Developing NHS Grampian's Plan for the Future 2022-2028
Phase One Engagement Report

Introduction

As part of the development of NHS Grampian's Plan for the Future 2022-2028, and to find out the views of our staff, communities and people, we held two stages of engagement to hear from you on what is important for your health and wellbeing now and in the future.

The first phase of our public and staff engagement ran from 28th June until 31st August and this report summarises the feedback received during that process.

In our first phase of engagement, we asked the people of Grampian what is important to them about health and care services via an online survey or by attending a facilitated engagement session. This engagement comprised of six questions:

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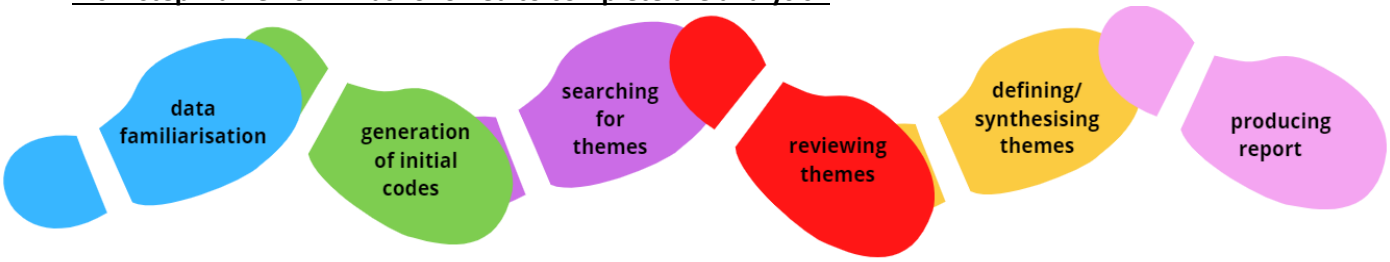
- Can you think of 3 things that you liked or appreciated about any health and care services you have used, or were available in Grampian before COVID-19?
- Do you have any worries, concerns or disappointments about any health and care services that you have used, or were available in Grampian before COVID-19?
- Can you think of 3 things that you liked or appreciated about any health and care services you have used, or have been available in Grampian during COVID-19?
- Do you have any worries, concerns or disappointments about any health and care services that you have used, or have been available in Grampian during COVID-19?
- Thinking about the things that help to keep you (and those you care for) well and in good health, what are the 3 things most important things to help achieve this?
- Do you have any worries or concerns about your (or anyone you care for) health and wellbeing? If yes, what are these worries, concerns or disappointments about?

Responses to the online survey and notes from group discussions were analysed thematically using NVIVO version 12 (QSR International, Doncaster). Thematic analysis allows for important patterns of data to be identified and interpreted to improve understanding on a particular topic.

A six-step framework[2] was followed to complete the analysis:



Codes were derived inductively based on themes identified in the data. Team members coded a number of response sets, elaborating on the meanings of codes and defining more specific codes where necessary. A number of response sets were co-analysed by another team member and followed by discussion, if needed, to reach consensus regarding interpretations. Each team member then further analysed a cluster of related themes and sub-themes (e.g. "access"; "quality").

1. Braun V, Clarke V, Boulton E, Davey L & McEvoy C (2020). The online survey as a qualitative research tool, International Journal of Social Research Methodology. DOI: 10.1080/13645579.2020.1805550
2. Braun V, & Clarke V (2006). Using thematic analysis in psychology. Qualitative Research in Psychology, 3, 77–101.

Data were coded independently by team members, with public health researchers being consulted to resolve uncertainties and reach consensus on themes and interpretation. One team member had an overview of all the data and also contributed to decisions on themes and interpretation.

