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Integrated Care Board

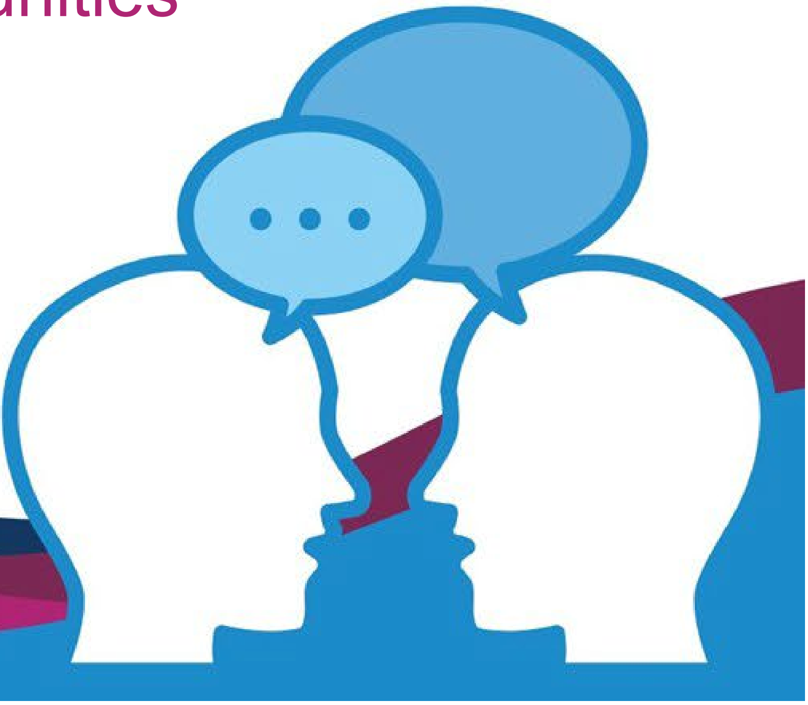
Insight

Pre-consultation engagement report

Right care, right place: proposed reduction in beds at Royal Lancaster Infirmary

Listening to communities

April 2026



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Introduction

NHS Lancashire and South Cumbria Integrated Care Board (ICB) is investing in a variety of ways to reduce demand on hospital services by increasing capacity in the community. This includes investing in more primary care, partnership working in local communities and collaboration with voluntary, community, faith and social enterprise organisations. This is part of a national shift to move care from acute settings closer to communities in neighbourhoods.

As a result of this work, University Hospitals of Morecambe Bay NHS Foundation Trust (UHMBT) is proposing to close two wards (48 beds in total) in the Castle View Unit at the Royal Lancaster Infirmary (RLI). If approved, the closures would happen gradually:

- **Stage 1:** One ward (24 beds) would close in late 2026.
- **Stage 2:** The second ward (24 beds) would close later, but only if it is safe to do so.

The case for change was presented to NHS Lancashire and South Cumbria Integrated Care Board on 19 March 2026 and was approved. However, no final decision has been made to close any wards, and a detailed pre-consultation business case (PCBC) is being developed.

The proposal is not about cutting services. It is about:

- Making sure people receive the right care, in the right place, at the right time.
- Reducing unnecessary hospital stays.
- Shifting care closer to home where possible.

As of 28 April 2026, 25 per cent of beds at the RLI are occupied by patients who do not have a need for ongoing medical care – they do not meet the criteria to reside. The wards in Castle View were originally used for rehabilitation but are now mostly used for patients who are simply waiting for onward care – not for those needing acute medical treatment. These patients would be better supported outside the hospital.

Evidence shows that every extra day in hospital can slow recovery, especially for older people. Helping people return home sooner supports better outcomes, independence and wellbeing.

The proposal reflects national NHS priorities to shift care:

- From hospital to community: moving care away from hospitals and closer to home, focusing on community and primary care.
- From sickness to prevention: shifting focus from merely treating illness to preventing it, addressing health issues earlier.
- From analogue to digital: modernising services through digital technology to reduce admin, improve efficiency, and enhance patient experience.

You can read more about the proposal on the ICB website: LSC Integrated Care Board :: Right care, right place: proposed reduction in beds at Royal Lancaster Infirmary.

This report analyses feedback gathered during a period of pre-consultation engagement that took place between 27 March and 27 April 2026, which will be used to inform the PCBC.

Executive summary

This report summarises what we heard during pre-consultation engagement about the proposal to reduce bed capacity (two wards/48 beds) in the Castle View Unit at the RLI, alongside plans to strengthen community-based alternatives.

Feedback was gathered through a mix of targeted community outreach (25 people) and questionnaires: a community engagement questionnaire (281 responses), alongside smaller patient (12) and family/friend/carer (6) questionnaires. Two pieces of standalone feedback were also received via email, bringing the total number to 326.

