals with learning disabilities. The opportunity to engage could also be used as an opportunity for empowerment for the individual, creating a win-win situation.

Further, families and carers of those already receiving care should be provided with an opportunity to input into the project/redesign.

More broadly, need to think more laterally about how to effectively publically engage across the island. For example, stakeholders noted that to engage different age groups, different strategies will need to be employed to do this effectively. This includes using internet based strategies (social media etc.) and video conferencing if required. It was also noted that response times have to be tailored to meet the needs of the demographic targeted.

Consideration should be given to co-designing and co-producing the process with the individuals that are going to be affected. This will truly bring to life the ideas (as outlined in the slides) of putting the individual at the centre of services.

Funding considerations

For partnerships to function effectively, there needs to be a consideration of how funding

flows will facilitate this.
Consideration should be given to capitated budgets, potentially pooling of resources (no further response provided on how this might happen!), and using incentives within these arrangements to achieve the desired outcomes. The CCG is also considering using outcomes based contracts for certain services.
Could consider what the best organisational structures could be to make sure incentives are properly aligned to achieve the best outcomes for service users.
The example of the Surrey Downs project was raised – where there is a move to providing more proactive care, through collaboration between mental health, acute, community and primary care sectors.

xvi) Staff events – Professional Reference Groups - 18th May, 7th June

Meeting summary note	
Meeting name	PRG
Date	18th May 2016
Location	
MLAFL team members present	John Rivers, Mike Bulpitt
Presentation method	
Number of attendees	15

Issues discussed and outputs (continue overleaf if required)

How Can Our Working Groups be More Ambitious to Tackle Our Big Challenges?
Do we have a clearly owned and understood case for change that can be shared across working groups?
Responsibility for delivery needs to be clear – e.g. does the System Resilience Group take on some of the ideas suggested? Working Groups need to signpost where the work will be done rather than take on responsibility to deliver change themselves.
Discussions are mostly based on “small steps” which makes it difficult to have a whole new model. The Individual Needs Framework could be used to answer some of the needs that can be used. Working Groups need to have access to the framework.
The vision needs to be coherent and be accompanied with a clear plan so that decisions about changing services can be made.

> System Leaders need to provide a clear vision to the whole system for what the vision is but the PRG itself can also help to push on what that vision is

Working Groups need more focus on the bigger picture e.g. “what does prevention look like”.
Stronger voluntary sector and LA-based ideas are needed, specifically in Women’s and Children’s and Frailty.
Localities are clearly part of a thread across the Working Groups.

Bravery in Working Groups can be much higher and needs more focus on what the care system will stop doing. The system is not yet clear what it is prepared to stop doing.
The impact of changes needs to be considered in more detail and be bigger and more outcomes based (for the whole system). Outcomes will govern what goes into redesign and what is taken out of it.
Clarity on what we have that we don't want to lose because outcomes are already good is not yet clear.
Balance of innovative thinking and transformation needs to be matched to scope and inter-connectivity needs to be much clearer. Risk tolerance needs to be set and we have to be more honest about what will stop being provided.
Behaviour and culture to deliver change needs to be different at all levels of the organisations in the care system.
What are we currently providing that doesn't add value and may actually be duplication of a service, no matter how long provision has existed for.
If we stop doing certain services or the way in which we provide them, we need to change the way patients move through the system. The associated impact of stopping a service needs to be balanced against doing a service differently.
Outputs need to link ideas closely with the analytical modelling to inform commissioning and provision decisions and/or planning.
Language may be stuck in "old" or more health-based territory rather than inclusive of the whole care system, including the voluntary sector.
The MLAFL concept can be used more widely across the Working Groups - i.e. a set of clear principles to inform decisions that are taken.
The workforce planning is crucial and should be done alongside the WISR process in a way that is safe as well as achievable.
Financial impact needs to be included with the ideas that are proposed. This needs to be balanced with proposals of neutral cost improvement that improve quality and/or safety. The overall proposals do still need to meet overall financial challenges.
Working Groups need to draw on the support of the SRG and other groups.
MLAFL workstreams that can underpin or align with WISR proposals/ideas need to be activated to support the output of the Working Groups.

