An Evaluation of the Transition of Services at UHNM (Phase 2: April-November 2015)

Report Completed July 2016

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Contents

LIST OF ACRONYMS

DNA	Did not Attend
UHNM	University Hospital North Midlands
ECS	Engaging Communities
TSA	Trust Special Administration
STP	Sustainable Transformation Programme

EXECUTIVE SUMMARY

This project aimed to evaluate the transition of services following the development of University Hospitals of North Midlands NHS Trust (UHNM). The research follows findings obtained from an earlier project (Phase 1) carried out by Engaging Communities (ECS) which analysed service users' experience and public perspectives towards the transition of services in order to form recommendations that would ease the impact of the transition. The current project, undertaken by Healthwatch Staffordshire, delivered by Engaging Communities, set out to explore patient, public and staff experience following the transition of services and identify any areas of best practice and requirements for further improvement. During the project, Healthwatch used public and staff surveys, staff focus groups, patient interviews, and Enter and View visits to evaluate the transition of services between County Hospital and Royal Stoke. The analysis also draws upon the Healthwatch Experience Exchange platform and a social media monitoring dashboard which analyses feedback on NHS services and public sentiment online.

This evaluation was undertaken 12 months after the integration of services during which time there was significant service change and transfers.

It should also be noted that only staff from County Hospital took part in the focus groups, however staff surveys were completed across both sites. The comments and perceptions of all patients and staff are equally important and provide valuable insight into how people viewed issues at a point in time. A number of prevalent themes were highlighted:

Capacity

Staff and patients felt that there was a capacity issue in the Trust which subsequently impacted upon bed shortages, waiting times and delays in discharge. There were several accounts from staff regarding temporary agency staff and the impact that this has upon working practice as well as some staff feeling vulnerable due to the lack of consultant support after hours.

Transport and Parking

Transport and parking has been highlighted as an ongoing issue although it is recognised that this is a national problem for hospitals. Staff highlighted issues regarding the shuttle service timetable and access for elderly and disabled patients. Patients highlighted concerns regarding drop off points for the shuttle bus, lack of parking spaces and assistance for vulnerable patients. Concerns were also raised about hospital appointments and difficulties in attending Royal Stoke from Stafford at inconvenient times without transport.

Communication

Communication was arguably the most important theme to emerge from this study. Whilst there were other themes that came to light, communication was an underlying issue that seems to have exacerbated both staff and patient concerns. The Trust has confirmed that they have several measures in place to counteract the difficulties that have been highlighted throughout this report, however disseminating information to some patients, staff and members of the public seems to have been ineffective which in turn has had a negative impact upon the experience and satisfaction of the transition of services.

All three themes identified in this research also emerged in the Phase 1 project carried out by ECS. Whilst the Trust has worked hard to counteract the impact of the transition of services, it seems that some public and staff concerns still remain. Staff engagement was incorporated into the second phase of this research to triangulate public, patient and staff findings and provide a more holistic overview of the transition of services from different target groups.

Key findings from this study form the basis for several recommendations to UNHM to further improve the experience of staff and patients during the ongoing transition of services between Royal Stoke and County Hospital and continue with good practice. It is hoped that the recommendations provided will support the improvement of patient and staff experiences. A summary of the recommendations are detailed below and supporting evidence is provided throughout the report.

Key recommendations

Patients and staff taking part in this exercise had some concerns around temporary staff, staff expertise, discharge and the pressures on A&E at Royal Stoke. Some participants consider this to be a result of the transition, however it is also noted that A&E pressures are a national concern and not solely related to UHNM.

Regarding concerns surrounding staff capacity, the following recommendations are proposed:

1. Whilst acknowledging that initiatives have been put in place to look at ways to alleviate pressure on A&E at Royal Stoke through the Sustainable Transformation Programme, continued evaluation and assessment needs to be undertaken to assess the efficacy and impact of these initiatives and identify further opportunities for reducing demands on A&E services.
2. Provide (at minimum) one on-call doctor on site at County Hospital between the hours of 5pm-10pm so that nurses feel less vulnerable and support can be provided to avoid patient transfer to Royal Stoke. Also increase awareness of access to support during this time period.

Based on the feedback received regarding transport and parking the following recommendations are proposed to improve patient satisfaction of this service.

1. Ensure that all staff are aware of shuttle bus times and that availability of taxis on request. Also continue to monitor staff satisfaction regarding shuttle bus times and how this coincides with shift patterns.
2. Ensure that the provision of information about the shuttle bus booking system is consistent to all patients.
3. If shuttle bus drop-off points cannot be moved closer to the entrance, consider having a volunteer on all shuttle buses to chaperone elderly/infirm to the hospital entrance with wheelchairs if necessary.
4. Consider using telephone confirmation to ensure that patients are aware of the options available to them when travelling to appointments, particularly for people travelling between sites for the first time.
5. Raise patient awareness of the NHS low income scheme that can support travel costs for hospital appointments such as keeping the website up to date or providing information in patient appointment letters for those without internet access.

6. Ensure that all frequent service users are aware of the concessionary parking permits before travelling to appointments.
7. Ensure that patients are made aware, during their appointment, that discounts for parking payments are available if clinics are overrun.
8. Make car park volunteers more visible at both hospital sites and ensure that patients and carers are aware of the support available to them.

The following recommendations are proposed to improve communication of the transition and the integration of staff between the two hospitals based on the feedback received.

1. Ensure that information that is publicly available to patients has been received and is understood. This could be done by asking patients upon arrival at hospital if they are satisfied with the information they have and if they require any further information as to how the service would affect them. Make sure that the public are aware of where to get information from. If this is the PALS office, ensure that patients are aware of the relevant contact details and opening times.
2. Ensure that staff, such as doctors and nurses are communicating with their patients effectively and often enough so that patients are informed about their treatment and how this is affected by the transition e.g. where they will go for their consultation appointments, pre-operative checks, diagnostics and treatment as these may be different.
3. Improve the information provided to patients regarding discharge and the required self-care that must take place to ensure long term recovery
4. Continuously monitor the satisfaction of staff about the information that has been provided to them regarding the changes and the impact this has upon their job role and expectations.
5. Improve the coordination and transfer of information between the two hospital sites such as patient records and notes. It is acknowledged that a new IT system is being implemented by the Trust in November 2016. However, in the interim, the Trust must be transparent that there may be set backs with patient records in order to manage expectations.
6. Ensure that all staff are made aware and receive all adequate information about staff integration initiatives and internal communications. Continue to monitor staff experience and highlight any areas of dissatisfaction.

INTRODUCTION

The local health economy in Staffordshire has undergone and continues to undergo a period of transition and transformation. Following recommendations from the Trust Special Administration (TSA) particularly regarding the Maternity, Paediatric and Emergency, Urgent and Critical Care Unit. Mid-Staffordshire NHS Foundation Trust and the University Hospital of North Staffordshire NHS Trust were dissolved and merged to form the University Hospitals of North Midlands NHS Trust (UHNM) in November 2014. At this time, Engaging Communities (ECS) were commissioned to carry out public engagement activities to explore the public's perspectives towards the transition of services and to develop practical recommendations to suggest ways in which any negative impacts of the service transition could be minimised.

The transition of services to UHNM began in November 2014 and in 2015 Healthwatch Staffordshire undertook an evaluation of the transition of services (Phase 2) to evaluate the effectiveness of the transition and the impact that it has had on staff and patient experience. Specific health challenges in Staffordshire should not however be seen in isolation. At a national level there are significant pressures on the NHS to deliver safe and efficient healthcare that supports sustainability whilst the demands of an ageing population with a diverse range of health care needs rises; all of which is taken into account during this evaluation process. The evaluation included a range of engagement activities to explore patient and staff experiences during the transition of services between County Hospital and the Royal Stoke University Hospital. It uses evidence and insight to propose recommendations to continue best practice and reduce any negative impacts which have arisen as a result of the service transition.

The Transition

The newly created University Hospitals of North Midlands NHS Trust (UHNM) integrated the services of the Mid Staffordshire NHS Foundation Trust and the University Hospital of North Staffordshire NHS Trust. During this transition, the hospitals in Stafford and Stoke-on-Trent have been renamed as the County Hospital in Stafford and The Royal Stoke University Hospital in Stoke-on-Trent. Cannock Hospital, which was part of Mid Staffs NHS Foundation Trust has been absorbed into the Royal Wolverhampton NHS Trust.

As part of the creation of the new Trust, there has been a substantial reorganisation and relocation of services between the two hospital sites as recommended by the TSA. Consultant-led maternity services and acute paediatrics are amongst the services that have moved from County Hospital to

Royal Stoke, and new services at the County Hospital will include orthopaedics, dermatology and eye surgery.

The new Trust received an additional investment of over £250 million, with £150 million spent at the County Hospital site and £100 million spent at the Royal Stoke site. This investment symbolises a moment of change for residents in Staffordshire and their local NHS, and will or has already helped to fund:

At Stafford:

- The refurbishment of A&E to double the space and reduce overcrowding; (ongoing)
- Expanded outpatient facilities especially for emergency access clinics; (ongoing)
- Opening and refurbishing more wards and operating theatres; (part way through)
- Double the number of single rooms with en-suite facilities; (part way through)
- A new MRI scanner (completed)
- A refurbished midwife led maternity unit with a modern birthing pool; (completed)
- A new chemotherapy unit (opening June 2016)

At Stoke:

- Re-commissioning of four old wards into two state of the art wards to create an additional 64 beds;
- 12 additional beds (8 opened so far) in the new critical care unit (to add to the current 40);
- The creation of a new Orthopaedic Centre with 56 new beds; (completed)
- New operating theatres in a state-of-the-art unit;
- The opening of 12 new maternity beds and the expansion of the neo-natal unit;(completed)
- The completion of new car parks with over 300 additional spaces; (completed)
- The opening of a new 28-bed children's ward (completed)

BACKGROUND

Phase 1

Since the announcement of the transition, research reports have contributed to the process by providing recommendations to the Trust based on patient and staff perspectives. In a report produced by Engaging Communities titled '*The transition of services following the creation of University Hospitals of North Midlands NHS Trust*', research aimed to explore public perspectives towards the

transition of services and provide practical recommendations of ways to reduce the impact of the transition of services. The Phase 1 project successfully engaged with 60 people through focus groups, 81 people through an online survey and 109 people through public events.

Findings revealed that some residents of Stafford believed that travelling to Stoke was too difficult for patients; some expressed concerns for vulnerable service users, such as children and pregnant women. Participants believed that it would take at least half an hour to travel to Stoke and that, in some cases, it is not possible for patients to travel that distance; especially if they do not have their own transport. There were concerns about the cost of transport. Many participants suggested that it would be too expensive to travel to Stoke from Stafford. Additionally, patients revealed that the car parking prices were also an issue. During this time, many people were uncertain if UHNM would provide transport between sites; some said that transport between sites should be free and some believed that a shuttle bus service with a low cost would be a good service to implement.

Participants in the 2014 report expressed confusion and uncertainty regarding the transition of services. However, many participants made suggestions of ways that UHNM could communicate with their patients and staff, such as the need for more information about the location of services which had moved and which services were not being transferred. Participants stated that they would like to be informed about UHNM by writing to patients personally, creating articles in local newspapers such as the Sentinel and using webpages.

Capacity issues at the Royal Stoke hospital were also highlighted. Many participants questioned whether the Royal Stoke would be able to deal with the increasing demands on services. People also raised concerns about whether staff would be properly trained if there was higher demand for services. Other participants believed that the demand for services was so high because the provision of community services was inadequate. It was suggested that it was important to improve the provision of community services because there would be more people using them. Whilst some participants were negative about capacity, some believed that the transition could improve capacity because discharges would take place seven days a week rather than five days a week.

From the findings of the **first study** in 2014, the following recommendations were proposed:

- The Trust should improve communication with service users, support groups and the general public.
- The Trust should expend effort to address transport and accessibility issues faced by service users and visitors to both hospital sites. Since then, significant improvements have been made

to improve transport and accessibility issues although evidence suggests there is still some dissatisfaction and a lack of understanding of what support is available.

- The Trust should seek to improve the relationship between community services and hospitals to alleviate capacity issues. Since then the Trust have integrated with Bradwell and Cheadle and set up a new division of community partnerships.
- The Trust should develop co-design panels to identify heavy users of specific services to recommend improvements to services such as maternity, neurological conditions and paediatrics, resulting in a 'best practice' approach. The Trust subsequently worked with Healthwatch to establish patient and carer workshops which focussed on the development of care pathways for long term conditions including heart failure, diabetes and respiratory services which culminated in the production of a report which was used to inform the pathway development.

Phase 2

Healthwatch Staffordshire has evaluated the transition of services between Royal Stoke and County Hospital by exploring service user, staff and wider public feedback on the transition to identify new or existing issues which have developed during this period and explore areas for further improvement. This study utilised a mixed methods approach by drawing upon both primary and secondary data. Feedback was sought from the public, patients and UHNM hospital staff in order to form an all-encompassing overview of the transition.

PLAN & METHODOLOGY

The following section outlines the research objectives and methodological approach. A discussion of the methodology justification and quality assurance for research design and execution is also provided.

Objectives

The overall objective of this research is to evaluate how the transition of services between the two hospital sites was managed, what worked, what did not work, what the impacts were on staff and service users and how any outstanding problems could be further reduced.

The methodological approach was built upon the following research questions:

(1) What was the experience of staff during and following the transition?

(2) What were service users' experience during and following the transition?

(3) What worked well?

(4) What didn't work well?

(5) What further measures could be done to improve staff and patient experience and minimise any existing negative impact throughout the transition of services?

Methodology

This project utilised a number of diverse methods to engage with different stakeholders such as frontline staff and patients to explore the impact of the transition of services at UHNM.

The table below demonstrates the engagement and data collection carried out for this project.

Method	Target Group	Participant numbers	Location(s)	Dates
Public Survey	Patients	31	Stafford & Surrounds (55.6%) Cannock Chase (25.9%) South Staffordshire (11.1%) Stoke-on-Trent (3.7%) Other (3.7%)	October – November 2015
Staff Survey	Staff	7	County and Royal Stoke Hospitals	November 2015
Patient Interviews	Patients	4	Staffordshire	November 2015
Staff Focus Groups	Staff	6	County Hospital; No attendance at RS Hospital	November 2015
Enter & View	Patients & staff	7 visits	County Hospital & RS Hospital	April – September 2015
Experience Exchange Monitoring	Patients & public	-	Staffordshire	April 2015-February 2016
Social media monitoring	Patients & public	-	Staffordshire and national	April 2015-February 2016

Enter and View

ECS hold the contract for Healthwatch Staffordshire, which has a statutory duty and responsibility to undertake independent Enter and View visits as part of continually monitoring service delivery through concerns and feedback in health and care settings, and reporting this to the public. Enter and View visits have a clear purpose; they are used to ensure effective evidence gathering and reporting where people receive care. Visits can be either announced or unannounced and they offer scrutiny which is independent of the NHS. Enter and View visits can have a number of purposes:

1. To collect the views of service users, patients and residents
2. To collect the views of carers and relatives of service users
3. To collect the views of staff
4. To observe the nature and quality of services
5. To collate evidence based feedback and produce reports.

Analysis of Enter and View visits were well placed as a method for this evaluation as they are able to provide real time experiences from those who are receiving services as well as scrutiny of the services in question. Visits are undertaken by Authorised Representatives who are trained volunteers. They are able to focus on areas of identified concern and it is recognised that their position as a lay person means that service users and others are more comfortable sharing experiences with them than they would be an official or employee because of their independence.

For this project, Enter and View visits were conducted to provide an opportunity to observe the daily operation of both UHNM hospital sites whilst the transition of services were taking place. Our visits targeted services that have recently transitioned or developed at both UHNM hospital sites. The sites included the Maternity units at both County Hospital and Royal Stoke, and the Endoscopy Unit, A&E and MAU, Ward 10 and 12 and the Trauma and Orthopaedic ward at County Hospital.

Staff focus groups

Focus groups were used in this project due to the multitude of advantages they offer. They allow for flexibility within the engagement schedule, the ability to adapt and accommodate more or less participants, they can create a more relaxed environment that is more conducive for individuals to share their viewpoints, and they can reveal new areas of debate that may not be explored in interviews (Bryman,2008; Berg and Lune, 2014). Importantly focus groups allow participants to express their beliefs, feelings and behaviours in their own words and expose how individuals construct changes in health and social care provision by drawing on different forms of knowledge, values and experiences (Wisker, 2001; Conradson, 2005). Focus group findings can give indications

of what is likely to be acceptable to people, and more importantly why or why not. Therefore, focus groups are an ideal methodological tool to explore staff perspectives towards the transition of services at UHNM.

Focus groups with staff were conducted during this project to understand how the transition of services affected staff members at both County Hospital and at the Royal Stoke. Unfortunately, participation was low and only staff from County Hospital attended the focus groups. Participants were recruited via a global email sent out to all UHNM staff as well as some further publicity undertaken by Healthwatch and the Trust.

Staff that attended the focus groups were asked about how changes were communicated; if and how frontline staff were involved in any decision-making regarding changes to services; what challenges staff faced during the transition; issues that may have affected patient experience (both positive and negative); and what could have been done to improve the ways in which the transition of services was implemented (see Appendix A for focus group template).

Surveys

Surveys are easy for participants to understand and use. They allow both qualitative and quantitative analysis of responses and help to explore majorities within public feedback. Surveys allow complete anonymity of the respondent which is important when exploring potentially sensitive or personal experiences. They also provide a quick and easy way to collect a high volume of data from individuals living all over the county and when qualitative questions are used, they have the capacity to gather in-depth patient feedback. It is well noted that social surveys are particularly useful for eliciting public attitudes and perspectives towards complex economic, social, environmental and political issues, and valuable for exploring complex behaviours and previous experiences (Parfitt, 2005; McLafferty, 2007; Bryman, 2008).

