Consultation topic	As of April 2016: Engagement that has taken place (number of events/briefings etc.) Approximate number of people inter	As of April 2016: Approximate number of people engaged	Key themes emerging from engagement	How this engagement has been built into work stream plans
MATERNITY	Healthwatch, interested stakeholder groups and UHL patient partners PPAG, Healthwatch and UHL PPI representatives and members of the public involved in the options appraisal validation session 2015 Breast Friends. Discussion with Breast feeding support group 2015. 12 people attending Rutland women. Event sponsored by Healthwatch Rutland. 6 attendees. 2015 Charnwood Breast feeding support group 7 attendees discussed MLU options. 2015 Healthwatch, interested stakeholder groups and UHL patient partners in a midwifery led care options appraisal. 2015 Women and mothers Toddler Town Huncote. 2015 Healthwatch and internal stakeholders Women's preferred option discussion, 2015 Women and mothers Toddler town Wigston 2015 Healthwatch Women's project board (monthly meetings) Members of the public -UHL Annual General Meeting 2015 Sikh women Sikh community Centre Health fair 2015 Asian women Sharma women's centre 2015 BCT PPAG meeting bi-monthly- 20 people group assuring the plans of the programme Leicestershire Equalities Group 30 people representing different protected characteristics received a briefing about the shape of the proposed changes including the maternity proposals Members briefings - Briefings have been made to Leicestershire and Rutland county councillor and Leicester City overview and scrutiny members	Approximately 1400 people	Safety of both mother and baby Increasing the numbers of home births alongside making people aware that risks of home births are the same as MLU birth Recognition of challenges around providing midwifery-led care in Melton Mowbray Ensuring equitable access to services Need to offer additional/enhanced post-natal care to all women Recognition of financial constraints; need to offer more for less, whilst maintaining high quality standards of care. Benefit criteria prioritised at public event on 3/6.	All acute services to move to the LRI to ensure co-location of all emergency and obstetric-led services, and appropriate high quality environments with good clinical adjacencies, offering service efficiencies for consolidation. Consideration of King's Fund and NICE recommendations on best practice for childbirth and reconfiguration of maternity services. Option to provide a standalone MLU at the LGH for accessibility to ensure choice. Commitment to supporting an increase in home births and improving post-natal care for all women across LLR

	Health and Wellbeing Boards Briefings have been made to the Health and Wellbeing boards. These briefings were held in public and the papers made public. Leicester Mercury patients panel 6 members of the public have been briefed about the proposed changes Review BCT Partnership Board The partnership board have been briefed in public with a few members of the public present			
HINCKLEY HOSPITALS	2 public engagement events (attended by approx. 2000 people) Regular stakeholder events held in conjunction with the district council Regular key stakeholder meetings and briefings such as with local MPs and Councillors	Estimated at 2200	**Service access:** • Increase services offered at the GP practice • Improve access to diagnostics (bloods) • There is limited out-of-hours GP services • Recognise and utilise community and voluntary services • More education to support self-care and prevent illness **Services and access** • Everyone fed back a desire for services to stay local. There were mixed views around whether services should be provided in hospital or provided in a wider range of community venues • Everyone wanted improved diagnostic and pathology services, with shorter waiting times for diagnosis and results emerging as a significant issue for people and family carers • Family carers want smoother systems for delivery of medication and transition to adult care for children • Family carers find the process of making a GP appointment difficult and **Endoscopy** Is it acceptable to move endoscopy to another site? • Keep it local • Make sure it is accessible • Local is good for carers • There must be good transport links and parking • Keep it all it one place • New purpose built site needed - a modern ‘fit for the future facility’ with the right equipment • Must be staffed by specialists	• Offer the choice in the consultation of moving more planned care and diagnostic services to GP surgeries • Maintaining as many services as possible in the local area where it is sustainable to do so in the longer term (for example procedures requiring general anaesthetic via bottled gas will soon not be viable) • Endoscopy services will be enhanced and continued to be provided locally. • Local people will have the choice in the consultation of services provided in Hinckley Health Centre (adjacent to the current Hinckley and District hospital); ensuring services are local and accessible.