Urgent Care
Will the group be empowered to make change happen or are they just advisory?

Planned Care
Scope unclear.
Proposals for on/off island decisions needs more support outside of the Working Group. The group can make radical suggestions but isn't making the decision. Reassurance that decisions sit "higher up" needs to be communicated to all Working Groups.
We need to define what does a service look like in the future (e.g. neurology) and then decide how we get to that point with the resources available.

The STP process needs to be linked to how this group produces proposals.

Women's and Children's
Intergenerational closure and social capital was less clear from an NHSE assurance viewpoint.

Frailty
No specific comments

Mental Health
If crisis café is undertaken, where does funding come from and what does that mean we have to stop?
Content was agreed upon but detail on the extent of services suggested needs to be made much clearer (e.g. the delivery detail).

LTCs
Cultural shift for both those providing and receiving care needs to be clearly demonstrated. Evidence of where this actually works (as it is very challenging) is needed for the Working Group to propose a feasible idea.

Ideas to shift or tackle elsewhere?
Serious resource is needed to create a new workforce plan that matches to WISR proposals.
Common threads across Working Groups, including workforce and IT need to be linked.
All Working Groups need to know what else can help provide the common threads to support proposals made (e.g. what workforce planning can be done to support ideas).
Changing behaviours needs to start now and potentially not wait for the end of the Working Group process (e.g. co-ordination in MH for those in crisis). Leadership decisions can be supported by members of the PRG to help implement change more quickly and make a different. Service specific groups could be used to drive some of these changes more quickly (e.g. changing care of cancer post-treatment could be lifted and used across many services).

Actions:
Share contact details of PRG members across PRG
Share Individual Needs Framework with PRG members and in Working Groups
WISR Board to share its Vision with PRG members
WISR Board to be informed that financial impact of proposals needs to be included

Meeting summary note	
Meeting name	PRG
Date	7th June 2016
Location	
MLAFL team members present	John Rivers, Mike Bulpitt
Presentation method	
Number of attendees	15

Issues discussed and outputs (continue overleaf if required)

The Professional Reference Group recognised the large amount of work that has gone into developing the ideas so far, and the enthusiasm of those involved. The presentations were well summarised and very clear in their explanation.

The Working Groups should consider:

- There is a need for broader vision in the thinking and ideas to ensure benefits are realised across a wider range of areas.
- We would like to see evidence of how the working groups informed their thinking (this may have been due to time constraints of presentations).
- We recommend the Working Groups come together to hold a combined session, to discuss common themes that are being developed across the areas, in particular acute assessment, ambulatory care, record sharing, care planning and IT solutions.
- What methods are being followed to ensure the ideas generated by the working groups tie in with the Sustainability and Transformation Plan?
- Which of the ideas is most likely to lead the change where others will then follow? As we cannot do all at once, what can be done quickly / first?
- Can you provide more detail on where the areas of cost savings lie? There is no ‘new money’ and all budgets will need to be released through cost saving initiatives to fund future service improvements.
- What will we stop doing, as well as start doing differently (better). For example, if we introduce a new initiative what other services will we no longer provide?
- How could housing support be incorporated into ideas more. For example, how can we involve housing support to reduce delays in hospital discharge?
- We would like to see more Focus on prevention and early intervention in social care across the ideas. The overall thoughts were we are weaker on this.
- How could the workforce be developed? For example, the Island cannot recruit physiotherapists or Advanced Practitioners. How can we establish stronger partnerships and work closer with Southampton and Portsmouth?
- Each working group should identify one redesign option that can be implemented this

year and save money.

Frailty

- The ideas do not seem to fit into the broader vision, and feel a little separated from other projects and what's currently happening. Can we provide more structure around them and see where they can link into existing work?

- There should be clearer separation between Dementia and Frailty, as the ideas came across as confusing.

- Explore the function and purpose of the Isle Age well service (Dementia inpatient unit) the service has more Importance over the building and its location.

