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HEALTH AND SOCIAL CARE IN BUCKINGHAMSHIRE

Report on Phase 2 of Public
Engagement for Buckinghamshire
Integrated Care Partnership

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Date: January 2021

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Acknowledgements

We would like to express our thanks to the Buckinghamshire Integrated Care Partnership for commissioning this engagement exercise and for their help in carrying it out; in particular, thanks go to Dan Leveson, Kim Parfitt, Lesly Clifford and Dee Irvin.

We would also like to say thank you to the people who participated in the engagement and to the people and organisations who helped us to recruit them.

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Verve
January 2021

1. EXECUTIVE SUMMARY

This document reports Phase 2 of engagement undertaken by Verve on behalf of Buckinghamshire Integrated Care Partnership.

83 people took part in engagement exercises comprising online focus groups and one to one interviews by telephone, zoom or email. The fieldwork took place between 25th November and 21st December 2020.

This Executive Summary draws together the main findings from Phase 1 (survey) and Phase 2 (qualitative research) of this engagement.

DIGITAL APPOINTMENTS

Most people who had experienced digital appointments were positive about their experiences. There was a tendency for younger people to be more accepting of digital appointments. The main concern people had was a desire to be seen in person, especially when an examination is needed.

Participants raised concerns that account needed to be taken of people who did not have, or could not use, technology.

There needs to be clarity from professionals about how appointments systems are running and when and how people can have in-person appointments so that people understand what is available to them.

Reasonable adjustments need to be made regarding digital appointments for people with some disabilities and for people for whom English is not their first language. Consideration also needs to be given about how to ensure that people without the means of having digital appointments are not excluded.

DELIVERY OF SERVICES AND KEEPING PEOPLE SAFE

There could be better understanding of how NHS111 works. Although people were fairly familiar with the service there was a lack of understanding about why there were so many questions which did not seem relevant to their call. More information could be available to the public about how the system works.

Consideration should be given to making reasonable adjustments to NHS111 for people with some disabilities (such as deafness or speech impairments) and those for whom English is not their first language.

People were generally receptive to the idea of travelling further for earlier appointments. Phase 1 (the online survey) of the engagement suggested that older people were less likely to be willing to travel than other age groups. Phase 1 did not ask whether people had their own transport.

Phase 2 found that rather than age being the main barrier to travel, it was access to their own transport that was the main barrier. Service providers should ask about transport when considering whether to refer patients out of county.

A further consideration relating to attending appointments out of county was how patient records would be accessed if different systems were used.

People who lived nearer to High Wycombe than to Stoke Mandeville expressed strong views about the lack of an A&E at Wycombe Hospital. The ICP should consider providing compelling and credible reasons for the locations of A&Es in the region and in the county.

COMMUNITY HUBS

Community Hubs were not well known, but the idea was well received.

66% of the Phase 1 survey respondents said they would prefer to recover at home rather than in a hospital, if it was safe. The survey did not explicitly ask about discharge from a hospital into a community hospital. Phase 2 participants' views were that beds in community hospitals were necessary, whether they were Community Hubs or not, to provide care for those who could not be discharged from hospital to their homes; the people we talked to said that community beds should be returned to Marlow and Thame community hospitals.

Some people from areas of deprivation suggested that Community Hubs should be in areas of most need.

Further engagement with people who had used these services could help develop a patient driven model of the routes into and out of hospital care based on experience.

HEALTHIER LIFESTYLES

The majority Phase 1 survey respondents said they would like healthier lifestyles, and people said they were receptive to professional advice about improving their lifestyles. Phase 2 respondents queried whether public health campaigns are effective in persuading people to make lifestyle changes unless policy changes went hand in hand with advice.

The public may need to be convinced that suggested lifestyle changes work and that current advice is better than that which has gone before.

Participants in Phase 2 generally held the view that early intervention with children and young families might be a better use of campaigns.

EFFECTIVE COMMUNICATIONS

In Phase 2 people gave their views about the most effective ways for ICP to reach the largest number of people. There was agreement across the board that multiple communication

methods would be needed to ensure wide coverage. Important messages needed to be sent from trusted sources.

Participants in Phase 2 welcomed the chance to take part in the engagement exercise. Consideration should be given to how to engage a wide and representative sample of Buckinghamshire residents in the future to enable the public voice to be heard in the planning of services.

RECOMMENDATIONS

1. We recommend that the ICP considers how it might have regular contact to keep residents up to date on plans, and to consider how urgent communications might be made.
2. The ICP should consider how it can gather data on people's preferences for communication.
3. We recommend that the ICP in general and especially GPs communicate with Buckinghamshire residents about how services work and about any changes that are needed. Effective communication is likely to ensure that residents feel informed.
4. We recommend that more publicity is put in place about the services offered by Community Hubs. Engagement with people who had used Community Hubs and community hospitals could help using a human centred design approach to develop a community pathway.
5. We recommend that the ICP continues to engage with the residents of Buckinghamshire to ensure their involvement in the planning of future services.

2. INTRODUCTION

Buckinghamshire Integrated Care Partnership (ICP) comprises organisations who deliver and commission mental health care, social care and physical health care in Buckinghamshire¹.

The population of Buckinghamshire is growing. There are projected to be approximately 75,000 more people living in Buckinghamshire by 2030 (a 14.4% increase from 2018). There will be over 50% more people aged over 85. People are living longer but not all these years are in good health. 1 in 5 adults are physically inactive, 2 in 3 adults are overweight or obese, 1 in 9 adults smoke and 1 in 5 adults drink harmful levels of alcohol.²

Analysis shows that starting from birth and continuing throughout life, people living in the most deprived areas have poorer health – with people in the most deprived areas having the worst health outcomes. In the most deprived areas, there is higher prevalence of low birthweight and infant mortality, higher levels of long-term conditions, lower uptake of health screening and higher rates emergency admissions. Further, in these areas the premature death rate (deaths under 75) is twice that of the least deprived areas.

Buckinghamshire ICP needs to consider how services will be delivered in the future to meet health and care challenges. With these things in mind the ICP has begun a programme of engagement with Buckinghamshire residents; the first phase of the engagement was an online survey which received 2818 responses and was reported in late 2020; for the second phase of the research Buckinghamshire ICP commissioned Verve to undertake a co-design workshop with stakeholders and focus groups and interviews with residents of the county asking about a range of topics about health and social care services.

The work was designed to complement Phase 1 of the engagement. Phase 1 was a survey which gathered data from over 2,800 responses; the majority of respondents were White females with an average age of 60. Phase 2 was designed to actively seek representation from a diverse range of Buckinghamshire residents, especially groups who are not often reached by such research, such as people living in areas of deprivation.

