Arden&GEM

NHS

Arden and Greater East Midlands
Commissioning Support Unit

Consolidation of engagement reports for NHS Leicester, Leicestershire and Rutland

September 2018

Contents

1. Background

Over the past five years Leicester, Leicestershire and Rutland (NHS LLR) have undertaken regular engagement with stakeholders, patients and the public to inform commissioning decisions. As a result of this considerable research, a wealth of insight has been gathered about what stakeholders, patients and the public feel is important across a range of health services.

The purpose of this report is to consolidate the information gathered across the reports and understand if information within them relates to the community services currently provided, and informs plans for future provision. Such information will also identify gaps in the engagement previously undertaken and necessary to inform decision making on community services. Therefore, the findings of this report are twofold:

- to identify relevant information/themes to support the future provision of community services
- to identify gaps where further engagement is recommended.

2. Introduction

The analysis undertaken across a number of reports highlight key factors of importance to stakeholders, patients and the public. Over 4,300 people have taken part in the engagement and consultations examined. In addition three reports did not indicate their total reach and another series of five listening events with up to 50 attendees at each event. The issues of Communication, Integration of services and Access to services are prevalent across all reports with other issues highlighted by specific stakeholder groups.

The report aims to determine if findings relate to any of the following community services currently provided by Leicestershire Partnership Trust:

- **Integrated Locality Teams -** responsible for joining up and coordinating the care provided by multiple professionals to patients within their defined geographical place (locality). Concentrate on the following with effect from April 2017:
    - Adults with five or more long term conditions.
    - Adults whose acute care costs are predicted to be three times the average over the next twelve months.
    - People with a frailty marker regardless of age (impaired function).

- **Home First** services support people to remain in their homes when they are having a health or social care crisis rather than needing to go into hospital or a care home. Home First Services also help people get home from hospital quickly and provide them with rehabilitation and reablement to help restore their health, wellbeing and independence.

- **District Nursing Services –** Teams, led by district nurses, to deliver care in people's own homes for those who are housebound, and in GP practices, health centres and community hospital clinics for those who are mobile.

- **Community Nursing Services** - provides nursing care within the community. The aim is to help patients to remain healthy and independent for as long as possible, and to support high quality palliative and end of life care.

- **Intensive Community Support** - enhanced care packages in the patient's own home of both nursing, physiotherapy and occupational therapy with medical care provided by the advanced nurse practitioner (ANP).

- **Community Hospital Beds** (including stroke beds) - Medical cover is provided by Advanced Nurse Practitioners with consultants visiting the wards twice weekly. Physiotherapy and occupational therapy are provided to all inpatients cared for in a general community hospital inpatient bed. Multidisciplinary care is provided in partnership with other professions and providers.

- **Community Therapy Services** (not including MSK physiotherapy)

- **Community integrated Neuro and Stroke Service** - an integrated, responsive, specialist rehabilitation service in the most appropriate environment for patients with acute neurological problems, long term neurological conditions and stroke survivors.

- **Primary Care Co-ordinators -** a team of registered healthcare professionals who work within the Emergency Department at Leicester Royal Infirmary (LRI). Their role is to identify and arrange care for patients who could be cared for in the community. The team will assess each patient and family using an assessment criteria to ensure that they receive the most appropriate care for their condition. They provide an outreach service for patients who are discharged home.

Information given by patients and the public in any of the reports analysed which relate to the services outlined above have also been considered in how they may relate to the following:

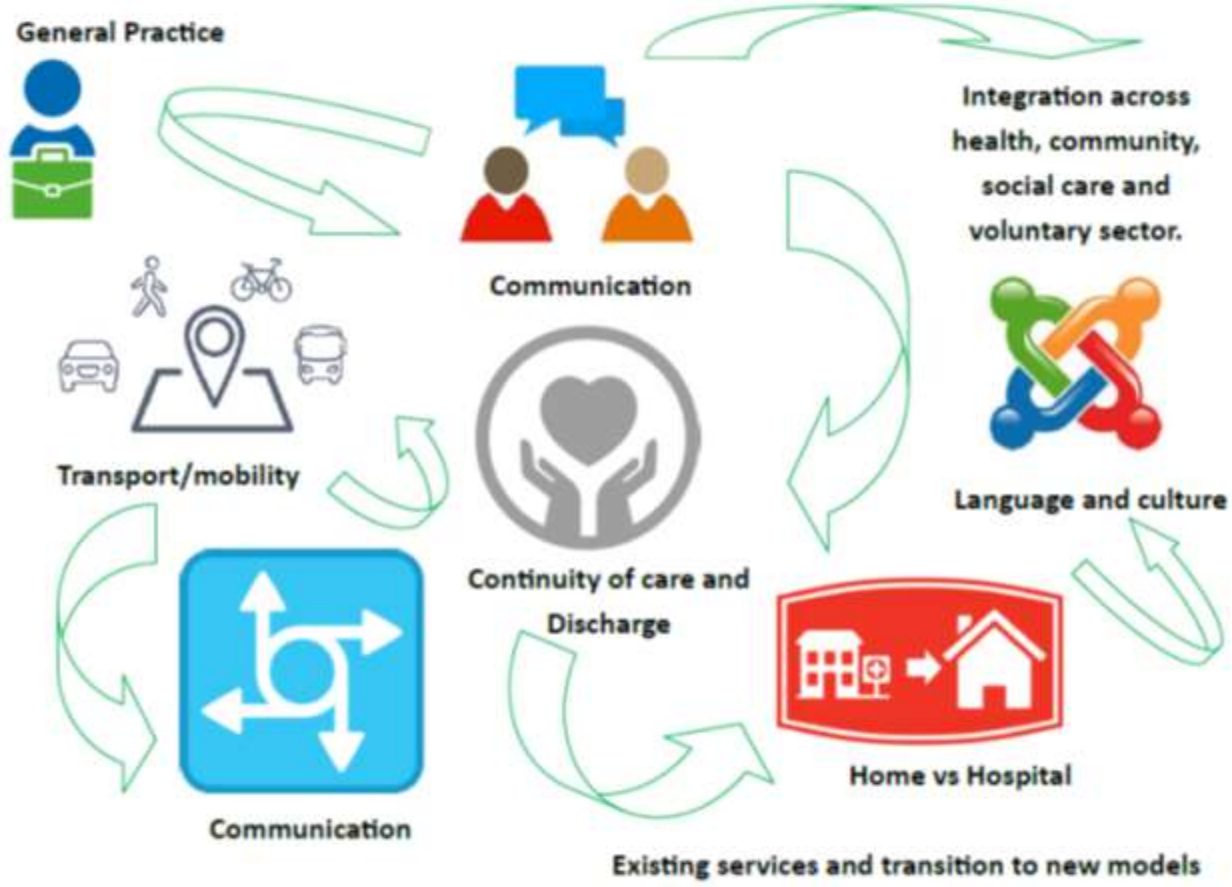
1. Hospital admission from community services
2. Hospital discharge into community services
3. Home First as a principle
4. Integrated locality teams
5. Community hospitals
6. Inpatient and outpatient beds
7. District nursing
8. Protected characteristics

To summarise a thematic analysis has been undertaken to identify:

- the key themes across all the reports and,
- specific themes pertinent to patients, carers and staff and variations
- Highlight relationships across themes and distinct difference across cohorts of people – patients, carers and staff
- key areas of good practice
- key areas for improvement
- key areas of concern
- high impact actions informed by the analysis that need to be influence this work

The reports examined are listed in Appendix A.

3. Findings from the consolidation of reports



3.1 Key themes across all reports

Analysis of the reports has highlighted a number of key themes which have implications for community services.

3.1.1 Communication

‘The issue of communication remains firmly placed as one of the elements of care that matters most to the participants. Service users’ and carers’ perceptions of the quality of the healthcare they received are highly dependent on the quality of their interactions with their healthcare professional and team.’ [SUCRAN report]

There are a number of themes around communication including:

- The quality of the interaction between service users/family and staff reflects dignity and compassionate care and contributed to staff satisfaction.
- Access to shared records is frequently mentioned – a single integrated patient information system that everyone can access. Shared IT systems which allow the efficient transfer of records and remove the need for service users to repeat their case history “*story telling fatigue*”.
- Communication between services/organisations to support transfers and discharge
- Communication between staff, in particular across services, which may be hampered by different terminology

Organisational, and personal communications as well as IT systems which support sharing of information across services, are considered by all stakeholders to play an important role in the smooth running of services.