- Concerns from the PRG that an integrated care centre is not a solution to current issues with inpatient's model of care e.g. the Shackleton ward would soon be flooded with demand.

Children Young People and Families

- Overall very clear well defined project ideas.

- Define further how barriers between community, hospital and professional 'silos' will be broken down. Try to link the Paediatric Assessment Unit closer with strengthening communities, and think about how we can formalise better professional working (e.g. with Southampton).

- ASD and ADHD: there are really two options here – commissioning a better service on the mainland or see whether we can provide it on the island.

Urgent and Emergency Care

- Could we make A&E "less attractive" so users are more likely to use other services to improve the engagement with the public?

- We really need to define what 'urgent care' means and then communicate this. We then need consistency of this definition across settings.

- We should focus on upscaling 111 and their staff, so they do not just send to people to A&E.

Long Term Conditions

- Overall, the redesign ideas lacked a little focus and detail, in particular around what the locality teams would really do on a functional level.

- There is a feeling of significant overlap between LTC and Frailty

- There is a real opportunity now that we have PARIS to integrate care planning between the Council and NHS.

- It was suggested the Working Group should focus on two linked conditions that are associated with high admission rates e.g. breathing difficulties, heart failure.
- We recommend that you review the outputs from the Symphony Project in Yeovil, for examples of good practice in integrated pathway management for patients with complex, long term conditions.
- The Working Group should consider more self-management coaching for both clinicians and people.
- Consider how we could support the Trust to treat LTC patients to reduce the burden on Trust staff. Please consider developing initiatives around this.
- Directory of services – please do not start a new DOS and learn the lessons from the experience of 111.
- Locality teams – this significantly needs more information for the PRG to have a view. For example, what will be their structure and composition? Where will they be?

Planned Care

- Learn from improvement projects carried out previously in cancer service redesign when looking to reduce outpatient appointments.
- The Working Group and/or the WISR process needs to tackle the issue of on/off island provision.
- The Working Group should RAG rate the key services against predetermined criteria, and this information feeds into the Sustainability and Transformation Plan. Focus on health outcomes and quality.

Mental health

- It was felt that this workstream needs to link in more with other workstreams
- The Working Group should consider how we can map Safe Havens across other conditions
- Moss Side in Manchester has very good examples of “crisis cafes”. We recommend you look into this to see whether we can bring learnings back.
- How do we assure that the Recovery Houses are sustainable? there should be further investigation into Community based options as cheaper alternatives

xvii) Staff events – Professionals Engagement Event - 17th March

Meeting summary note	
Meeting name	Professionals Engagement Event
Date	17th March 2016
Location	
MLAFL team members present	Carol Ogilvie, John Rivers,
Presentation method	
Number of attendees	N/A

Issues discussed and outputs (continue overleaf if required)

<u>Verena Notes: (Table 5 notes)</u>
- Urology
- Neurology
- Haaemotology
- Technology
- Education System
- Workforce

<u>Mental Health</u>
- Lack of support and cannot recruit
- Stop bouncing back and forth between services
- Youth mental health is worse
- There is only one children’s Mental Health Consultant
- There should be somewhere they can go, a safe place – not A&E
- Mental Health Café-s role of voluntary sector/self management

<u>Urgent Care</u>
- Beacon Centre – Acute transfers, ECP Pilot
- Long Term Conditions is not such an issue – exception of strokes
- Diabetes in care homes
- Care Home nurses should do injections
- Recruitment: more active in getting health care assistants etc lower skilled
- Support in schools is important

<u>Carol Ogilvie (Table 3 notes)</u>
- Prioritise work streams
- GP – Quick wins

<u>End of Life</u>
- Frailty – end of life – Urgent Care –Mental Health (Dementia)
- Is admission considered a failure?
- Localized centres specializing in high quality. 1st issue is to ensure only people who need to go to hospital go there and others go elsewhere
- Homes phone for advice – directed to 111 then 999- admitted unnecessarily
- OOH care in homes seeking advice, but adverse to risk, 111 becomes 999 (via diagnostic software)
- Training for Homes Staff in End of Life/General Care Support