Overall, people recognise the benefits of supporting recovery at home or closer to home when safe but emphasise this will only be trusted if community and social care capacity, coordination and responsiveness are demonstrably in place.

Key findings

What people valued about inpatient care

- Kind, caring and professional staff who listen, explain and reassure.
- Confidence in clinical care, diagnosis and treatment.
- Feeling safe with 24/7 support, monitoring and timely access to pain relief/medicines.
- Basic needs being met (food, cleanliness, comfort) and a calm, supportive ward environment.
- Efficient access to tests and specialist services once admitted.

Key issues and concerns raised

- **Access and flow:** long waits, lack of beds and reports of corridor care.
- **Staffing pressure and responsiveness:** delays to call bells and concerns about basic care needs (toileting, hydration, feeding and dignity).
- **Communication:** difficulty getting clear updates; inconsistent information between teams; families feeling excluded from discussions.
- **Environment:** noise affecting rest, cleanliness/comfort issues and ward facilities.
- **Discharge and transfers:** delays (particularly waiting for take-home medicines), disorganised planning, and some reports of rushed/premature discharge or weak handover to community services.
- Nearly **88 per cent** of community questionnaire respondents with recent inpatient experience said there are **gaps in community and social care support**.
- Community questionnaire respondents' **top three concerns** about leaving hospital were **support at home, having a care plan, and safety at home**.

Views on care closer to home (and what would build confidence)

- Many people support recovery at home or in a community/step-down setting **when it is safe**, but repeatedly highlighted that **one size does not fit all** and decisions must be based on individual circumstances.
- Nearly **two thirds** of respondents to the community questionnaire who had spent time in hospital said **recovery was better after leaving hospital**.
- More than half of respondents to the community questionnaire believe people **recover best by leaving hospital as soon as they are medically fit**, with the right support.

- Nearly **90 per cent** of respondents to the community questionnaire would be **happy to receive care at home or closer to home** when it is safe.
- There is strong concern about gaps in **social care capacity** (availability of carers, care packages and care home places) and delays in **rehabilitation and equipment** (physio/OT).
- People described services as feeling **not joined up**, with unclear ownership and weak communication between hospital, community health and social care.
- Confidence would be improved by **a clear, coordinated care plan**, a **named contact/coordinator**, and **responsive access** (including out-of-hours support) if needs change or deterioration occurs.
- Some people also raised concerns about **digital exclusion** – for example, that **repeat prescription ordering** can be harder for older people without online access, potentially increasing medication lapses and avoidable admissions.
- Assurance that community provision is **high quality** and adequately resourced, with appropriate clinical input, and that families/carers are involved and supported.

These insights will be used to shape the pre-consultation business case (PCBC), including how the proposal is communicated, and the evidence required to demonstrate that community and social care alternatives are safe, coordinated and sustainable before any reduction in bed capacity is implemented.

While people raised important concerns about the inpatient experience, the factors that most shaped confidence in a safe reduction in bed capacity were the readiness, capacity and coordination of community health and social care, and the strength of discharge and transfer pathways.

What have we been talking to people about and why?

Currently, too many people remain in hospital beds even after they no longer need hospital-level treatment. This isn't anyone's fault – it is how the system has evolved – but it isn't what patients want, and it isn't what is best for their health.

Healthcare professionals are clear: when people, especially older people, stay in hospital longer than they need to, their health can worsen. Longer stays can lead to:

- Loss of strength and mobility
- Reduced confidence
- Memory decline
- Loss of independence

This can make it harder for patients to return home and may mean they need more support in the future. People recover better and faster at home or in community settings, when it's safe for them to do so. At the same time, the NHS is under real financial pressure. Wards being used for patients who don't need acute hospital care take money away from services like emergency care and planned treatment.

The pre-consultation engagement focused on understanding people's views and lived experience of receiving care as an inpatient in hospital, what was good/positive about that care and what was bad/negative. The engagement also allowed people to share their views on out of hospital care, or community services and social care, as well as understanding where people feel care would be best delivered.

What have we talked about before?

Prior to the pre-consultation engagement, a robust desktop review was carried out which supported the case for change. The review looked at existing insight gathered between 2023 and early 2026 by UHMBT, the ICB and partners, drawing on:

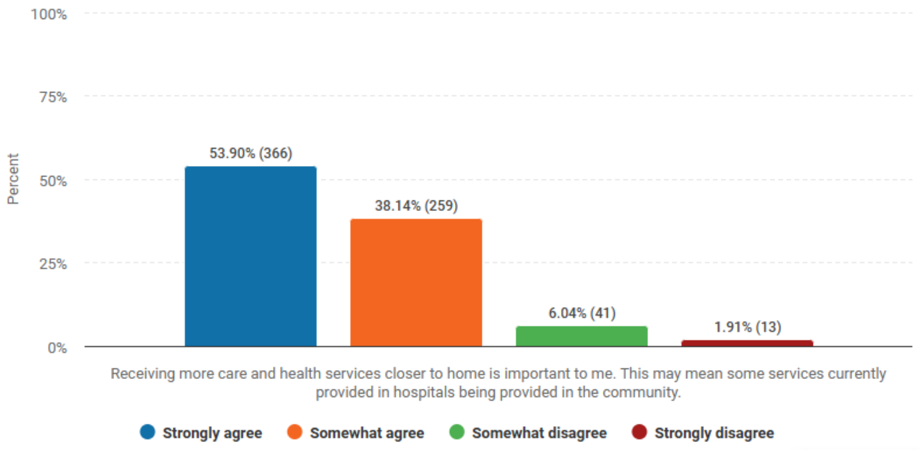
- Patient experience data and complaints
- ICB led engagement and insight reports
- Healthwatch intelligence
- Survey data (e.g. GP Patient Survey, Virtual Citizens Panel)

The desktop review incorporated the views of over 24,688 people across various insight gathering programmes. Overall, the insights highlighted strong public support for more community-based models of care and care closer to home, but also identified significant risks and system weaknesses that must be addressed if such a shift is to be safe, effective, and publicly supported.

Patient experience feedback showed that while overall ward satisfaction scores are generally positive, concerns persist regarding staffing levels, communication, and discharge processes, with several comments identifying delays or unsafe discharge arrangements linked to gaps in community support and coordination.

Reports of community services and onward care not being available or poorly organised raised questions over whether services could cope with additional pressure caused by ward closures. We also know, from other service change programmes, people are very loyal and defensive of their local hospital and therefore take a negative view of anything that is perceived to be down-grading or removing services. If the proposal was to be approved, one of the biggest considerations must be how the change is communicated; it must be done in a way that promotes understanding and reassures patients.

Following the completion of the desktop review, and during the time of the pre-consultation engagement, a wider future health and care services questionnaire was circulated to people living across Lancashire and South Cumbria. A total of 685 people responded to that questionnaire, notably, 92 per cent of respondents agreed to some extent that receiving more care and health services closer to home, which may mean some services currently provided in hospitals being provided in the community, is important to them.



At least 88 of those people were from the Morecambe Bay area. You can view the insights report for that questionnaire here: Have your say on planning health and care services for the future

Who have we heard from and how?

Deciding who to talk to

Fifty-four per cent of patients discharged from the Castle View Unit are female, and female patients account for 55 per cent of not meeting medical criteria to reside (NMC2R)-attributable bed days associated with discharges from the unit. This slight female bias is to be expected given the population pyramid for older patients, who are more likely to be users of the unit (only four per cent of Castle View discharges are aged under 65, with 69 per cent aged 80 or over). People on the wards have mainly medical conditions covering a wide range, such as dementia and Parkinson's disease, and with mobility issues and might need home adaptations and ongoing care needs.

The ICB’s system intelligence service identified the main long-term conditions for people in that age range as being:

- Diabetes
- CKD
- Cancer
- Atrial fibrillation
- COPD
- Heart failure
- Dementia
- Rheumatoid arthritis

Consequently, support groups and networks aligned to the above conditions were targeted for this engagement.

How did we speak to people?

To ensure feedback opportunities were as accessible as possible a range of engagement techniques were adopted.

Several face-to-face engagement opportunities were delivered through community outreach which included meeting with the Barrow Resolve and Women’s Community Matters groups, as well as direct conversations with a number of individuals – delivered by the ICB’s engagement team.

Three separate questionnaires were developed:

- a generic questionnaire to support community engagement – shared across a wide variety of stakeholders and VCSFE partners in the Morecambe Bay footprint for onward distribution and via the ICB’s Influence Network;
- a questionnaire aimed at people currently being cared for in the Castle View Unit – delivered face to face by UHMBT’s patient experience team;
- a questionnaire for family/friends/carers of people currently being cared for in the unit – delivered face to face by UHMBT’s patient experience team.

How many people got involved?

Throughout the course of the pre-consultation engagement, feedback was received from a total of 326 people broken down as below:

- Direct correspondence – 2
- Community outreach – 25 people
- Community engagement questionnaire – 281 responses
- Patient questionnaire – 12 responses
- Family/friend/carer questionnaire – 6 responses

A breakdown of the demographics for the questionnaire respondents is provided in appendices 1, 2 and 3.

What did we hear?