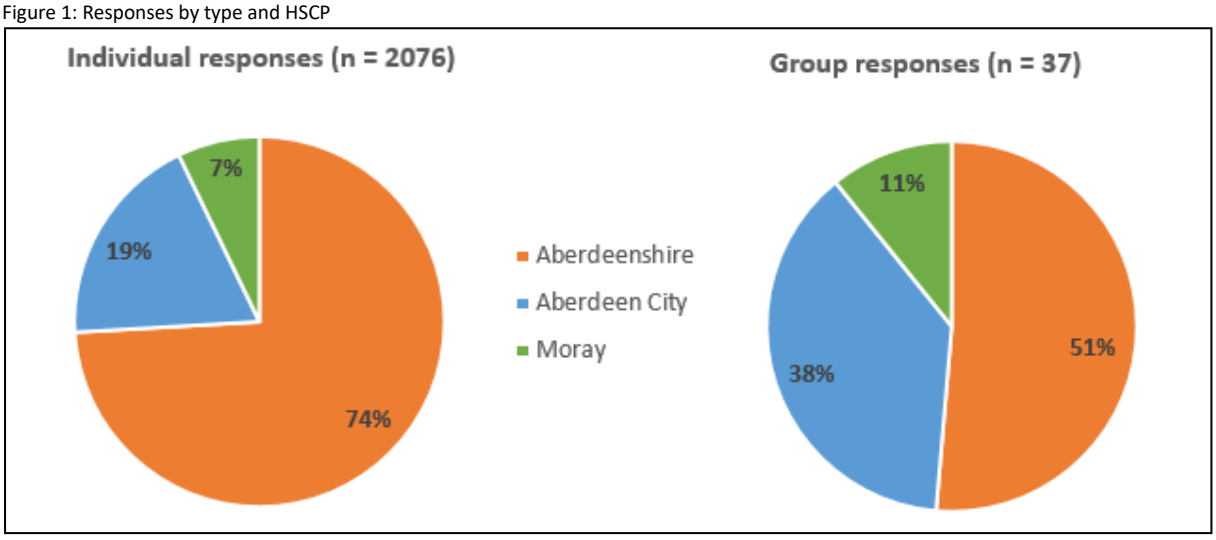
Survey Demographics

Though the purpose of the engagement was to gather qualitative feedback, there were optional demographic questions asked as part of the survey that provides some information on respondents.

Overall, the online survey received 3905 responses, though a large proportion only completed the demographic questions and did not provide any qualitative feedback, therefore 2,113 of these were used for analysis. Of these, 98% were from individuals and 2% from groups (either self-identified as a staff team/department or a community group).

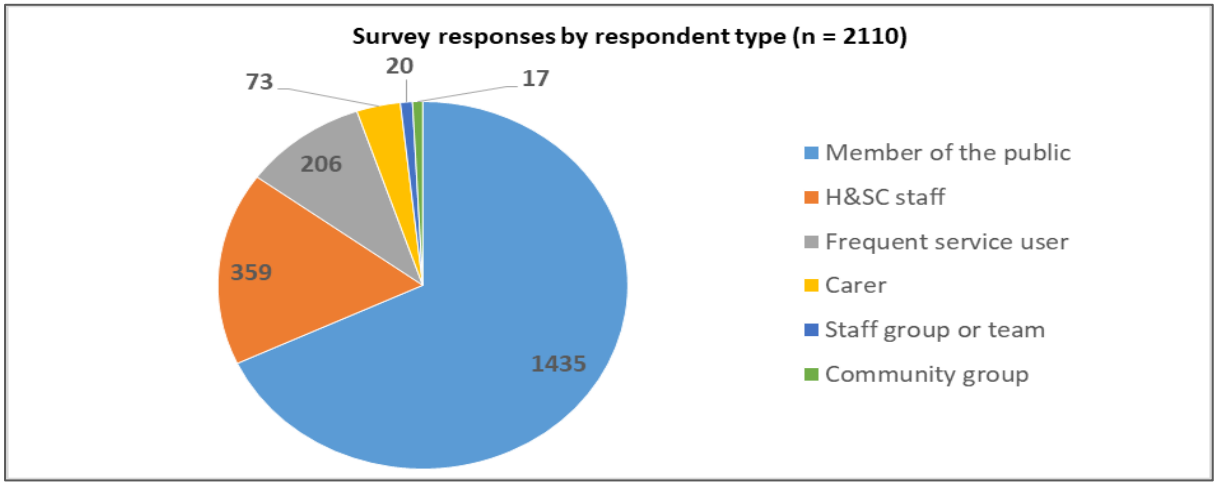
We asked respondents to indicate which Health and Social Care Partnership (HSCP) area they were from and most answered this question. As shown in figure 1, the majority of responses were from Aberdeenshire, with almost three quarters of individual responses and just over half of group responses from this HSCP.