Only one Phase 2 respondent had completed the survey for Phase 1, the rest saying that they had not heard about it – they said they did not follow Buckinghamshire Council or Buckinghamshire Healthcare NHS Trust on social media.

The topics covered in this phase were similar in nature to the questions in the survey which comprised Phase 1 but allowed more depth of understanding of people's views. This phase was also designed to boost the involvement of groups who were underrepresented in the survey.

¹ The health and social care partners are Buckinghamshire Clinical Commissioning Group, Buckinghamshire Healthcare NHS Trust, Oxford Health NHS Foundation Trust, FedBucks (a group of GP practices), Buckinghamshire Council and South Central Ambulance Service NHS Foundation Trust.

² Data from Director of Public Health Report

As the work took place between 25th November and 21st December 2020 COVID-19 restrictions were in place and in-person meetings were not possible. The co-design workshop, all of the focus groups and some of the interviews took place online using Zoom; most of the interviews were carried out on the telephone but two were undertaken by email for people who had disabilities which precluded them using Zoom or the telephone.

2.1 RECRUITMENT STRATEGY

Our initial strategy to invite people to take part in the engagement was twofold: to make use of contacts which the ICP already had of their stakeholders (to invite stakeholders to the co-design workshop and to work with them to recruit people known to them to take part in the wider engagement) and to use the Resident Panel which had been recruited approximately eighteen months before the engagement started.

We emailed and telephoned a list of 21 community groups supplied by the ICP, and members of the ICP emailed a further 11 community groups with whom they had personal contacts and various stakeholder groups.

To boost our initial strategy, we generated a list of other community groups in the county and contacted them by email or telephone to ask for their help in recruiting people to the groups and interviews.

The Resident Panel contained approximately the details of approximately 1400 people who had agreed to have their details kept on file so they could be contacted for research. Prior to this engagement we believe that the Resident Panel had been contacted to ask them to take part in a survey. We would recommend that the Resident Panel list should be validated and updated for future use.

In total eighty-three people participated in the research, and to recruit these we made over 450 telephone calls and sent almost 700 emails.

To gain views from as wide a variety of people and ranges of views as possible the following types of people were particularly targeted for recruitment:

- People under the age of 24
- People over the age of 75
- People from BAME communities
- People with disabilities
- Carers
- People from LGBTQ+ communities
- People living in areas of deprivation.

A focus group for people was held for each of these characteristic groups and a further five focus groups were held with a mixture of people from these characteristic groups and people

who did not fall into any of the groups. Some people represented more than one characteristic group. 24 interviews were also undertaken with people who could not take part in focus groups.

2.2 DEMOGRAPHICS OF PARTICIPANTS

Monitoring data was collected when participants were recruited. We sent out two forms to all participants after they had taken part in the research – one collecting demographic data and one giving an evaluation of their experience of the research process. This section gives data derived from the recruitment process as it is more complete than the forms returned by participants. All demographic details can be found in the Appendices. Further demographic details can be found in the Appendices.

Of the 83 participants 59 people told us their age (24 preferred not to answer this question):

Age Group	Number of participants	% of all participants who gave age
16-24	3	5%
25-34	5	8%
35-44	7	12%
45-65	7	12%
55-64	11	19%
65-79	23	39%
80+	3	5%

51 females and 32 males took part in the research.

The 83 participants had the following characteristics:

	Number	% of all participants
People with disabilities or long-term conditions:	28	34%
Carers:	23	28%
BAME:	21	25%
LGBTQ+:	6	7%
Living in areas of deprivation³:	34	41%

Note: Adds to more than 83 (100%) as some people represented more than one characteristic group

³ This was determined by partial postcode data supplied by Buckinghamshire ICP and areas of deprivation identified in Buckinghamshire's Joint Strategic Needs Assessment

2.3 METHODOLOGY

2.3.1 TOPIC GUIDE

A topic guide was designed for use in all the fieldwork, in collaboration with the ICP. It reflected the topics used in the online survey which comprised Phase 1 of the engagement. A copy of the topic guide and an explanation of how topic guides are used can be found in the Appendices.

2.3.2 FOCUS GROUPS

Twelve focus groups were held using Zoom. Between two and eight people attended the groups which lasted approximately 90 minutes. Details on the groups can be found in the Appendices.

2.3.3 INDIVIDUAL INTERVIEWS

Interviews were offered to people who could not take part in focus groups. Twenty-four interviews took place – 2 by email with people with disabilities (one deaf and one who could not speak), 2 by Zoom for people who preferred that method and 20 by telephone. The interviews lasted approximately 60 minutes.

2.4 QUALITATIVE RESEARCH AND ANALYSIS

2.4.1 ABOUT QUALITATIVE RESEARCH

It is important to note that the methods employed in this research were qualitative in nature. This approach was adopted to allow for individuals' views and experiences to be explored in detail. Qualitative methods neither seek nor allow data to be given on the numbers of people holding a particular view or having a particular set of experiences. The aim of qualitative research is to define and describe the range of emergent issues and explore linkages, rather than to measure their extent.

2.4.2 ANALYSIS

All focus groups and interviews were digitally recorded with the participants' consent.

Qualitative data is rich and detailed. The primary aim of any analytical method is to provide a means of exploring coherence and structure across the accounts given in focus groups and interviews whilst remaining true to the narratives and intentions of the participants.

The method used to analyse the data produced by this engagement exercise involved summarising the data from recordings and research notes according to the themes of the topic guide and then identifying features within the data, for example, looking for similarities and differences between people with different characteristics, comparing and contrasting their perceptions, accounts and experiences.

Verbatim quotations are used throughout this report to illustrate points made; such quotations are referenced by focus group or interview number.



2.5 ABOUT VERVE

Verve is an independent full-service agency which supports organisations in engaging with members of the public.

The remit for this piece of work was to hold a workshop with stakeholders to co-design the work, and then to conduct twelve online focus groups and twenty one-to-one telephone interviews to engage with residents of Buckinghamshire about health and social care services in the county.

2.6 THIS REPORT

This document reports on Phase 2 of the engagement exercise and has been produced independently by Verve. Phase 2 was qualitative in nature. Many of the topics covered in this phase were similar to the questions asked in the Phase 1 survey. Where there are data from Phase 1 which relate to the findings from Phase 2 these are shown in boxes in the relevant sections.

3. CO-DESIGN WORKSHOP

A stakeholder workshop was designed to allow input from a wide group beyond the Integrated Care Partnership in the design and planning of the resident engagement process.

ICP partners invited their stakeholder contacts to attend a Zoom workshop hosted by Verve.