3.1.2 Transport/mobility including public transport, car parking and access

Another frequently mentioned issue is that of travel between the service users’ home and healthcare services including:

- Travel, in particular for those who do not drive or have mobility issues, with long waits for patient transport.
- Accessibility and convenience of public transport, in particular for those with mobility issues. Services physically closer may not be well served by public transport.
- Car parking issues have a major impact on accessing services

Easy access to services is a high priority for patients and their families.

For those living at home or in sheltered accommodation support to stay mobile (eg blue badges, wheelchairs and home modification) is an important issue. Not only does this give the service user independence it also makes caring for the user easier.

"Older people have more problems getting places. Our village has almost no public transport. When we have to give up our driving licence, we shall be unable to travel to your "other local places." Please build a replacement in Ashby."

'..local is really important for many people, particularly those with no car, like many elderly'

" Ashby needs services locally, not miles away. Elderly relatives need to visit locally - unable to travel.'

3.1.3 Integration across health, community, social care and voluntary sector.

Some of the themes are indicative of issues with integration including:

- There are calls for better pathways between healthcare services and the voluntary and community sector
- Poor quality of transfer experience between services
- Some service users mentioned concern around accessing services across borders, out of their usual geography
- Transfer between services/handovers are potentially stressful times for service users, where continuity of care can be lost when they move from one service to another
- All stakeholders want to be aware of all available services – a Directory of Services
- Working relationships between services clearly impacts on stakeholder experience

Staff, patients and carers all recognised the need for closer integration between services, including social care, to deliver the care needs of the patient.

3.1.4 Continuity of care and Discharge

Transfer between services/handovers are highlighted as potentially stressful times for both staff and service users, in particular older people. Patients have said that support they get before and after hospital stay, including discharge planning, is a very mixed experience. Issues relate to involvement of family carers, speed of the process, the key role of joint working between health and social services in particular where services cross boundaries. A clear, timely discharge letter' is called for.

A relative "*expressed difficulties with discharge planning, their frustration with the process and lack of joined up working between health and social care"*

I am appalled to think that patients I usually care for are possibly going to be at risk by being discharged from the acutes too early and sent home to a service that is inadequate and understaffed. Many times we have patients readmitted from home after being discharged prematurely and cannot manage or have inadequate services." (Health professional)

Lack of continuity within teams, eg agency care teams, District nurses, GPs is also highlighted.

3.1.5 Existing services and transition to new models

Comments on what may be lost or gained through service changes hinge around

- Loss of existing high quality services and long term relationships both between service users and staff, and between staff
- Loss of local heritage/buildings
- Effective transition of services from existing model to new
- Value for money of the existing estate
- Estates issues in existing facilities including poor equipment
- Service users want to be engaged in the co-design and co-production

The insights reflect concerns about loss of existing relationships and services, and apprehension about new relocated, services.

3.1.6 General Practice

The importance of access to GP services is clear from responses from all stakeholders. This includes

- Access to GP services, in particular same-day appointments and a known GP, are a common issue for service users
- Extended services within General Practice has been suggested
- The links between care homes and primary care are key to provide adequate out of hospital support for service users

3.1.7 Home vs hospital

Feedback from service users and family around being “at home” or in sheltered accommodation/hospital is mixed. Those living at home report loneliness and social isolation while others prefer to receive their care at home with the freedom this gives. Community based organisations are particularly valued by those living at home.

Recognition of the importance of the role of family carers is a key factor for users living at home. Family carers report issues around paperwork, coordination of care, lack of involvement in their loved ones care, increased burden on the families, and lack of support. They also mention the need for personal support, respite and future planning.

‘if people are cared for in their homes as is proposed it puts a huge burden on other family members when they can least cope.’

3.1.8 Language and culture

The use of understandable and consistent terminology, without jargon, and accessible resources are important to the user experience.

Vulnerable groups report the lack of availability of translation / interpreter services. They also report that healthcare staff do not have an awareness of the cultural differences common to these groups and suggest that training would be appropriate.

3.2 Specific themes for different cohorts and stakeholder groups

3.2.1 Key themes for service users / family carers

The following insights were extracted from engagement exercise involving both service users (patients) and their families and responses cannot be analysed separately.

- **Communication**

Service users and carers’ perceptions of the quality of the healthcare they received are highly dependent on the quality of their interactions with their healthcare professional and team - ‘a positive experience of care’.

