

Input into Priorities 2021 – our long list

This is a working document which will be regularly updated as we gather more information and data.

The table below sets out the information and data that have been gathered over the past year and includes information from our internal data collection, Healthwatch England (including the 'Because We All Care' campaign), Local Accounts, feedback from partners, attendance at meetings and so on.

- Column 1 sets out the theme or issue
- Column 2 captures the evidence / source

As we move through the process of priority setting, we will do more work to categorise priorities for example identifying large-scale research projects, task and finish work, or capturing insight to feed into the system. We will also work on understanding the impact we can have and whether this would be on a local, cross-Tyne, regional or national basis.

1. Healthwatch Newcastle/Gateshead issues

Theme / Issue	Why is this important and what evidence do we have?
<p>Data from #BWAC Healthwatch England campaign which we have been part of since the start of the Covid-19 pandemic</p> <p>#BWAC and analysis from our feedback centres</p> <p>For prioritising, for all of these it would be helpful to know how many times it come up under ~BWAC or the feedback centre</p> <p>There is a general theme across much of this about chronic under capacity in the system – appointment delays, access to a specialty – what impact could we have on any of them if we scope the nature of the problem. If we could have no practical effect, are they the best projects to look at?</p>	
<p>Dental services – accessing routine appointments, treatment, and urgent treatment this presumably only applies to NHS dentistry? This needs to be explicit – there are three types of dental access in the market.</p>	<p>Given</p> <ul style="list-style-type: none"> • general shortage of NHS dentistry nationally (since the ‘new’ dental contract a decade or so ago), though not actually so bad here • NHS further restricted/much reduced NHS dental appointments due to Covid-clean requirements <p>We could scope the problem locally, but not sure what we could achieve by way of outcome or impact if we did.</p> <p>(The comment about being offered a private appointment by an NHS dentist needs careful contextualising before being even considered as a basis for a project – we don’t know, for example, that the offer was not made because there were no NHS appts available for a while – don’t want to be sued for defamation!)</p>
<p>Mental health services – access to support and anxiety over impact (impact of what?) over the long term (what does this mean?)</p>	<p>This is a recurrent theme for CNTW.</p> <p>We already know that there is insufficient capacity in the system (locally and nationally) for ‘lower level’ mental health issues like anxiety and depression and IAPT was introduced to help with this.</p> <p>What impact could we have by scoping this? We will not impact capacity directly and cannot really recommend moving resources from other more intense needs to meet these.</p> <p>If this is Covid related, is it about general/non-specific anxiety or more focussed such as debt, abuse, job loss, bereavement, fear of contagion? Would there be benefit in scoping how many people need what? Provision may come from several directions.</p>
<p>Hospital parking availability and charges</p>	<p>This has been addressed by NHS, but not banned as the money is an income stream for non-clinical services/maintenance.</p> <p>We could not influence finding more carparking at any of our hospital sites (too built up) so unlikely to be able to impact availability unless looking to increase some parking for special groups to the detriment of all others.</p>

	<p>Is this current or historical? Charges are at the discretion of the hospital, but NHS guidance was that they should have been waived during Covid?</p> <p>Could we look a bit wider about how accessible the sites are via public transport (all supposed to be reducing car traffic to reduce carbon) and if new bus routes may be an option? Or widening patient transport services (also help taxi firms rebuild!) or using digital to avoid having to go the hospital site at all for some things? All potential solutions</p>
<p>Waiting times and access to NHS 111 service these are two different things for me, and not sure what we would look at.</p> <p>Waiting times presumably refers to appointments – outpatient? GP? consultant? diagnostic tests? by specialty/service area e.g. cancer?</p> <p>NHS 111 is not involved in waiting times – unless we mean the time it takes them to answer the phone</p>	<p>Not sure what this one is asking us to look at.</p> <p>NHS 111 has long been an issue and worse in some places than others which seems to depend on the nature of the owner of the contract (some are staffed with clinical staff, some not).</p> <p>HWE report on NHS 111 due out next week - basically nearly 80% of respondents were pleased with the service. Respondents were largely unaware that they could book hospital/GP appts via 111. What would we want to show and what impact could we have on the service? Promoting the access via 111 on our website, based on HWE, would not require a project.</p> <p>Does waiting times refer to the Covid backlog waiting times? It could all get worse as we come out of Covid if staff take holidays or quit with exhaustion. Large new intake for training this year, but 3-4 year delay before fully competent.</p> <p>We could scope the problem - the trusts already have the data of the delays because they are standard returns to NHS E - but not sure what change we could generate. Might have an impact if we identified specific areas of problems compared to others, but don't want to pit the RVI against QE!</p>
<p>Appointment cancellations presumably this refers to hospital appointments (or does it include GP, dental and opto as well).</p>	<p>Is this a problem across all specialties or are we looking at some specifics such as cancer treatments again or major operations? Would it be covered in the waiting times above as a joint look?</p> <p>This data should be readily available from the two trusts – its standard data collection</p> <p>As above, we could do a comparison between services, but if we scoped it out, what change could we effect, or what impact would we have on generating change?</p>
<p>GPs – access to service and quality of service would need to be clear about what the issues were</p>	<p>How many people at how many practices raised these issues? Need to be clear it is a real problem and not a few upset patients. Need more detail to make a judgement on these two.</p> <p>Does 'access' mean that people can't get GP support, or that they don't like phone consultations or accessing online? Different problems to address and potential different recommendations. Very different experience in different practices using different provider models – have suggested this before and could be beneficial to recognise good practice/models/companies and how it fits with different patient demographics. Digital access is certainly not going away and will grow under 'co-operation' under ICS and 'place'. Some interesting examples already out there. Also</p>