Verve organised and chaired the co-design stakeholder workshop and undertook the recruitment of participants, the fieldwork for the project and the analysis and writing up.

Sixteen people responded to the invitation and seven attended the workshop. Attendees represented patient participation groups, Healthwatch Bucks, a hospice volunteer and a director of a music therapy not-for-profit organisation. Several members of the ICP also attended the workshop.

Brief presentations at the beginning of the workshop covered:

- A brief background to Buckinghamshire's integrated care system
- Information about how COVID-19 had impacted on services, and
- An explanation of the ICP's engagement strategy

The rest of the workshop was a discussion by participants. Participants gave information about the sorts of issues they had heard from their own groups and made suggestions about the types of information which might be gathered from the upcoming engagement.

Suggestions were made about how to reach people to ask for participation in the engagement, including asking for input from community groups, contacting people by post (if their addresses were known), joining Zoom groups which had been arranged by others, and, if COVID restrictions lifted during the course of the engagement, visiting community groups in person.

Participants agreed to be contacted again by Verve during the recruitment process if their help was needed.

4. FINDINGS

This section presents the findings of the fieldwork undertaken for this engagement exercise. The findings are given in sections: digital appointments, keeping people safe, community hubs, healthier lifestyles and preferences for communication.

Where the data from the Phase 1 survey relates to the findings from Phase 2 these are presented at the start of each section.

4.1 DIGITAL APPOINTMENTS

Survey data on appointments:

- Most digital appointments were with GPs
- Generally, people were satisfied with the appointments they had had but satisfaction fell for older people
- Most people said they were willing to have digital appointments in the future, but willingness was less amongst older people
- The major concern people had was the inability to be physically examined

Digital appointments are deemed to be any appointment which takes place on the telephone or by video.

Most usually respondents had experienced telephone appointments with their GPs; some had had telephone appointments with hospital consultants, physiotherapists or nurses and a small number of people had had video appointments, usually with hospital consultants – these often were with dermatologists who wanted to be able to see a skin condition.

For many people digital appointments had worked well, especially for follow up appointments. People felt less confident about diagnostic or first appointments, which they felt should be done in person to establish a diagnosis and a relationship with a service provider.

Video appointments were deemed to be a better option by many – even though there were fewer experiences of them. Seeing the person they were talking to appealed to people, and they felt that there was more chance of picking up nuanced information about how people were.

Concerns raised included not being able to be examined by healthcare professionals, issues around missing non-verbal signs and signals and having digital appointments established as the norm for the future. People feared that they would not be able to see health and social care professionals in person in the future.

For some people articulating their concerns and symptoms in digital appointments was difficult, in particular when they were doing so for someone else – for example someone they cared for or a

child – and these people felt that having a face to face appointment was easier as a health professional could see the patient and ask questions based on their look and demeanour.

For some people with disabilities digital appointments were difficult – for example people who were deaf and those without speech; people in this category did not know how they would be able to access digital appointments, unless someone else could help them. Similarly, some participants worked with people with little or no English and said that digital appointments would be very challenging for their clients unless they had someone with them to translate, but this raised issues around confidentiality.

When talking about digital appointments people discussed the fact that COVID-19 had necessitated sudden changes to how they were offered appointments with their GPs and, for some, with hospital consultants, physiotherapists and social care providers. None of the participants had received information from their GP surgeries about how digital appointments would work, or whether or when they might be able to see a healthcare professional in person.

Whilst people understood that during the pandemic there needed to be precautions taken there was confusion amongst GPs' patients about whether they could have an in-person appointment, with some people assuming that they could not. Participants were unclear how GPs were working, or what services they were delivering during the pandemic, with many saying that they had found it harder than usual to get any sort of appointment with a GP. Generally, patients did not like having to discuss their medical needs with receptionists (now called Care Navigators in some surgeries) before they could speak to a doctor or other health professional; they questioned why this was necessary.

4.1.1 WHAT WORKS WELL

Some participants said that they liked the flexibility of digital appointments, meaning that they could be at home or at work whilst waiting for an appointment, and that they felt relaxed when talking to a health or social care professional because they were in their own environment.

One person said:

"I had a telephone appointment with my GP and it worked very well. I didn't feel rushed. I spoke to the GP and he called me in for a follow up the next day." (FG01)

Digital appointments worked well for people with learning disabilities and autism. One participant who worked in this field said that her clients found digital appointments less stressful than attending in-person appointments, especially when the clients know the professionals they are talking to.

A person with mental health issues said that she liked the option to keep herself 'hidden' on video calls with her therapist, but she thought that in-person meetings were better for bonding with health and social care professionals.

Generally, people felt that digital appointments worked best when they were talking to a health or social care professional they already knew about a condition that had already been diagnosed.

4.1.2 PROBLEMS WITH DIGITAL APPOINTMENTS

People worried that digital appointments were not suitable for all health and social care situations. Generally, participants had concerns that not enough account had been taken of people for whom digital appointments would prove difficult or impossible – for example, those who did not have, or could not use technology, people with disabilities which precluded them using telephones or video calls and people with little or no English.

"Zoom and telephone consultations have given patients and doctors different ways of communicating and there are lots of good things about that, but, thinking of my husband who had a telephone consultation last week, and he's very deaf, and they didn't ask about that. I was sitting by him trying to tell him what they were saying - he would have been better with a Zoom conversation because he could have seen them and lip read" (FG01)

The most expressed concern was not being able to be examined by a doctor. Some participants had had digital appointments which they felt should have been face to face appointments, for example, to examine a recently changed mole or an ongoing problem with difficulty in walking. These patients said that they had not been offered face to face appointments and were concerned that their problems could become worse if they were not examined. Further, people thought that doctors would miss non-verbal communications from patients, such as how they looked, how they walked, and their facial expressions, especially in telephone appointments.

Some people said that they found it difficult to articulate their symptoms and feelings in a telephone appointment. Those who were discussing the healthcare needs of others were particularly concerned about this aspect – whether they were carers of adults or parents of children who were too young to be involved in a digital appointment. One carer, who looked after her very elderly mother with dementia, felt that in person a doctor could have at least addressed some questions to her mother, and made assessments of her, but that in a telephone call this could not happen.

It was clear that professionals had different approaches to how they offered timings for digital appointments, including:

- Appointments at a specific time and date – these were generally for video appointments such as physiotherapy
- Appointments for a specific date but in a time window - for example some hospital and GP appointments were given with a time window which might be 'morning' 'afternoon' or within a time period of two hours or more
- Appointments without specificity – for example some people were told that a doctor would ring them 'at some point' – some had a date given, but the call might come at any time, and others said they had just been told that they would get a call, but with no date given. These were reported to be some GP appointments by telephone.