This is supported by

Relationships with staff which are fundamental to quality of care. This particularly evident in well-established Community Hospitals where patients and relatives are happy with care, and feel that they are “among friends”. Spending time with staff is part of building this relationship.

Communication/continuity of care between the hospitals and patients including handovers and communications across the health system

Communication between professionals working across health and social care

Accessible and correct information on their diagnosis and treatments, and support to self care.

- **Use of technology**

Improved use of technology including digitised patient records and shared computer systems to reduce repetition of health information – “story telling fatigue” – is a common theme.

- **Transport, access and mobility**

Travel between the service users’ home and healthcare services, in particular for those who do not drive or have mobility issues, is a particular issue. Accessibility and convenience of public transport is important. Services physically closer may not be well served by public transport.

Car parking issues have a major impact on accessing services.

Staff and service users have indicated the importance of retaining mobility. For those living at home or in sheltered accommodation support to stay mobile (eg blue badges, wheelchairs and home modification) is an important issue. Not only does this give the service user independence it also makes caring for the user easier.

- **Service delivery**

A number of themes relating to service delivery are mentioned.

While service users were positive about integration and more joined up working across health and social care, including voluntary and community sector, there was concern regarding cross border provision of social care services.

Users want to see consistent patient service regardless of access route or provider

Access to GP services, in particular the ability to see the same GP, and efficient and effective links between GP surgeries and hospitals

Patients note issues around discharge procedures and lack of joined up working with social care

- **Language/culture**

Service users and carers comment on the use of jargon. They stress the importance of appropriate terminology and accessible language which will help them understand their diagnosis and treatments. Information should be appropriate, accurate, relevant and in an accessible format.

The lack of translation or interpreter services and culturally appropriate resources is an issue for members of vulnerable groups.

3.2.2 Key themes for frail elderly at home and in care homes

- Loneliness, depression and unhappiness in particular for those in their own home

- Transport including public transport services to healthcare facilities, and retaining mobility which gives them freedom and allows them to get out and about
- The importance of support and from family, community organisations and health professionals. In particular users highlight the importance of continuity of care and knowing the professionals who care for them, and developing a relationship with them
- Management of NHS continuing care
- Personalisation of care, one size does not fit all
- Quality and responsiveness of joined up care across primary, secondary and community care
- Medicines optimisation
- End of life care planning

3.2.3 Key themes for family carers/relatives

- Carers describe feeling ignored, and left out of care planning and decisions including future care options while they want to be acknowledged, valued and involved in care for their loved ones
- Carers describe the burden of coordinating care for their loved one such as increased paperwork and financial issues, managing paid carers. A concern was expressed that more care in the home places additional burden on relatives and carers
- Carers have called for simpler explanations and information
- Carers see health professionals support as their key to staying independent, in particular home help and community support
- Carers feel unable to support their loved one through self care
- The importance of carers' health including emotional support and " life after caring"
- Working carers highlighted issues they have managing care around their working patterns
- There is a need for recognition and support for different types of carer including young carers, co-carers, parent carers

Family carers indicate that they want to me more involved in the decisions around the care of their loved ones, and need support to enable them to manage.

3.2.4 Key themes from vulnerable groups

While most of the reports did not include significant numbers of individuals from vulnerable groups, a number of themes were identified from the EDS2 reports from vulnerable groups. These include

- Access to GP and other health services

- Lack of translation/interpretation services and accessible resources
- Issues managing conditions diagnosed before moving to the UK
- Lack of staff awareness around particular conditions or cultural differences

Issues for staff managing service users in vulnerable groups:

- Staff need to be properly trained to understand and recognise those specific health risks and health care needs of people in vulnerable groups , including those with mental health problems and learning disabilities
- To act sensitively and professionally

3.2.5 Key themes for staff (including agency carers)

- Relationships with patients and families are very important, and staff would like more time to build these relationships. They would also like to see better relationships between health professionals/with other teams
- IT systems giving easier access to patient data
- A Directory of Services across the health system including when and how services can be accessed
- More community based support services around recovery and preventing hospital admission
- Staff development, including training and career development
  - More inter-professional and inter-organizational training would strengthen links and support work with different communities, eg protected communities, dementia and mental health
  - Staff indicate that they do not feel valued. They do not feel that they celebrate their successes.
- Staff called for a better working environment with up to date/functioning equipment
- Care home staff value access to outside professionals including GPs, district nurses and Physiotherapists is important.