	<p>a discussion on HWE re face-to-face by patient choice not need – not seen as returning any time soon, and online systems to triage are seen as here to stay.</p> <p>Does the 'quality of service' mean the standard of care has gone down (poorer outcomes, personal attitudes are changed?) or that they don't like the access issues, or the answers they get?</p>
<p>Young People / children From 'Don't Box Me In' internal research (see N&G project report)</p>	
<p>Access to NHS? Dentistry</p>	<p>Are issues here different for children to the adults above? if so, what are they?</p>
<p>Access to information to enable decision-making and responsibility for own care</p> <p>These issues are generic and not just related to children.</p> <p>Shared/informed decision making (patient with clinician) and self-managed care (taking responsibility for own care) will be big areas for development in the future and under ICS.</p> <p>Whole libraries about all of this and developments over the last decade.</p> <p>Have suggested both these areas (for adults) before and they were also mentioned by the CCG at the engagement meeting on Monday</p>	<p>Accessing information has potential for big impact both for general health care information and self care agenda. Informed joint decision making (SU and clinician together) is a target for NuT this year.</p> <p><i>In general</i></p> <p>Information per se was on last year's list for Gateshead as 'accessible information standards'. It is also an issue re health (and general) literacy to understand searching and also understand what is found (committee applicants were hot on this)</p> <p>Past HW projects have repeatedly brought 'lack of information' up as a need– usually, a lot of good information is in fact available online and in paper format on request (comprehensive, reader friendly, good presentation, multilingual, etc.), but service users are not aware of it or how to find it (digital literacy, access to appropriate IT). It seems many practitioners don't know either.</p> <p>At a general level as well as CYP specific, could run an audit of what is actually available (on line? on paper?, where, from whom) for at least some areas of care (NHS, charities, etc), as well as the standard of the material. Look at how its handled/handed out by health services? Role of parents – enabling them, how they manage information and their child? Parents allowing their child to make decisions is probably beyond our scope.</p> <p><i>Re informed and/or joint decision making</i>, one outcome of a research project in Newcastle a few years ago, as part of a bigger NHS initiative, and was a whole library of decision aids. Current resources are all at https://www.england.nhs.uk/shared-decision-making/guidance-and-resources/. For children this could involve both the child and the parent in any decision and choice of options.</p> <p>Self managing care (taking responsibility) may be a YP themselves or as a 'unit' with their carer. It was part of 'patient activation and engagement', and to some extent the expert patient programme.</p> <p>Not sure what outcomes and impact we would be hoping to achieve in practice.</p>