Two separate surveys were used in this research to capture feedback from both the public and UHNM staff. The public survey was publicised in three Healthwatch Staffordshire newsletters between September and December 2015. Respondents for the staff survey were recruited via a global email sent to all UHNM staff. Whilst survey responses were low for this project, the statistical significance of consumer satisfaction is that public feedback is valuable and should be taken on board regardless of the sample size. Only test statistics can confirm that findings are statistically significant. Statistical significance relates very particularly to hypothesis testing which requires a specific set of assumptions. It is very difficult to quantify assumptions in a market research setting which relies entirely upon the value of consumer stories. According to Lee Resource (2016) for every

customer complaint, there are on average, another 26 unhappy customers who have remained silent. Newell-Legner (2016) also confirmed that It takes **12** positive experiences to make up for one unresolved negative experience. The power of individual feedback (particularly if it is negative) therefore has much greater 'significance' than the power of numbers or sample sizes. This is a qualitative piece of research which voices public concerns in order to make recommendations for improvement.

For the public survey, respondents were asked about the level of information received about the changes; if the required healthcare was received; what issues were experienced; and how the experience of the transition could be improved. A targeted approach to patients who had transferred from Stafford A&E to Royal Stoke was also included in the surveys which asked about their specific experience of the transfer. For the staff survey, respondents were asked about how changes were communicated; what challenges staff faced during the transition; how the coordination of transition made staff feel and whether it affected job satisfaction; how the transition affected patient experience; what worked well with the transition of services; and what could have been done differently to improve the ways in which the transition of services was implemented (See Appendix B for survey template).

Patient interviews

Interviews with patients were conducted during this research. This method provides analysis of verbal exchanges where one person, the interviewer, attempts to elicit information from the person relating to a particular topic of interest (Valentine, 2005). This method of research offers the chance for the researcher and interviewee to have a more wide-ranging discussion than a questionnaire would allow whereby the researcher can explore issues more thoroughly and interviewees can explain the complexities and contradictions of their experiences.

Interviews with patients and members of the public were undertaken to ascertain the impacts of the transition of services that they might have experienced with respect to waiting times, cancelled appointments, communication, or staff attitudes; whether they were informed of the changes with respect to the transition; if patients received the healthcare they needed and whether their experiences were positive or negative; and how their experience could have been improved. The participants for the patient interviews were recruited following the public survey which asked if the respondent would be interested in taking part in a short telephone interview (see appendix C for patient interview template).

Social Media Analysis

Alongside the results from the Enter and View visits, staff focus groups, surveys and interviews, social media analysis was also conducted through our Social Media Monitoring Dashboard. This analysis provided additional intelligence by exploring public opinion and experience of the health service changes published on social media and Healthwatch Staffordshire's experience exchange platform. To highlight and analyse the sentiments of the public towards the transition of services, Experience Exchange and Digimind were used as the principal collection of sentiments via on-line media.

Data analysis

The findings from the engagement and sentiment analysis were analysed using thematic analysis (Braun and Clarke, 2006; Bryman 2008). Braun and Clarke (2006) advocate thematic analysis as a useful and flexible method to analyse qualitative data that provides findings in an understandable format. Its advantages for use in this study include its flexibility and its ability to incorporate both researcher and participants' contributions. It has the capacity to capture conversational outputs at a precise point in time, in this case at a pivotal point in the evaluation of the transition of services at UHNM.

In addition to a qualitative analysis, a comparative analysis of key themes and the frequency of positive and negative feedback across the different target groups was carried out. Bar charts are included within each theme section to demonstrate the comparison of each theme.

Quality plan

ECS has a responsibility to ensure that the research it undertakes and creates is of high quality and aligned to best practice across the industry. Research ultimately provides the evidence on which sound decisions should be made, which is why it is important to state up front how quality was ensured during this project. The Research and Insight team underpins its research activities by applying the Market Research Society Codes of Conduct (MRS, 2014). ECS are a company partner of the Market Research Society.

During this project ECS adhered to a strict data protection policy that ensured that:

- Everyone handling and managing personal information internally understood they were responsible for good data protection practices;
- There was someone with specific responsibility for data protection in the organisation;
- Staff who handled personal information were appropriately supervised and trained;

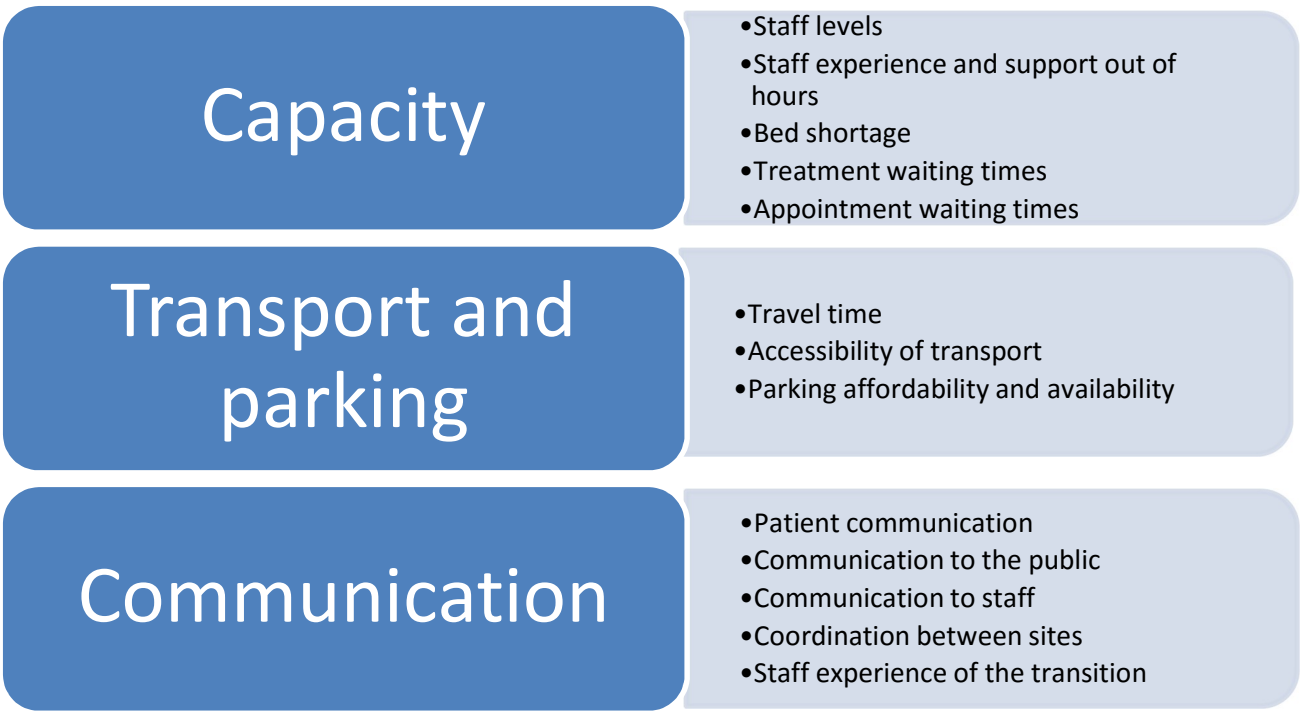
- Queries about handling of personal information would have been promptly and courteously dealt with had they been received;
- The methods of handling personal information are regularly assessed and evaluated;
- Necessary steps were taken to ensure that personal data was kept secure at all times against unlawful loss or disclosure.

ECS have firm guidelines for data storage, data retrieval, data security and data destruction. There is also a strict process in place should a data breach occur (which includes containment and recovery, assessment of ongoing risk, notification of breach, evaluation and response). To further ensure the quality of the final report, an internal peer review process was initiated to ensure that the report is fit for purpose before submission. Where data is not robust it was statistically suppressed to prevent disclosure.

FINDINGS

The findings revealed three prominent themes around the UHNM transition of services which were also consistent with findings from Phase 1. These include capacity, transport and parking, and communication. Consistency in the three main themes identified before and after the transition suggests that concerns raised by service users in phase 1 are still prominent following the transition and are also supported by staff feedback. Each of the themes will be outlined separately in the following section to discuss their broader context and implications (see figure 1.1).

Figure 1.1: Themes and sub-themes of thematic analysis



Capacity

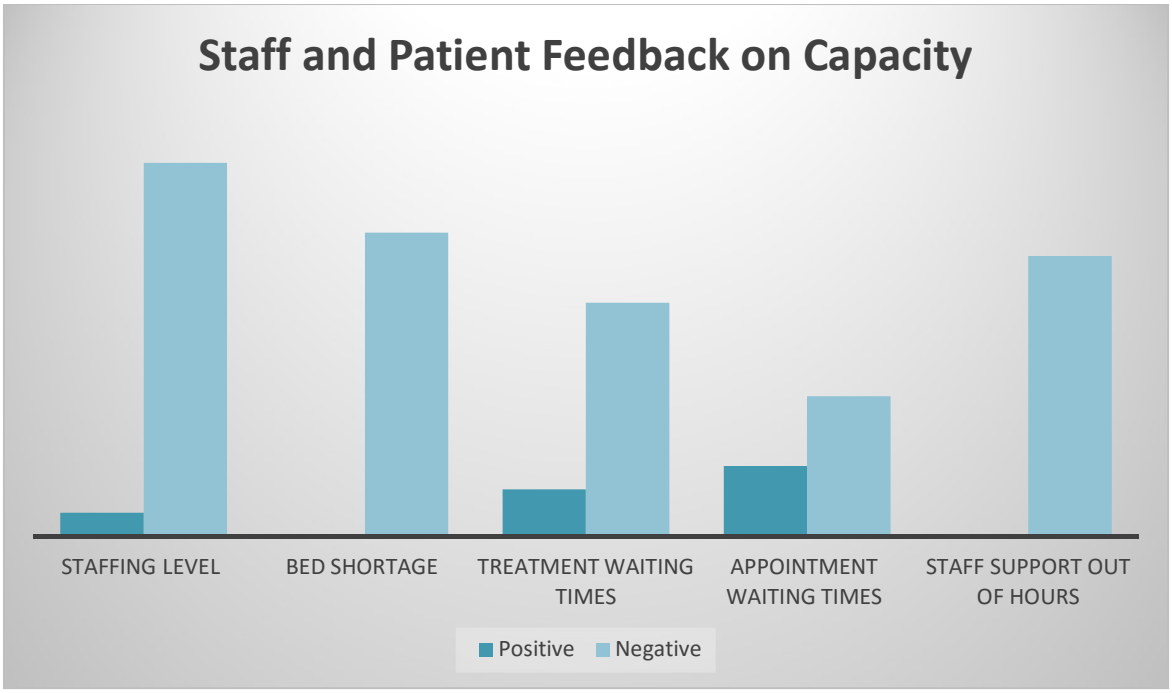
This theme encapsulated public, patient and UHNM staff feelings around the transition of services and how this has affected the capacity of Royal Stoke Hospital and County Hospital to deliver high quality care. It should be noted that some areas of concern regarding staff capacity may not be a direct consequence of the transition of services, as at times there has been a history of capacity being overstretched at the two hospitals. However, the transition of services is consistently highlighted as a factor influencing the concerns amongst the public around staffing levels and bed shortages as well as possibly reiterating an ongoing issue that has not been resolved through the transition period.

Capacity issues were highlighted consistently across both target groups as shown in chart 1.1.

This theme was split into four further subthemes:

- Staffing levels
- Bed shortage
- Treatment waiting times
- Appointment waiting times
- Staff support out of hours

Chart 1.1: Positive and negative feedback on capacity sub-themes



Staffing levels

Staffing levels were found to be a cause for concern by staff, patients and the wider general public. Some staff felt that capacity reduced during the transition as a result of people applying for jobs elsewhere which caused additional strain on service provision. Patient satisfaction regarding treatment reflected these concerns, some highlighting that the quality of treatment reduced due to increased waiting times and staff informing patients that they were "very busy" when confronted with concerns. Feedback also indicates that the perception of some patients is that the poor quality of care was likely due to poorly qualified staff. The result of capacity shortage was suggested to have impacted upon waiting times for treatment whilst in hospital as well as the quality of care that was received and the information that patients were given when discharged.

Many of the sub-themes within the context of capacity are inter-related. Qualitative analysis of staff feedback highlighted that staffing shortages may be a result of the transition of services due to staff leaving the Trust and looking for employment elsewhere. The reduction in staff is said to increase demand and as a result, some staff have become dissatisfied and under increased pressure. This was suggested by both patients and staff to have impacted upon waiting times for both appointments, and treatment when attending hospital as either an outpatient or an emergency.

Suggested causes

Regarding patient experience of staff pressure, the following comments were made by patients during one to one interviews:

"Staff were running from bed to bed. I think there's too many people for too few resources" (Patient Interview Participant 1).

Some patients had concerns that the staff capacity shortage at County Hospital was a result of increased population in Stafford which increased the number of people using the service, *"Stafford needs to be restored to being a hospital… They're building 700 more houses at the top of my road, in addition to the 1,800 army staff that have just come back, so they're increasing the population of Stafford hugely, and yet they're downgrading the hospital"* (Patient Interview participant 2)

The idea of capacity issues resulting from increased population were also identified in Healthwatch Feedback in 2015. One local resident commented *"With Stafford's population ever growing, does it not make sense to bring back services to Stafford so that people can receive treatment at a 'local' hospital? Furthermore, there is a possibility that the strain on Stoke Hospital is going to mean that corners may be cut, putting people's life at risk."* (Healthwatch Feedback, October 2015)

In a public survey on the evaluation of the transition, general concerns around staff capacity were also highlighted. One participant argued that the cause of limited capacity was a result of the transition since resources at Stafford are now *"under-utilised... while conditions at Stoke are unacceptable"* (Public Survey Participant 7). Some participants who took part in the survey also commented that their experience of the transition of services would have been improved if staff capacity was increased. It was also ranked as one of the top three mentioned quotes in all of the surveys completed.

Analysis of staff feedback suggested that the cause of low staff capacity was a result of increased staff turnover following the transition of services. One member of staff commented that *"During the lead up to our moving from Stafford to Stoke, there were a lot of staff changes and staff applying for posts elsewhere which made the move very difficult because of staff shortages"* (Staff Survey Participant 3).

Analysis also suggested that capacity issues were a result of increased admissions from County Hospital following the transition. Another member of staff commented that they *"had to absorb the additional activity without additional staff to support the increased activity"* (Staff Survey Participant 7).

In support of the capacity issues highlighted, Enter and View visits by Healthwatch suggested that more staff may be needed to provide the best possible patient experience. The report confirmed in reference to the Maternity Assessment Unit at Royal Stoke that *"this is an extremely busy unit and it is suggested that two extra staff would make for a better patient experience"* (Enter and View report, April 2015). It was also confirmed that *"There was staff sickness on the ward and the remaining staff felt stretched".*

In conjunction with these highlighted causes of low staff capacity, the CQC inspection carried out in April 2015 confirmed that there were high levels of nursing vacancies and sickness was problematic. The CQC and UHNM 2025 Vision report also indicated that there was a lack of doctors and consultants at the Royal Stoke Hospital:

"The consultant to patient ratio varied between 1:14 and 1:21. This meant that intensive care standards that require one consultant to not more than 14 patients were not consistently met". The report also confirmed that *"Achieving safe staffing levels was a constant challenge for the organisation and there was a heavy reliance on agency and locum staff to support this"*. Recommendations by the CQC were that *"The hospital should review staffing arrangements in medicine and the emergency departments to ensure that there are sufficient numbers of nurses" (CQC 2015).* Concerns around staffing highlighted by the CQC reinforce findings from both staff and patient feedback in this study.

The nurse staffing levels may be even more difficult to sustain because the NHS faces 48,000 fewer nurses by 2016 (The Conversation, September 2015). Not only does this affect UHNM, but this could also place more strain on community health services. In the Phase 1 report by ECS, participants were concerned about the strain on community midwives and their competency if more pressures are placed upon them. The CQC inspection also concluded that there was an over-reliance on agency and bank staffing. This is said to increase the likelihood of nursing staff who are unfamiliar with the wards they are placed on and unable to develop relationships with patients, which can be detrimental to service users' experiences (Blackhurst, 2015; UNISON, 2012). Problems of sickness and staff levels could also potentially lead to significant financial losses; Jeremy Hunt reported that the annual bill for agency staff rose from £1.8 billion to £3.3 billion (Grierson, 2015). Consistency in findings between Phase 1 and Phase 2 suggest that concerns around staffing capacity have not been reduced during the transition period.

Staff expertise and support out of hours

Another element of staff capacity related to staff expertise and the consistency of staff within the hospitals. There were concerns around agency staff, temporary staff and patients being apprehensive about staff expertise and the quality of care they received. This issue was also found to be related to the lack of consultant expertise available on the Surgical Ward Stafford after 5pm.

Consultant support

Patients commented that not being able to access emergency care in time by travelling to Royal Stoke from Stafford *"would not have happened if there was a consultant at Stafford".* It was also highlighted that *"there should be a consultant available at Stafford 24 hours of the day"* (Patient Interview participant 2). Undoubtedly, some members of the public would prefer that A&E at County Hospital re-open 24/7. However, Healthwatch consider that in the absence of this happening, there may be measures that can be taken to mitigate the impact of overnight closure – these include ensuring there is strong on-site cover for the GP Out-of-Hours service overnight, that patient transfers are well managed and that close monitoring of numbers from Stafford presenting overnight to Stoke is carried out to help identify whether the public perception of the impact on capacity at Stoke is borne out through the numbers.

Staff focus groups following the transition of services also supported many of the patient concerns regarding the level of staff expertise available at the hospital. The lack of consultants during certain hours of the day was found to impact the staff confidence and feelings of vulnerability since they had concerns about ill patients deteriorating without a consultant present after hours.