3.3 Relationship across themes and distinct differences across cohorts

3.3.1 Key areas highlighted by all stakeholders

- Relationships and communication between clients and staff, between staff and between services including knowing who to contact and how
- Transport, parking, access and mobility
- Integration of services (including community and voluntary sector) such that everyone knows what services are available and how to access them
- The importance of family carers
- Appropriate use of IT to support access to information

- Both staff (including NHS 111) and carers indicated that they do not feel able to support service users to self care.

3.3.2 Key areas highlighted by different stakeholders

- **Frail elderly service users**

Frail elderly clients living in their own home specifically highlight issues around loneliness and isolation, and dependence on their carers, relatives and support services to manage their condition (including medicines and future planning).

There is also a fear that increased care at home may result in an additional burden on relatives and family.

‘I don’t get help early and then things get worse then I can’t cope.’

‘I can’t cope on my own.’

‘Everything is OK if my husband is well. What happens if he is ill? We have no one. I have no support.’

If people are cared for in their homes as is proposed it puts a huge burden on other family members when they can least cope.

- **Family Carers**

While carers are key to supporting service users, they report feeling ignored and left out of the process of care planning for their loved one. In addition they are managing financial issues, benefits and paperwork to support their loved one and themselves.

‘ I felt like social services always took more notice of other members of the family even though I was the only carer. It was easier for social services to take the advice of the majority’

- **Protected characteristics**

Apart from the EDS2 research, few of the reports present insights from vulnerable groups, and this should be addressed with further primary research.

While communication is key across all groups, those with protected characteristics specifically highlight language issues (including translation/interpretation services), literacy issues and poor relationships with healthcare staff and difficulties accessing health services.

“When we receive letters from the doctor or hospital, we are not able to read them.”

“We don’t want any special services or treatment; we would like to have access to the same services as everyone else.”

“It is difficult [to get the healthcare you need] when you are on the roadside because you have no postcode.”

“Very rarely you get an interpreter at the GPs, they always ask to bring family member.”

“People do not know where to go to seek support. Services need to be more accessible and visible at the community hubs, and projects.”

“We do not take into account stories from Poland- feel ignored and let down.”

“Language barrier used as an excuse by staff, but Somali community feel it’s not that but because of the community they belong to.”

- **Healthcare staff**

Many of the issues for staff mirror those for service users/carers. Key issues include:

Good relationships between staff and service users is important to staff, they want more time to get to know their patients and provide a high quality service.

The importance of systems and process to support communication, in particular IT systems such as shared patient records

Poor communication between staff and between organisations and services is also an issue.

Staff value community organisations which support patients, in particular those living at home.

Inter professional and inter-organisational training is put forward as a key to support personal resilience, closer team working and career development. The importance of education was highlighted in the context of vulnerable groups.

Staff feel unable to be proactive around supporting their patients to manage their condition.

Staff are aware that they do not know about other services available and want a Directory of Services

Maintaining mobility in their patients helps staff to care for them.

Staff do not feel valued, and want the opportunity to celebrate their successes.

Staff in community hospitals comment on their poor working environment and the state of their equipment which is not always in good working order.

“Staff identified a need for improvements in IT to give them joined up accessible records, and a common IT interface.”

“The one clear theme from the healthcare professionals’ event was integrated IT systems. This was cited in all the discussions and included improved interface between departments and organisations; improved access to records; technology providing a better tool; and information availability.”

“Joint training and networking events would have a positive impact on service delivery and integration.”

4. Key areas of good practice

Many of the reports concentrated on issues and concerns, and positive comments were relatively sparse. However, below are examples described as good practice in the reports.

Staff and services

- High quality care where patients were treated with respect
- High standard of hygiene and cleanliness of the wards
- Staff training and support

‘Family can visit at any time’
‘I got used to the staff. It was like coming home’
‘Brilliant team, they are fantastic, very supportive. Staff has same beliefs and know the ethos of the home’
‘Age UK support me. They give me lots of training’

Communication

- Involving patients and carers by sharing documentation including patient records and care plans
- The TB service was described as responsive with good communication

‘Care plans; sections you can record activities they have enjoyed, physical disabilities etc.’