	<p>Could scope out good practice and build it in as a 'service' from Healthwatch to signpost good sites? Could develop 'health literacy guides' about how to find and understand information? Briefing papers in multi languages? Student engagement? Co-production (enhanced engagement) with some specialist groups?</p> <p>Likely to highlight skills needs and time needs for a practitioner to do effectively.</p>
<p>Issues with autism diagnosis — misdiagnosis, blaming (who/what?), paperwork barrier, lack of awareness of the GP referral route (by whom?)</p>	<p>Don't know how many people this would apply to – the size of the problem (suggested about 1-2% of the population?)</p> <p>Difficult to get a handle on autism and ASD because it covers so many things and the issues cited are also variable.</p> <p>Diagnosis/misdiagnosis is a clinical training issue – who (apart from experts) has done it and who should do it and at what level? – awareness/recognition, when to refer and how, making a diagnosis, ongoing management? We could highlight gaps, and at best we could recommend levels of training per practice, but low prevalence and diversity makes this more difficult to handle.</p> <p>The GP referral route is also a training issue – for whom though? Service users? GPs? Different approach for each? Back to information sources?</p> <p>Looking at barrier issues may be helpful, but actual and service user perceived blockages may be very different.</p>
<p>'Lost in Translation' internal research (see report)</p> <p>looked at Arabic translation services for people associated with a housing company in Gateshead</p>	
<p>Translation Services – access, service provision, waiting times</p> <p>Presume this means for during a consultation?</p> <p>Is this in relation to health or social care or both?</p>	<p>This has also come up before, particularly with refugee/asylum seekers (about 480 in Newcastle) and European nationals - presumably still the focus here. The biggest need (number) is probably still with long resident families who have difficulty with English. No idea how many service users would be involved or how many languages (and variants) would need to be considered (about 6,500 languages spoken in the world).</p> <p>There are now a lot of app-based translation services available via internet – used for holidays and so forth as well as professionally. Many service providers now use on-line language interpreter services, either with a standard library of phrases, or live online access to a human interpreter (QE, RVI, some GP practices), which will potentially reduce the need for in person interpreters, and allow for a wider variety of languages to be covered. These have IT requirements, but presumably they can be met in part by the clinician and computer.</p> <p>There are often issues with the clinical knowledge of interpreters to be able to translate and explain issues to the service user in their own language – fluency is not enough on its own. Sometimes their English fluency can also be a barrier.</p>

	<p>There will still be issues about availability for live interpretation, but scoping the size of the problem could help focus on what languages are needed and how many interpreters are needed. Its also episodic work which makes scheduling complex.</p> <p>It could also lead to the development (co-production again?) of information sheets/infographics to help go through common problems and responses – need to scope what is already available.</p> <p>Some idea of good practice re reputable on line services to use or booking interpreters could be helpful (if not already out there).</p>
<p>From attendance at meetings and Voluntary Community Sector input</p>	
<p>Access to routine? Annual physical? GP? Health Checks for people with a Learning Disability</p> <p>Implication is that people do not get the health checks?</p>	<p>Don't know how many people this would involve. (See also health checks for carers below). All over 40s should also be offered well person checks.</p> <p>Not a <i>requirement</i> for GPs to offer, but can be requested if not offered. May not be relevant to all e.g. if seen regularly for other ongoing conditions by clinical services.</p> <p>Depending on numbers, could have a major impact on workload if rolled out to all.</p> <p>Could scope which GPs do/do not and why, but can't make non-providers do so on a recall basis, so difficult to see what impact we could have here. NHS guidance is quite clear.</p> <p>More difficult to look at what difference it would make in terms of identifying issues earlier, or early intervention</p>
<p>Feedback for attendance at meetings</p>	
<p>Access to health services for homeless people and asylum seekers and refugees</p> <p>Does this tie in with translation issues above?</p>	<p>This applies to a small number of people especially compared to some other issues above. (63 homeless, 480 asylum seekers/refugees in Newcastle)</p> <p>It's a topic we have looked at before and a lot of the issues came back to information needs and health literacy (see above)</p>
<p>Individual feedback to staff</p>	
<p>Pathway for podiatry</p>	<p>Podiatry has been an issue for a while - there is a shortage of podiatrists. For a while there was an issue with training provision and clinical placements, but should have been resolved a few years back. Doesn't mean enough people want to do podiatry.</p> <p>CCGs have the option to commission podiatry services or not. NIHCE guidance recommends footcare services related to long-term conditions such as diabetes, peripheral arterial disease and rheumatoid arthritis should be available on the NHS. NGCCG commissions services for Gateshead from North East Podiatry.</p>