- Must be JAG accredited

Hinckley Health Centre or Hinckley & Bosworth site?

- Town centre location is good for Hinckley (HHC)
- Community Hospital site is good for wider Hinckley & Bosworth area (H&B)
- Can we do both?

What else should we think about?

- What's happening to the current site?
- Hinckley & District site could be sold for redevelopment and use the proceeds to pay for capital investment
- Is this futureproof? Will nanotechnology replace the need for endoscopy?
- Will this require bringing people in from outside Hinckley? What knock-on effect would that have?
-

Day cases

Is it acceptable to move day cases outside of Hinckley, e.g. GEH/UHL?

- Yes
  - But only if waiting times are reduced; is this likely?
  - If a one off
  - But deliver pre and post-op care locally
  - If it means seeing the specialist
  - GP premises are not fit for purpose
  - Only if we do not have the facilities in Hinckley
  - But not everything, minor day cases should be closer to home
  - Leave major procedures out of town
- No
  - Transport and parking issues
  - Access issues
  - Prefer local services
  - Expand local services
  - This goes against the ten principles of the project
  - Increase capacity at weekends
  - Good experience of services in Hinckley
  - Save people going across the border

If locally delivered, would it be best from Hinckley Health Centre or GP Practices?

- Hinckley Health Centre
  - Better on one site
  - Create a community hub
  - GP premises are not fit for purpose
  - Too much already on
- GP Practices
  - Federation solution
  - Carry out minor ops
  - Maximise GPwSIs
  - Clinic one a month?
  - Happy to travel for a one-off

- GPs
  - Economies of scale
  - Its familiar to people and the bus routes are in place
  - If consultants spend more time travelling they spend less time seeing patients
  - Multiple sites won't work
  - Is there enough funding and capacity within GP practices?
  - Will require joined up IT

What else should we think about?

- Right place, right time, right professional
- Will we still have choice?
- We need more data to make an informed decision. What's the volume?
- Specialist facility for cataracts?
- Think about recovery times and transport
- Is the workforce is available?
- What if multiple procedures are required?
- More important that facilities have maximum, 24/7 use
- It must be viable
- Joined up pre and post op care
- How does this fit with increasing age and obesity factors?
- If waiting times go up, it is not a good trade off
- Who owns the hospital?

Outpatients

What do you like about this option [to maintain outpatients at HHC]?

- Good transport links
- Local and accessible
- All under one roof
- Reduce waiting times
- Increase the offer
- Use the Health Centre & H&B Hospital to full capacity

What else should we think about?

- Capacity and workforce
- More use of care navigators
- Parking
- Referral pathways (pre op and post op) and the transfer of information
- Mental health services?
- Physio services at the leisure centre
- Diagnosis and prevention
- Wider offer of services; what else could be delivered?
- Increase in the population
- Affordability

ACUTE HOSPITALS 3 TO 2	Patient representatives involved in service reconfig work stream involved in development of proposals 3 Members of BCT PPIMAG members attended option workshop Public Formal consultation in 2000 on moving from 3 sites to 2 Patient representatives and Healthwatch - Part of team who developed and confirmed the preferred option in 2013 Public BCT public engagement campaign in 2015 stating plans to move from three sites to two. 1000 respondents Public UHL "Delivering care at its best" engagement in 2015. Significant public engagement. BCT PPAG 20 people group assuring the plans of the programme on a bimonthly basis Overview and Scrutiny Approved changes to emergency floor layout and "mothballing" of some beds Leicestershire Equalities Group 30 people representing different protected characteristics received a briefing about the shape of the proposed changes including the UHL 3 to 2 shift Overview and Scrutiny 3 overview and scrutiny groups (Rutland, Leicestershire and Leicester City) have discussed the outline of the plan to increase ICS and reduce community hospital inpatient sites plus the shift of planned care to the community. These meetings were held in public and the papers made public. Member's briefings. Briefings have been made to Leicestershire and Rutland county councillor and Leicester City overview and scrutiny members Health and Wellbeing Boards. Briefings have been made to the Health and Wellbeing boards. These briefings were held in public and the papers made public. Mercury patients panel 6 members of the public have been briefed about the proposed changes BCT Partnership Board The partnership board have been briefed in public with a few members of the public present The documents UHL Strategic Direction (2014) and Delivering Caring at its Best (2015), which discuss the reduction of three to two sites were circulated to stakeholders and also via face to		• Overall acceptance and understanding of the need to reduce the number of sites that services are delivered from. • An understanding that some services for clinical best practice, need to be located together. • The Generals Hospital if not a location for acute health services, is a good location for non-acute care, and research	• Subject to the outcome of the consultation, a midwife led unit will be located at the General site.