The narrower the window of time an appointment was booked for the more people felt satisfied, as they could plan to take the call. There were concerns about missing calls which had broad time windows.

People with mobility issues said that they would like service providers to allow the phone to ring for longer to allow them time to answer the call.

Some people said that their appointments did not happen when they were expected, but they got calls at a later time or day. Although people understood that health and social care professionals were busy they said that they were not offered apologies or explanations.

4.1.3 THE PERSPECTIVE OF PROFESSIONALS WHO HAVE USED DIGITAL APPOINTMENTS

Some participants were professionals who had used digital appointments in their work during the pandemic. Their roles were: a consultant paediatrician, a psychologist, a charity leader, someone who worked as an advocate for people with disabilities, someone who worked in clinical trials, and a support worker for people with addictions. For them, the benefits of digital appointments had outweighed any problems. One person, working with adults with learning disabilities and autism, said her clients found the appointments less stressful. However, she thought that they worked best for people who were already in the system and knew the professional they were speaking to.

There were also perceived benefits for patients who had long distances to travel, for example, attending clinics at the Spinal Injuries Unit at Stoke Mandeville hospital:

"Because Stoke Mandeville Spinal Injuries Unit has such a huge catchment area for our patients... for people who would have to travel a long way to Stoke Mandeville for an appointment, they found them hugely beneficial. These are check-ups and if people have needed MRIs or anything like that I know that some have had them at their local hospitals and the results have been sent across to their consultant - which means the best use of time, the best use of facilities and it is much more environmentally friendly, rather than having to travel vast distances and saves money for the patients" (FG05)

Professionals also perceived a benefit of being able to have more appointments in a day if they were not having to travel to see people.

However, some issues around safeguarding were identified, for example, when seeing people in person there are continual assessments being made about things such as whether people are walking properly, whether they have bruises and whether they are keeping themselves clean. In digital appointments these things can be missed and, further, there could be someone in the room with their client, influencing what the conversation and the answers being given.

4.1.4 WHAT GOOD WOULD LOOK LIKE?

There was consensus that to make digital appointments work well health and social care professionals should be trained, even at the simplest level of making a telephone call for example, to use a headset or hold the phone to their ear rather than using a speaker, which can

distort sound and make it difficult for some people to hear clearly. Other training suggested was how to be empathetic in digital appointments and how to ask the right questions. One person said:

"I think there needs to be a bit of training for the GPs on how to communicate in an empathetic and effective way when you can only do it by sound - because all the visual clues have gone." (FG06)

One question which people did not like being asked was "What do you expect from this appointment" – this was universally disliked as people felt that it was a question they could not answer.

Some people suggested that service users could be trained, possibly through GP surgeries, on how to use the technologies needed for video appointments or, at least, be given a set of instructions on what was needed.

For people who are deaf using a video system which provides voice transcription, or some form of captioning, would be an improvement – but this would have to be on a mainstream service which was available to the patient at home, rather than on a specialist service which patients could not access.

4.1.5 THE FUTURE

Participants assumed that digital appointments would continue after the pandemic. There were concerns, however, that digital appointments should not be the only methods health and social care professionals use. It was deemed essential that there should be a package of options, including in-person appointments for those who want or need them, and there was a strong feeling that it should be the patient or service user who chose what sort of appointment they would have.

"I think telephone appointments can be a good idea, but I wouldn't want them to be relied upon solely - I think you need to be seen at some stage" (IV04)

Some concerns were expressed about a two-tier system developing in which those who did not have the means to participate in digital appointments would be seen in person, with no-one else allowed to have face to face appointments.

One person had had a video appointment with a hospital consultant who had taken his own laptop to work as his department did not have the equipment to enable video calls to be made. Participants said that if there is an expectation that video calls will be used in the future equipment must be in place.

4.2 DELIVERY OF SERVICES AND KEEPING PEOPLE SAFE

Survey data on keeping people safe:

- Long waiting times relating to urgent care and NHS111 were cited as problematic
- Most people were willing to travel further to hospital for planned care if it meant having an earlier appointment – but not on too many occasions. Public transport was considered to be a problem for travelling further.
- The youngest and oldest age groups were less likely to want to travel further.

During the pandemic health and social care services had to be delivered differently in order to keep service providers and service users safe. This included asking people not to go to seek urgent care without first having called NHS111, in order to reduce the numbers of people in waiting rooms. People were asked to take COVID-19 tests and to isolate before attending planned care appointments.

Participants were asked about their experiences of using different services, and their views on them.

4.2.1 CARE SETTINGS

People understood that urgent care was for non- life-threatening conditions, however, some chose to go to A&E at Stoke Mandeville (and, for a very few, to other hospitals such as Wexham Park, John Radcliffe in Oxford or Milton Keynes University Hospital, depending on where they lived). They rationalised this choice in a number of ways:

- Some assumed A&E was a better service than urgent care centres
- People living near Stoke Mandeville went to the nearest hospital
- Some said they did not want to have to make decisions on what type of care was needed, particularly if they were deciding for someone else
- For some there was confusion about what was delivered where

Some people had experience going to urgent care centres and finding that they could not get the tests they needed and being redirected to A&E – when this happened the next time they had a need for urgent care they went straight to A&E in case the same thing happened again.

Participants who lived closer to Wycombe Hospital than to Stoke Mandeville Hospital said that they felt there should be an A&E at Wycombe Hospital, to serve the population of the area, and, relatedly that the journey to Stoke Mandeville Hospital from places such as Marlow and High Wycombe was long and difficult, with many saying the roads were bad.

Some participants had used the Urgent Treatment Centre (UTC) at Wycombe Hospital. Some people had gone to the UTC because they considered it to be the closest place to get help, and others had been signposted there by NHS111. In both of these cases there were instances where patients had then been sent on to Stoke Mandeville A&E because the UTC could not treat them. People who had experienced being referred on to Stoke Mandeville said that in future they

would go straight to the A&E because they felt the time to treatment had been lengthened by first attending the UTC.

4.2.2 USE OF NHS111

Generally, NHS111 was viewed positively, and its use was understood. Many people who had used the service felt it was good – with people tending to view it more positively if they had had a good experience and what they perceived as a suitable outcome; these people said they would use the service again.

Two main problems were identified with the service. The first was the length of time people had waited for a doctor to call them, in some cases as long as eight hours. The second problem was the number and nature of questions asked by call handlers to determine the course of action to be advised. People felt that questions did not always relate to the reason they were calling – for example a woman with severe back pain was asked if she was bleeding; service users felt that there should be a way of skipping irrelevant questions to move more quickly through the process.