Impact on nursing staff

Some Staff also raised concerns about their own professional capabilities and the pressure they were under without suitable expert support during out of hours which meant they were required to fulfil roles they were not qualified for. One staff member commented that they *"have patients coming in at 12 noon for surgery but the consultants finish on the ward at 5pm and therefore, we need to refer to a registrar for a patient transfer if a patient has any difficulties i.e. if they bled there are no surgical doctors with us after 5pm but patients can be with us until 10pm… It makes us worried and anxious if we have problems with patients on the ward if the patient is unwell as there is no one to review them"* (Staff Focus Group).

Another staff member expressed their concerns over professional medical support during out of hours, *"We used to be able to ring the junior doctors and if we had a bit of a query we could seek their advice but that's not there anymore because they took away the service"* (Staff Focus Group).

This was confirmed by all participants who agreed that *"there should be surgical junior doctors on call so that we have someone to call and seek advice from. It's the fact that we do need them because it's about decision making as well as advice and reassurance, there is nobody to review the patients"* (Staff Focus Group). The Trust have confirmed that colleagues at Stafford have always had access to medical advice from an on call anaesthetist and their own physicians. Whilst this would be of some benefit to nursing staff, one participant confirmed that even with on call support at Stoke, staff still feel vulnerable. From the feedback received regarding out of hours support, it is recommended that communication to staff is improved about what support is available and that staff do have access to Consultant and Physician support out of hours.

Staff training and handovers

Many members of staff admitted that when their shifts were transferred to other hospitals there was no induction or handover which could potentially have impacted the quality of care they provided during their shifts. One staff member commented that *"I didn't know where anything was or how the ward worked, it was really bad but I just had to get on with it because nobody else knew what was going on either as there were a lot of temporary staff. I didn't have any kind of handover or induction really"* (Staff Focus Group). This account was confirmed by other members of the groups that there was a general lack of understanding amongst temporary and transferred staff.

This problem is likely to be further reinforced by a high rate of temporary staff who are not accustomed to the systems and processes used at the hospital. An Enter and View conducted by Healthwatch in 2015 also reported that *"At least fifty percent of the staff are agency supplied, and it was explained that Stafford is still having trouble recruiting more qualified nurses."* (Enter and View, September 2015). The Trust have confirmed that all wards have local induction packs however a number of comments in feedback from staff have indicated that handover and induction is poor. It is advised that induction packs are reviewed or additional feedback is sought as to how inductions and handovers can be improved.

Impact of staff capacity issues

The lack of both capacity and medical expertise on the wards is also seen to be having an impact on waiting times. Hospital staff commented that the lack of doctors on the ward increases waiting times for medication and discharge for patients since they were unable to fulfil the role of authorisation.

One staff member commented *"Because of the lack of doctors it takes longer to get the medication back up so we do get people saying I've been sitting here for 3 hours and still haven't got my medication and that's because we haven't got the same number of doctors. We used to be able to call the doctors up to the ward to come and do it whereas now we have to go down to theatre to get them to sign it off as they are not on the wards"* (Staff Focus Group).

Enter and View reports conducted by Healthwatch Staffordshire at the Trauma and Orthopaedic Ward in County Hospital suggests the lack of staff and suitable expertise results in delayed discharge for patients who are healthy enough to leave. Feedback suggested this was due to care plans not being put in place efficiently as a result of social workers being on annual leave. *"One lady was ready to discharge herself as she had been there for four weeks medically fit but social workers had not yet put together a care package for her and she was not able to return home until this was completed even though she had someone that was willing to look after her. Staff said that this was a common problem"* (Enter & View, May 2015). An Enter and View report from County Hospital also confirmed that communication from the hospital staff to patients regarding discharge was an issue which may have perpetuated dissatisfaction with the service. It is therefore suggested that the Trust not only improve communication and manage expectations of patients, but that they liaise with the Local Authority and Staffordshire and Stoke-on-Trent NHS Partnership Trust, regarding any reported issues of social workers and to alleviate any impact upon bed shortages in the Trust.

This was also supported by another Enter and View report from July 2015 which stated that *"The husband was upset because he had received a call from the doctor to advise him that his wife was able to leave hospital, but because the social worker was on annual leave and had not prepared a care plan for her, she was unable to be discharged"* (Enter & View, July 2015).

Although this indicates good practice in that patients are not being discharged without care plans in place, it seems that fit and well patients are having their hospital stay unnecessarily extended due to the limited availability of social workers. In turn, delayed discharges were found to impact upon bed capacity since beds were being used unnecessarily by patients who are fit enough to go home. It is acknowledged that a new model of care (My Care, My Way) has been implemented following the initial Phase 1 report which aims to co-ordinate care around the patient so that they can be discharged as soon as possible when medically fit to do so. Whilst feedback from Phase 2 of the research suggests this may not yet have had an effect, it is suggested that a review of the effectiveness of the new model of care is conducted. The discharge policy for UHNM states that plans for discharge will be communicated to family and staff will work with family members to ensure the correct level of

community care is provided. Given the feedback received regarding delays in discharge due to the lack of effective planning, it is suggested that family members should be more actively involved in planning for discharge and further protocols should be in place to allow staff to use family members to support the discharge in terms of additional home care or other elements of support; or that the options available to them are communicated more effectively.

Whilst the cause of staff shortage is seen to be varied, the impact on patient experience and the quality of care is found to be consistent. Some patients suggested that waiting times for appointments and treatment may be a result of the staff capacity issues following the transition and there are concerns from patients around the quality of care for patients as a result. One member of staff suggested that waiting times for referrals and treatment may be affected due to lack of professional medical expertise on the ward who are qualified to authorise transfers, medication and discharges.

There seems to be a lack of consistent regular staff working on the units as was highlighted in the Healthwatch Enter and View report for Ward 12 at County Hospital. Feedback from patients and staff suggest that this can make it more difficult to establish and maintain good relationships; this also places more pressure on nursing staff. In the 2025 Vision report, the authors stated that the Trust will develop new roles for nurses and health professionals to deliver care traditionally undertaken by junior doctors, however until training is provided for these roles, staff will continue to feel unsupported and patients will have concerns about the quality of care they receive. It must be noted that this feedback was a snapshot in time between August-November 2015. The Trust have confirmed that they have a robust and comprehensive workforce and development plan in place since the transition which may have alleviated some of the issues raised during this study. It is advised that continuous monitoring of staff satisfaction and perception is evaluated to ensure that staff feel competent and supported to fulfil their roles; we understand that this is a priority for the Trust.

Whilst these findings are consistent in Phase 2 of this project following the transition of services (although some transitions are still ongoing), the study conducted before the transition (Phase 1) also highlighted staff levels to be an area of concern. This suggests that measures put in place by the Trust to alleviate this issue during the transition and following the recommendations from the ECS report have had little effect.

Extracts from Phase 1 suggest that *"There's not enough staff."* (Phase 1, October 2014) and that *"They need extra staff, they need trained staff."* (Phase 1, October 2014). These findings imply that some concerns around staffing prior to the service transition are still evident following the transition of services and therefore further improvements in this area may be required.

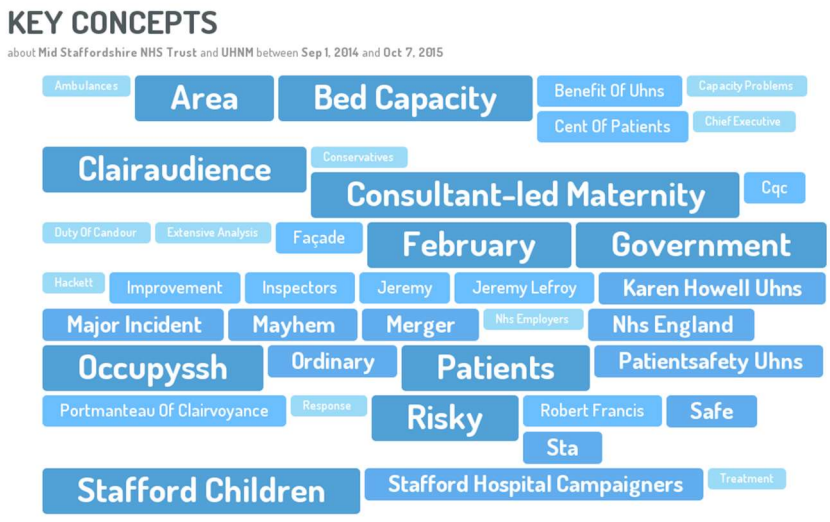
It is not surprising that the further sub-themes of 'bed shortages', 'waiting times for appointments', 'waiting times for treatment' and 'staff support out of hours' were consistent in the feedback relating to capacity issues from staff and patients. These sub-themes were explored individually to identify what impact they have had on patient experience and the quality of care they received during the transition.

Bed shortage

Bed shortages was highlighted as a consistent factor amongst feedback from staff, patients and the wider public. This was sometimes said to be linked to delays in discharge due to staff shortages or staff who are unqualified to administer discharge. Findings also suggested that this was further influenced by an increase in patient numbers following the transition and subsequent changing pathways.

According to the CQC report (2015), the bed occupancy rates within the Trust has risen dramatically to 92% across all specialities and 99% for adult bed occupancy. This is higher than the national average (88%). Analysis from our social media monitoring dashboard suggests that bed capacity is a prominent concern amongst the public as shown in figure 1.2

Figure 1.2: key trending themes in social media



Several sources have reported on the impact of bed shortages, particularly on breach of waiting in excess of 12-hours for A&E services at the Royal Stoke University Hospital (CQC, 2015; Express and Star, April 2015; ITV News, July, 2015). This correlates with NHS tracking data which indicated that

only 63.8% of patients were seen in 4 hours during the winter. Royal Stoke is considered to be a busy A&E department which causes difficulty in trying to determine if the transition of services is an influencing factor to the long waits at A&E. However, feedback from patients during Phase 1 before the transition and Phase 2 after the transition suggest that the reduction of County Hospital's A&E hours may have influenced the number of patients going to Royal Stoke A&E department thereby increasing waiting times. If not, this is certainly the perception of some patients. A review on Experience Exchange demonstrates some of the concerns:

"At UHNM (Royal Stoke), in A&E last night the queue went round the corner and the waiting area there were a huge number of walking wounded… All beds in the wards were full and they were waiting for some to become available so they could move patients out. This was at 8:15 PM -before the overflow from Stafford began to arrive. Try not to be ill!" (Experience Exchange, June 2015).

It is acknowledged that UHNM made a press release statement in the New Year acknowledging the pressures and the measures they were taking to resolve them which demonstrates that this problem is already acknowledged. Feedback leading up to that time however confirms that the problem has been persistent in the experiences of patients and staff during the transition.

Cause and impact of bed shortage

Regarding the experience of patients, some of the participants who took part in this study argue that bed shortages were a result of overcrowding which means that treatment and bed allocation is delayed until they become available. One participant commented that *"Stoke hospital is just so crowded that they haven't got beds… I know they haven't because on one occasion there was a man sitting on a chair in the ward because there was no bed for him, they were on level 4 alert"* (Patient Interview Participant 1).

Issues of waiting for beds were also confirmed by staff members who commented that *"I have a patient who had a procedure in Stafford who became unwell; vomiting and temperature went up so we booked a bed in Stoke and referred him. I assumed that he went to a ward in Stoke but the next time he came in for his regular appointment at County, he told us that he had been on a trolley bed in A&E until 4am…and that wasn't the first time that has happened, its happened with different patients too"* (Staff Focus Group).

A member of staff who took part in an online survey confirmed that bed shortages and waiting times were a result of an *"11-16% increase in Stafford patients since the transition because of changing pathways"* (Staff Survey Participant 7).

An Enter and View visit to County Hospital in July 2015 confirmed that this issue was consistent across both hospitals. Feedback suggested that this was often down to delays in discharge as highlighted earlier. The report commented in regards to a delayed discharge that *"this was felt to be bad practice, the bed this lady was using could have been used for someone else"* (Enter & View, July 2015).

UHNM have made noticeable efforts to reduce bed shortages during and following the transition through the increase of over 100 beds at Royal Stoke where the majority of the problems tend to relate to. There is however a sense of concern around bed shortages and the impact this has on treatment times and risk to patients which is likely to impact patient experience and overall concerns of attending the hospital for emergency treatment. The Trust have pointed out that they can only provide the amount of beds that they are commissioned for, and that perceived bed shortages are often due to the amount of people who are medically fit for discharge. It is therefore vital that the Trust work more closely with the Local Authority and other health providers in order to prevent delays in discharge assessments and planning. Also, as part of the Together We're Better Transformation Programme, it is proposed that intermediate care to increase care in the home should prevent admissions and readmissions, particularly for the elderly. Not only should this reduce bed shortages but it should improve patient satisfaction of the care they receive. It is advised that continuous monitoring of bed availability is conducted when the transformation programme is put into action.

Treatment waiting times

Waiting times for treatment was found to be an inter-related factor associated with bed shortages and staff capacity. Many patients who engaged in the research following the transition had negative experiences after being transferred to Royal Stoke. Bed shortages, overcrowding and lack of medical expertise were found to be persistent factors influencing the time patients waited for treatment once arriving at the hospital.

Cause and Impact

Delays in waiting times were found to impact on the quality of care administered to patients, some of whom experienced being left without pain relief for several hours. One participant commented during a public survey that her *"husband attended Stafford A&E with multiple leg fractures. Diagnosed, scanned etc. at Stafford but then transferred by ambulance to Stoke as orthopaedics had moved the week before. Left for nearly 12 hours before being seen at Stoke - they were aware of his transfer and had a bed, but no doctor saw him and no pain relief administered for hours. The extent of his injury and the treatment necessary had been determined at Stafford - only to be done all over again at Stoke. What a waste of resources!"* (Public Survey Participant 7).

With regards to waiting for pain relief, another participant commented that she was *"left in pain for 10 hours…constantly being told by nursing staff that [she] was on the wrong ward and they were unable to find a medic to prescribe any pain relief… I am still very traumatised by it all and have no faith in Royal Stoke Hospital"* (Public Survey Participant 12)

Some patients commented that they face a long wait 'every time' they attend County Hospital which confirms that these instances are not happening in isolation. One participant in a public survey commented *"Waiting times at County Hospital are still not good. Optometry and paediatrics are always running late, and 'sorry we're very busy' does not count for much when it happens every time"* (Public Survey Participant 6).

Feedback from patients who have been transferred between Stafford and Stoke indicates that they can be waiting an excessive amount of time for treatment, often referenced to the A&E department. Findings suggest however that the problem resonates in the hospital's intention of transferring patients to a ward at Royal Stoke however with bed shortages in the ward, they are then forced to wait in A&E where they are left without treatment and/or pain relief for some time. Staff feedback supports this conclusion *"If a patient becomes unwell they have to be referred to Stoke and we have to ring the site team to see if there is a bed available as sometimes the patient needs to go on to a ward, but if there are no beds available they have to go to A&E at Stoke which is unacceptable but it is out of our hands"* (Staff Focus Group).

According to the authors of the CQC report, the Trust has consistently failed to meet the national standard of waiting times for treatment for over two years. This suggests that there were issues regarding waiting times before the transition of services began. In response to this, the Trust has attempted to provide solutions to bed shortage, which shows that efforts are being made to improve the capacity for patients at UHNM hospitals. In 2015, the then chief executive of UHNM, Mark Hackett, stated that even more beds would be added to the Royal Stoke Hospital. Whilst this does demonstrate resolutions proposed by the Trust to address issues highlighted by service users, feedback from patients in November 2015 suggest that any additional measures have had minimal impact on patient experience.

Other methods have been proposed to reduce the pressures on the Royal Stoke hospital: Fox (2015) suggested that sending more GPs to A&E may reduce the number of waiting times significantly. This is congruent with our A&E report which revealed that many patients would travel to A&E to receive treatment for an issue that could have been treated at other health services, such as GP surgeries and minor injuries units, which places unnecessary strain on A&E services (Axon, 2014).

Furthermore, the CQC reported that a number of patients had been referred to A&E unnecessarily which places more burden on UHNM (CQC; 2015). In support of this, UHNM reported that there was a major incident in which operations were postponed in order to deal with the acute and emergency situations (UHNM, 2015). Therefore, it is important to continuously inform patients about what constitutes as a problem that needs to be treated in A&E, and what can be treated using other services. Recently, a non-emergency unit was introduced to UHNM to combat the demands placed on the A&E department at Stoke through the ambulatory emergency unit which deals with GP referrals. This unit has been designed to treat people who are in emergencies but do not necessarily have to go to A&E which will allow patients to be treated quicker and sent home quicker (Signal 1, October 2015).

Appointment waiting times

Waiting times for appointments was found to be consistent across feedback from patients, some of which were experiencing anxiety and distress in relation to suspected life threatening conditions and delayed appointments.

Cause and Impact

Some patients have indicated that waiting times for appointments is having an impact on their wellbeing if anxious about their prognosis. Feedback includes comments such as *"I was left in tears"*, *"I am very traumatised by it all".* This was referenced on several occasions to the increased work load at Stoke.

One lady commented that *"appointments were cancelled time and time again which meant I was over 6 months in seeing a bowel consultant following major bowel cancer. The attitude of the locum oncologist at County Hospital was terrible, I was left in tears… having to wait 6 months initially when worried my cancer may have returned is not acceptable".* The lady goes on to explain that when she received surgery at County Hospital the care was *"not good at all"* and she had *"no dignity"* (Public Survey Participant 13).

Another lady commented after discussing reasons of why an urgent consultation for a cancer operation was delayed for 6 months that *"Staff in North Staffs are actually run off their feet, 12-hour shifts, they're working very, very hard. It's not them, it's the system and the management"* (Patient Interview participant 3).

Healthwatch feedback during Phase 2 also commented that *"Yesterday, I decided to contact Stoke Inpatients department to ensure my notes had been received, and to get an update on waiting time. A very apologetic operator informed me that my notes had been received but I was looking at*

a 30 week wait. She also admitted during the conversation that Stoke were struggling with the increased workload." (Healthwatch Feedback, October 2015).

As this feedback reveals, some of the participants have had to endure extensive waits for appointments. This is suggested to be a result of increased workload following the transition from Stafford to Stoke. Feedback of this nature following the transition confirms that waiting times are still considered an issue, that staff pressure has increased and that these issues are unlikely to be resolved during a period of increased pressure caused by the transition of services.