Figure 1: Responses by type and HSCP



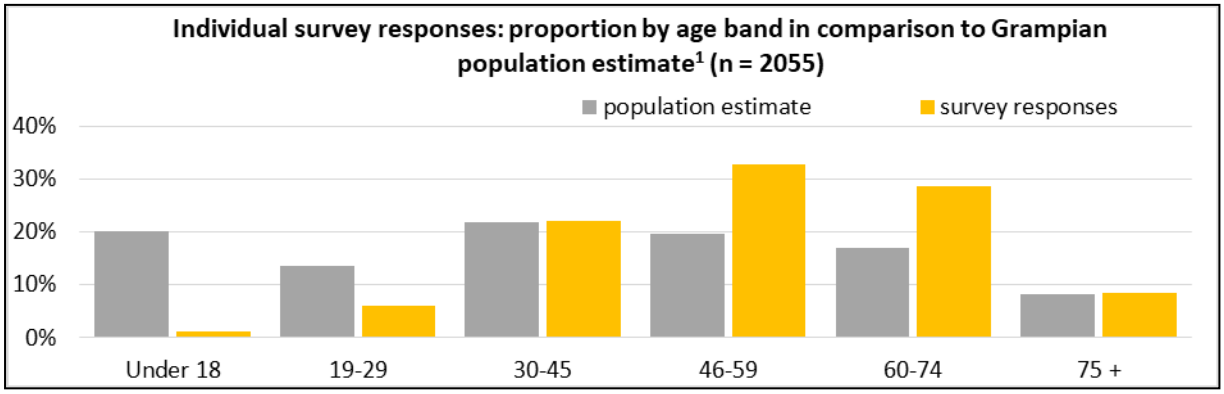
Almost 70% of individuals responded as “a member of the public” and the breakdown is illustrated in figure 2.

Figure 2: Breakdown of responses by category (n = 2110)



Individuals were asked their age bracket and figure 3 shows the breakdown of responses by age bracket. Comparing the age of individual responses against Grampian population estimates provides an indication of how representative the breakdown could be interpreted to be. The 30-45 and 75+ age bands appear representative of the overall Grampian population proportions, while the 46-74 age range appears over-represented and the under 30s under-represented. This helped focus planning for phase two to aim to achieve engagement through all age brackets.

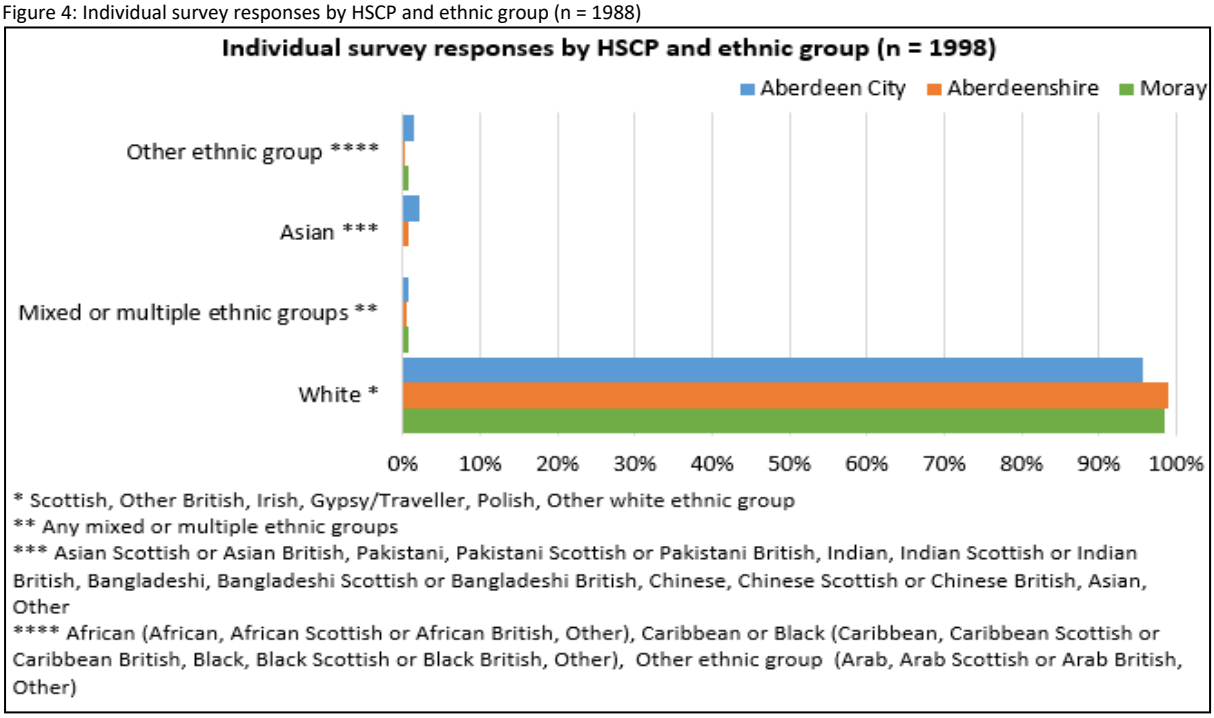
Figure 3: Individual survey responses: proportion by age band in comparison to Grampian population estimate[1] (n = 2055)