Some people had experienced NHS111 as being over cautious – for example, calling ambulances when the patient did not think they needed one, or advising people to go to A&E when they thought that urgent care or an out of hours GP appointment would be more appropriate. Participants said they understood why there was a tendency to err on the side of caution, but they found this aspect frustrating.

A small number of people said that they did not want to use NHS111 because the call handlers were not health professionals – they said they would have more faith in the service if it was staffed by nurses. This led to conversations in the focus groups about the nature of the service being mainly about appropriate sign posting, which most people found acceptable and useful.

People with disabilities such as deafness or not being able to speak said they could not use the telephone to access NHS111, but assumed that there would be an online version they could use. However, currently although NHS111 can be accessed online there is no option for a call back other than by telephone – the advice for deaf people is to start the process again by calling 10881 111 using the text relay service. There were no instances where people who could not use the telephone had not been told how they might use the service.

4.2.3 SERVICES AT WYCOMBE HOSPITAL

People who lived in or near High Wycombe (that is, people who lived nearer to High Wycombe Hospital than to Stoke Mandeville Hospital) had the view that the population density of the area should merit full hospital services, such as an A&E and maternity services.

There was a general view from participants that the distance between High Wycombe and Stoke Mandeville was too far for people needing emergency services, and the road was not good. One person said:

"I would like to know the numbers of people who have died because they had to travel to Stoke Mandeville, rather than going to High Wycombe which is nearer. I see ambulances with blue lights on every day and I wonder how many people are going from High Wycombe to Stoke Mandeville. I wonder how many people make that long, bumpy journey." (FG01)

It was thought that the current hospital should be improved, or a better and bigger hospital should be built locally to ensure that full hospital services were available to people in High Wycombe and the surrounding areas.

4.2.4 TRAVELLING FURTHER FOR SOME APPOINTMENTS

The number of people waiting for planned care (that is, appointments arranged in advance at hospitals or community clinics) has risen during the pandemic. The NHS is considering ways of reducing the amount of time people have to wait and might consider working with neighbouring hospitals to provide some tests or treatments, which would mean asking people to travel further. Participants were asked their views about the prospect of being asked to travel further for some appointments.

Generally, people who had their own transport said they would be willing to travel to neighbouring hospitals for tests and diagnostic appointments, especially if this only meant going once or twice, with further treatment being delivered closer to home. For these people travelling further to reduce waiting times was seen as a positive.

Some people pointed out that travelling to Stoke Mandeville was a problem for them, and other hospitals might be easier to reach.

People who did not have their own transport queried how they might get to other hospitals, there being an assumption that journeys would be difficult by public transport and expensive if taxis were used. Some asked whether the NHS would fund travel or arrange patient transport for them.

Time was a factor for some people. For some people working full time, or having parenting or caring duties, travelling further could be a problem if extra time was needed. For example, one person said:

"I travelled for two hours recently for a dental appointment and I had to take half a day off, because work only gives me two hours for a medical appointment" (FG02)

Some participants asked how patient records would be transmitted from one trust to another – having had experiences where their records had not been in place if they had been referred out of county because different systems could not ‘talk’ to each other; this was seen as potentially a major hurdle, and people said they would want to be reassured that the records would be in place when they arrived at their appointment.

Communication was seen as key, with a view that if people understood why they were being asked to go somewhere else, or do things differently, they would be more likely to take up the options:

"They need to be honest. If the public is told 'we have a log jam, we're just coming out of a crisis, it's going to take months for us to get through this log jam and we would like people who can to go to another county'" (IV18)

4.3 COMMUNITY HUBS

Survey data on community services:

- 38% of people said they or their family had received health or care services in the community, or at home, in the last 3 years
- 88% of people said that they were satisfied with care they had received from community hospitals
- The lowest levels of satisfaction were for mental health support (53%)

People were asked about their awareness of Community Hubs and their views on what could be delivered in them.

Knowledge of Community Hubs was low, even amongst people who lived in Marlow, Thame and Amersham.

When the purpose of Community Hubs was explained to people the idea was well received (with the caveat that beds should be available as well as day services). Some people who had experienced lack of communication between services, or a lack of joined up services, felt that co-locating services in Community Hubs might overcome some of these problems.

Some participants felt that Community Hubs should be beneficial in areas of deprivation. One person said:

"These are a fantastic idea and should be available in areas where there are health inequalities. I have helped to set up things like blood pressure clinics in my community and they get good take up. The Hubs should have community clinics, support visiting clinics, have check-ups etc." (FG12)

When asked what sort of services could be available in Community Hubs suggestions were:

- Health visitors
- Breast feeding advisors
- Post-natal advice
- Community midwives
- Pharmacies
- Child and adolescent mental health services

- Adult mental health services
- Crisis support
- X-rays
- Social prescribing
- Exercise classes
- Healthy minds
- Follow up appointments
- Annual health checks
- Chiropody
- Podiatry
- Blood tests
- Blood pressure checks
- Physiotherapy
- Occupational therapy
- Nutrition classes
- Cooking classes
- A day centre
- A café
- A place where the community can meet, generally

Community Hubs were seen as an opportunity to bring communities together, to assuage loneliness and to bring services closer to people, especially those for whom travelling to hospitals was difficult.

Although there was little knowledge of Community Hubs participants were aware of community hospitals. The people we talked to said that they thought that community hospitals, whether they were Community Hubs or not, should have in-patient beds. People viewed beds in community hospitals as a necessity for patients who could not immediately return home safely after being in hospital, especially those who lived on their own or whose family circumstances were such that there was no-one to care for them. Participants understood that it was important to get patients out of hospitals as quickly as possible, but people believed there needed to be provision for what they variously called step-down care, convalescence, and rehabilitation. There was a view, often expressed, that people living alone would fare better when recuperating if they were in a community hospital because they would be looked after, and their needs attended to.

4.4 ENCOURAGING HEALTHIER LIFESTYLES

Survey data on healthier lifestyle advice:

- Generally, people said they were receptive to healthier lifestyle advice from professionals
- The main barriers to living more healthily were lack of time (for those aged under 55) and health conditions or age (for those over the age of 55)

Participants were asked what they thought would work to help encourage people to have healthier lifestyles and whether they thought that campaigns about making healthier choices worked.

Generally, people thought that advertising campaigns about healthier lifestyles did not really work, as most people knew that, for example, they should drink less, eat more healthily and not smoke, but did not change their behaviours. Some people thought that only taxation and/or banning sugar, tobacco and alcohol would work.