- Reduce fear/Risk adversion via Training
- Locality linked to Quality – Read Best Experience
- Right information to do the right thing at the Right Time
- Current route is complicated eg. Beacon, offered a level of support (open access) from Word and parents drove around to ward to be admitted

Chlidren's

- Have a higher expectation of what treatment they need for their children
- Children's service would like to create an outreach team to support GP referrals in their own homes (avoiding admissions) – only 30% of GPs have paediatric training
- Missing a trick with telemedicine – accepted that phone calls between GPs and ward is tele medicine
- Paediatrics – lack of GP training is a big issue
- Paediatricians – Keen to hold community clinics

- How can we lower parents' expectations? What 0-18 years indicators – Red/Amber/Green for the use of professionals and parents?

Mental Health

- Should we focus on it as a separate area or should we try and integrate – (A&E consultant said no)
- GP- MH patient with an acute infection (aggravated Dementia, Nightmare in homes/on wards)
- A&E Cons – mildly confused would want to send home with support of social care – not available in the main
- Mental Health is very subjective, no constructive system approach
- Would be helpful to have a similar indicator as the 'What 0-18' for children, for Mental Health
- Send out a Crisis Team Member to the homes to support management of confused patients – link with supplying training to care home staff
- Pool of nurses to supply temporary support with Care Homes and families (again education)

Bevan– Notes

- Long term Conditions – too broad a category
- Frailty – should be 'older people'
- End of Life Care is a pathway, Frailty is a condition – you can't compare them
- Vulnerability – does it need to be a standalone category
- Can't have Women's and not Men's
- These priorities are too health focused – Social care is missing
- Current priorities don't seem to be 'whole system'
- These categories don't take account of all the determinants of the conditions
- Needs more focus on third sector
- Should we have an exercise to identify what are the minimum service requirements?
- Should the categories be different? Ie. Integration, Prevention & Self Care
- Ignores a lot of work that is already ongoing
- Why have these areas been selected?
- These need to be torn up and started again
- This is duplicated by the Vanguard work going on for a year
- These don't feel like a whole system review

John

- Frailty/Urgent Care/Chronic Conditions
- Urgent care – There is a lot of work to get people working sufficiently differently – not just medical; also urgent social care
- Social death
- End of Life not a priority – how does it permeate throughout
- End of Life can happen in lots of different
- People dying of frailty
- Jo Hesse– Women and Children's Care and Mental Health because they're key to education and preventative
- Carers – used to be common theme running throughout
- Carers have more access to being able to care at hoe
- Beef up discharge so people know how to handle things when they're out of hospital so they don't find themselves coming home
- Know what is upporting people at home, work out what is at need
- Mike and Nigel @ hospice: Preventative health and general wellbeing
- If you were starting at a blank sheet, where would we start?
- Nigel – create a generalist culture rather than pigeon-holing into the 7 specialist areas
- Mike – People vote with their feet to go to the place where they can get access
- Jo Hesse – People want access to information
- Help people think through how they're going to handle their older years
- How can we reinvigorate the community ethos and social capital around people
- Scandinavia- has focused heavily on prevention and now seeing benefits in better outcomes
- Some of the 7 areas are pathways and some (eg Mental Health, Vulnerability and Frailty) cutr across lots of areas
- For long term conditions, there's a big issue around 'coming to terms'
- Frailty without diagnosis
- Mental Health
- Long Term conditions is a real crisis
- Emotional wellbeing and being taught in school how to handle adversity

Unknown – Charlotte?

- Mental Health
- Long Term Condition – GPs
- End of Life – done well
- Frailty – treated in the community, have improved since we introduced the Action Team
- Assessing people for discharge in acute rather than at home
- More staff at the preventative and public health
- More care navigators and crisis team
- End of Life Care – Acute needs better comms; GPs having a similar model but for frail people. A model similar to domiciliary care but by specialized staff; so maybe acute staff in the community
- Intermediate care beds/Stroke
- Mental Health is a biggest concern
- Actually reaching out to patients who DNA or drop off
- GP Triage – not made much difference?