Direct correspondence

Two individuals shared direct correspondence with the Trust and ICB. One individual presented a detailed set of case studies which can be summarised as below:

The correspondence raised strong concerns about the proposed closure of the beds at RLI, arguing that the beds provide a crucial “step” between acute treatment and safe discharge home. The individual accepts the principle of supporting people at home where possible, but questions how this can work in practice given limited capacity in physiotherapy, occupational therapy and (especially) hospital social work to complete assessments, coordinate funding, and put appropriate packages of care in place. They highlight that many older people have complex needs and limited informal support (living alone, unsuitable housing, frail partners, distant families), so discharge decisions depend on reliable, timely community services – yet the current system is described as inconsistent and already struggling.

Using detailed case studies, the individual describes risks of unsafe or poorly supported discharge and of variable quality in care homes and home care: delayed or absent rehab, lack of equipment/adaptations, poor continence/toileting support, inadequate OT/physio follow-up, and medication errors or timing problems that can worsen conditions like Parkinson’s. They also argue that bed pressures are already evident (patients placed on other wards while awaiting Ward 22), so removing beds may worsen flow and safety rather than improve it. Alongside this, they call for stronger intermediate/step-down “convalescent” provision with embedded therapy and practical rehabilitation facilities, and raise a separate concern about repeat prescription ordering becoming harder for older people without digital access – potentially increasing medication lapses and avoidable admissions.

Community outreach

Of the 25 people spoken to in total, this included 17 women and eight men aged:

- 24-34 = 1
- 35-44 = 3
- 45-54 = 1
- 55-64 = 11
- 65-74 = 3

- 75 and older = 6

Thirteen people identified as a carer or family member, while 12 were patients. Twenty-four people described their ethnicity as white British and one Eastern European. Fifteen people lived in Barrow, two in Kendal, five in Lancaster, one in Millom and two in Ulverston.

Four of the people we spoke to shared views relating to an inpatient stay of less than one month, 16 had a stay of 1-3 months, and five 3-6 months.

The tables below, and all subsequent tables of this manner in this report, demonstrate the top five themes in frequency order with representative example phrases for each question. Example phrases are primarily taken verbatim from responses (with minor typo correction only where needed for readability). In a small number of cases, wording has been lightly edited for brevity/clarity (e.g. shortened with an ellipsis) or combined where multiple responses used very similar wording. Themes and frequencies are based on all responses and individual responses may be counted in more than one theme.

Q1: What was positive about the stay?

Theme	Frequency	What people valued	Example responses
Feeling safe/ in safe hands	11	Reassurance that they/their loved one was safe, in the right place, and being properly cared for (reduced fear and worry).	“Feeling that I am in safe hands and don't have to worry” “I got looked after and was not frightened of feeling so poorly”
Kind/caring/ Compassionate staff	6	The attitude and interpersonal care from staff (kindness, compassion, being listened to), and the impact this had on patients and families.	“The nurses were wonderful, kind, caring and compassionate” “Caring staff, knowing my mum was safe”
Clinical care/treatment/ medication	6	Confidence that staff knew what they were doing and the person was getting the right assessment, investigations, and treatment/medication to improve.	“...getting the right help and medication” “...knowing they are getting the best treatment”
Pain/symptom relief/feeling better	5	Relief from pain and symptoms, and reassurance that discomfort was being managed so the person could recover and return home.	“Knowing someone I love is not in pain” “Safety, being looked after, pain managed”
Family reassurance/ respite from worry	4	Space to rest and reduced emotional burden for family/carers (not feeling alone or out of depth; confidence their loved one was supported).	“...having some respite from the worry” “The respite it gave me...”

Q2: What was negative about the stay?

Theme	Frequency	What people wanted	Example responses
Separation from family/ home/pets	9	Comfort and emotional wellbeing from being with loved ones and in familiar surroundings (including home and pets).	“Being away from my sons and daughters is hard” “Being away from my home and cat”
Ward environment noise/distress	3	A calm, quiet, dignified environment – especially for people who are distressed or nearing end of life.	“The ward was very noisy and people moving around a lot...” “...being surrounded with patients who were distressed/noisy was also difficult”
Bed pressures/ moves/transfers	3	Stability and continuity (not being moved between wards; timely transfer to the right place).	“Being moved around when beds were needed...” “...bed shortages and her having to move wards”
Communication/ coordination gaps	3	Clear, consistent updates and a named person to coordinate care and information (so people don’t feel left in the dark or have to repeat themselves).	“Lack of information sharing, updating the information...” “Lack of information sharing, no keyworker or coordinator”
Travel burden for visiting	2	Being able to visit easily and regularly without long journeys or added stress/cost.	“having to travel to visit...” “Travelling to visit...”

Q3: How was the discharge process?