In this sample of Buckinghamshire residents there were participants who had been given advice by healthcare professionals about healthier lifestyle choices, but they had not acted on the advice – they said they knew what they should be doing and might think about it in the future. There was an overall view that health inequalities cannot be solved by giving lifestyle advice, that more needs to be done about solving housing problems and poverty.

"I think until we get some good social housing with support for the people living there we are not going to get anywhere. They know it is higher risk in areas of poverty, so that is where you need to fix the problem - you need better support in those areas." (FG05)

Participants were generally of the view that understanding the underlying causes and reasons for unhealthy choices needed to be understood before they could be tackled.

It was felt that working with children and young families would be more productive and beneficial than trying to tackle adults' unhealthy habits, as good habits for the future could be formed. Ideas such as promoting exercise for young families in outdoor spaces, teaching cooking skills to children and young parents, and giving all school children at all levels of education free school meals were thought to be good places to start.

4.5 PREFERENCES FOR COMMUNICATION

People were asked how they thought Buckinghamshire ICP could best communicate with residents of the county.

Many people spontaneously mentioned the regular updates they had received from Martin Tett, leader of Buckinghamshire Council, during the pandemic. The tone of the communications was felt to be very good, and better than many UK government communications. People liked the fact that the information pertained directly to them, as it was local, they thought that there was a human feel to them, and the messages were not 'preachy' or severe.

All participants said that to reach the highest number of people many different communication routes would be needed. People thought that important messages should be sent from trusted sources, for example, health related messages should be sent by GPs.

People in younger age groups tended to like electronic messaging better – by text, social media or email – although some said that they might scroll past some things as they got a lot of material by these routes.

People with learning difficulties, some with mental health problems and older people said they would prefer to have physical messages, and that the most likely to be read was a letter specifically addressed to them, and from a trusted source, and GPs were mentioned as a route for this. Some suggested that local community leaders could cascade important information.

For other people receiving important information by emails, texts and letters would work.

People had many ideas about how more general messages and information could be circulated, including:

- On buses and at bus stops
- On posters in shopping centres and town centres
- At local sports facilities
- In local newspapers
- On local radio
- In council tax bills or electoral roll reminders
- Leaflets in libraries
- In pharmacies – including putting information in with prescriptions
- In village halls
- Handed out by people who work in the community, such as district nurses
- Leaflets sent to households
- Via community groups and churches
- On apps people use to book GP appointments
- On GP websites

It was thought that if targeted messages were needed the Council and Healthcare Trust would have enough information between them to be able to send messages of importance, for example, about different types of health screening, rather than blanket coverage which would be inappropriate for some people. It was also assumed that information would be held somewhere in the system about what language people would need information in, and that this could be used to send information out appropriately, rather than people having to ask for different language options.

Generally, the people who took part in this engagement exercise appreciated the chance of talking about health and social care services and liked having the opportunity to take part in helping the ICP to think about the future. All of the participants said that they would be happy to take part in future engagement and were glad that the ICP were giving residents the opportunity to be heard.

5. CONCLUSIONS

This work sought people's views on a variety of topics. People told us about their experiences and views of digital appointments and the delivery of services whilst keeping staff and service users safe now and in the future; there were discussions about Community Hubs and promoting healthier lifestyles; finally, people told us how they thought the ICP could communicate effectively with as wide a range of people as possible.

DIGITAL APPOINTMENTS

Although most people who had had digital appointments were positive about them there were concerns expressed by the people who took part in this engagement about being able to access in-person appointments with their GPs. There was little understanding about how GPs were currently serving their patients, or what patients might expect when they needed care. Participants had not been made aware by GPs how digital appointments would work or if/when they might expect to be seen in person. It appears that anxiety about the current and future appointment systems could be allayed to a large extent if patients had received communications from their GPs about their working practices.

Reasonable adjustments need to be considered for patients with extra needs, for example, people with disabilities which would prevent them using digital services and people for whom English is a second language. Further, thought needs to be given to how to ensure that people without the means to take part in digital appointments are not excluded from care in the future.

It should be made clear to patients that in-person appointments are available now, and in the future, if they need to be physically examined or require diagnostic testing.

The workforce delivering digital appointments should be trained in how to use the technology, including how to engage with patients effectively and they should have the equipment they need to enable them to use digital appointments effectively.

DELIVERY OF SERVICES AND KEEPING PEOPLE SAFE

There could be better understanding of how NHS111 works. Although people were fairly familiar with the service, and people had used it and were relatively satisfied with it, there was a lack of understanding about why there were so many questions asked in the initial stages of contact which did not relate to the problem they were calling about. Again, consideration needs to be given to how patients with some disabilities, such as deafness or speech loss can use the NHS111 service, with better explanation given about the requirements for a call back or use of 10881 111 using the text relay service – participants who might need to use this did not know about the service.

Learning is needed to ensure credibility of NHS111 to get people to the right place the first time. There could be more information for the public about how the system works and why the algorithms used require questions which might seem inappropriate.

People were generally receptive to the idea of travelling further for earlier appointments, however the group who would face most problems were those without their own transport. Consideration should be given to asking patients about how difficult it would be for them to travel when considering where to refer them.

A further issue to consider if people are travelling out of county for appointments is how their records will be available at the receiving hospital, and how results will be available at the originating hospital.

People who took part in the evaluation who lived nearer to High Wycombe than to Stoke Mandeville expressed strong views about the lack of an A&E at Wycombe Hospital, saying that an area with a large population should have services locally, and that travel to A&E at Stoke Mandeville was difficult because the roads were bad. Participants from in and around the High Wycombe area would like BHT to consider reinstating A&E and other services at Wycombe Hospital, to ensure that their needs are met closer to home. The ICP should consider providing compelling and credible reasons for the locations of A&Es in the region and in the county.

COMMUNITY HUBS

Community Hubs were not well known, but well received as a concept. However, beds in community hospitals were deemed necessary for what people variously called convalescence, rehabilitation and step-down care. There was an overarching view that some people could not be discharged to their homes and would fare better in a small community hospital ward than they would elsewhere. Participants would like BHT and Buckinghamshire Council to consider reinstating beds at Marlow and Thame community hospitals and keeping beds in community hospitals in other areas.

Suggestions were made that Community Hubs should be placed in areas of deprivation to address the health needs of local residents.

Further engagement with people who had used Community Hubs and community hospitals could help to develop a patient driven model of the routes into and out of hospital care based on experience of the services rather than the hypothetical thoughts of people who had not used the services.

HEALTHIER LIFESTYLES

Participants in this phase of the engagement felt that public health campaigns might not be effective in persuading people to make lifestyle changes; there were suggestions that campaigns without changes to policy were unlikely to make a difference to people. Policy changes mentioned included sugar taxes and alcohol pricing.