Table 6

- Which area – could have the biggest positive impact on outcomes and quality?

Mental Health

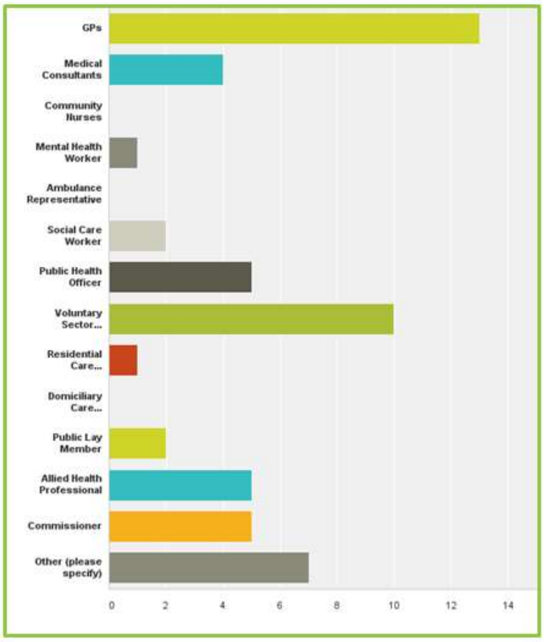
- Integration and diversity of provision
- Maximizes prevention of EI opps? LTCs, MH, self-management (LTCs and short term) makes the best use of existing work?
- End of life care – dying in a choice of person choosing (eg home, hospice, NH), permission to paramedic, not to take people to hospital who are dying
- GP out of hours service
- Can we feasibly change? Frailty, LTCs in localities
- Transmission of care plans for EOLC patients which effectively straddle 111 and 999
- MH Cross cutting these
- 65s over consulting GPs x 2 – management of urgent care (walk in centre fuelling demand) hub triage availability; ambulances sent out inappropriately
- Need to add rationing/triage to walk-in centre patients – to be able to wait up to 4 hours (2 hours)
-

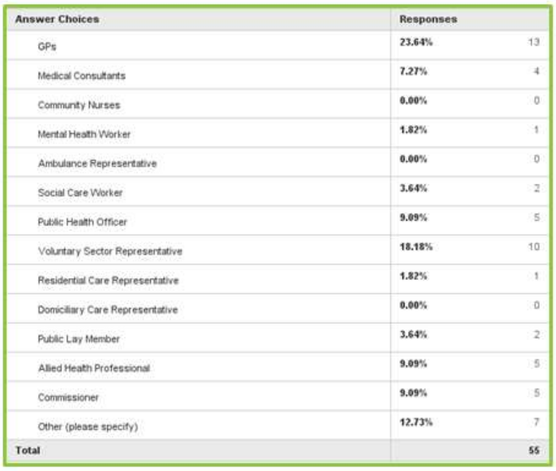
Table 7

- Transitions from 18-25 – this comes up as an issue across all areas
- End of life – good links with primary care
- Good links with paediatrics end of life support, however this may not be the same for the families of the person that is dying/died
- IT – We need to have one system, or systems that talk to each other
- Communication is key to all
- Prevention and Intervention is everyone's business- example of fire services and long term gain from prevention
- Leadership – we as the workforce can start to make the change now

Engagement Event Survey Results

What professional group do you belong to?