	<p>Treatment may be provided free depending on how serious a condition is – if health or mobility is not impacted, not likely to get free treatment and must arrange privately. All NHS referrals must go through a GP.</p> <p>Service model is similar to opticians or dentists where even if commissioned, patients pay for treatment.</p> <p>Not sure what we could affect by scoping this one out. What would we be trying to achieve?</p>
<p>Individual feedback following inpatient with severe nut allergy being given food containing nuts</p>	
<p>Approach to allergies in healthcare settings – what do individual settings do, what is good practice (e.g. coloured patient bands)</p>	<p>Not sure how big a problem this is – sounds like a big problem for one unfortunate person.</p> <p>Could check policies and procedures and frequency of such as issue coming up, and or good practice recommendations if necessary.</p> <p>Trust should have looked at this one incident as a never event or as a significant event audit – what would we add?</p>
<p>Healthwatch business</p>	
<p>Patient and public engagement</p> <p>Like many organisations we are thinking ahead and want to understand things like:</p> <ul style="list-style-type: none"> • What have we learned about engagement over the past 12 months? • What will we keep doing? • When will people feel confident about coming together for focus groups, conferences etc? • Who has been left behind / disadvantaged? 	<p>This is routine internal company business and should go on anyway as part of normal business practice.</p> <p>I have been suggesting ‘projects’/‘objectives’/‘targets for both Comms and engagement and this would seem to fit with that.</p> <p>It ties in with those vital comms and engagement strategies and policies we need to develop.</p>
<p>Responding to place-based approaches to work</p> <p>Gateshead and Newcastle are both moving to place-based / locality ways of working.</p> <p>How might Healthwatch Gateshead and Healthwatch Newcastle need to respond?</p> <p><i>A place-based approach targets an entire community and aims to address issues that exist at the neighbourhood level, such as poor housing, social isolation, poor or fragmented</i></p>	<p>‘Place’ is a fundamental concept to ICS so something that is happening across the NHS, not just here. G&N may end up in the same ‘place’.</p> <p>This is something TUN/HW should be doing as part of business development (would feature highly on a PEST and SWOT), not a HW project as consumer champion. Likely to be highly relevant in responding to the next tender iteration. Also, a lot of guidance coming out on HWE covering the roles of HW in ICS and new Health White Paper environment that provide guidance.</p> <p>Don’t think this should be a project priority for HW. Using projects for internal business will dilute what we can show we have achieved to our commissioners in support or a new tender.</p>

service provision that leads to gaps or duplication of effort, and limited economic opportunities. PCGs revisited!!

2. Other ideas (TB)

<p>Carer support e.g. personal health checks for carers</p> <p>Identified as an unmet need when looking at housebound patients - carers needs only assessed in respect of the person they care for.</p> <p>Also ties in with NIHCE quality standard now out for consultation – potential to become hard guidance.</p> <p>Higher need for the overstretched carers during and post Covid</p> <p>GP QOF target</p>	<p>Scope how widespread the checks are and how effective.</p> <p>Perceived benefits (carers and providers)</p> <p>Do they follow the NIHCE guidance?</p> <p>Barriers to getting the check (e.g. can't leave care)</p> <p>How can they be improved.</p> <p>What needs to change locally?</p>
<p>Health literacy</p> <p>A frequently raised concern about service users ability to access information that would help with using services and with looking after themselves or others.</p>	<p>Also discussed above under information needs. Big implications</p> <p>Could look at who knows what and how they access stuff – different parts of the system, different service user groups.</p> <p>What people want and why (could be culture/age specific, for example). Barriers to access (e.g. privacy concerns, IT issues)</p> <p>Could work as a developmental project and/or co-production of support materials for the website – and to share with others.</p>
<p>What are the mental health needs coming out of Covid?</p> <p>There is a lot of talk about there being needs, but less about any detail or provision</p>	<p>See also mental health issues above.</p> <p>Scope areas of need (see above) and how best to meet those needs – type of service, provider etc.</p> <p>How could the greatest number be best helped? By whom, including self-help.</p> <p>Community engagement project?</p>
<p>Care leavers support/transition</p> <p>Long been an issue for young people and how they are supported to make the transition for a care setting to independent living. Under Covid this seems to have been made worse with homelessness resulting.</p>	<p>Scope out what should be done and work with young people about their and their friends experiences and how the system should/could be improved, who should be involved, etc. re good practice.</p>
<p>Use of digital technology to support health service delivery and self-care</p>	<p>See also access and GP services above</p> <p>Opportunities are mega huge and especially with the sophistication of modern smartphones, FitBits (or equivalent), and other technology.</p>

<p>This has essentially arrived so how can it be used most effectively – it will not be an option going forward</p>	<p>Whole agenda showed quality gains but were not largely picked up. Covid has kick started the ambitions in the health legislation and past surveys HW has done for HWE/NHS.</p> <p>Could review what is in use locally and how well it serves people and how to sell the benefits as ICS rolls out</p>
<p>Social prescribing</p> <p>Now incorporated into the role of PCNs, so one to look at across the city (LY project in Newcastle Outer West evaluating the Ways to Wellness research project and its reception)</p> <p>Part of the self-care and self-help agenda</p>	<p>Look at what is being included, how it is being managed (e.g. need for link people and their role and employment), how it is funded, who can benefit (e.g. in less deprived areas of Newcastle)</p> <p>Look at a good practice guide and suggestions for improvement.</p> <p>Also ties in with 'place' as there will have to be commonality or cross sharing for equality</p>
<p>Priorities/objectives for communication and engagement</p> <p>to bring them in line with the other areas, and to provide targeted focus for increasing impact in these crucial areas</p>	<p>Company business so suggest as work for the relevant managers, not as one of the annual projects.</p> <p>Evaluation of contacts and effectiveness of practice over the past year, evaluation of our recent adpption of social media – uptake, outcomes, effecivenss. comparison to others?</p> <p>Look at what to build on and what to scrap, where to innovate and where to adopt</p> <p>To inform comprehensive strategies and polices for TUN/HWN/HWG</p>