	face meetings with key stakeholders.				
GENERAL COMMUNITY HOSPITALS RECONFIGURATION	Service reconfiguration work-stream Patient representative	An individual involved in the development of proposals as part of the project team	Approximately 1100	• Care closer to home which is easily accessible • big city hospitals should focus on specialist and emergency care, with some simpler care being done in the community hospitals/ GP services • When asked what was most important if someone in your family needed a simple health procedure which did not require a stay in hospital, waiting time was most important to approximately two thirds of people engaged with. • When asked what was most important If someone in your family needed a major operation waiting time was most important to most people.	• Increased number of planned care services to be carried out in the community in GP surgeries or community hospitals • An increased use of 'Hospital at Home' beds so that people, when ready to b discharged from acute care can recuperate at home with support from the Hospital at Home service.
	Members of the BCT Patient and Public assurance group (PPAG)	Three members of the PPAG attended three workshops to discuss the proposed changes and to agree which options were viable and which not			
	Alliance Patient and Public Group	A number of individuals as part of the project team that designed the planned shift of planned care services to community hospitals			
	Public	Public engagement campaign used to confirm the direction of travel for the programme and assess the view of the public on travel time. 1000 respondents			
	BCT PPAG	20 people group assuring the plans of the programme on a bimonthly basis			
	Leicestershire Equalities Group	30 people representing different protected characteristics received a briefing about the shape of the proposed changes including the increase in care at home and reduction of inpatient sites			
	Overview and Scrutiny	3 overview and scrutiny groups (Rutland, Leicestershire and Leicester City) have discussed			

COMMUNITY HOSPITALS (St Luke's Hospital, Market Harborough, Rutland Memorial Hospital, Feilding Palmer Hospital, Lutterworth, St Mary's hospital, Melton Mowbray)	**Public consultation (16 June to 5 October 2008) -** NHS Leicestershire County and Rutland (NHS LCR) held a public consultation about the future of community health services in Leicestershire and Rutland. More than 1000 responses (876 completed questionnaires) _____ **Public engagement survey (April-May 2012)** giving people the opportunity to give their views on community and elective care services. 365 completed surveys ELR CCG PPG Network discussion		Strong support for: • care closer to home (89% strongly agree or agree); • local diagnostics (98% strongly agree or agree); • increased GP Services (87% strongly agree or agree); • five one-stop hubs (84% strongly agree or agree); and • 82% of people would rather not travel to city centre care setting. Issues raised by respondents • accessibility; • need to resolve inequalities and address needs • extending opening hours and gaining immediate access • importance of "Diagnostics" • need to work with key partners. _____ Survey responses highlighted the preference for services to be local and the importance for services to be delivered as close to home as possible. The majority of respondents ranked local GP practice as the most preferred location for diagnostic, day case and out-patient services, closely followed by Melton Mowbray hospital, as an important location. Further to this, respondents asked for excellent, up to date equipment and treatment and more of it, saying that they are more likely to attend appointments if they can get treatment locally. It was suggested that diagnostics and outpatient appointments should be undertaken locally, with more complex treatments and operations to take place at larger hospitals. Many commented on how it feels to be treated in their local community stating more of a personal service and a community feeling of being cared for. There were many comments made on issues of visiting larger hospitals for treatment which also verifies the preference for local services. Some respondents stated that attending	Engagement processes have enabled us to understand current issues and the breadth of potential for bringing together community and primary care services. Our aim is for each locality to have the right level and range of services to serve the needs of local patients. To achieve this, Primary Care is placed at the core of our model development with a proposal for discussion centred on wraparound community services to achieve greater integration of health and social care professionals. We have identified a number of areas that need to be addressed through the proposed model to ensure a solid foundation for community services. These areas are not exhaustive and include: 1. Changing the current model of community services commissioning to give the CCG and its GPs more accountability to influence how services are delivered; 2. Creation of joint GP/Provider posts to enhance accountability; 3. Delivery of a rehabilitation and re-ablement model that moves services from a hospital to a home environment; 4. Improving access to community services that are currently considered sub-optimal including physiotherapy; 5. Expanding the times when care is available both at home and in health facilities; 6. Establishing clinical support networks and services in acute and primary care to identify, enable and manage both complex care, frail elderly and sub-acute care locally; 7. Making the most of the land and estate available to deliver local services avoiding unnecessary travel to acute hospitals; 8. Minimising service barriers through simplified specifications and joint commissioning of primary, social and community services; and 9. Changing the model of community services commissioning to focus on outcomes rather than inputs.