As part of the demographic section, respondents also had the option to indicate their ethnic group. For those with a completed ethnic group, over 98% of individual responses were from the White ethnic group. Again, this helped target engagement for phase two to get a broader representation across multiple ethnic groups.

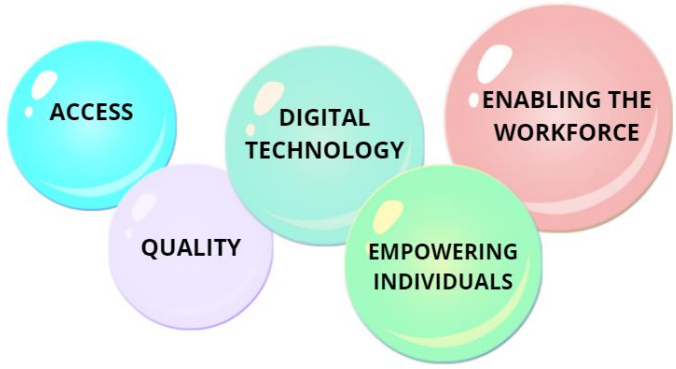
There was variation across the HSCPs and, due to the very low number of responses for some categories, we have aggregated some responses into the combined other ethnic group.

Figure 4: Individual survey responses by HSCP and ethnic group (n = 1988)



Findings from Thematic Analysis

Five key themes emerged from analysis of survey responses and group discussion:



These were identified as the themes with the highest number of references in the survey responses and feedback from the group discussions showed a similar pattern. These main themes, along with relevant subthemes, are shown in Table 1 and expanded upon in subsequent sections.

Table 1: Main themes and sub-themes derived from the survey

Themes & sub-themes	Number of references*
Access	
Primary Care	1,448
Availability of services	1,382
Local/Community services	650
Waiting times	576
Quality	
Care	728
Face-to-Face contact	1,064
Digital technology	815
Empowering individuals	2,692
Enabling the workforce	1,350

* There may be multiple references to a theme within one response so numbers of references differ from overall numbers of response.

It should be acknowledged that themes were closely inter-related and there was a natural overlap between several, e.g. digital technology and face-to-face contact.

The bulk of the feedback was in the 'during COVID-19' questions, so each theme has been split into concerns and positives during COVID-19, with any notable similarities or differences compared to pre COVID-19 highlighted. Direct quotations from survey responses have been included periodically to illustrate further.

THEME 1 – ACCESS

1.1 Access in Primary Care

Access in Primary Care Concerns during COVID-19
Difficulties accessing care – unable to get through on the phone, difficulties with E-consult, blocked by receptionists, many stories of struggling to be seen.