Proposed resolutions

Some participants felt that the best way to combat the issue was to return services to County Hospital:

"With Stafford's population ever growing, does it not make sense to bring back services to Stafford so that people can receive treatment at a 'local' hospital? Furthermore, there is a possibility that the strain on Stoke Hospital is going to mean that corners may be cut, putting people's life at risk." (Healthwatch Feedback, October 2015)

"Stafford needs to be restored to being a hospital… They're building 700 more houses at the top of my road, in addition to the 1,800 army staff that have just come back, so they're increasing the population of Stafford hugely, and yet they're downgrading the hospital" (Patient interview participant 1).

These participants believed that the increasing population numbers and increased strain on Stoke Hospital requires the Trust to return services back to Stafford. It is appreciated that the Trust are implementing recommendations of the TSA; this therefore needs to be considered within the context of the STP plans across Staffordshire and Stoke on Trent.

Summary of staff capacity

A number of issues have been highlighted regarding staff capacity during the transition of services. Staff shortages have been noted on a few occasions to potentially impact the level of expertise on the ward and the pressure staff are under without the support of doctors. Findings suggest that the absence of consultants during the evening can increase pressures at Royal Stoke if patients need to be transferred due to complications. If ward beds at Royal Stoke are unavailable, this becomes problematic due to limited options other than referral to Stoke A&E department. Staff concerns suggest this is not the most resourceful way of treating patients, especially when there are already issues with capacity at the A&E department in Stoke.

The causes of low staff capacity are also found to be a result of increased demand of patients in the A&E department at Royal Stoke following the transition of services. Capacity is also found to be influenced by staff sickness and staff turnover.

The effect of low staff capacity, amongst other influencing factors associated with the transition is that there are a limited number of beds available for patients attending Royal Stoke. This means that for patients being transferred from County Hospital, they are often forced to wait for prolonged periods of time in the A&E department until a bed becomes available on the ward to which they have been referred to. When bed shortages are an issue, the quality of care is found to decrease. This particularly relates to the lack of pain relief whilst waiting for treatment. The Trust highlighted that the Trusts in-patient survey showed that pain management has improved, however there is still evidence from patient feedback to Healthwatch that there are issues in the administration of pain relief which is often related in delays to treatment and extensive waiting times. Feedback relating to pain relief include the following; *"I was constantly told by nursing staff I was on the wrong ward and they were unable to find a medic to provide me pain relief… this was a catalogue of appalling care and I am traumatised by it all"* (Public Survey). Other comments relating to pain relief can also be found on page 28.

Bed shortages are also found to be a result of delays in discharge caused by staff capacity and delays in care packages for patients ready to leave hospital. This has been highlighted on a number of occasions and is found to reduce patient experience following the transition of services.

The lack of professional expertise at County Hospital out of hours is considered to put patients at risk if an emergency occurs, which also creates added pressure for Royal Stoke A&E department if a transfer were necessary.

Regarding waiting times for appointments, patients have increasing concerns regarding appointment cancellations and prolonged waiting times, sometimes in excess of 7 months. For patients who have anxiety about life threatening conditions and who have previously experienced poor quality of care during their treatment, as evidenced above, this is found to impact on their mental wellbeing.

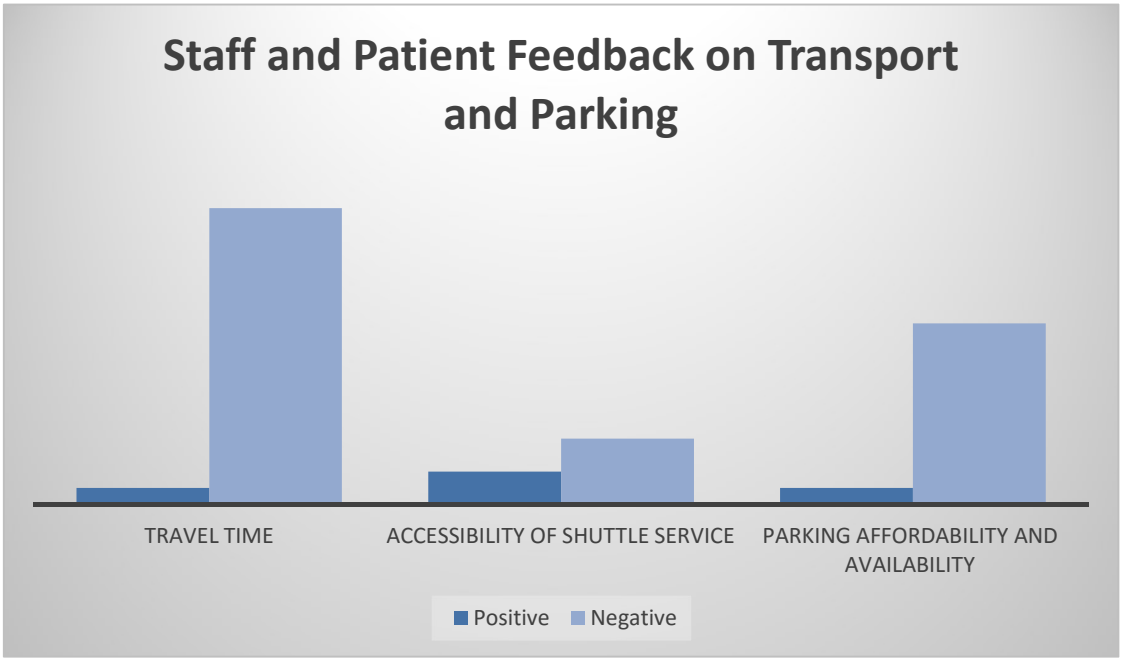
It is suggested in light of these findings that through the work of the Together We're Better Programme and Sustainability Transformation Plan, the movement of patients through different pathways is an area for further consideration to alleviate staff capacity issues, reduce bed shortages in wards and in A&E and improve treatment and appointment waiting times for patients.

Transport and parking

During Phase 2 of the UHNM transition research, transport and parking was another issue which was prominent in the feedback from staff, patients and the public. The frequency of issues relating to transport and parking is demonstrated in figure 1.3 which was found to be across the following three sub themes:

- Travel time concerns
- Accessibility of transport
- Parking affordability and availability

Figure 1.3: Positive and negative feedback on transport and parking



Travel time

Travel time was highlighted as a consistent issue amongst all target groups in this research. Patients expressed concerns and anxiety about travelling to Stoke from Stafford and the impact this would have during emergencies. Some were also unaware as to why they had to travel to Stoke which indicated that communication of the change was not effective and was not alleviating concerns around travel. Staff also found the journey to be problematic in that travelling between hospitals was required for training courses and for shifts which they found to add time onto their working day. What was found to be disappointing amongst patient feedback is that when general feedback on their experience of the transition and the quality of care they received was positive, the overall experience was ruined by journey time. Patients also expressed concerns around the accessibility of

Royal Stoke for visitors of inpatients and the impact this may have on their experience at the hospital.

During Phase 1 of this research, it was found that people were concerned with the increase in travel times during emergency situations. An extract from our 2014 report revealed that a mother was told that her *"daughter would be dead if I hadn't managed to get her to Stafford… they said half an hour later and it would've been too late. So for me to go to Stoke, it would've been too late."* (Phase 1, October 2014). Another respondent commented that *"We need to keep the children's ward and PAU at Stafford. My sons and many other children's lives depend on it. An extra 16-mile journey to a hospital can be the difference between life and death for a seriously ill child."* (Phase 1, October 2014).

Also during Phase 1 of the research, public listening events conducted by members of the CQC revealed that people were concerned by the distance to Stoke and believed that this may be an increased risk to health (CQC, July 2015).

Data collected from our Social Media Monitoring Dashboard during Phase 2 evaluations confirmed that concerns around long journeys between the two hospitals is a concern that remains following the transition:

"Stafford's pregnant women shouldn't have long journeys to access maternity services. UHNS is already over-stretched." (Digimind, October, 2015).

These extracts confirm that issues around travel time were reported before the transition occurred. During Phase 2, similar feedback was received with regards to patient concerns around the time it takes to travel from Stafford to Royal Stoke. It is a possibility that these concerns were influenced by recent incidents during the transition in which pregnant women have given birth whilst travelling to the maternity unit in Stoke since consultant-led maternity services were discontinued at Stafford. Whilst these incidents were addressed, they have clearly had a lasting impact on the perceptions and concerns of the public.

Patient emergencies

Since the changes in maternity services have taken place, feedback from Phase 2 public engagement suggests that there are concerns regarding the stress of travelling for pregnant women and new mothers. A response taken from the public survey revealed: *"I understood the changes, I used the maternity ward at Stoke 9 months ago, the service was amazing but I had to travel for 55 minutes*

every week there and back for appointments… I can't knock the maternity ward team they were brilliant in every way possible, I just found it was very far from my home and family, and when I need A&E I'm very scared of the journey getting there and the length of time." (Public Survey Participant 12).

Whilst these concerns are taken on board, there have been very few stories about women not getting to the hospital on time during labour which suggests that the concerns are a reflection of fear rather than reality. However, concerns around travel time to maternity services is not in isolation as they also seem to be raised across other departments in the hospital. In a patient interview, one participant commented that *"A&E needs to be reinstated because anyone having a heart attack at 2am isn't going to survive that journey to Stafford"* (Patient Interview Participant 1).

Impact

It is apparent that the prospect of long travel times causes stress and anxiety for some service users. During a public survey, one participant highlighted that increased travel distances impacted upon family being able to visit patients at Royal Stoke and the impact this has on the patient. It was commented that *"because she was in Stoke for 3 days, her friends were not able to visit due to the distance and she felt very lonely and isolated during that period"* (Public Survey Participant 21). This participant was concerned about the stress and physical barriers that travelling to Stoke would impose on elderly people, especially if they do not have their own form of transport. The Health and Equality Impact Assessment Steering Group identified in their report that the greatest negative impacts arising from the TSA's draft recommendations is the effect on carers and visitors of extended journeys to more remote hospitals to visit in-patients. The Steering Group proposed extended financial support to facilitate travel, increased awareness of the national Healthcare Travel Cost Scheme, multi-site / multi-day parking permits and continued support for the Voluntary Transport Scheme. Recommendations were also made to increase onsite family accommodation for children in-patients and to make visiting times more flexible for families travelling long distances. Feedback from patients, families and carers during this research indicates that these recommendations from the report have either not been implemented or have had minimal effect.

Staff travel

Concerns regarding travel times were not only identified by patients but also by staff. Feedback from some staff members expressed concern around the distance between County Hospital and Royal Stoke and the impact that this had on their shift pattern and hours of work. Whilst this related to the accessibility of the shuttle bus service provided by UHNM for transport between the two hospital sites,

concerns were generally regarding the travel time between Stafford and Stoke which was not previously required before the transition. One Staff member commented *"The travelling is also a nightmare and adds an extra hour onto the working day making it a long and tiring day"* (Staff Survey Participant 3). Another member of staff commented during a focus group that *"A lot of the meetings are always at Stoke. They have tried lately to do different things but it's a 35-40-minute journey to and from Stafford to Stoke for an hour's meeting you're off the unit for 3-4 hours whereas to come down here is 5/10minutes"* (Staff Focus Group). This was confirmed by another staff member who confirmed that *"if you have to travel to Stoke, you are adding another couple of hours onto your day, so instead of doing an 8 hour shift you are doing a 10-hour shift because of the journey time from Stafford to Stoke and back again"* (Staff Focus Group). Using skype, video and tele-conferencing and webinars is a suitable and practical solution to alleviate these issues and minimise staff travel between the two hospital sites. Whilst the Trust have confirmed that interactive training and meetings is currently available, feedback from staff suggests that they may not be aware of this or that it is not used enough.

Travel times for staff, patients and families is found to be a consistent issue across all target groups. Patients have concerns and fears around travel time to A&E and the maternity services which is causing stress and anxiety about accessing the hospital. Concerns have also been raised regarding family being able to visit patients in hospital and the impact this has on their mental wellbeing and recovery. Staff have commented that these concerns have resulted in patients avoiding calling ambulance services for fear of transfer to Royal Stoke therefore increasing the risk to patients if in a life threatening condition. Staff have also raised issues regarding travel time in relation to attending Royal Stoke for training courses, meetings and shifts which is said to add additional hours onto their working day.

In light of the feedback provided, further monitoring of the impact that the transition has had on access to treatment and patient satisfaction is considered important for reviewing the effectiveness of the transition. Regarding A&E closure at County Hospital during out of hours, this seems to be a persistent issue which has featured in both categories of travel times, staff support and waiting times for patients accessing treatment. This is therefore an issue which requires further consideration in the future due to its persistent impact and relationship to other factors that reduce patient satisfaction.

Accessibility of transport

In the Phase 1 report, participants were asked about their opinions regarding the introduction of a shuttle bus service between the Royal Stoke Hospital and Stafford's County Hospital. Though participants indicated that it was a good idea, there were several people who expressed the following concerns:

"You see my son's got a specialised wheelchair that doesn't fit on the bus so then what do I do with him" (Phase 1, October 2014).

"Provided that people on that bus are physically well, if not then that might not be the best place for them to be." (Phase 1, October 2014).

Elderly and disabled access

Participants were concerned that the shuttle bus service may not be accessible to all patients and thus, they may be overlooked. These findings were consistent in Phase 2, suggesting that the issue had not yet been resolved. Participants discussed a negative experience of the shuttle bus service due to the lack of consideration for elderly people at drop off points in the hospital. One lady commented in feedback to Healthwatch, *"I was appalled that this elderly couple were left to find their own way to the reception which is not a pedestrian-friendly area. If you're not familiar with Stafford and are in poor health, it makes for a difficult walk; certainly you would not abandon people to find their own way if you cared about them."* (Healthwatch Feedback, October 2015).

As demonstrated, some have criticised the shuttle bus for not dropping elderly people near the entrance of the hospital and considered this as dangerous when being forced to walk across the car park, especially if they are suffering from a health condition at the time. This issue was not isolated to the elderly, another patient commented in feedback to Healthwatch Staffordshire that *"The bus that goes from Stafford to the Hospital will not go on to the hospital site so from the road to the hospital is quite a walk. Took a taxi for the next time I attended the hospital at the cost of £40."* (Healthwatch Feedback, October 2015). An Enter and View report by Healthwatch also commented that *"drop off areas are not always close to the appropriate ward/unit being visited. This would be a particular issue for older patients, patients with limited mobility or patients with young families"* (Enter and View August 2015). These comments suggest that the experience of using the bus service is not pleasant for some users and there are concerns around its use by elderly patients who may also be traumatised by the long journey to Royal Stoke following the transition. The Trust have confirmed that the drop off points for the shuttle service are at the closest location to the entrance that is possible. Whilst it is appreciated that emergency access has to be taken into consideration when planning these drop off points, it is suggested that volunteers are used more extensively at drop off points to chaperone elderly/disabled passengers to their desired location within the hospital. It is also suggested that shuttle buses are made wheelchair friendly.

Concerns around accessing Stoke to attend appointments were highlighted on a few occasions. An interview with a patient confirmed that *"for some people like the elderly, with no form of transport, it*

would be quite traumatic to keep going all the way to Stoke" (Patient Interview Participant 1). During a Staff focus group, participants also commented that *"the buses are awful as well, I always feel travel sick and some people call them bone shakers"* (Staff Focus Group) and that *"the drivers drive really fast".* Recent feedback on Healthwatch Experience Exchange from May 2016 highlighted that an 82-year-old lady was given a next day appointment to attend Royal Stoke (travelling from Stafford) at 7am. On this occasion, no support was offered to the elderly lady in order to assist her in attending the appointment. This is just one example of where the Trust are failing to support vulnerable patients following the transition.

It is acknowledged that the shuttle service was designed primarily for staff whilst allowing patients to book on; given the patient feedback regarding accessibility and satisfaction of the service, it is advised that the Trust consider providing a dedicated shuttle service for patients using any profit from the car park charges that the Trust confirm is put back into patient services.

Findings indicate that concerns regarding access to the site still remain following the transition of services, even with the introduction of the shuttle bus service. The Trust have confirmed that the location of the shuttle bus drop-off points are at the closest convenient point to the hospital entrance. Whilst it is appreciated that due to emergency access points, it may not be possible to drop off outside the entrance, it is suggested that each shuttle bus has on board at least 1 volunteer who can assist elderly/disabled patients to the main entrance in a wheelchair.

Cost

The cost of the shuttle service was also highlighted as a problem for staff and patients attending Royal Stoke. A report from a Healthwatch Enter and View Visit in 2015 confirmed that *"There was concern that acute treatment could only be provided at Stoke. To offset this problem there is a link bus service provided, this however requires booking 48 hours in advance and has a cost of £5 per return journey. This goes some way to address the issue but is not an adequate solution e.g. drop off areas not always close to the appropriate ward/unit being visited. This would be a particular issue for older patients, patients with limited mobility or patients with young families"* (Enter and View, August 2015).

Patient feedback on UHNM raised concerns around cost of transport and how staff are seen as a priority; *"I found out bus passes are not acceptable and you have to pay £5 here, whereas NHS employees go for free, the priority here is the staff, who come before the patients, this is a disgrace and the service is not fit for purpose"* (Experience Exchange, October 2015).

Paying for travel to receive treatment from the hospital following the transition was deemed unacceptable and patients felt that they were treated unequal to staff who are able to use the transport for free.

Some participants are aware that in some areas of the county, people who are eligible can use transport schemes to get to hospital appointments, *"There are car schemes available. You know, there's Ring and Ride sort of business, South Staffs Council run one and there are car schemes in Penkridge and local villages"* (Patient Interview Participant 2). It was however highlighted that some participants feel it is unclear whether these schemes are available for every area of the county, or whether it is something just provided in South Staffordshire. This is also considered to be a communication issue in the information that has been disseminated to service users during the transition.