‘The team have always involved me [the family]. They ring me if any problems’
‘[Staff] do listen to what I think’

Travel
- Telephone consultation which saved visits to hospital

Integrated services
- Support from the voluntary sector and community groups including peer support, statutory and advocacy services
- Access to outside professionals (eg GPs, district nurses, physiotherapists) helped care home staff
- Within primary care access to MDTs and nurses to support GPs freed up time for those most in need
- End of life care planning through close relationship with residents and families

‘Physios, mental health team, inspection units coming together and one standard check list so everyone singing off the same hymn sheet’
‘Having easier access to GPs, district nurses’
‘Easy access to multidisciplinary teams’
‘End of life care. Good symptom control. Team work, compassionate focus on resident. It achieved a peaceful death for resident’
‘Towards end of life, making resident pain free and comfortable’
‘Having an ANP to do ward rounds so GPs can target those at most need to medical intervention’
‘District nurses are supportive’

Carers
- Recognition of carers and young carers

Vulnerable groups
- Use of Liaison Nurses (Learning Disabilities)

5. Key areas of concern

There were numerous comments made around key concerns that affect a wide range of people. These concerns featured across all reports and have been listed below.

Areas of concern across all feedback:

- Poor quality of transfer experience between services
- Waiting times for appointments and treatment
- Lack of out of hours or weekend access to GPs
- Receptionists and phone systems are a barrier when trying to make an appointment in some areas
- Lack of access to GP (same day appointment not available) results in inappropriate
- attendance at A&E
- Lack of Parity of esteem for patients who suffer with a mental health conditions.
- Slow discharge process partly because of cross county complications and the need to work with a number of different social services to arrange discharge care packages

Areas of concern with particular groups:

People with complex needs

- Loneliness, in particular for those living in their own homes. Need support and someone to turn to in crisis or end up in hospital
- People who live in their own home are significantly more depressed and unhappy compared to those in sheltered accommodation.
- People do not perceive health services as proactive. Where community outreach services exist people need to know about them.

Frontline staff

- Lack of speed and responsiveness when they make referrals
- Poor equipment and work environment
- Lack of recognition, successes are not celebrated

Carers/Family carers

- Concern around delivery and implementation and lack of funding
- Perceived lack of appropriate carer support, egs Services for working carers
- Concerns about the interface between health and social care, and questions around how delivery plans will be monitored to track improvements in carer experience
- Proposed services will not be local/convenient/easy to access
- Transport/car parking difficulties accessing new locations
- Losing heritage (but others say building not fit for purpose with poor facilities, insufficient parking and a lack of diagnostic facilities)
- Services (including therapeutic, rehabilitation and other outpatient services

- Both acute and community will not be put in place prior to ADH closing, if ever. Concern about transition
- Lack of consideration of local population growth
- People living with complex long term health issues rely heavily on hospital teams
- Car parking
- Not involving carers in discharge process
- Hospitals/GPs not involving carers
- Lack of emotional support
- Recognition of different types of carers (eg adult student, co-carers, parent carers)
- Principle of carers' health
- Family carers feel ignored by health services. They are not involved in decisions and care planning and so are unable to do their best work
- 'life after caring' – need help to rebuild lives
- Financial issues, benefits and paperwork are a burden

Somali engagement

- Hard to get GP appointment
- Lack of compassion by carers coming into patient's home

Eastern European engagement

- Lack of action by GP in particular if diagnosed before moving to UK
- Difficult to get GP appointment
- Lack of interpreters
- Lack of awareness about NHS system

LGBT

- Discrimination around sexuality and transgender people
- More funding required to support mental health, depression and anxiety to meet the needs of LGBT people
- More confidence that personal data around sexuality will not be shared

LASS (Leicestershire Aids Support Service)

- Lack of confidentiality
- Staff not wearing gloves
- Lack of knowledge of illness
- Do not see the same GP/doctor

Gypsy and Travellers

- Having no permanent address is an issue regarding notes, correspondence, registering
- Poor reading skills/literacy an issue with respect to following instructions, correspondence

6.Conclusion

This report reflects the wide ranging engagement and consultation which has already been carried out across NHS LLR and which can be used to understand the development of future community services. However, the analysis indicates that further engagement would be valuable, in particular with members of vulnerable groups.