Perception that GP service is not available for most and only ***"urgent"*** cases accepted.
Feelings of lack of support/abandonment – effect on mental health.
Disengagement from the service due to negative experiences. Loss of confidence in the service.
Triaged to other team members – mainly negative response to this (seen as cost-cutting).
Directed to other services – pharmacy, NHS24
Inequity of impact – fear that burden will fall on elderly, poor, hearing impaired.
Health consequences – delayed diagnosis for serious conditions, emergency care needed, anxiety & other mental health issues. ***"I worry that we have an underlying condition that hasn't been diagnosed. I'm also concerned that healthcare isn't available when we need it"***
System consequences – pressure on other services due to inappropriate GP referrals or patients attending A&E.

Access in Primary Care Positive feedback during COVID-19
An opportunity to give access based on clinical need rather than skill in navigating the system. ***"Total triage/care navigation- significantly reduced poor use of GP time, right person at right time. Learning to work differently."***
E-consult improves access – quick/easy, appropriate for some conditions, cost savings (end to wasted appointments and time/money attending the surgery).

Questions on pre-COVID-19 experience reveal that issues around access to Primary Care are not new, but now they appear exacerbated and more prevalent.

1.2 Availability of Services

Availability of Services Concerns during COVID-19
Cessation of important routine checks - blood tests, blood pressure, dental/eye /hearing tests, podiatry, health visitor services, antenatal services, long-term condition reviews, screening, B12 injections, full contraceptive options.
Emergency care - very sick people having to attend A&E/wait, long wait on phone to 111, don't know who to turn to in emergency/lack of help, slow ambulance response times.
Communications - poor information online leads to individuals relying on Google, difficulties in being able to take call-backs if e.g. at work, perception of services being 'closed' delaying presentation, having to be an emergency to be seen ***"Passed from pillar to post from doctor to community to here's a number to call or try Woodend direct to get hearing test no-one takes direct responsibility for anything these days."***
Health consequences – delayed diagnosis/treatment/surgeries have potential to cause actual harm, limited rehabilitation options meaning poor recovery, worsening long-term conditions, effect of long COVID, impact on mental health and wellbeing, subsequent impact on social care.
Fear that services won't return.
Individuals feel they're being forced to seek private care.

Availability of Services Positives during COVID-19
Faster response in emergency situations.
Greater flexibility in appointment times.
Continuation of specific services - examples of treatment continuing, access to medication/ pharmacy, continued palliative and end of life care, blood hubs, ***"Although things were seriously stretched in the main things didn't stop which was incredible."***

Pre-COVID-19 concerns show many of these issues are not new, e.g. lack of flexibility in appointment slots, lack of support for carers, lack of mental health support/services, surgery cancellations, and no regular checks for older people or increasing intervals between screenings.

1.3 Community/Local services

Community/Local services Concerns during COVID-19
Closure/Reduced Services at community level.
Specific services mentioned which have been reduced or removed from communities - Minor Injury Units, A & E Services, out of hour's services, outpatient clinics, maternity services, rehab services, end of life care services.
Travel - need to travel further to access services, lack of optimal public transport to ARI from rural areas, families unable to visit as regularly if relative admitted to ARI. ***"Safe, healthy and sustainable transport – there are many parts of the region with poor provision of public transport"***
Poor communication - lack of updates and information about local services being reduced/cancelled.
Emergency Care - concerns about accessing ambulances within suitable timescales in rural areas.

This theme was also apparent in pre-COVID-19 concerns – as above and in addition

- Perception of services being 'centralised' to ARI
- Downgrading of Dr Grays Maternity Unit
- Reduction of outreach to local community hospitals by ARI Consultants
- Travelling further to Community Hubs for procedures previously done at GPs
- Concern of the added pressure to ARI with Community Hospital closures

Community/Local services Positives during COVID-19
Community Pharmacies - available throughout pandemic, access to advice/medication, good linkage with medical practices. ***"Pharmacies made it easier to gain access to medicines when people couldn't during lockdown"***
Local COVID services (testing and vaccination) - avoiding unnecessary travel, appreciation of some services still available locally

1.4 Waiting Times

Waiting Times Concerns during COVID
Communications – lack of updates and information, no-one available to answer questions, length of time waiting on the phone.
Also lack of follow-up and delays in results.
Impact of COVID - redeployment of workforce, reduced numbers able to be seen in clinics, not enough staff available.
Health consequences – delays putting health at risk, effect on quality of life, affecting mental health and wellbeing, coping with chronic pain. ***"Long waits for people requiring surgery. A lot of people have had to endure severe pain who might have been operated on very quickly to reduce complications"***
System consequences - waiting times for diagnostics impact on Primary care who need to manage symptoms meantime.
Feeling of being bounced between Primary and Secondary care.