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Public engagement programme (October to December 2015) – Programme of engagement activity on the proposed model for the future delivery of community services in East Leicestershire and Rutland.

121 completed questionnaires.

Nine community groups, representing the seldom heard and including the nine protected characteristics, (Equality and Diversity Law 2010) were visited to listen to their views.

A total of 48 conversations took place with members of these groups.

ELR CCG PPG network discussion

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Workshop discussions at 3 x PPG Locality meetings (February 2016) – further outreach engagement to understand people's views in more detail

appointments at larger hospitals is more time consuming due to the distance of travel, long waiting times and difficulty in parking. Others commented that smaller units would have shorter waiting times and some said they liked community hospitals as they found them less intimidating. Other comments made highlighted that having local facilities frees up critical pressures of larger
hospitals.

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87% of respondents to the survey were supportive of our current proposed model for the future delivery of community services.
The findings of the survey, which was conducted over 13 weeks in the Autumn of 2015, show that there is wide support overall for services closer to home, joined up working and better communication at all levels.

Those respondents that did have concerns mentioned a variety of areas, including:

- the resources that would be needed to implement these changes – affordability and 'do-ability'
- the complexities of change on such a scale
- staffing levels and recruitment
- 'public transport' and car parking
- communication between professionals and about the services available
- lack of detail about the model – how will this affect me and my family?

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When asked "What does the term 'community services' mean to you?", discussions were focused around four key areas:

- services/professionals
- conditions
- locations
- types of patients

Although the responses varied across the three events, there were some common themes emerging, particularly relating to the services/professionals that people saw coming under 'community services. Services/professionals discussed more than once included:

- District nursing care
- Psychological/mental health services
- Pharmacy
- Opticians
- Dentist
- GPs

Our proposed model is likely to require significant organisational change both within each locality and by community service providers requiring leadership, time, skill and resources to ensure change is achievable.

Robust governance arrangements including joint working with and through Local Authority structures will be essential to ensuring strategic alignment and successful local implementation.

Most aspects of the proposed model do not require formal public consultation over and above robust engagement.

Issues affecting ELR community hospital in-patient beds form part of the Better Care Consultation.

Further engagement will be undertaken as we move forward with developing the community services model to ensure there are sustainable and appropriate services to meet local people's needs in our communities.

			• Health Visitors • Midwives When the discussion included which groups of patients used community services, older people were cited most frequently. All three groups also discussed wider definitions and services not typically classed as 'healthcare' such as: • voluntary groups • social services • preventative care The findings of this engagement give an insight into the expectations of local people in respect of the services that should be available in the community.	

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