The Trust have confirmed that a price comparison was carried out before setting costs for the shuttle service which is competitive to other modes of transport between the two sites. It is however suggested that a frequent user pass is available to patients and staff using the service regularly so that they receive a discounted rate for travel.

Booking system

Another concern regarding the accessibility of the shuttle service related to the booking system staff and patients are required to access for booking transport. Participants raised concerns about the difficulties they had encountered when trying to book a place on the shuttle bus and the impact this has had on their appointment times. Healthwatch feedback confirmed, *"The helpful receptionist rang the bus company who told me I need forty-eight hours' notice, I was unaware of this and it was an emergency appointment, she said it was too late at 10am…"* (Healthwatch Feedback, October 2015).

During this incident, the patient was not given 48 hours' notice for their appointment and was therefore unable to book a place on the shuttle bus. This highlights gaps in the current service and that in circumstances which require emergency bookings, there are no options for travel assistance to patients. This issue also highlights a communication issue in that patients are unaware of the protocol for booking transport and therefore an improvement in information provision is required.

The Trust have confirmed that adequate information about the booking system is provided to patients in hospital letters, on the website and in leaflets at the PALS office. Evidence from this study does however suggest that information provided to patients has been inconsistent, some having been told that there is no need to book, some being told bookings must be made 24-hours prior to appointments and some having been told to book 48-hours prior to appointments. Shuttle service issues have also

been raised in patient user groups and are being responded to by the Trust. It is therefore advised that all UHNM staff are aware of the shuttle service booking process and information that is provided to patients to ensure that it is consistent and correct.

Frequency of service

The frequency of transport was highlighted as another issue affecting the experience of both staff and patients. Newspaper reports suggest that infrequent shuttle services cause issues for staff because the bus schedule may not fit in with their work timetable. One nurse said that this is problematic for doctors, nurses and cleaners whose shifts begin at 8am on Saturdays (Blackhurst, October 2015).

An Enter and View report conducted by Healthwatch also highlighted that *"Staff training is paramount but to some extent is impaired by the fact that the staff have to attend mandatory training sessions at the Stoke site. This requires a member of staff to be absent for approximately 5 hours for a 2-hour training session. It was suggested that it would be more economical for a tutor to come to the Stafford site to conduct the training and this would minimise disruption of rotas"* (Enter and View, August 2015). The length of time taken to attend training events at Stoke was a result of the bus timetable whereby if a course finished shortly after the bus had left, staff were required to wait a prolonged period of time until the next bus arrived therefore adding further time onto their journey. Staff appreciated the costs in travel time and time away from their wards and acknowledged the difficulties in travelling from Stoke to Stafford. It was therefore suggested that training is delivered via a web based platform or DVD to save resources.

Following the transition of special care baby unit and maternity services to Stoke, staff commented that it was *"promised that they would put transport buses on from Stafford to Stoke for 2 years, but in September we got an email to say that 1st October there were cutting down the weekend transport service after 8pm. This causes issues… as if you work a late shift or weekends, it is really difficult to get back to Stafford, especially if you work a 12-hour shift"* (Staff Focus Group)

Furthermore, the amount of notice that staff were given on the change to the bus service was too short for them to be able to make arrangements for their shifts, as evidenced by the following extract taken from a staff focus group. *"It was supposed to run for 2 years initially and the bus would be protected for 2 years but then we heard it was a year but nobody knew what was happening and it changed at really short notice- 2 weeks I think so there was no time to get your shifts sorted"* (Staff Focus Group). Some of the staff interviewed argue they were left with little notice to make arrangements to get to work if they do not drive. Therefore, cutting down the hours of the bus service may cause prevalent issues for staff.

In addition to the impact on some staff, a reduced shuttle service has undoubtedly affected some patients. Participants criticised the service because the shuttle bus is not as frequent as stated on the UHNM website which refers to hourly; *"The bus service between the two hospital sites is not convenient; it only runs every 2 hours and it is necessary to book your place in advance."* (Healthwatch Feedback, October 2015).

It seems that concerns regarding the accessibility and cost of the transport service offered by UNHM was prominent in Phase 1 as well as Phase 2. In Phase 1, one patient participant highlighted that *"The travelling costs of that on money, you can't do it. You'll literally be scrimping by, the amount of times we have appointments…" (Phase 1, October 2014).* Another participant highlighted that there is little choice other to that access the transport provided even-though they are not satisfied with the cost, "*There is no transport to Stoke hospital from Stafford hospital… patients must book on the bus if and when they have an appointment at Stoke (no visitors on the bus) it will cost £5 return…" (Phase 1, October 2014).*

The shuttle service provided by UHNM has shown to be a consistent issue in staff and patient feedback across both phases of the research which suggests that any changes made to the system have not been well received. Patients and staff have raised concerns regarding the accessibility of transport for the elderly and the journey they are required to make from the bus drop off point to the hospital reception. The cost of the service has been criticised as having priority for staff who are able to use the service for free when patients have to pay £5 and the process for booking the shuttle is found to be inaccessible for patients who have emergency appointments with less than 24 hours' notice.

The Trust have confirmed that there is a taxi service available upon request from the Trust if staff shifts do not align with the shuttle service timetable. The timetable was also set based on a consensus of staff feedback about the most convenient times and frequency of the service although there were inevitably some staff that did not choose the option that was set. Because the transition of services has taken place and staff and service users have expressed concerns regarding travel time and accessibility, it is recommended that staff and patient satisfaction of the shuttle service is continuously monitored in order to identify areas for improvement. It is also advised that communication of information to staff regarding the availability of taxi transport at request is improved.

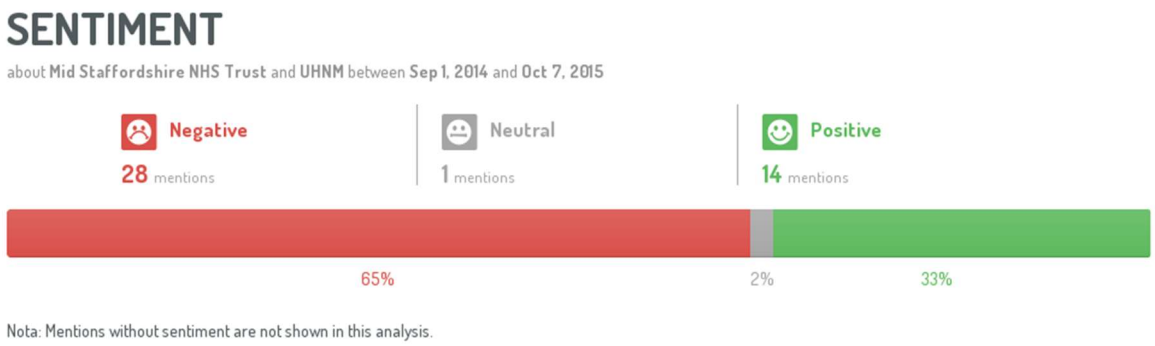
Parking affordability and availability

Parking at Royal Stoke Hospital is found to be a controversial issue amongst patients and the general public. As an issue within UHNM parking has been consistent during both Phase 1 and Phase 2 of the

research. During Phase 1, both the cost and the number of parking spaces were highlighted as problematic by patients. One commented that *"It's £5 for 4 hours parking up there. It's ridiculous, absolutely ridiculous."* (Phase 1, October 2014). Several months after the Phase 1 report was published, it was reported on the UHNM website that car-users would be expected to pay more money from April, 2015 (UHNM, 2015).

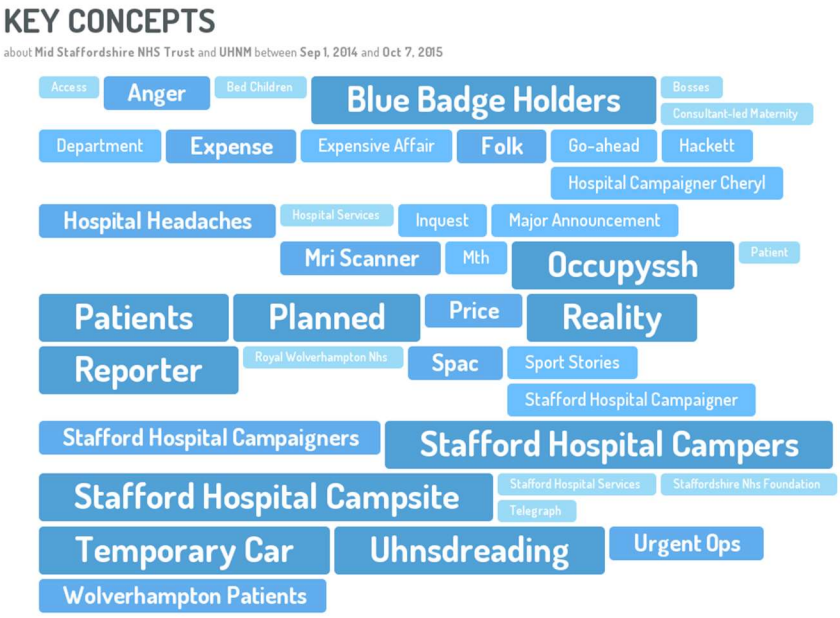
Since then, parking ticket costs have consistently received negative attention online (see figure 1.4).

Figure 1.4: Public Sentiments towards UHNM Parking Spaces.



Analysis of social media during this time also identified that some concepts also related to costs, meaning that the general public have been discussing cost of parking online via Twitter, Facebook and other social media sites. Figure 1.5 shows that words such as "price", "expense" and "expensive affair" appeared in relation to parking:

Figure 1.5: Key Concepts Regarding Parking



Cost

During a patient interview in Phase 2, the issue of parking costs was also highlighted in regards to the impact of waiting times on parking charges. The participant commented *"Instead of paying £1.60 [for parking], you may be paying the next ramp up charge because its £2.60 because he's [the consultant] late. You're not done within the hour; it's taking two hours"* (Patient interview participant 1).

Cost was also highlighted earlier in the report regarding the impact that travelling to Stoke has on families visiting their relatives in hospital. One participant commented that *"Friends were not able to visit due to a number of barriers - time, cost, lack of own transport, and worries about car parking in Stoke." (October 2015).* As demonstrated, the parking issues in Stoke means that people are more reluctant to visit their relatives/friends in hospital, which can impact on the wellbeing of patients using the service.

Analysis of our social media monitoring dashboard during Phase 2 also highlighted concerns around the cost of parking on Twitter. One member of the public posted *"Imagine circling the Royal Stoke Hospital car park for a space for 45 minutes, then having to pay £3.60 for the privilege"* (Digimind, September 2015).

Furthermore, it was reported that disabled service users would also need to pay for parking spaces, which provoked a lot of criticism:

"I think this is awful. I know disabled people have an additional hour at the hospital, but when I was a lad you didn't have to pay to park anywhere, but that's all changed I guess… Elderly people on pensions and the like don't have a lot of money and many of them need to get a taxi to and back from the hospital as well" (Staffordshire Newsletter, April 2015).

As explained in the quote above, parking charges are statutory, regardless of socio-economic status and therefore less affluent groups may be limited in how they travel to hospital. Another key concept that emerged referred to "Blue Badge Holders" in regards to the act of making disabled patients pay for their parking. Similarly, disabled patients criticised the introduction of parking fees. A newspaper report quoted *"The mere fact that the person is disabled often means that they are on disability benefits and therefore on a limited income. Therefore, once again, the less able to pay are being targeted"* (Stoke Sentinel, March 2015).

Feedback across both Phases 1 and 2 of the research indicate that there is a continued issue with the parking costs which patients are not satisfied with. It may therefore be a factor worthy of further consideration at UHNM to increase patient satisfaction of using the hospital services.

The Trust have pointed out that they do not make a profit from parking charges. Any income over and above maintenance costs is put back into patient services. They have also commented that refunds for parking are available if clinics over-run. It is recommended that the availability of refunds is communicated more effectively to service users so that they aware of the options available to them.

Parking spaces and access for vulnerable patients

Accessibility of parking for both patients and the public has been discussed on a number of occasions and is consistent in feedback from both Phase 1 and Phase 2. This is in reference to both the number of parking spaces and the impact this has on accessing the hospital, and for the residents in surrounding areas. And also the impact that issues with parking have on elderly or disabled patients.

Regarding the impact of parking difficulties on taking elderly or disabled patients to appointments, some respondents have commented *"I struggled to walk the distances needed in Royal Stoke, and have realised that should I need to take my 94-year-old mother to an appointment there we would find it nigh on impossible on our own because of the distance from the nearest drop off to the entrance, and then to the reception desk. Whoever designed this appears to have had no understanding of the mobility problems that many people experience."* (Public survey, participant 25).

The same issue was highlighted by another participant who commented that *"Car parking operating staff do not give a damn about your problem when you are trying to park. During my experience on Monday 19th October, I had transported two elderly family members to attend an appointment. After several minutes of trying to park I had no option but to drop the two off at the main reception area. Leave them and go and find a parking space. One hour later, I had parked… I then approached the main reception desk to locate the family members who had taken it upon themselves to move to the appointment. I asked if they could track them and was told no. Once again less than helpful"* (Public Survey Participant 17).

These participants highlight the difficulty in dropping off patients at Royal Stoke. Some of the difficulties might be unavoidable due to the size of the hospital site and therefore the distance between the drop-off area and some hospital units. However, the issue that can occur when dropping off less mobile patients whilst having to find a space to park could be alleviated. The Trust have confirmed that there are car park attendants available at both sites to offer advice and volunteers available to assist patients in getting safely to their point of care. It is recommended that the way in which patients can access volunteer support is revisited, such as call buttons at parking meters etc.

Issues regarding the number of parking spaces is also consistent across Phase 1 and Phase 2. During Phase 1, one participant commented that *"It would need to at least treble the size of parking places at UHNS and at least double the numbers of doctors and nurses"* (Phase 1, October 2014).

Analysis of our social media monitoring dashboard during Phase 2 also highlighted dissatisfaction with parking spaces. One lady commented via twitter *"Visiting time at Royal Stoke Hospital. Dreadful shortage of parking spaces!"* (Digimind, June 2015)

Impact

As a result of both increased parking charges and the lack of parking spaces at the hospital, reports have commented that *"It means a lot of patients and staff will choose to park all over Hilton Road and the surrounding streets."* (Stoke Sentinel, March 2015)

The identified parking issues and its subsequent implications does not only affect patients and staff, but people who live near to the hospital. Newspaper extracts from Stoke Sentinel found several quotes from residents surrounding Royal Stoke Hospital which found that the lack of parking spaces and the cost of parking at the hospital was causing patients and visitors to park in nearby residential areas. One member of the public commented *"Several times I have tried to let people know they need tickets to park there and all I got in return was verbal abuse…we shouldn't have to put up with that… it is*

laziness really. They don't want to walk and they don't want to pay, so they sneak up here and leave their cars." (Stoke Sentinel, September, 2014). Another confirmed that *"We don't want any old people parking willy-nilly in front of our house. We have young children here. It is a security issue and this would help us to keep a closer eye on things." (Stoke Sentinel, September, 2014).*

Several months after this feedback was published, it was reported that 300 extra spaces have been created at the Royal Stoke Hospital and 300 extra spaces have been created at the County hospital (Express and Star, September 2015). This is hoped to ease the pressure on parking capacity, which is a positive step forward however feedback on Experience Exchange and on our Social Media Monitoring Dashboard has demonstrated mixed reviews since the increase in parking numbers which suggests the impact may not have been as significant as hoped. The following feedback was given in December 2015 and February 2016 after the additional parking spaces had been installed:

"Could not find a disabled space outside A&E" (Experience Exchange, December 2015)

"Suggestion- Park & ride or obtain more land for patient parking" (Experience Exchange, February 2016)

Feedback was found to be mixed with the above documenting less positive experience. The comment below on Experience Exchange does however demonstrate that some visitors have had positive experiences of parking following the introduction of the additional spaces. This was however early in the morning which may be an influencing factor to the volume of cars in the carpark. *"Experience good on the whole, there is lots of parking spaces available first thing in the morning, just a difficulty to judge how much time to put on the parking machines, especially if you don't know how long you are going to be."* (Experience Exchange, November 2015).

In summary of the key findings for transport and parking, service user feedback suggests that travel time is a consistent concern following the transition of services, some of which argue that the transition should be reverted due to the potentially life threatening implications if treatment is not received in good time. Access of transport and the provided shuttle service does not seem to be communicated efficiently to service users who have difficulties booking transport and argue that the cost and frequency of the service is not to their satisfaction. Issues regarding elderly transport service users is also considered unsafe. With regard to parking, affordability and availability continues to be an ongoing concern raised by service users which is having wider implications on surrounding residential areas.