Feeling that going private is the only option. ***"Looking to go private for an operation as felt very dismissed by a doctor who wouldn't explain pros and cons of choices offered or give even the vaguest idea of the waiting list (months? years?)."***
Specific services mentioned: ED/A&E/Ambulance service, 111 triage, Mental health/CAMHS, Psychotherapy, Elective surgery, Orthopaedics, Gynaecology (1), Diabetes, Dentistry, Optometry, Physiotherapy, Occupational therapy, Podiatry (1), Audiology, Paediatric ENT and Screening.

Questions on pre-COVID-19 experience reveal similar themes with the additions:

- Concern about out of date medical info by the time you get to appointment
- Transfer times between hospitals
- Perception of Treatment Time Guarantee "written into law" and not being adhered to

Concerns expressed more frequently pre-COVID-19 (158 references) than during COVID-19.

Waiting Times Positive feedback during COVID-19
Able to be seen urgently when needed. ***"I was seen very quickly when presenting with a potentially urgent complaint"***
Time taken at appointment - quicker process as fewer patients.

2. QUALITY

2.1 Quality of Care

Quality of Care Concerns during COVID-19
Lack of holistic approach - focus on speed of discharge risks safety and impacts on quality rehab, less able to give patient-centred care, lack of follow up.
Lack of continuity of care - between different professionals, impact of workforce issues (e.g. locums), misplacement of samples/results. ***"Lack of continuity in diagnosing an illness, lack of availability of specialist Drs, poor information sharing, leaving me feeling isolated, confused and in pain"***
Lack of equitable care - perception of 'postcode lottery'.
Poor communication – perception that staff can be rude, abrupt or uninterested, reduction in face to face appointments gives perception of less compassion, face masks impact on engagement face to face.
Too much focus on COVID-19 to detriment of other conditions.
Too much focus on medication/disease management.
Poor way of approaching 'do not resuscitate' conversations.
Restrictions in wards limited patient rehabilitation.
Delays in presentation lead to missed diagnoses, increase in health debt/unmet need.
Isolation - individuals facing diagnosis alone.

Quality of Care Positive feedback during COVID-19
COVID-19 care praised – acknowledgement of staff going 'above and beyond', saving lives or providing dignity at the end, support from individual practitioners. ***"Amazing dedication of local healthcare workers and doctors during very difficult time"***
Value placed on NHS by wider community.
Improved cleaning protocols.
Medication delivery service.
Ability to see patients who needed to be seen more quickly (staff comments).
Tighter triage processes (staff comments).

2.2 Face-to-face contact

Face to Face Contact Concerns during COVID-19
Face-to-face appointments not available. ***"Increased automation of services was always going to happen. COVID rapidly brought this on quicker. My only fear would be losing too much human contact and too quickly (some is essential and can't be replicated by automation or remote services)"***
Poorer quality of care.
Potential for misdiagnosis.

3. Digital technology

Digital Technology Concerns during COVID-19
PUBLIC
Lack of choice - digital becoming default, 'forcing'/'bullying' into using, 'told off' for not being able to use, money saving exercise.
Confidentiality - maintaining this in home setting, data security (e.g. sending photos).
Access - exclusion of vulnerable groups, lack of technology to use, internet connectivity issues, competency in using digital, support needed for hearing impaired.
Stressful for patients.
Health consequences - delays to diagnosis and treatment.
Appointment times not flexible enough.
Strong preference for a choice of appointment type – digital doesn't work for all types of appointment.
EConsult – takes too long, too many questions, shouldn't information be in record? Errors – advising to call 111 when not urgent.
STAFF
Pace of change - need adequate workforce capacity, paper-based records still used in some areas.
Access - lack of/outdated IT equipment, access to systems needed, competency in using digital better training needed.
Not appropriate for all appointments (e.g. importance of touch for end of life care).
Difficulty assessing patients remotely – rely on patient report.