If public health campaigns are to continue the public may need to be convinced that the suggested lifestyle changes work and current advice is better than that which has gone before.

Generally, participants felt that early intervention, working with children and young families to embed healthy behaviours at an early stage in their lives, might be a better use of campaigns.

EFFECTIVE COMMUNICAIONS

All participants thought that in order to reach the largest number of people multiple channels of communication were needed, and for the most important messages consideration should be given to writing to all residents of the county. Communications were thought to be more likely to be effective if they came from trusted sources, for example, health messages from GPs. Communication channels and the tone of messages needed to be appropriate for the audience and the message.

Generally, participants welcomed the chance to take part in the engagement exercise and were willing to be recontacted if further work is done in the future.

Consideration should be given to how to engage with a wide and representative audience of Buckinghamshire residents in the future to enable the public voice to be heard in the planning of services.

6. RECOMMENDATIONS FOR COMMUNICATION AND ENGAGEMENT

In this section we make recommendations specifically regarding communication and engagement. We feel that the ICP has some work to do to keep people informed about services, progress on plans and how things work in order to keep people's trust in the future.

Our recommendations, based on this engagement, are that the ICP communicates with Buckinghamshire residents clearly about how it is working.

1. We recommend that the ICP considers how it might have regular, general, contact to keep residents up to date on plans, but that there is also a plan for how to communicate at speed when urgent messages are needed. The most important messages need to be sent from trusted sources in ways that are likely to reach the highest number of people.
2. The ICP should consider how it can gather data on people's preferences for communication, for example by asking people if they want information by email or letter. This could be done by adding a short questionnaire into annual mail outs such as council tax information or electoral registration – the questionnaire could be put into the envelopes with the paper information with an option for filling in online.
3. We recommend that the ICP in general and GPs in particular communicate with Buckinghamshire residents about how services work, when changes are needed and what the changes will mean for them. Effective communication is likely to ensure that residents feel informed and they are more likely to be understanding when changes are needed.
4. We would also recommend that more publicity could be given to Community Hubs in the areas where they operate. It was clear from the engagement that people did not know about them or understand what their purpose was. Further engagement with people in local areas could help to develop the Community Hubs in ways that would enhance the areas around them and have wider benefits. Engagement with people who had used Community Hubs as well as people who had used beds in community hospitals could be done to develop a human centred design of a community pathway.
5. Finally, we recommend that the ICP continues to engage with the residents of Buckinghamshire to ensure that their voices and views are heard as planning for future services continues.

7. APPENDICES

7.1 TOPIC GUIDE

Topic guides are used in qualitative research to list areas which are to be explored in focus groups and interviews. Unlike questionnaires used in surveys, topic guides do not have to be followed in a particular order; rather, they are used as a memory aid for the researcher to remind them of the main themes to cover. The order in which themes are covered and depth in which they are covered depends on the participant's experiences and knowledge (for example, a participant might have little or no experience of some topics, but much more experience of others, where they would have more to say).

The following topic guide was used for all the fieldwork in this engagement:

Opening

- Thank for taking part
- Explanation of why work is being done, and for whom
- Confidentiality and anonymity in reporting
- How the session will work
- Ask permission to record

Digital appointments

- Experience of having telephone and/or video appointments
- What might the future look like for digital appointments?
 - Strengths
 - Weaknesses
 - What will 'good' look like – why?
- Explore thoughts on when these sorts of appointments are suitable and not suitable

Keeping people safe

Planned care

Urgent services

Emergency services

- Explore views on services – including changes to delivery during the pandemic
- Use of NHS111
- Potentially travelling further for tests/care post-pandemic if services can be delivered further afield more quickly
- Explore any issues of trust in the system

Community Hubs

- Explore views about Community Hubs
 - What works well?
 - What could be improved?

- What are the core services from the NHS, Council and voluntary sector which need to be delivered locally?
 - Why?
- Where should they be delivered?
 - Could any of this be done digitally?
- How could services be better joined up?

Encouraging healthier lifestyles

- Explore views on what could make a difference
- Explore views about campaigns
- What else could be done?

Effective ways of communicating with people

- Ways for health and social care services to tell people about their services

Thank and close

- Anything more people want to say?
- Explain how the data from the research will be used
- Explain that engagement is likely to be an ongoing process
- Ask for permission to recontact

7.2 NUMBERS OF PARTICIPANTS INVOLVED IN FIELDWORK

The tables below show the numbers of people involved in focus groups and interviews.

Focus Groups

Reference No.	Characteristic	Number recruited	Number attended
FG01		7	5
FG02		8	5
FG03		6	4
FG04	Young People	5	2
FG05	People with disabilities	6	5
FG06	Carers	8	8
FG07	BAME	7	5
FG08	LGBTQ+	4	3
FG09	Age 75+	7	7
FG10		6	6
FG11	Areas of deprivation	7	2
FG12		8	7

Seven of the focus groups were recruited to try to include involvement from people from different groups in society: young people (aged 25 and under), people with disabilities and long term

conditions, carers, BAME people, LGBTQ+ people, people aged 75 and over and people living in areas of deprivation.

The remaining five groups were not recruited for any specific characteristic; these groups contained mixes of people, including some people with the characteristics identified above (generally these were people who wanted to take part but who could not make the dates of the other groups).

The numbers recruited and the numbers who attended are shown and are discussed in other parts of the report.

Interviews

Reference No.	Characteristics	Method
IV01	Disability – deaf	Email interview
IV02	Disability – speech	Email interview
IV03	Carer	Telephone interview
IV04	Age 75+	Telephone interview
IV05	Age 75+	Telephone interview
IV06	BAME	Telephone interview
IV07	Carer	Telephone interview
IV08	Disability – mental health	Telephone interview
IV09	Carer	Telephone interview
IV10	Age 75+	Telephone interview
IV11	BAME, Carer	Telephone interview
IV12	Carer, Age 75+	Telephone interview
IV13	Carer	Telephone interview
IV14	Disabled – MH	Telephone interview
IV15	Age 75+, Disability - physical	Telephone interview
IV16	LTC, Area of deprivation	Telephone interview
IV17	Carer, Age 75+, Disability – physical	Telephone interview
IV18	Representative of action group	Zoom interview
IV19	BHT employee, Carer	Zoom interview
IV20	Representative of Marlow Hub	Telephone interview
IV21	Disability – learning disability	Telephone interview
IV22	Area of deprivation – community representative	Telephone interview
IV23	-	Telephone interview
IV24	Charity representative	Telephone interview

2 further people were recruited for an interview but were unable to take part

Interviews were offered to people who could not take part in focus groups – this is discussed in earlier parts of the report.