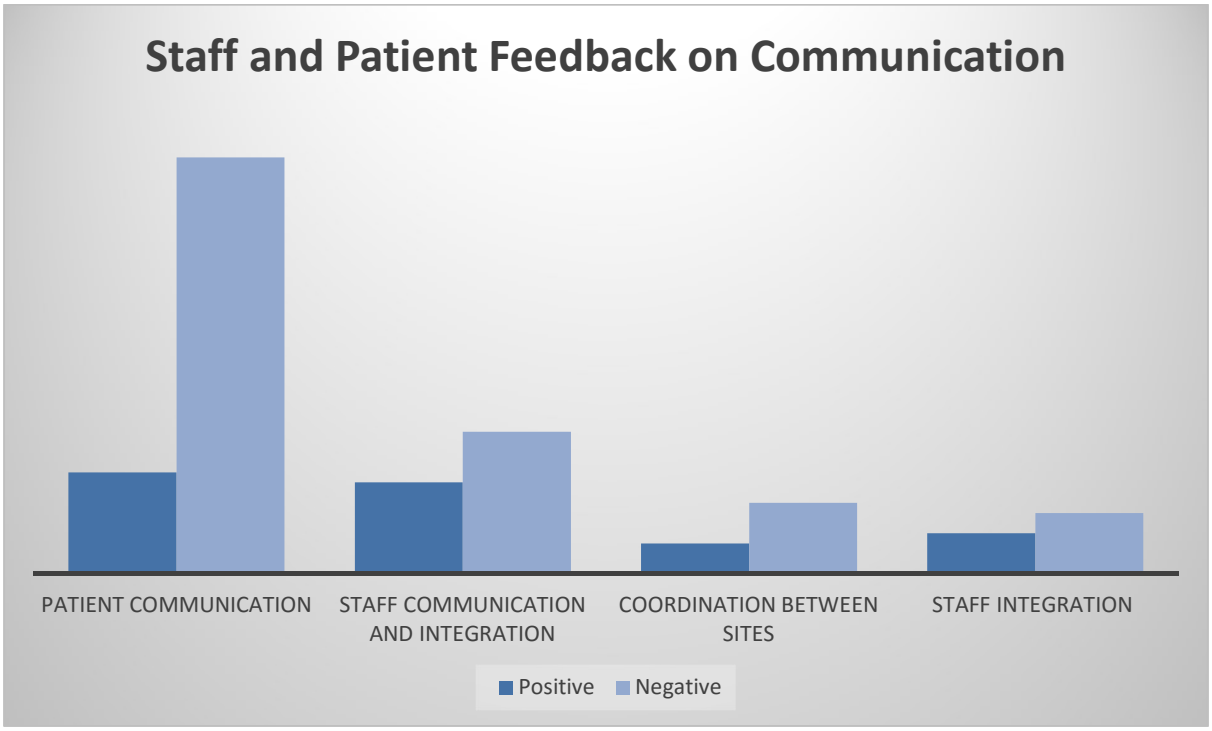
Communication

Communication issues manifested in various different ways, from the public feeling uninformed about the changes to the level of communication from the Trust to the staff throughout the transition of services. For example, an Enter and View Representative commented *"Communication from the top down needs to improve. It also needs to improve with patients"* (September 2015). Figure 1.6 demonstrates the proportion of positive and negative statements of both patients and staff regarding communication.

Communication was categorised into four subthemes:

- Patient communication
- Communication to public
- Staff communication
- Coordination between sites.

Figure 1.6: Positive and negative feedback on communication



Patient communication

Communication of information to patients was found to be a problem within UHNM where some patients said they have either not been adequately informed about the changes which occurred

during the transition or they have not received adequate information about their treatment, discharge or aftercare.

Treatment

Some patients have reported issues relating to the ways in which their treatment has been communicated to them. These service users have also argued that communication has negatively impacted upon their healthcare. Although it is recognised that some issues highlighted may have been present before the transition, feedback from service users suggests that the transition has exacerbated some patient concerns. One participant who took part in a public survey commented that *"No nobody explained anything. I was taken from Stafford hospital to ward 101 Royal Stoke hospital as told there were no surgeons at Stafford. I was misdiagnosed as having to need appendix removed in fact I had a perforated bowel and abscess"* (Public Survey Participant 12).

Similar experiences were found with other patients who are unsure of what treatment they are receiving and why. One patient commented, *"Communication! Still don't know what is going on, even though I have had first appointment with Urologist on 21st August, and an ultrasound on 14th Sept, next appointment on 19 Oct. Tests all seem to be for UTI, but don't know have not been told. Just assumed that from the writing on the urine sample request and the Ultrasound exam. At a worrying time like this, better communication is vital"* (Public Survey Participant 24). Another patient commented *"Nobody explained anything to me, I was very distressed and unwell; it was a frightening experience"* (Public Survey Participant 10). If patients are concerned about their health and their diagnosis, being poorly informed about the process of their treatments and the tests they are undertaking is evidently causing anxiety and concern. Whilst it is acknowledged that the Trust engaged extensively with service users prior to the transition, recent feedback suggests that there is still a lack of understanding as to what changes have taken place, what changes are ongoing, and how this affects patients. A call was made to Healthwatch in May 2016 asking for information about what service moves had taken place and where they will now go for treatment. This is just one example of where information has failed to communicate effectively.

Discharge

Other patients have commented that during the transition they experienced poor communication from the hospital regarding their appointment times and discharge. One participant commented, *"After the operation I was discharged without knowing what aftercare I needed, this left me feeling confused and concerned"* (Public Survey participant 13). This highlighted that communication was

found to be poor before and after treatment at UHNM and that patients were left confused and concerned about their health following discharge.

Whilst some service users reported exceptional care from staff, communication was persistently an aspect of healthcare where some have also felt let down. A participant from the public survey commented, *"On ward staff were excellent, from nurses to cleaners. When I was discharged I was given a bag with medicine in – No instructions, letter or guidance on my condition (Gall bladder removed)"* (Public Survey Participant 4). A patient interview participant during Phase 2 commented, *"My husband had major surgery on the Monday, went out on the Wednesday, we were given no information whatsoever, nobody to come and call, you know, we were just sort of thrown out. No communication, no, communication was dreadful. Trying to get information is like pulling teeth… I think when you leave hospital after an operation, you could be given a sheet with things like, 'oh, you must drink more' or 'you must drink less' or 'don't eat such a food'…"* (Patient Interview Participant 1).

Lack of information provided to patients during discharge is potentially detrimental in that it may impact their prognosis for long term recovery if the correct self-care is not administered by the patient. This may delay recovery and result in readmission to hospital. These patient comments suggest a need for more information to be given to the patient upon discharge.

Signposting

Regarding general information in Hospital wards for patients, communication was also found to be an issue. An Enter and View visit in September 2015 reported that *"Efforts have been made to put lots of information on large noticeboards, for patients and visitors. The boards appeared to have too much information on them with lots of small writing, this made it very difficult to read and take in. The ward manager was made aware of this and she said that she is looking at simplifying the information displayed"* (Enter and View, September 2015).

Appointments

Some staff also reported inadequate patient communication whilst the transition of particular services (such as urology and breast cancer) was occurring. This is likely to have had an impact on appointment waiting times as evidenced in earlier quotes around staff capacity. The impact of this on patients with serious life threatening conditions is found to be very distressing as evidenced in earlier findings.

One patient commented about *"Having to ring up to remind of appointments that haven't come through. Lost samples. One nurse in particular was very rude to me when I went in for an operation"* (Public Survey Participant 3).

Staff also confirmed these failures, one participant commented that *"Patients were lost in the system. First of all, urology went over and there were so many patients that were lost in the system because they were just sent a letter that cancelled their appointment but the letter was confusing. A lot of the urology patients are elderly and thought as they hadn't had a letter from the hospital they didn't think they needed to go so how many people have we lost in the system because everyone was cancelled to swap them to the Stoke system and they were just lost"* (Staff Focus Group). The impact of losing patients in the system with serious life threatening conditions is potentially dangerous if patients do not have the capacity to follow up on their health prognosis. The findings suggest that the transfer of patient records and management of information has been limited during the transition.

There also seems to be a lot of confusion about what hospital patients are expected to attend and the communication between hospitals is seen to have been poor. This has resulted in appointments not being made and treatment for cancer patients being delayed. One staff member commented *"We had that with the breast patients that went to Wolverhampton they were getting letters if they went with the consultant to Wolverhampton but if they said no they didn't want to go to Wolverhampton they were ringing the Wolverhampton number and were told you will just hear from Stafford but then didn't hear anything. Breast cancer patients on waiting lists not getting seen for their surgery and were turning up and unbeknownst to them their consultant had gone to Wolverhampton"* (Staff Focus Group).

Another staff member confirmed that communication of outpatient appointments is poor and discussed the impact that this has on patient confusion. Some staff spoke strongly about the impact of poor communication of outpatient appointments to patients, particularly the frail/elderly. It was commented, *"The way we communicate outpatient appointments to patients is in the main, quite poor. I am still repeatedly asked by visitors to the hospital where to go for their appointments. When I see their paperwork, the maps are not good enough and there is no description of the different entrances and most efficient route to take. This is particularly problematic for the frail and elderly, who cannot walk the long distances required to correct their course. The signage around the hospital is also inadequate and does not effectively guide patients around the hospital. The signage is too small and a significant number of visitors cannot find their way to their destination"* (Staff Survey Participant 7).

Staff have indicated that there has been confusion for patients in terms of where they should be going for their appointments following the transition of services and attending appointments in unfamiliar locations. Given that many patients will be attending new sites for appointments and treatments, a more conscious effort should be made to provide concise and valuable guidance. It seems that some patients may have misunderstood where their treatment was taking place which led to them not attending their appointment. It also seems that service users are getting lost whilst trying to find the correct location. Some staff have suggested that better signage, more information and better maps would help service users to find their appointments. In turn, this would help to prevent DNAs.

Communication to the Public

Feedback from some members of the public suggests that communication regarding the transition has been ineffective. Some participants commented that they don't understand what transitions have taken place, why the transition needed to take place and some have argued that the public were not informed before the transition took place which from the sentiment of patients during face to face discussions, has caused some degree of frustration.

A respondent from the public survey commented, *"I don't understand why all services have to be moved to (Royal) Stoke which appears to me to be completely overwhelmed by the extra patients"*, which is largely inaccurate since only a small number of services have been stopped at Stafford and the transition of services is not wholly from County to Royal Stoke; some services have been moved from Royal Stoke to Stafford. It does however demonstrate that the public are not aware of what transitions have taken place which has affected their judgement of the transition. Lack of communication between the UHNM Trust and the public means that service users are unaware of the benefits of the transition of services.

Transparency

From the feedback received, there seems to be a common theme of lack of transparency around services being discontinued and a sense of frustration has developed around the way in which the transition was handled and the public consultation which took place before plans were finalised. This theme arose out of comments in the public survey questioning the honesty of the Trust and the information that has been provided to patients. One participant commented, *"The communication is very misleading. Plus, UHNM are moving services from Stafford ahead of deadlines. It seems like they do want they want, very arrogant."* (Public Survey Participant 23); another commented, *"I would like them to be honest in what the changes were about instead of white washing over every aspect"* (Public Survey Participant 14). Participants also indicated that *"there has been no coherent presentation of all*

the changes that have happened or are planned" (Public Survey Participant 25). When asked what information the public would have liked to receive about the transition, one participant commented *"That they were taking place!"* and another commented *"I would have liked to know BEFORE they were taking place"*. Other participants commented in response to what information they would like to have received, *"What was going to happen", "How this was going to affect me",* and *"Exactly what services were moving".*

Healthwatch can confirm that public engagement events, radio and TV interviews, press releases, staff briefings and thousands of leaflets relating to service changes were carried out prior to the transition. The Trust said that one to one consultations with patients were also carried out, for example all paediatric patients with long term conditions were spoken with personally alongside their families about what the changes meant to them. Changes were discussed extensively at Board meetings which are open to the public and the issues also had an unusually high national profile.

This information was provided very early on in the transition and has not been ongoing even though service transitions are still taking place. It is suggested that information is disseminated on a central repository as was the case with the 'It's Our Time' Webpage; this needs to be kept up to date. Having up to date information would alleviate concerns regarding the accessibility of information.

Concerns from the public is also recognised by staff who commented that patients are frustrated and confused following the information provided to them and how this is likely to have affected patient experience and the impact on patient health. One staff member commented, *"In my opinion, the changes led to increased confusion and frustration for patients. A significant number of services, in a short space of time changed location, for example, so patients were suddenly having to travel to different locations for services (e.g. phlebotomy). I am also concerned that the increased number of care pathways and referral between sites will lead to patient frustration and in the worst case scenario, patient harm due to delay in treatment"* (Staff survey Participant 5).

Effective patient communication is vital for ensuring a smooth transition of service and increased patient satisfaction. The consistency of poor patient satisfaction amongst this sample of respondents regarding the communication and dissemination of information suggests that this is potentially a factor impacting patient satisfaction and in effect, patient safety if appointments and treatment is delayed for serious life threatening conditions. Recommendations are proposed to review the way in which information is disseminated and ensure that the content is transparent and accessible by all service users.

Communication to staff

Communication to staff is also found to be an issue within UHNM, especially during the transition in relation to staff /patients at County Hospital. The issues that have been identified include problems with email communication and a lack of inductions/handovers occurring when needed. The transition of services has affected the communication between staff, particularly in areas where staff members have to carry out shifts on unfamiliar wards. These issues were touched upon briefly regarding staff expertise and training, however the cause of staff having insufficient knowledge is linked to the lack of information and training available to them.

Staff that took part in the focus groups were all based at County Hospital which means that there is a certain amount of bias in feedback from staff about the levels of communication. However, their feelings reflected concerns of the service users interviewed about the communication that they received which suggests that the issue is consistent across both hospital sites.

Methods of communication

Staff talked about the need to use other means than global emails to communicate with staff as infrequent use and the volume of generic information being circulated meant that some important information would be missed. One staff member commented, *"Using global communication to try and get to everyone is not an effective way to communicate and is better to personalise it and break it down into service areas that make the information relevant and appropriate to each audience. The same message will have varying degrees of relevance to staff depending on your role and area of work"* (Staff Focus Group).

Tailoring the emails so that only relevant information is sent to each unit would be preferred. It was commented that some staff members don't have time to check their emails whilst on shift so they sometimes miss information. Plus, some have limited access to emails because they do not have their own desk and computer at work.

The Trust have commented that managers are expected to take some responsibility for ensuring their staff are kept informed via department and directorate briefings. 1200 staff responded to a survey sent out by the Trust on internal communications and these have now been revitalised in line with that feedback. This was available on line as well as being handed out to staff at canteens on both sites. It is however reinforced that from staff feedback, issues were raised in relation to the capacity of integration champions to undertake the role effectively alongside their 'day job'.

Staff handover

Moreover, staff members from County Hospital who had covered shifts at Royal Stoke during the transition reported issues with communication in that they were not informed of the ward process, nor did they feel that other staff members had sufficient knowledge. It was reported, *"I did do a couple of shifts over at Stoke and I didn't know anything or how the ward worked so it was really bad but I just had to get on with it. But no-one else on the ward knew what was going on either as there were a lot of temporary staff"* (Staff Focus Group). This feedback is consistent with an Enter and View visit conducted by Healthwatch which reported that *"A nurse spoken with did not know what was happening that day with the ward changes and that everything seemed to be reactive rather than proactive"* (Enter and View, September 2015).

On the other hand, a student received a full induction when they started their position at County Hospital, *"For me on the ward I received a full induction at County and always told that I would be only working at County Hospital. Every question I had was answered and the induction for students was really fulfilling and gave me everything I needed and all my questions were answered fully"* (Staff Focus Group).

This participant's positive experience is something that could be replicated across all of UHNM. It may be that this individual received a thorough induction because they are a student and might be viewed as inexperienced and thus in need of an extensive introduction. However, as the evidence suggests, it is also important to ensure experienced staff members are given an induction when working on a ward they have never worked on before. Even a basic induction could make a staff member feel more at ease with working in a new place and enable them to keep up with the pace of the unfamiliar working environment. Staff Focus Groups revealed the benefits of face to face meetings before services were moved as they don't know who is who or what roles staff fulfil at Royal Stoke. Having met some of their counterparts, this was found to have improved communications and information sharing protocols. Whilst the Trust have confirmed that they do have an induction process on all wards, it is still evident that some members of staff were not satisfied with handovers and inductions. It is therefore suggested that handovers and staff briefings for both permanent and temporary staff is embedded.

Coordination between sites

Coordination of information has been highlighted on various occasions in relation to patient records. It has also been reported that service users' test results are not being transferred between County

Hospital and Royal Stoke Hospital in a timely manner. There are also situations occurring where patient notes are delayed in their arrival at the correct ward and patients are made to wait until the staff get access to them.

Duplication

In some instances, staff have been dependent on verbal histories provided by the patient. One patient commented, *"when I went for the follow up appointment, he turned around to me and said 'You need to have an ultrasound', I said, 'No, I have already had an ultrasound four weeks ago, the results should be on your system"* (Patient Interview Participant 2).

This issue was confirmed by another patient who commented *"They are just not communicating between the two hospitals, there's a lot of waste of money through lack of communication; they repeat things that has already been done"* (Patient Interview participant 1).

IT systems and record management

Furthermore, feedback suggests that IT systems at Royal Stoke Hospital and County Hospital are different and has been identified as an issue regarding the coordination of services between the two sites. An Enter and View visit reported that *"It was noted by the Representatives that secretarial staff were having to use two patient information systems, one for Stafford and one for Stoke… This should be addressed to simplify the procedure and possibly reduce potential errors"* (Enter and View, August 2015).

Another staff member confirmed that issues with communicating patient information was a result of different IT systems. Staff confirmed that *"The big issue is that we are on Medway and Stoke is on CIS and those two systems don't talk to each other and that has been a major issue and it still is a major issue especially with us having Stoke patients"* (Staff Focus Group).

However, this issue is not isolated to UHNM as there are concerns nationwide about the efficiency of how patient notes are managed and not being shared between practitioners (NHS Institute for Innovation and Improvement 2013).

UHNM have confirmed that this issue is being addressed in year through a major IM&T project.

When questioned about the involvement staff had in the decision making process for the transition, (a) participant (s) commented, *"You kind of had to work it out for yourself, I'd end up ringing around anybody to find out information about the IT system. It took us 5 months to get access to the clinical information system across from Stoke and just get passed from one IT department to another and that's still ongoing"* (Staff Focus Group).

When asked about the challenges staff faced regarding the transition, (staff confirmed that poor communication between the two hospitals resulted in staff being unaware that patients were attending the clinic). One staff member commented *"A patient added on yesterday and I only knew about them because they rang the ward to ask if they were coming so then I chased that up but because they are last minute the secretary can't put her on the computer until she has these inpatient transfer forms… then the notes aren't here so you are chasing around to find them because she's on a ward so they haven't got the notes anymore and they've moved them to somewhere else – we still haven't got them now, this morning and the patient is going to theatre"* (Staff Focus Group). Staff seem quite distressed about the poor management of patient records and the impact this has on their ability to perform their duties at the hospital, as well as the impact it may have on patient waiting times and delays to treatment.