Theme	Frequency	What people wanted	Example responses
Overall good/okay/ straightforward discharge	10	A smooth process without complications – feeling the discharge “worked” and people could get home as planned.	“Straightforward” “Discharge was okay for me”
Delays/waiting to go home	7	Timeliness – being able to leave hospital when ready, without long waits for arrangements to be put in place.	“Waiting to go home took too long!” “It took a long time to organise everything for him to come home”
Medication/ prescription delays	2	Having medicines ready promptly at discharge, so people aren’t kept waiting and can go home safely with what they need.	“Waited for prescription for hours” “...I had to wait hours for my medication”
Transport/at-home arrangements delays	2	Practical coordination (transport and home-based assessments/support) to be organised quickly and reliably.	“...we had to wait a long time for transport to be organised” “I had to wait longer that I wanted to whilst

			assessments took place at home”
Clear/sensitive information and planning	2	Good communication – clear explanations and sensitive planning so people understand what will happen and risks are managed.	“Excellent, explained everything I needed” “There was a real need for the process to be handled sensitively and carefully...”

Q4: What was recovery like?

Theme	Frequency	What people wanted	Example responses
Home supports recovery/ comfort	15	Being in familiar surroundings (and happier/more settled) once well enough – feeling that home aids physical/mental recovery.	“Once I felt better I recovered better in my own home” “I recover better at home once I feel well enough to be there”
Hospital needed for treatment/ stabilisation	6	Access to the right medical care (treatment, monitoring, stabilisation) to get well enough to leave safely.	“I felt better once I was in hospital and received the treatment I needed...” “Recovered better in hospital because he needed to be there to have the right medical treatment...”
Ready/well enough before going home	6	Confidence that discharge happens at the right time – only once symptoms are controlled and people feel reassured it’s safe to recover at home.	“He recovers better at home but I need to know he is well enough to be at home” “I always feel better once I'm home but only when I feel physically well enough and reassured”
Balanced discharge/avoid premature discharge	2	Getting the balance right – neither keeping people in unnecessarily nor discharging too early; safe handover of information to prevent avoidable readmission.	“I was discharged too quickly and ended up being admitted again two days after discharge.” “One of the issues was that information wasn’t passed on as it should have been”
Mental health needs/joined-up support	2	Joined-up planning and support (including mental health) so recovery at home is properly supported and doesn’t deteriorate.	“...her mental health is a big factor in her recovery and services need to talk to one another...” “...with the right help and planning she does better at home but unless handled carefully things can very easily go wrong”

Q5: Do you feel you could/should have accessed any services in the community which may have prevented you from being admitted to hospital in the first place/what are your thoughts on access to services in the community to prevent admission/?

Theme	Frequency	What people wanted	Example responses
Accessing community/ third sector support (positive)	9	Local, practical and emotional support that helps people stay well at home; social connection (clubs); charities providing food/financial help; services that are known and easy to use.	"We have and do access many local community services here and they have helped us enormously" "I do access local services in the 3rd sector and they are very good"
Not needed/not appropriate (circumstances require hospital/medical expertise)	7	Care that matches clinical need, including access to specialist medical expertise when required; realistic decisions about what can/can't be supported in the community.	"No I didn't feel it was appropriate in my circumstances" "No I don't you feel safe in hospital knowing the staff are experts in your need for treatment"
Not sure/ unknown what is available (signposting)	2	Clear information about what support exists locally, eligibility, and a straightforward way to find out/ask for help.	"I don't always know what is available in my area or who to ask to find out" "I don't know but probably not"
Services not joined up (coordination/ information sharing gaps)	1	Joined-up care with information sharing, coordination, and a lead professional/keyworker to reduce duplication and ensure support is coherent.	"Again what we have found is that the various services no longer work together effectively or share information properly so that there is often little if any coordination/keyworking/lead professional and they are risk averse"
Services/ workforce need more time/continuity (repeat questions, knowing the person)	1	Continuity and time to build understanding of people's histories and needs; less repetition and more personalised treatment/medication choices.	"I think there should be more services that have the time and can take the time to get to know people like my mam who has a history of involvement with all services so that they can understand her, not keeping asking her the same questions and also prescribe the best treatment and medication"

Q6: Do you believe there are gaps in community/social care provision?

Twenty respondents said they believe there are gaps and five were unsure, below are the themes from further comments made.

Theme	Frequency	What people wanted	Example responses
Funding pressures	6	Stable, sufficient funding for community, social care and voluntary/third sector services so support is available when needed.	“Yes there are gaps in all services including charities due to lack of funding” “Yes I know that there is not enough funding available”
Staff shortages/ turnover/ recruitment	4	Enough staff, with continuity and stability, so people get consistent care from a workforce that is retained and supported.	“Yes there are long waits and lots of staff turn over and shortage in all services” “I think there seems to be a shortage of staff everywhere”
Lack of integration/ communication	2	Joined-up working across services, with clear communication and information sharing so people feel confident and supported.	“There are gaps due to lack of funding but there are also gaps because of the lack of working together or integration...” “Yes. Total lack of communication. Rather frightening”
Waiting times/delays	1	Timely access to support without long waits, so needs are met early and don’t escalate.	“Yes there are long waits and lots of staff turn over and shortage in all services”
Complex needs not well supported	1	Tailored, proactive support for people with complex needs and multiple issues, so they don’t fall through gaps.	“Yes definitely especially for people like my mam who has a complex and long history of involvement and use of health services”

Q7: What do you feel helps people with recovery?