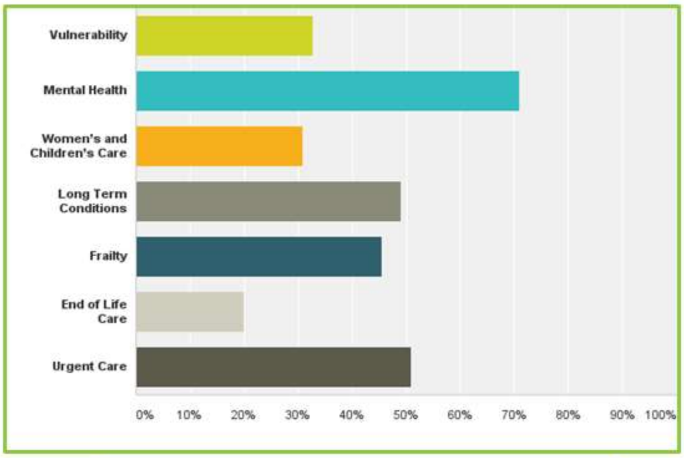




Answer Choices	Responses	
GPs	23.64%	13
Medical Consultants	7.27%	4
Community Nurses	0.00%	0
Mental Health Worker	1.82%	1
Ambulance Representative	0.00%	0
Social Care Worker	3.64%	2
Public Health Officer	9.09%	5
Voluntary Sector Representative	18.18%	10
Residential Care Representative	1.82%	1
Domiciliary Care Representative	0.00%	0
Public Lay Member	3.64%	2
Allied Health Professional	9.09%	5
Commissioner	9.09%	5
Other (please specify)	12.73%	7
Total		**55**

Other	• Citizen co-option
• Contract management officer	• Lead nurse acute and community
• Head of midwifery and nursing quality	• Nursing
• Domiciliary care representative	• Accountant (seconded to MLAFL)

Which three emerging focus areas would you want the island care system to focus on the most?



Answer Choices	Responses	
Vulnerability	32.73%	18
Mental Health	70.91%	39
Women's and Children's Care	30.91%	17
Long Term Conditions	49.09%	27
Frailty	45.45%	25
End of Life Care	20.00%	11
Urgent Care	50.91%	28
Total Respondents: 55		

xviii) Staff events – Clinical Engagement Event – 13th January 2016

Meeting summary note	
Meeting name	Clinical Engagement Event
Date	13th January 2016
Location	
MLAFL team members present	N/A
Presentation method	
Number of attendees	N/A

Issues discussed and outputs (continue overleaf if required)

FEEDBACK

- Prioritised CAHMS and integration
- Better understanding clouds children services
- Education services and schools
- Incompatibility of IT between GP and Hospital
- Doctors strike
- Delayed discharge issues
- Inconsistencies of GP referrals
- Complex discharge summaries
- Emergency department hold ups
- Poor social care
- Poor availability
- Preventing discharge
- Bed blocking
- Out of hours GP service
- No reactive stroke care pathway
- Lack of public responsibility re education
- Too many AE admissions
- Management of unplanned urgent care
- Lack of understanding
- Behavioural issues with paediatrics
- Mental health illness

PRIORITIES

Poor patient flow
Caring better in community for patient
Strengthening community services
Childrens support family’s education and child protection
Integrated shared record involve community nursing
Rapid community access i.e. diagnostic imaging
Secondary care disease
Hospital avoidance scheme

THINGS GOING WELL

Integrated hub
Crisis response team
Poppy ward

Palliative care
Macmillan services
52 week
SPARCS
2 week cancer referral
Crisis management

QUESTIONS

Manpower and bridge the gap
How to train the whole workforce – why are we not training HCA's and nurses - Dr Yoganathan

- What do we expect good care to look like? J Rivers
- Need to share information – IT is a big problem
- Over the next year are they going to be given directions on engagement?
- John Rivers explained that this is the question he is asking them?

What must we do to engage you? J Rivers

- Dr Henderson - Need Time from practice to take part, stop duplicating workloads, such as dementia reviews, arthritis reviews. Can they opt out of some services to enable them to take part in the new vanguard.

- Come to them for a meeting instead of going into Newport and taking time out of work - GP Ventnor

What to you want to be involved in ? Dr Pugh

- Regular update on a regular basis to enable to feed in to.
- Dr Harms – use people who know their subject so they can focus
- Organisational support , don't feed the beast, focussed, don't come in at the end, face to face, voting buttons, right skills at right time, continuously updated, needs to be otherways - Dr Gladdish

Vote
A little bit over a long period of time?
(few hands)
A short intense blast?
(few hands)

Provide cover like the half day GP day.
Joint meetings first and secondary care teams and social care team

Time during the working day to be provided to those taking part.
CPD should be given to encourage them to attend – Dr Yoganathan
Can IOW do something differently to keep doctors?
Provide free accommodation to junior doctors to make it more attractive here
Opportunity to integrate training between hospital and GP's
Who should be doing jobs that you didn't need a medical degree for? Dr Pugh
Community and patients need to be involved and have a sense of co design, it has to be that way – J Rivers

MLAFL website doesn't look very different, not much change.