Some of the difficulties in transferring patient records seems to resonate in the format of documentation. Staff commented that *"it will always be a bit awkward in terms of getting the paperwork across in time because some stuff is on computer but some of it isn't if it is a recent emergency admission and everything is in the notes"* (Staff Focus Group). More robust and systematic processes for patient record management seems to be an important requirement for the Trust following the transition.

There were some positive experiences of the transfer in terms of learning about the systems and processes of the wards that staff were being transferred to before the transition took place. One staff member commented, *"On our ward we have had the opportunity to work with our counterparts in Stoke and spend a day with the staff so that we could see their processes and likewise they have come across to Stafford. That included the admin staff as well. So for our area we have probably done really well… We know the ward manager and get to know them, can put the face to the name and build an effective working relationship so that's worked really well for us because we have seen their issues and vice versa…"* (Staff Focus Group).

Feedback regarding the communication between staff and the circulation of information between and around the hospital seems to be a consistent issue within the staff participants following the transition. The implications of this are likely to have an impact on the level of communication to patients if staff are also unaware of what is happening. The waiting times for treatment and appointments is likely to be effected also if there are delays in patient record delivery between the hospitals. If there is confusion for both staff and patients regarding appointments and referrals, it is likely that this will impact DNAs and the cost of those missed appointments which will subsequently lead to delays in receiving treatment as highlighted in staff feedback.

Staff experience of the transition

There is some variation amongst those interviewed regarding the experience of staff during the transition of services regarding its management and coordination. It is clear that the transition of services has affected how some staff feel about their roles within the Trust. On the other hand, there are some clear examples of how the transition of services was managed well and communicated to staff effectively.

Staff involvement in transition

Staff reported that at times it felt that decisions were being taken without understanding the service in question. Staff at County Hospital felt like they did not know as much as they needed to about the transition; this is congruent with findings from the CQC report (July 2015) where authors stated that staff from the County Hospital *"felt isolated and that Trust senior managers had not engaged with them."* Furthermore, the authors reported that staff were unsure about the Trust's aims and what role the staff had in achieving the objectives. Comments made by staff suggest that staff morale is low, and this lack of involvement may have been a contributing factor. Staff in the focus groups said that they would like to see more engagement by senior staff with a request that Mark Hackett was more visible to staff at County Hospital (April-May 2015).

"Senior Execs need to be visible to staff. I understand that they are all very busy but it would be good if the Chief Exec could come to the wards and talk to staff directly. Some of my staff might not even know who Mark Hackett is or what he looks like" (Staff Focus Group).

Some staff reported very positive experiences with the transition and integration of staff. One participant for example commented *"the move from county went very well we were all actively encouraged to be part of the new trust, from my perspective, job satisfaction increased"* (Staff Focus Group). Another commented *"it didn't affect me personally, I felt motivated and geared up for the changes. I was very surprised at the other staff reactions however- I realised that other people didn't feel the same way and I found this aspect difficult to understand and to deal with"* (Staff Focus Group). This shows that there was a mixed experience from staff regarding the transition and communication.

Staff divisions

Some of the staff from County Hospital said that they did not feel that the Trust has a single identity rather that it is still two separate organisations, Royal Stoke and County Hospital.

"Communications to patients don't portray us as one Trust and still emphasises the Stoke or Stafford hospitals" (Staff Focus Group).

Furthermore, the staff at County Hospital said that they felt that they were seen as an inferior site and their views were not taken into consideration. One member of staff commented *"I still think that they think we are the inferior part of the organisation. It's kind of we are a small hospital but we have been through massive scrutiny and [are] probably one of the safest hospitals in the country right now because of the scrutiny that we have been under. We've learned a lot and we've been down the path of doing certain things and realised that it didn't work… and just don't feel that has been recognised, acknowledged or taken on board… Sometimes it feels like we are going backwards…"* (Staff Focus Group).

Another staff member reinforced this issue, commenting that *"It feels that everything has to be done the Stoke way and lots of people say that and some of our systems, etc. are better"* (Staff Focus Group).

There was some positive feedback regarding efforts from the Trust to minimise staff divisions however from the perspective of this staff member, a lack of consistency has prevented this from happening. *"There were some good work at the beginning in trying to bring everyone together and the people are really nice but once the merger had taken place it didn't continue and wasn't sustained engagement or bringing together. It now feels like an 'us and them' situation which is what they were trying to avoid"* (Staff Focus Group).

The Trust say that in all their communications they are making every effort to stress that County is a different but equally important hospital to Royal Stoke. It is also acknowledged that the Trust have engaged with staff and patients through 'in your shoes' events. Whilst this is the case, it may be beneficial for the Trust to monitor staff feedback more closely to see how their perceptions change following the implementation of staff and patient recommendations.

Job satisfaction

The staff gave examples of where policies and procedures were developed to encourage working relationships, one staff participants commented in relation to a joint day case chart *"we know the ward manager and can put a face to the name and build an effective working relationship so that worked really well for us because we have seen their issues and vice versa and we are trying now to get a joint day case chart which is going to be a combination of theirs/ours systems and ways of*

working and getting the pre-am's document produced together based on both systems so that has worked really well" (Staff Focus Group).

Due to changes in services, some staff were experiencing decreased job satisfaction which is a likely explanation of why there had been a high staff turnover affecting staff capacity following the transition. An Enter and View visit in May 2015 confirmed that *"The emergency skills of staff are not utilised and some staff said they felt de-skilled… Staff worked well in the environment as a team although it had been recognised that the ward had virtually been downgraded as trauma patients were only admitted to Stoke. Therefore, staff were mostly only supporting recuperative care at Stafford. This seemed very unfair as dedicated staff wanted more responsibility to utilise their skills and to further their careers"* (Enter and View, May 2015).

When questioned about challenges they faced during the transition, a member of staff commented, *"I felt like I was having to build my professional reputation and standing in the organisation from scratch again and it feels very dismissive. You go to meetings and you've got something to put forward or contribute and you feel that it's not taken seriously or valued…"* (Staff Focus Group).

These comments suggest that the transition of staff to different wards means that they feel that their skills are now underutilised or that their expertise is not valued in their new location. This is likely to impact job satisfaction of staff at UHNM which may subsequently further impact the rate of staff turnover and capacity at the Trust. It may also impact the attitude of staff members towards patients if they are dissatisfied with the role they are fulfilling. This in turn would impact patient satisfaction and experience.

The Trust has made numerous attempts to engage with staff about the plans for the Trust, including presentations, displays and promotions in the staff canteen and information on the intranet. This seems to have had a positive impact on some staff members in terms of their inclusion in the transition plans. Additionally, there are regular staff bulletins which are structured around the vision and the board were planning visits to services where staff can discuss the vision directly with board members. Staff also attended regular integration meetings where information about service development is shared and staff go back to their departments to feedback to their teams and there were other examples of effective staff involvement in the transition. Feedback from staff regarding their involvement in the transition confirmed that *"There was excellent communication and targets set nearer to the merge date with respect to equipment, decontamination, storage issues, etc. When she came to visit she understood how we were all feeling and identified what worked well in the*

department that could be implemented back at RS to improve general turnaround times. We felt like we were included in the decision making when she came over to visit as often as she could" (Staff Survey Participant 1). Another member of staff commented *"We had regular meetings with our manager and she was very good at feeding back what information she had but other areas might not have had that same support. She did keep us updated on a regular basis and attends a lot of the meetings and encourages us to do the same"* (Staff Focus Group).

This feedback is positive in that its impact is likely to improve job satisfaction and increase the understanding of staff regarding their new roles following the transition, both of which will have a positive impact upon patient satisfaction and quality of care.

It is however recommended that all staff are supported in this way and any feedback regarding their satisfaction or dissatisfaction of their new roles is taken on board and changes to be made accordingly where this is possible. The Trust point out that this is part of the appraisal process which has been amended and relaunched in line with staff feedback.

Integration champions

When questioned about what challenges were faced during the transition and how these were overcome Integration Champions were thought by some to be ineffective in alleviating the stress and confusion amongst staff during the transition. This was thought to be due to the impact that the transition was having on themselves and the lack of preparation they had for dealing with the impact of the transition on other staff members. One staff member commented that *"Integration Champions were put in place to mitigate this impact [low staff morale following the transition], but we were also affected by the changes and had our own difficulties to deal with. Managing the effect on staff was too much for the Integration Champions to deal with - we were less prepared for the level of impact than we should have been. Most areas had too few integration champions - ideally there should have been one Integration champion for each team. Some areas had none at all. A significant number of Integration Champions felt disempowered as it was perceived that their Senior Management Team were not fully engaged with the staff impact element - SMTs had so much to deal with logistically and operationally"* (Staff Survey Participant 5).

Also, some focus group participants were unaware that there had been 'Champions' for the transition. It seems that some champions were more active than others and therefore some units were not as informed and supported as others and there were also some examples of good practice regarding integration, one participant commented *"We had regular meetings with our manager and she was very good at feeding back what information she had but other areas might not have had that same*

support. She did keep us updated on a regular basis and attends a lot of the meetings and encourages us to do the same" (Staff Focus Group). Another participant commented *"we have people coming to our department from Stoke who have similar roles and that worked quite well to understand how to work closely together"* (Staff Focus Group). These comments evidence a number of instances where the transition has worked very well.

Some participants also said that they had been kept informed by their line manager who had been pro-active in sharing information and had encouraged them to take part in meetings and the focus group. Not all staff had received the same sort of input from their managers and as a result felt that they had been less informed. Feedback therefore suggests that there should have been a more consistent approach and delivery of the integration champion role and their engagement with staff.

Quality of care

Despite difficulties that the staff faced during the transition and the impact this had on their job satisfaction and morale, feedback from patients suggest that their difficulties did not always affect their attitude and that the quality of care was on occasions very positive.

One patient commented that *"The staff are marvellous; they're the highest of the highest really. I think they treat everyone the same"* (Patient Interview Participant 1). *This was reinforced by another patient who commented that "The staff were actually brilliant. That appointment happened right on time, there was no problem with that appointment in the imaging department, it happened right on time, and the staff were very helpful, very understanding…" (*Patient Interview Participant 3).

On one occasion, a patient actually highlighted concerns about the system and the impact it is having on staff at the trust. The patient commented, *"They were wonderful! But the system is letting the nurses down, I think"* (Patient Interview Participant 1). This feedback is insightful and would indicate that staff have been trying to maintain a positive attitude towards patients. This patient however has the opinion that the system at the Trust is letting nurses down which appears consistent with some staff feedback.

Conclusions

The findings from this evaluation highlight the views from patients who have experienced transfers between the two hospital, the staff at UHNM and the general public, towards the transition of services.

It is clear that amongst the small numbers interviewed there are ongoing concerns amongst the public about their changing hospital services, many of which are considered to have been the result

of poor communication about what impact the transition would have on their treatment, what services where being moved and why, and general information within the hospitals regarding signage and parking. There appear to be some communication issues amongst some staff which are impacting their understating of the processes and systems they are expected to embed following the transition which is found to impact their job satisfaction and morale.

Parking and transport was found to be an issue amongst some of those interviewed. The shuttle service implemented to alleviate issues regarding travel between the hospitals was found to be dissatisfying both in terms of transport frequency and cost, as well as the drop off location for service users and the danger to elderly patients accessing the hospital from the drop off point. Parking is dissatisfactory amongst many patients and residents in the surrounding area, both in terms of cost and the number of spaces. This is found to cause patients and visitors to park in neighbouring residential streets which is causing complaints by residents in the area. The introduction of 300 spaces at both hospital sites does not seem to have had a significant positive impact on parking demand at Royal Stoke although the effects of this will be still be embedding. Families and carers also have serious concerns regarding the lack of assistance for elderly or vulnerable patients who need to be dropped at the hospital reception and left alone while their accompanied adult parks the vehicle. More assistance is needed here in terms of volunteer chaperones from the vehicles to the hospital entrance. The journey time between the two hospitals is also a cause of concern for patients who deem the system to be unsafe for emergency patients.

Staff capacity is seen to be a cause for concern amongst some staff and patients. Many patients have commented about waiting times for treatment and appointments and the traumatic experiences they have encountered whilst waiting for beds. Staff have reinforced concerns of capacity, commenting that they feel extremely stretched and that they do not have adequate expert medical/clinical support during certain hours of the day. Capacity is thought to have resulted in high staff turnover following the transition which is likely a result of low staff morale and underutilised expertise amongst highly skilled staff.

Whilst multiple issues were affirmed, a persistent theme throughout was the praise for staff in terms of the care and treatment that patients received whilst in the care of UHNM. In addition, there were aspects of the transition where staff praised the management of the changes.

RECOMMENDATIONS

Following a thorough analysis of all feedback obtained during Phase 2 of the evaluation of the UHNM transition, the following recommendations are proposed:

Capacity

Regarding capacity, there is evidence of pressure at A&E at Royal Stoke. This is found to be a result of patient transfers and bed shortages in wards, as well as the impact of A&E closure at County Hospital out of hours. That being said, many patients highlighted that the care they received was excellent and that staff were very kind and caring.

Recognising that some time has passed since the initial engagement had begun Healthwatch shared these recommendations with the Trust. The trust confirmed that they have detailed information about where patients come from which shows that the reduction of A&E at County Hospital has not impacted the demand at Royal Stoke. The Trust also claims that reducing A&E waiting times is a corporate priority and their findings suggest that 30% of inappropriate attendances at A&E is impacting upon pressures at Royal Stoke. It is recognised that A&E pressures are a national problem and alternative access to services needs to be addressed by the whole health and care economy. UHNM are currently involved in a pan-Staffordshire programme whereby UHNM are one element with shared workstreams and priorities. The Sustainable Transformation Programme will make increasing access to community care, a key consideration.

Staff feedback also highlighted concerns, feelings of vulnerability and lack of confidence from nurses at County Hospital in Stafford, particularly since the A&E department hours were reduced. The Trust have advised that nurses at County Hospital have always had access to an on call clinician, the Trust now also have an on-site Clinical Director who works alongside the Operational Director to provide visible leadership and support to staff at County Hospital. Findings from this research however suggest that some nurses still feel vulnerable without the presence of clinicians during their shifts and are not always aware of the support that is available.

Whilst A&E pressures are appreciated as a national concern, the following recommendations are proposed in light of the findings in this study:

1. Whilst acknowledging that initiatives have been put in place to look at ways to alleviate pressure on A&E at Royal Stoke through the Sustainable Transformation Programme, continued evaluation and assessment needs to be undertaken to assess

the efficacy and impact of these initiatives and identify further opportunities for reducing demands on A&E services.

   a. Continuously monitor bed capacity and causes of bed shortages and record this information so that measures can be put in place to prevent bed shortages in the future e.g. absence of social workers when patients are ready for discharge.
   b. Recognising this as a weakness that affects the Trusts performance, work more closely with external social workers to provide more timely care plans for patients who are ready to be discharged from hospital
   c. Ensure that patients are fully informed about waiting times for treatment and appointments, including raising awareness of smart phone app for live waiting times.

2. Provide (at minimum) one on-call doctor on site at County Hospital between the hours of 5pm-10pm so that nurses feel less vulnerable and support can be provided in the case of emergencies to avoid patient transfer to Royal Stoke. Also increase awareness to staff of the support that is available to them during this time period.
3. Ensure that all staff are made aware and receive all adequate information about staff integration initiatives and internal communications. Continue to monitor staff experience and highlight any areas of dissatisfaction.
   a. Consider ways of improving staff moral following the transition
   b. Ensure that staff are adequately trained to fulfil their expected roles and that they are fully aware of systems and processes
   c. Ensure that staff skills are utilised to their maximum potential for job satisfaction and suitable use of resources.
   d. Monitor the impact of leadership and development programmes that were introduced in April 2016.

Transport & Parking

Patient and staff experience of the shuttle service was mixed. There was positive feedback regarding the service overall in terms of its benefit for patients and staff travelling between the sites with no other means of transport. Experience of the service users however was less positive with issues being highlighted regarding the cost of the service, the comfort of the bus, the frequency of travel times and the pick-up and drop off points for patients, particularly the elderly or disabled. The Trust confirm that the drop off points for the shuttle bus are at the nearest practical and safe locations to allow buses to stop safely. Whilst this is the most suitable location for drop off points, public

feedback suggests that they are not satisfied with the location of the bus stops and do not feel safe walking from the bus stop to the hospital entrance as previously concluded. There were also concerns regarding the system for booking the shuttle bus and how this accommodates emergency appointments. It was also found that information provided to the public has been inconsistent regarding booking. This has caused difficulties for some patients who were told they could not book onto the bus less than 48 hours before departure when they were only given their appointment 24 hours prior. Feedback suggests that staff traveling from County Hospital to Royal Stoke for training and meetings not only incurs costs to the Trust and is inconvenient for the staff, but takes staff members away from their ward shift for a significant amount of time. The Trust indicated that the shuttle service is designed to offer the best solution for all departments regarding timing and shift patterns. It was said that staff also have the ability to request a taxi when working outside of the shuttle bus timetable.

Other concerns related to the bus service times, awareness of the booking system process, cost of using the service and drop off points for the elderly or infirm. Whilst information regarding financial support for travel has been improved on the website, some patients said they were unaware of what support they can receive. The Trust indicate that they have a volunteer support scheme running at both sites to assist disabled/infirm patients from the car park to the hospital entrance. Healthwatch has received feedback that the presence of attendants and volunteers is not consistent, and suggests that patients are unaware of the support available to them. The Trust have also confirmed that their tariff for the shuttle bus offers a reduced cost when compared to other means of transport between the two sites and that if patients are using the 'Park and Ride' system, then a concessionary parking permit is available. Whilst these concessions are beneficial, some patients still expressed disappointment about the cost of travelling between the two sites which was not a necessary journey before the transition. Patients also expressed disappointment with car parking costs when appointment times are delayed and that there are no discounted permits for frequent/disabled service users. The Trust confirmed that patients are entitled to a discount if delays are a result of overrun clinics which can be processed by visiting the car parking office. From the feedback received in this study however, patients who raised concerns were not aware of the discounts available to them.