Theme	Frequency	What people wanted	Example responses
Kindness/ compassion/ time to listen	7	Warm, human care – staff who are kind, patient and compassionate, take time, and listen/understand what matters to the person and family.	“Kindness, compassion, time...” “Kindness, understanding, time to listen...”
Right medication/ treatment/clinical expertise	7	Skilled clinical care (good doctors/nurses, thorough assessment) and getting the right medication/treatment (including pain	“Correct medication, medical expertise...” “...the correct and best medical treatment”

		management, surgery if needed).	
Leaving hospital when fit/ ready with right support	7	Being discharged at the right time (medically fit/ready/stable) with tailored support for the person and family, so recovery can continue safely at home.	"...leaving hospital as soon as they are fit with the right support..." "As long as they are completely ready!"
Joined-up care/shared information	5	Good coordination between professionals and services – shared records, information passed on, and fewer repeated questions – so decisions are well-informed and trusted.	"Shared records/information being passed on makes a big difference..." "Shared information, not having to keep answering the same questions..."
Family/friends/ pets support	2	Emotional and practical support from loved ones (and pets), helping people feel safe, motivated and cared for during recovery.	"Being able to see their family..." "...family, friends, pets"

Q8: What are your thoughts on care being provided closer to home rather than in hospital?

Theme	Frequency	What people wanted	Example responses
Prefer home/ closer to home if possible	9	Comfort, familiarity and wellbeing from being at home/near home, where people often feel better and more settled.	"Yes I believe they are better at home" "I would much rather be at home or as close to home as I can be"
Right support available at home (including carers)	7	Reliable, adequate home-based support (community services, carers, consistent staff) so home care is safe and workable.	"I would be happy as long as there was the right support available at home" "If there was the right amount of care, easy access to services and consistent staff..."
Safe/appropriate timing (hospital first if needed)	5	Safety and clinical appropriateness – staying in hospital until well enough and/or having necessary treatment first before home-based care.	"I am not sure about it and I think people should stay in hospital until they are well enough for discharge" "Happy it right support available as long as my dad has received the medical treatment he needs in hospital first"
Shared decision-making/ individual circumstances	5	Care tailored to the person's needs and context, agreed in partnership with the patient and family/carers (not "one size fits all").	"It needs to be worked out on an individual and nuanced basis..." "If needed it is a good idea as long as the

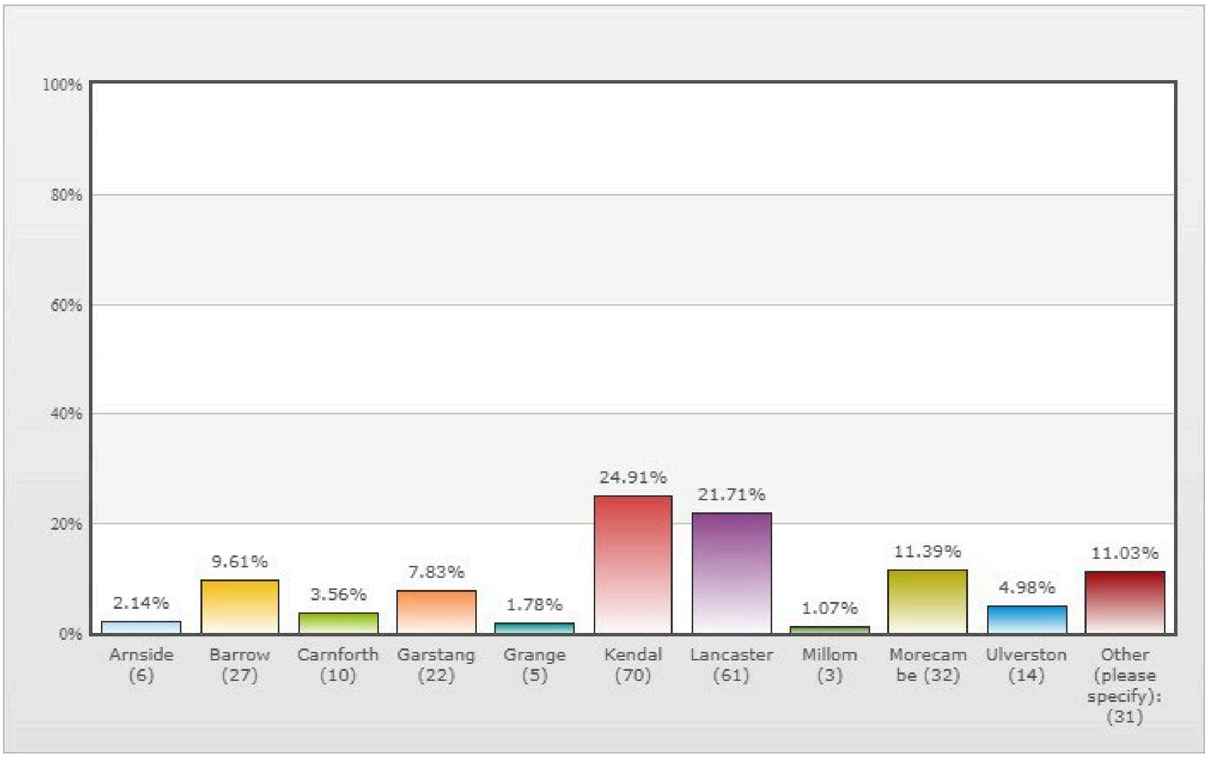
			person concerned is in agreement”
Support for family/carers/ inequality of support	5	Recognition that families/carers may carry a heavy burden, and that not everyone has the same resources – support should be equitable and include carers.	“It is very hard for family who are looking after someone they love in difficult circumstances and they need support too!” “...feel sorry for those who do not have anyone at home”