3. Statutory organisations

Theme / Issue	Why is this important and what evidence do we have?
<p>CNTW NHS Foundation Trust - Quality Account 2019/2020</p> <p>Would be concerned that we were being asked to do the audit or research work for the statutory services that they should be doing for themselves for service information. The have cited 'areas of concern', but not what they would be asking us to do, or to what purpose.</p>	
<p>Out of area bed usage on adult and older people's mental health wards</p>	<p>This is data the trust should already have on computer – what are they asking for? To what purpose? What impact would any work of ours have?</p>
<p>Waiting times for adult Autism Spectrum Disorder diagnosis service</p>	<p>This is data the trust should already have on computer – they know who is on the waiting list and when they went on the list.</p> <p>What are they asking for? To what purpose? What impact would any work of ours have?</p>
<p>Waiting times for adult ADHD diagnosis service</p>	<p>Ditto</p>
<p>Waiting times for the Gender Identity Service are also an area of great concern</p>	<p>Ditto</p>
<p>Gateshead Council Children's Adults and Families Director's response to request</p> <p>Would these projects, if prioritised, be just Gateshead?</p> <p>Not sure how many potential beneficiaries there might be for any of these areas – could affect priority rating.</p> <p>Too little information about what they might be looking for to do any sensible prioritisation on these. Would be guessing.</p>	
<p>Qualitative experience of ASC during the pandemic (especially as the Adult Social Care annual survey was not undertaken this year)</p>	<p>Does this mean 'please will you do the ASC annual survey for us because we didn't do it this year'? Issues with access to any potential respondents?</p> <p>Do they want to explore ongoing care or new entrants?</p>
<p>Residential care – understanding what has changed through the pandemic.</p>	<p>Difficult with little access to care providers during Covid and potential issues of access as they are not statutory organisations.</p> <p>Also it has been changing throughout – look at it historically (how it has been) or how it is now or how it will be in a few months? Structure, process or outcomes? Latest change is allowing family to visit in person, which will need to be evaluated for its health and happiness impact as well as infection rates (automatically tracked by CCG)</p>
<p>Assistive technology/technology enabled care.</p>	<p>What aspect of it? What's available? What's being used locally (in social care in Gateshead?) and how successful it was? Assistive tech is a huge field, even before technology is included.</p>

	<p>Some good models for telecare, its potential benefits in promoting independent living and all that. Don't know what systems Gateshead has in place.</p> <p>See also below</p>
Digital offer (including online access to services/remote assessments)	<p>This ties in with the digital access and consultations for GPs mentioned above.</p> <p>Are they looking for an audit of what was used and how, or a service user evaluation of 'how was it for you?' What would they want us to achieve?</p>
Vulnerable young mothers – the offer in terms of mother and baby placements	<p>What do they want evaluated?</p> <p>Again, from what perspective – Availability? Suitability? Safety? Area? What people wanted vs. what they got?</p>
Non-accidental injuries for babies and young children	<p>Not sure what we could do with this one – comes under safeguarding which has its own investigative services.</p> <p>Don't see what we could do or how we could affect change</p>
Learning Disability accommodation offer	<p>What would they want to look at exactly? what was available, what the clients thought of it? the support that was offered and how well it worked? Looking at individual accommodation providers? Use of tech assistance to independent living?</p>

From Healthwatch Newcastle Prioritising 2020

Choosing a priority

1. Is it a statutory duty or requirement (including HWE initiatives we engage with)?
2. Does it meet a Healthwatch strategic objective?
3. Would it be a viable research project?

Additional criteria added in during discussion

1. What changes (outcomes) are we hoping to achieve?
2. Could our work make a difference/have an impact?
3. Is it evidence based? (where relevant)
4. Does it have SMART objectives?
5. Is it specific to Newcastle or common - should we consider doing it in partnership with others (e.g. Gateshead)

We should

- do projects that will have a significant potential for outcomes and impact –
 - greatest degree of change (improvement) for the greatest number
 - big significant impact for a small number
 - smaller change but for a big number of people
- not collect data which just further supports what we knew about anyway
- not collect data that just quantifies a problem we can do nothing to influence such as short staffing

In essence – do what, why, and can we make a difference?