Digital Technology Positive feedback during COVID-19
PUBLIC
EConsult - quick response time, easier to use if awkward or embarrassing issue, good for minor issues, good for requesting fit note.
Near Me - easy to use, avoids travel, flexibility of appointment type, fewer wasted appointments. ***"Giving patients the choice if they want a face to face, telephone or near me consultation."***
Other systems - able to get repeat prescriptions, send photos for review, online appointment booking, text reminders, virtual visiting, online cardiac rehab classes.
National systems - NHS Inform updated, 111 advice.
Online information - website information improved, BSL videos.
STAFF
Digital systems - Microsoft 365, electronic records, Vision Anywhere app.
Improved IT equipment.
Allowing for improved remote working.

Near Me - allows face to face options to be retained for those who need them, virtual clinics with other professionals.
MS Teams - improved communication, more effective meetings, saving time as no travel, accessible learning/training options. ***"Meetings on Teams were introduced saving travel time"***

This theme had a wide spectrum of positives and concerns, sometimes within the same response as illustrated by this quote:
"Greater use of video technology has been quite welcome and saved travelling but this should be an option rather than the only option"

References to 'before COVID-19':

- 94 similar positives, acknowledging that systems had started to be introduced but COVID has meant further/faster rollout.
- 46 similar concerns incl. mention of being 'behind the times'

4. Empowering Individuals

Empowering Individuals What is needed to stay well and in good health?
Know who to turn to when help is needed.
Quick, local access to healthcare when needed.
Self-management.
Being listened to / involved in care decision.
Access to information – online or leaflet form.
Medical professionals that know them.
Regular routine health checks.
Taking responsibility for Lifestyle choices - Stop smoking, Consume less alcohol, Healthy diet, Exercising, Reduce stress, Regular social contact.

Empowering Individuals Staff were asked what they thought would empower individuals
Education.
Good signposting to information / services.
National media / advertising on good health.
Promotion of healthier lifestyles within schools.
Being honest and transparent on options to change behaviours.
Engage with the public on what matters to them.
Provide holistic care.
Recognition that some people do not want to change behaviours, may require incentives to do so.

5. Enabling the Workforce

The questions were adapted a little for respondents that chose the 'member of staff' option and at staff team/department discussions:

1.Can you think of 3 things that you liked or appreciated about the way that service was delivered before COVID-19?

2.Do you have any worries, concerns or disappointments about the way that service was delivered before COVID-19?

3.Can you think of 3 things that you liked or appreciated about the way that service was delivered during COVID-19?

4.Do you have any worries, concerns or disappointments about the way that service was delivered during COVID-19?

5.We want to empower patients to take more responsibility for their own health and be able to live well for longer – how do you think we can achieve this?

6.What would enable and empower staff to carry out their role to the best of their ability, and be able to reach their full potential?

Below is a summary of what matter most to our staff –

Remobilisation of services
Clarity needed over areas with temporary ward/clinic closures.
Impact of slow remobilisation on waiting times / backlog / health debt.
Feeling remobilisation could have happened sooner.
Devaluing services that are not yet remobilised.
Learning needed from redeployment process.
Staff levels / pay.
Impact of under resourcing on individual staff members / need for appropriate staffing levels to ensure more than just firefighting – applicable pre COVID and has been made worse.
More efficient recruitment process to ensure vacancies advertised quickly.
Volume of staff in interim roles – impact on retention.
Acknowledgement of difficulties in attracting staff to Grampian but request that more is done on this.
Fair pay, including within social care sector.
Learning & Development
Need for career progression pathways.
Access to IT to participate in virtual learning opportunities.
Protected time for training.
Greater autonomy to pilot/test ideas.
Improved training provision for IT systems.
Increase opportunities to shadow staff in other wards/areas/depts.
Bank staff need access to CPD as well.
Quality annual appraisal process consistently across organisation.
Access to coaching and mentoring.
Induction processes need to improve.
Work patterns
Desire for flexibility working ability where roles allow (e.g. greater home working).
Need for adequate IT infrastructure to support flexible working.
Need for protected time for development, thinking, and spending time with clients/patients.
Flexible working does not mean staff have to be constantly available.
Reduction in travel times (e.g. commuting, travel to meetings) appreciated.
Need to break cycle of back to back meetings.
Adapting to change
Acknowledgement of 'all in it together' feeling at the beginning of the pandemic – great team working, adaptability, dedication.