APPENDIX FOUR – COMMUNITY MEETINGS

i) **Organisations that were contacted for engagement with protected groups**

A number of organisations that are active within the community on the Isle of Wight were contacted to help engage with hard to reach and protected groups. These include public meetings, telephone conversations and written communication and distribution of leaflets.

- 22 Argyll Street Care Home
- Acacia Care Home
- Active Living
- Age UK
- Age UK Men in Sheds
- Age UK’s Good Neighbour Scheme
- Ancona Care Home
- Autumn House Residential Home
- Barnardo’s
- Barnardo’s Baby Club
- Barnardo’s Breastfeeding group
- Barnardo’s Stay and Play
- Barnardo’s Under 25’s mum’s group
- Barnardo’s Ryde
- Barnardo’s Ventnor
- Beacon Centre
- Blackwater Mill Residential Home
- Bluebell House Residential Care Home
- Bowcombe Methodist
- Brading Youth Club
- Brighstone Care Limited
- Byrnhill Grove Registered Care Home
- Cameron House
- Capri Residential Home
- Care Navigators and Community Navigators
- Carter Avenue
- Cherry Blossom Care Home
- Clifton Cottage
- Cornelia Heights
- Cornelia Manor Residential Care Home
- Downside House
- Early Help hubs
- Eden House
- Equals
- Esplanade House
- Fairhaven House
- Fallowfields Residential Home
- Firbank Residential Care Home
- Grace Church
- Greyfriars Care Home
- Hazelwoood House

- Highfield House
- Highmead
- Holly House
- Homestart
- Inglefield Nursing Home
- Inspiring Women
- Inver House
- Isle Access
- Isle of Wight College
- Isle of Wight Hospice
- Isle of Wight Unitarians
- Isle of Wight Women’s Refuge
- Isle of Wight Youth Council
- Kingston Farmhouse Care Home
- Kite Hill Nursing Home
- Little Oaks Stay and Play
- Long term conditions network
- Magnolia House
- Mencap
- Merrydale Residential Home
- My Time
- Newport Residential Care Limited
- Newport Residential Care Limited
- Newton Lodge
- Northbrooke House Nursing Home
- Oddfellow’s
- Old Charlton House Residential Home
- Overbrook
- Pebbles Parent and Toddler Group
- Penshurst
- People Matter
- Plean Dene
- Pop Up Soup Kitchen
- Powys House Residential Home
- Quarry Oaks Care Home
- Ryde Baptist Church
- Ryde Cottage
- Ryde House
- Saxonbury
- Salvation Army
- Scope
- Sea Gables Residential Home
- Seagull
- Seven Gables
- Solent Grange Nursing Home
- South Wight Early Help Hub

- Springfield Nursing Home
- SSAFA
- St John’s Church
- St Thomas of Canterbury RC
- St Vincents Care Home
- Stonehaven
- Stoneleigh
- Summerhouse
- Sunshine Toddler Group
- Taunton House
- The Adelaide
- The Bays Children's Centre
- The Briars
- The Croft RCH Ltd
- The Elms Nursing Home
- The Laurels
- The Orchard
- The Salvation Army
- Tile House
- Trent House
- Vecta House Care Home
- Venner Avenue
- Victoria House
- Ward House Nursing Home
- Waxham House
- Wayfairers Fellowship Evangelical Church
- Way Forward
- Westminster House
- Westview House
- West Newport Family Centre – Homestart
- West Newport Family Centre – Baby Play
- Women’s Institute
- Woodside Hall Nursing Home
- Woodville
- Zion Chapel