Q9: How well do you feel people are supported by community and social care services after they have left hospital?

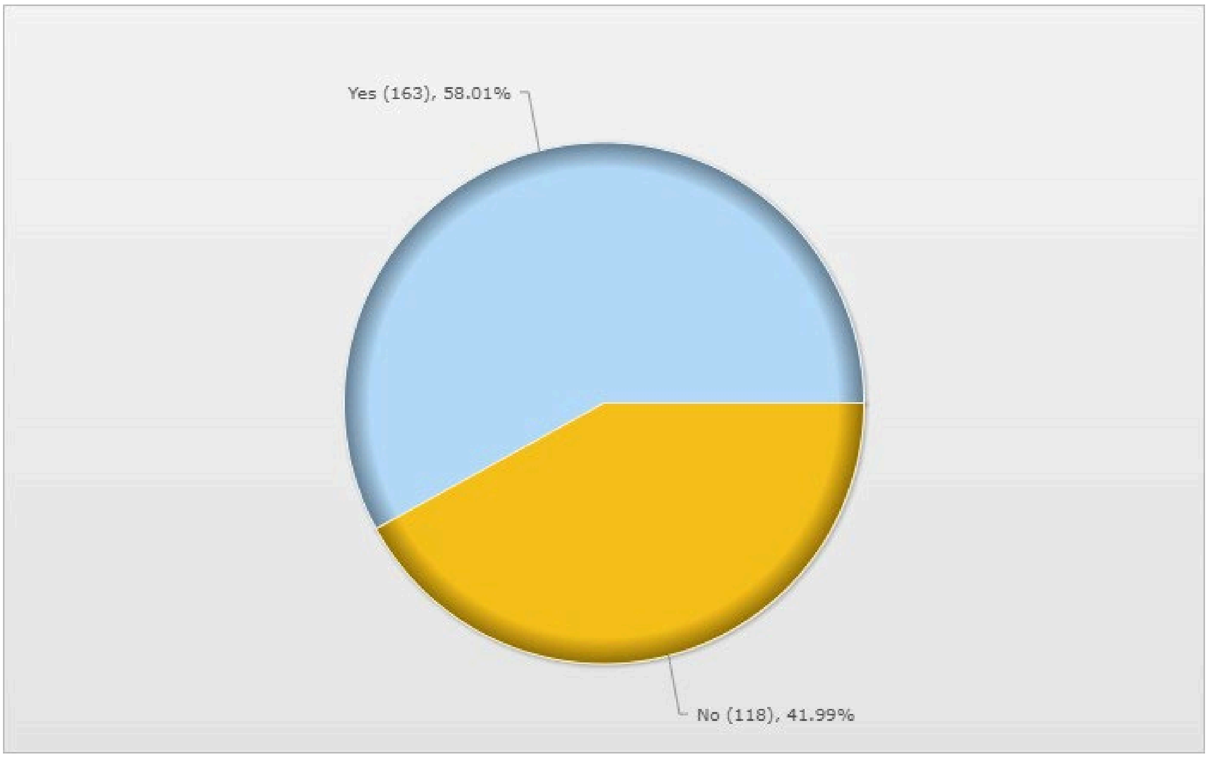
Theme	Frequency	What people wanted	Example responses
Poorly supported /under-resourced services	7	Sufficient capacity, time and resources in community/social care so support feels reliable and “proper” rather than stretched.	“There are not the resources available to support people properly” “They try their hardest but are also under resourced”
Family/ neighbours provide support	5	Informal support networks (family, neighbours, community) and feeling able to rely on people close by.	“Very well cared for by family, local neighbours and social care services” “I have the support I want and need and have good family and neighbours”
Not well supported (rating: fairly poorly)	5	A baseline expectation of adequate follow-on support after discharge – people want to feel consistently supported, not struggling.	“Fairly poorly” “fairly poorly often because of factors outside of their control”
Well supported (rating: fairly well/very well)	3	Adequate, reliable support after discharge – feeling that community/social care support is in place and working for them.	“Fairly well” “Very well in my case”
Lack of joined-up working/ information sharing	2	Better coordination between agencies, with information passed on and understood, so people don’t fall through gaps.	“...agencies do not seem to work together and information is often not passed on or appreciated” “Fairly poorly but some of this is the fact that agencies do not seem to work together...”