Key issues for further investigation may include :

- Organisational communications including IT systems which support sharing of information across services
- Patient and family access to services, including public transport, locality and car parking
- Mobility in particular for frail elderly
- The need for closer integration across all services (including social care, voluntary and community services) to deliver the care needs of patients in the community and its impact on continuity of care, in particular around discharge
- Understanding the impact of the loss of existing, well trusted local services, and introduction of new services
- The role of GP services, including access, range of available services and links between those living at home or in sheltered accommodation
- Issues of loneliness and isolation for those living at home
- Pressure on family carers
- Availability of translation and interpreter services
- Staff training and career development, in particular to support vulnerable groups

7. Recommendations

- It is recommended that all feedback from the consolidated reports is taken into consideration before a final decision is made
- Further engagement with people with protected characteristics would also benefit this study
- To ask specific questions around the services documented in section 2 of this report
- It would also be recommended to engage with the various patients, carer, staff and vulnerable groups using a range of engagement activities to allow greater feedback, this may include: online surveys, engagement events and focus groups.

Appendix A Reports examined

The reports below incorporated insights from 4,304 individuals through surveys, meetings and face to face, plus 6,268 recorded responses. In addition, two reports did not record reach.

Ashby CHS consultation - 473 individuals responded

- Ashby Community Health Services Review Board paper Appendices

BCT Frail and Older People Insights (LLR) - 494 individuals responded

- Report for integration executive final 210715
- Interim ELC LLR Frail and Older people insights v4 290415

Care homes review – 188 interviews with care home residents and families, healthcare staff

- West Leics CCG Care homes – high impact actions - Impact on life FINAL 070616
- West Leics CCG Care homes – high impact actions - Impact on health and care FINAL 070616
- Appendix two West Leics CCHG Care homes (Staff report)
- Appendix 1one West leics CCG Care homes – full resident and families interim

Clinical Navigation Hub

- WL CCG consolidation of research Report for engagement 150916 (consolidated report analysing 6,268 reponses and other reports which did not indicate reach)
- Urgent Care Vanguard ELC Programme Design (37 users and 18 frontline staff during trial of an urgent care clinical navigation hub)

Domiciliary Care engagement – 656 completed surveys and interviews

- Dom care Final User Engagement Report Sept 2016

EDS2 community engagement reports – Over 75 interviews with LD, African Caribbean, Somali, Eastern European, LGBT, HIV, Gypsy and traveller groups

- Rethink Meeting EDS2 feedback – 010615
- African Caribbean EDS2 workshop report
- Somali EDS2 final report
- Eastern European EDS2 workshop 27
- LGBT EDS2 workshop
- LASS EDS2 WORKSHOP
- Gypsy and Traveller EDS2 workshop

Healthwatch Leicestershire Coalville Community Hospital Enter and View visit – 10 interviews

- Healthwatch Leicestershire Coalville Community Hospital Report Final Web

Healthwatch Leicestershire Hinckley & Bosworth Community Hospital - over 17 interviews

- hwl_enterview_hinkleybosworth_
- community_hospital_report

- Healthwatch Enter and View visit to Hinkley & Bosworth Community Hospital report 2016

Healthwatch Leicestershire St Lukes Community Hospital - 11 interviews
- Healthwatch Leicestershire St Lukes Enter & View Report

Healthwatch Leicestershire Urgent Care Centres - 55 interviews across 4 UCCs
- HWL Urgent Care Centres Enter and View Report

HInkley Community Services Review – over 2000 people face to face and involved in events
- HInkley ELC programme anlaysis
- FULL VERSION HInkley Insights v2 26112014

Home First Engagement – 341 staff and public
- WLCCG Summary report and appendices draft 090517

Joint Carers Strategy consultation - 230 survey responses and 118 individuals face to face
- 2018 05 Carers Partners Consultation report v7

LGBT Out and About – total not specified from focus groups, telephone and online
- LGBTOut and About – Health and Social Care Report

Mental health Resilience and Recovery bubs consultation – 749 completed questionnaires and 450 face to face
- Consultation update briefing December 2016 final

Patient experience reports for UHL – Interactions with over 500 people attending imaging, maternity and urology clinics and reported compliments/ concerns
- Patient experience – Compliments & Concerns Qtr4 2017-18
- Summary report – Patient experience on the front line
- Patient experience on the front line – Imaging services
- Patient experience on the front line – Maternity services 03-08-17
- Patient experience on the front line – Urology services

SUCRAN Learning Lessons Review – total not specified but target of 50 per Listening Event
- Learning Lessons Summary report – Final version (2015)