Acknowledgement of the ability to make important changes happen quickly when all focused in same direction – how do we ensure we don't return to previous level of bureaucracy?
Need for greater innovation going forward.
Collaboration
Examples of ways in which teams/depts./orgs have worked together well during the pandemic.
Ability to work in a multidisciplinary way.
Important to keep collaborating across the system in its widest sense.
Acknowledgement that ability to network with colleagues is less at the moment due to no face to face events.
Communication
Appreciation for communication methods during COVID – daily briefs, huddles, etc.
Communication between departments/sectors need to improve (e.g. awareness of impact of changes on others).
Acknowledgement that MS Teams has improved communication ability in some ways, but less face to face with colleagues/teams has been detrimental as well.
Desire for open, transparent and consistent communications from senior leaders.
Impact of masks on ability to communicate well face to face with colleagues and patients.
Importance of timing of communications (e.g. 4.30pm on a Friday not appropriate).
Leadership / Management
Need for visible support from line managers and senior leaders / compassionate management.
Acknowledgement needed that staff need time to recover.
Importance of praise, appreciation and constructive feedback.
Less micromanagement / need to give staff autonomy / too hierarchical.
Need for clearly communicated priorities.
Development of management skills to support managers in their roles.
A lack of physical management presence during COVID pandemic.
Senior leaders need to be role models.
Staff appearing to be given new / promoted roles with no fair recruitment process.
Improved support for managers to address performance issues.
Wellbeing
Acknowledgement that strict infection control procedures kept staff safe during COVID.
Acknowledgement of feelings of isolation, fragmentation, stress and worry still continue.
Acknowledgement of difficulties for shielded staff.
Exhaustion / impact of being on 'high alert' for long periods.
Importance of ensuring staff able to take breaks / leave.
Unrealistic expectations of workloads remain.
Flexible working to improve work/life balance.
Access to wellbeing activities during work time.
Proper rest facilities in our premises.
Detrimental effect of feeling not providing good care.
Encourage and support staff to make healthy lifestyle choices.
Being valued
More obvious appreciation / give praise.
Impact of redeployment – staff feeling depersonalised and a number to be slotted anywhere.
Equal value on developing long term staff, not just new staff, trainees, students, etc.
Demonstrating trust and giving autonomy where possible.
Understanding, acknowledgement and appreciation of all roles by senior leaders.
Involve staff of all levels in decision making.

Summary

Analysis of these eight sub themes informed the questions used in focus groups and engagement sessions in phase two, in order to flesh out the detail further to understand the context and barriers and begin looking towards potential solutions.

Relevant elements of the feedback were also shared with other services/teams/partners to help inform their own planning and service development. In the interests of making best use of such detailed and valuable feedback that respondents have taken the time to provide, it is important to ensure it is fully utilised and there is no duplication by others going out to ask similar questions. This included the development of a series of 'Positivitree' resources, where positive comments praising staff and services were shared with our workforce to highlight that while we received many concerns, we also received many expressions of appreciation.

This report forms part of a suite of documents summarising the engagement approach and findings as part of the overall process. The feedback from both phases is also separately being analysed in terms of 'personas', illustrating the findings from the perspective of different identified population groups.

The analysis of both phase one and phase two will be triangulated with what we already know about population health needs, local and national policy and other drivers in order to inform the strategic intent of NHS Grampian, which will be set out in the Plan for the Future 2022-2028.

How we continue these conversations will form a key part of the way forward, in order to build on relationships and move away from 'a moment in time' engagement for a project towards the goal of collaboration and co-design of services.

Report produced by the Plan for the Future – Analysis & Evaluation Group
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