7.3 DEMOGRAPHICS

Demographic data were collected in two ways: during the recruitment process the recruiter asked questions to determine people's characteristics as she was recruiting to some groups for based on specific demographic characteristics, and secondly through equalities monitoring forms sent out after people had participated. The data collected during recruitment is more complete than that from the forms, as about half the participants did not return the forms. Both sets of demographics are reported below.

7.3.1 DEMOGRAPHICS COLLECTED DURING RECRUITMENT

The demographic data relating to the 83 participants, collected during the recruitment process was as follows (please note, some participants did not give all data – where this is made clear under each data set):

Age groups:

	Number	% of participants who gave age
16-24	3	5%
25-34	5	8%
34-44	7	12%
45-65	7	12%
55-64	11	19%
65-79	23	39%
80+	3	5%

NB data from 59 people, 24 people did not answer

Gender:

	Number	% of participants
Female	51	61%
Male	32	39%

Data from all 83 participants

Other characteristics:

	Number	% of participants
People with disabilities/long-term conditions	28	34%
Carers	23	28%
BAME	21	25%
LGBTQ+	6	7%
Living in areas of deprivation ⁴	34	41%

Data from all 83 participants

Note: Adds to more than 83 (100%) as some people represented more than one characteristic group

⁴ This was determined by partial postcode data supplied by Buckinghamshire ICP and areas if deprivation identified in Buckinghamshire's Joint Strategic Needs Assessment

7.3.2 DEMOGRAPHICS COLLECTED FROM EQUALITIES MONITORING FEEDBACK

Every participant received an email after they had taken part thanking them for their involvement and asking them to complete and return two forms: one collected demographic data and one which asked them to evaluate the fieldwork they had just taken part in (see below). The wording of the forms was supplied by Buckinghamshire Healthcare Trust and is the wording they use across the Trust when engaging with the public.

83 sets of forms were sent out and 41 fully or partially completed sets of forms were returned.

The tables below show the results from returned Equalities Monitoring forms:

1. What age group do you fit into?

	Number	%
0-15	0	0%
16-24	1	3%
25-34	0	0%
35-44	1	3%
45-54	7	21%
55-64	7	21%
65-79	16	47%
80+	1	3%
Prefer not to say	1	3%

NB 7 did not answer

NB percentages based on the number who answered

2. What is your Gender

	Number	%
Male	12	29%
Non Binary	0	0%
Female	29	71%
I use my own term	0	0%
Prefer not to say	0	0%

3. Do you identify as trans?

	Number	%
Yes	0	0%
No	41	100%
Prefer not to say	0	0%

4. Do you consider yourself to be disabled or have a long term health condition?

	Number	%
Yes	12	30%
No	27	68%
Prefer not to say	1	3%

NB 1 did not answer

NB percentages based on
the number who
answered

Do you consider that you have one or more of the impairments listed below?

	Number	% (see note below)
Physical impairment	6	40%
Speech impairment	2	13%
Mental health condition current or previous (e.g. depression)	5	33%
Blind or impaired vision not correctable by glasses	1	7%
Deaf or hard of hearing	4	27%
Wheelchair user	0	0%
Learning disabilities	1	7%
Prefer not to say	1	7%

NB:

9 people who had answered yes to the question above said they had one or more of the listed disabilities

2 people who answered no to the question above said they had one of the listed disabilities

3 people who answered yes to the question above did not choose any of the categories in this question

1 person chose the category 'prefer not to say' in the question above chose the 'prefer not to say' category in the list of disabilities

15 people chose at least one category and some people ticked two or more categories – therefore % adds to more than 100

5. What is your ethnic group?

	Number	%
White British	28	78%
White Irish	1	3%
White other	1	3%
White other: Romanian	1	3%
Mixed	1	3%
Black Caribbean	1	3%
British	1	3%
Indian	1	3%
Pakistani	1	3%

NB 5 did not answer

NB percentages based on
the number who answered

Rounding brings total to
101%

6. Are you pregnant or have you had a baby in the last 6 months?

	Number	%
Yes	0	0%
No	35	97%
Prefer not to say	1	3%
<i>NB 5 did not answer</i>		

7. How would you describe your status?

	Number	%
Single	6	16%
Married	24	63%
Civil Partnership	1	3%
Widowed	3	8%
Other (write in if you wish):	0	0%
Live with partner	1	3%
Partner	1	3%
Separated	1	3%
Divorced	1	3%
Prefer not to say	0	0%
<i>NB 3 did not answer</i>		

*NB percentages based on
the number who answered*

8. Please indicate your religion or belief

	Number	%
Atheist	4	11%
Buddhist	0	0%
Christian	28	74%
Hindu	1	3%
Jewish	0	0%
Muslim	1	3%
Sikh	0	0%
Other (write in if you wish):		

Not religious	1	3%
CofE	1	1%
Taoist	1	3%
Humanist	1	3%
Prefer not to say	0	0%

NB 5 did not answer

NB percentages based on the number who answered

9. How would you describe your sexual orientation?

	Number	%
Heterosexual	34	89%
Bisexual	0	0%
Gay/Lesbian	1	3%
Prefer to self-describe	2	5%
Prefer not to say	1	3%

NB 5 did not answer

NB percentages based on the number who answered

7.4 EVALUATION

All participants were emailed after the focus groups and interviews were completed. They were thanked for taking part and were asked to complete and return two forms: one collected demographic data (see above) and one which asked them to evaluate the fieldwork they had just taken part in. The wording of the forms was supplied by Buckinghamshire Healthcare Trust and is the wording they use across the Trust when engaging with the public.

83 sets of forms were sent out and 41 fully or partially completed forms were returned. The results of the evaluation are shown below:

Q1. Do you feel we explained the purpose of the meeting clearly?

	Number	%
No	0	0%
In part	3	7%
Yes	26	63%
Very clearly	12	29%
Unsure	0	0%

Q2. Did you feel that the discussion was well facilitated?

	Number	%
No	0	0%
In part	1	2%
Yes	27	66%
Very well	13	32%
Unsure	0	0%

Q3. Did you value the opportunity to discuss with others and explore ideas around the future of health and social care services in Buckinghamshire

	Number	%
No	0	0%
Yes	32	89%
Unsure	4	11%
<i>NB 5 did not answer</i>		<i>NB percentages based on the number who answered</i>

Q4. Do you feel the facilitator was receptive and your views were listened to?

	Number	%
No	0	0%
Sometimes	1	3%
Yes	18	45%
Very much so	21	54%
Unsure	0	0%
<i>NB 1 did not answer</i>		<i>NB percentages based on the number who answered</i>