Whilst there are measures in place currently such as interactive meetings and training events to alleviate this issue, the following recommendations are proposed.

Regarding the inconvenience and time wasted for staff travelling between sites:

1. Increase the use of interactive tools for meetings and trainings etc. so that staff do not have to travel between sites.
2. Ensure that all staff are aware of shuttle bus times and that the availability of taxis at request. Also continue to monitor staff satisfaction regarding shuttle bus times and how this coincides with shift patterns.
3. Monitor the demand for the shuttle service and assess whether more services should be provided such as having two busses per hour from **each** site, instead of one.

Regarding the accessibility for patients booking onto the system and accommodating elderly or disabled passengers:

4. Ensure that the provision of information about the shuttle bus booking system is consistent to all patients.
    a. If 48 hours' notice is a requirement, provide emergency access for patients with less than 48 hours' notice for emergency appointments.
    b. Provide more accessible information on how to use the shuttle bus, particularly how to book a place or consider removing the booking system process
5. If shuttle bus drop-off points cannot be moved closer to the entrance, consider having a volunteer on all shuttle busses to chaperone elderly/infirm to the hospital entrance with wheelchairs if necessary.
    a. Equip the shuttle bus so that it can carry patients who use wheelchairs
    b. Consider providing a dedicated patient shuttle service using profits from the car park.
6. Consider using telephone confirmation to ensure that patients are aware of the options available to them when travelling to appointments, particularly for people travelling between sites for the first time.
7. Make car park volunteers more visible at both hospital sites and ensure that patients and carers are aware of the support available to them.

Regarding the cost of transport:

8. Raise patient awareness of the NHS low income scheme that can support travel costs for hospital appointments for those who meet the eligibility criteria.

9. Consider introducing a scheme for parking/shuttle bus for the most frequent users of the service so that those with regular appointments can afford to attend them.

Parking was considered an issue amongst some service users, particularly regarding the cost of parking, the impact of treatment waiting times on parking, the number of parking spaces and the accessibility for elderly or disabled patients when travelling with a relative or carer facing parking difficulties. The parking system is found to be confusing to some, with little information provided by staff when approached for assistance. In light of the findings regarding parking and transport, the following recommendations are proposed:

1. Ensure that patients are made aware, during their appointment, that discounts for parking payments are available if clinics are overrun and provide frequent user permits.
2. Consider improving the information disseminated to patients and visitors using the car park by making parking attendants more visible and directing patients to free parking spaces
3. Raise more awareness about the volunteer car park attendants and consider improving the way in which this support is accessed i.e. call for assistance buttons near parking meters.

Communication

Whilst the work that the Trust has already done is acknowledged, both patients and staff still expressed concerns around the level of communication they have had with the Trust during the transition period which meant that they were confused about the location of specific services and the treatment patients were receiving. Communication was considered to be problematic by some regarding patient treatment and discharge, the information disseminated to the public regarding the transition services and to the staff in terms of their job roles at the new sites. Problems were also highlighted regarding the management of patient records and coordination between the two hospital sites which meant that patient treatment was being repeated and consultants were reliant on updates from patients to advance their treatment. It is acknowledged that significant efforts were made by the Trust before the transition to provide information to both staff and the public as to what changes would be made. Feedback since the transition however suggests that patients and staff are still uncertain as to the changes that have occurred, those that are ongoing, and the implications this has on them or how to access relevant information.

Some staff highlighted that internal communication and integration of staff during the transition was poor and sometimes staff were unaware of ward processes and procedures. Internal communications were revitalised in April following an internal survey at UHNM which was distributed both on line and in paper form with over 1200 responses (10% of the workforce). Since this research took place the Trust launched a leadership strategy providing a plethora of training opportunities for staff at all levels and are holding series of “in your shoes” and “in their shoes” public and staff engagement events which will place over the summer. The Trust will be providing Healthwatch with the findings from these events so that Healthwatch can continue to monitor progress.

In light of the findings regarding communication, the following recommendations are proposed. Regarding the information disseminated to patients and the public about the transition of services:

1. Ensure that information that is publicly available to patients has been received and is understood. This could be done by asking patients upon arrival at hospital if they are satisfied with the information they have and if they require any further information as to how the service would affect them. Make sure that the public are aware of where to get information from. If this is the PALS office, ensure that patients are aware of the relevant contact details and opening times.

Regarding the information disseminated to patients about treatment and discharge:

2. Ensure that staff, such as doctors and nurses are communicating with their patients effectively and often enough so that patients are informed about their treatment and how this is affected by the transition e.g. where they will go for their consultation appointments, pre-operative checks, diagnostics and treatment as these may be different.
3. Improve the information provided to patients regarding discharge and the required self-care that must take place to ensure long term recovery

Regarding the communication to staff about the transition and the impact on their job role, recommendations are to:

4. Continuously monitor the satisfaction of staff about the information that has been provided to them regarding the changes and the impact this has upon their job role and expectations.

a. Ensure that staff are fully aware of the procedures for wards that they have not previously worked on and that they are satisfied with the handover they have received.
b. Filter staff email to specific areas/units dependent on its relevance so staff do not miss important information which is diluted in irrelevant communications.
c. Hold workshops to encourage staff involvement in the shaping of services.
d. Review the Integration Champion system to ensure that it is being used as effectively as possible and provide additional support to those in that role.

Regarding the coordination between the two hospitals, it recommended to:

5. Create a comprehensive directory that staff from both sites can use to contact any staff member across UHNM. Ensure changes to the directory can be made easily so it's kept up-to-date.
6. Monitor the impact of the new IT system once installed
7. Ensure that consultants have up to date patient notes so that treatment/tests are not missed or repeated. It is acknowledged that a new IT system is being implemented by the Trust in November 2016. However, in the interim, the Trust must be transparent that there may be set backs with patient records in order to manage expectations.

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APPENDICES

Appendix A- Staff focus group template

UHNM EVALUATION OF TRANSITION STAFF FOCUS GROUP

1. *Before Starting*

- *Ensure the room is conducive to promoting discussions.*
- *Make sure you (the facilitator) set the tone for discussions and put the group at ease*
- *Ensure that every participant is given a chance to air their opinions (including the quiet ones)*
- *Make sure you monitor time closely and allocate enough time to each question.*
- *Inform people that they have a right to leave the group at any time*
- *Set ground rules: switch mobile phones off, everything will remain confidential, only one person to speak at a time, there is no right or wrong answers etc.*
- *Ask if the group are happy to have the group recorded audibly for the purposes of the write up only*
- *Capture all observations including non-verbal body language and morale*

2. Introduction

Activity	*INTRODUCTION*

Guidance	• **Spend no more than 5 minutes on this activity**
	• Welcome the Group
	  ○ Thank them for attending
	  ○ Invite them to sit wherever they wish
	  ○ Remember the points above
	• Introduce the purpose and context of the focus group
	  ○ Explain who ECS/HWS are
	  ○ Explain how the project came about
	  ○ Explain the format and duration of the focus group session
	  ○ Explain how the information will be fed back to UHNM
	• Explain how the information will be recorded
	  ○ Inform them that a note taker will be recording the information
	  ○ Inform them that no names will be recorded or comments attributed to any individuals
	  ○ Assure them that there any audio recording will be used for transcription only and destroyed thereafter
	  ○ Explain how information will be analysed and used
	• Make introductions
	  ○ Introduce yourself and co-facilitator
	  ○ Ask group to introduce themselves
	• Ask if anyone has any questions before you start

Observations	*(Capture questions and observations here)*

3. Semi structured interview script

Question	*HOW WERE CHANGES COMMUNICATED WITH YOU AND DID YOU UNDERSTAND THE CHANGES THAT WERE BEING MADE WITH THE TRANSITION OF SERVICES?*

Guidance	• **Spend no more than 15 minutes on this question**
	• Ensure everyone contributes
	• Prompts:
	  ○ What were the ways in which you communicated? Staff meetings, newsletter, phone call, email or via hearsay?
	  ○ Were you informed in any decision making?
	  ○ How did the transition of services and the way it was managed make you feel?
	  ○ Did it affect your job satisfaction?

Feedback	

Question	*WHAT CHALLENGES DID YOU FACE, IF ANY, DURING THE TRANSITION OF SERVICES, AND HOW WERE THESE OVERCOME?*

Guidance	• **Spend no more than 15 minutes on this question**
	• Ensure everyone contributes
	• Prompts:
	  ○ Communication – was this done appropriately? Were you told in plenty of time?
	  ○ Were you moved to a different hospital site? If so, did you face any issues with transport?
	  ○ Were there any issues with other members of staff, decision making or departments that you needed to overcome?

Feedback	

Question	*OVERALL, WERE THERE ANY ISSUES (POSITIVE OR NEGATIVE) THAT AFFECTED PATIENT EXPERIENCE?*
Guidance	• **Spend no more than 10 minutes on this question** • Ensure everyone contributes • Prompts:

	○ Communication and understandings amongst public? Were service users aware of situation? ○ Transport between hospital sites for new services? ○ Were there any complaints e.g. cancelled appointments and waiting times? ○ Any positive stories of good care e.g. staff, hospital environment etc?
Feedback	

Question	*WHAT DO YOU THINK WORKED WELL WITH THE TRANSITION OF SERVICES AND WHAT DO YOU THINK ID NOT WORK AS WELL?*
Guidance	• **Spend no more than 15 minutes on this question** • Ensure everyone contributes • Prompts: ○ Communication techniques (with staff or public) ○ Management and implementation of transition ○ Patient experiences
Feedback	

Question	*WHAT COULD HAVE BEEN DONE DIFFERENTLY TO IMPROVE THE WAYS IN WHICH THE TRANSITION OF SERVICES WAS IMPLEMENTED?*
Guidance	• **Spend no more than 10 minutes on this question** • Ensure everyone contributes • Prompts: ○ Communication techniques (with staff or public) ○ Management and implementation of transition ○ Patient experiences
Feedback	

Activity	*FOCUS GROUP CLOSE*
Guidance	• **Spend no more than 5 minutes on this question** o Summarise key findings for each question o Seek clarification on any ambiguous areas o Offer a last opportunity to provide any additional comments o Thank them for their support and input o Reassure them that we will keep all info confidential and non-attributable o Inform them of next steps o Leave email / phone number in case they think of anything else of use o Close meeting
Feedback	

Appendix B- Public survey

Thank you for clicking through to this survey. Healthwatch Staffordshire are undertaking some research around the transition of services between the County Hospital in Stafford (formerly Stafford Hospital) and the Royal Stoke University Hospital, as part of the creation of the new University Hospitals of North Midlands NHS Trust. We would very much appreciate your perspectives to the following questions

Top of Form

*1. Please tell us the area you reside in:

- Newcastle-under-Lyme
- Staffordshire Moorlands
- Stafford and Surrounds
- East Staffordshire
- Cannock Chase
- South Staffordshire
- Lichfield
- Tamworth
- Stoke-on-Trent
- Outside of Staffordshire

*2. Which hospital site have you used during the transition of services? (You may tick more than one option)

- Royal Stoke University Hospital
- County Hospital in Stafford

☐ None

☐ Other (please specify)

3. When did you last use services at the County Hospital/Royal Stoke University Hospital?

○ Less than 1 Month

○ 1 - 3 Months

○ 3 - 6 Months

○ 6 - 12 Months

4. Did you feel that you were informed of, and understood, changes to health services at County Hospital and/or the Royal Stoke University Hospital?

5. What would you have liked to have been informed about during the changes?

6. Did you receive the healthcare you needed?

7. Were there any specific issues you experienced or concerns you had? For example, communication, staff attitudes, cancelled operations, treatments, waiting times or hospital environments

8. How would you rate your experience of healthcare at County Hospital or Royal Stoke University Hospital during the transition of services?

- Very good
- Good
- Average
- Below average
- Unsatisfactory

9. How could your experiences of the transition of services have been improved?

*10. Consumer rights involved

- Rights to essential services
- Right to information and education
- Right to be involved

- [ ] Right to access
- [ ] Right to choose
- [ ] Right to live in a healthy environment
- [ ] Right to a safe, dignified and quality service
- [ ] Right to be listened to
- [ ] N / A or No answer left

*11. Key themes

- [ ] Privacy and dignity
- [ ] Confidentiality
- [ ] Equality
- [ ] Consent
- [ ] Safety
- [ ] Choice
- [ ] Complaints Process
- [ ] Opening hours
- [ ] Staff attitudes
- [ ] Falls/Incorrect Handling
- [ ] Communications with staff
- [ ] Staff communication with relative
- [ ] Failure to follow agreed procedures

- [ ] Records management
- [ ] Cleanliness
- [ ] Transport and parking
- [ ] Fees/Charges
- [ ] Appointments delay and waiting times
- [ ] Monitoring and accountability
- [ ] Procurement/commissioning
- [ ] Food and hydration
- [ ] Correspondence
- [ ] Cancelled operations/appointments
- [ ] Inadequate equipment/facilities
- [ ] General practice administration/management
- [ ] Quality of treatment
- [ ] Consultation and service coordination
- [ ] Admissions/discharge
- [ ] Suitability of provider/staff
- [ ] Diagnosis
- [ ] Referrals
- [ ] Service monitoring
- [ ] Suitability of treatment

- [ ] All aspects of clinical treatment
- [ ] Transfers
- [ ] Medication
- [ ] X-Rays/Test
- [ ] Access to information
- [ ] Access to Dentistry
- [ ] Access to GPs
- [ ] Access to Hospital
- [ ] Access to Social Care
- [ ] Health/Social Care Initiatives
- [ ] Car Parking
- [ ] Staffing levels
- [ ] Access to medical records
- [ ] Access to out of hours GPs
- [ ] Access to Mental Health Services
- [ ] Access to Community Care Services
- [ ] N / A or No answer left

Other (please specify)

12. If you are interested in providing more detailed information about your experiences as part of a telephone interview, please leave your name and a telephone number that we can contact you on below and a member of the Healthwatch team will be in touch shortly

*13. Are you interested in finding out more about Healthwatch Staffordshire and becoming a Healthwatch Member or Champion?

○ Yes, I am interested in becoming a Healthwatch Member (finding out a bit more about us)

○ Yes, I am interested in becoming a Healthwatch Champion (volunteer with Healthwatch Staffordshire)

○ No thanks!

14. If you answered yes to the question 13, please provide your name:

Appendix C- Patient Interview Template

UHNM Transition of Services – SERVICE USER INTERVIEW TEMPLATE

This template is designed to:

To understand the service users' experiences of services at County Hospital and Royal Stoke hospital.

To find out what aspects of their experience were positive and what aspects could be improved.

Suggested Steps

- Identify individuals willing to participate.
- Use the prompts below.
- Analyse the information (*ECS*).
- Look at themes, main issues and measure improvements (*ECS*).

Participants are invited to take part in a short interview to help us understand their experiences of the transition of hospital services, particularly with reference to services received at University Hospitals of North Midlands. This will help to highlight the positive and negative aspects of the transition of services, understand individuals' perspectives and identify ways to continue to improve the services.

Insights about patients' experiences will be shared with representatives from University Hospitals of North Midlands. While we may talk about aspects of your experience, you will not be identified in any reports, presentation or papers arising from the project.

Any information that is collected will remain confidential, and will be disclosed only with participants' permission.

If you have any questions about the interview, you can contact the following Engaging Communities Staffordshire representatives:

Sue Baknak:

Email: sue.baknak@ecstaffs.co.uk

Contact number: 01785 221703

Jacob Pritchett:

Email: jacob.pritchett@ecstaffs.co.uk

PLEASE USE BOXES PROVIDED FOR COLLECTING PATIENTS' RESPONSES

QUESTION 1: WHAT SERVICES DID YOU USE?
Supplementary Questions: - **How did you access these services?** - **Did you feel that you could access these services easily? If yes/no, why?** - **How long ago did you use these services?**

QUESTION 2: WILL YOU DESCRIBE YOUR EXPERIENCES OF USING THESE SERVICES, PLEASE?

Supplementary Questions:

- **Staff communication/attitudes?**
- **Staffing levels?**
- **Adequate equipment and facilities?**
- **Waiting times?**
- **Accessibility?**
- **Environment?**

QUESTION 3: WERE ANY CHANGES IN THE SERVICES COMMUNICATED WITH YOU BEFOREHAND?

Supplementary Questions:
- If so, what changes were these? - How was this communicated to you? - Did you like this form of communication? If not, how could it have been improved? - Did you understand? - Did you have any concerns? If so, were they addressed by the staff? - Do you think there are issues that still have not been addressed?

QUESTION 4: WERE THERE ANY ASPECTS THAT WERE PARTICULARLY POSITIVE/NEGATIVE?
Supplementary Questions:
- If negative, how do you think this aspect could be improved? - If positive, would you recommend this service to other people? - Do you have any other suggestions to improve services/reduce negativity? - Have your views changed since the transition? Why/Why not? - Have new issues arisen since the transition of services?

Appendix D- Staff Survey

Thank you for clicking through to this survey. Healthwatch Staffordshire are undertaking some research around the transition of services between the County Hospital in Stafford (formerly

Stafford Hospital) and the Royal Stoke University Hospital, as part of the creation of the new University Hospitals of North Midlands NHS Trust. We would very much appreciate your perspectives to the following questions

Top of Form

*1. Please state your role / job title e.g. admin, clinical, nurse ...

*2. Please provide your contact details (either telephone number or email address)

3. How were changes communicated with you and did you understand the changes that were being made with the transition of services?

4. What challenges did you face, if any, during the transition of services, and how were these overcome?

5. How did the coordination of transition of services and merger of the trusts make you feel? Did it affect your job satisfaction?

6. In your opinion, how did the transition affect patient experience? (Positive / Negative effects, e.g. Appointments, Cancellations, Transport, Service Quality)

7. What do you think worked well with the transition of services?

8. What could have been done differently to improve the ways in which the transition of services was implemented?