Community engagement questionnaire

Q1: Which of these large towns/cities do you live closest to?

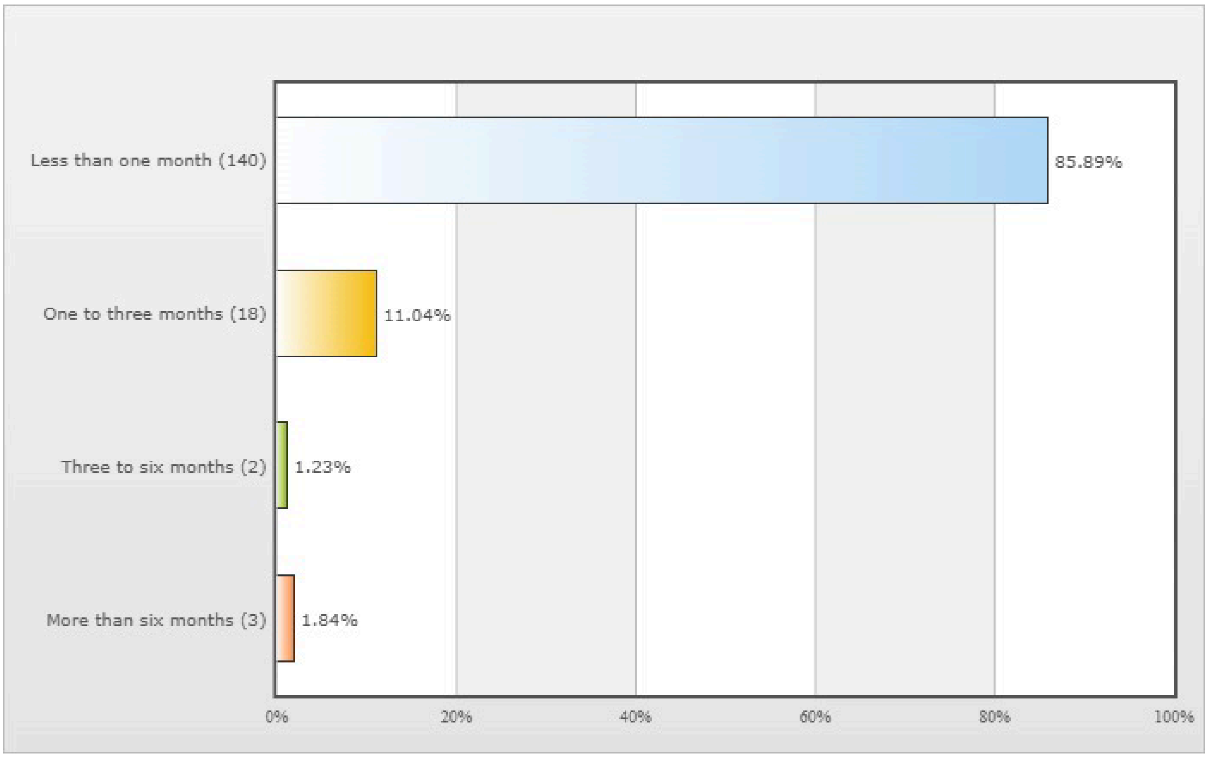


Q2: Do you have experience of spending time in a hospital ward as an inpatient or being the carer or loved one of someone who spent time in a hospital ward as an inpatient in the last two years?



The people who responded yes to the above question were then asked a set of questions directly linked to their personal experience.

Q3: How long was that stay in hospital?



Q4: What was good/positive about the time spent in hospital?

Theme	Frequency	What people valued	Example responses
Staff kindness/ caring/ professionalism	48	Compassionate, respectful staff (nurses, doctors and wider teams) who listened, were attentive, and did their best under pressure.	"Caring, professional nurses" "The majority of the staff with whom my husband (the patient) and I had contact were caring and compassionate and trying to do their absolute best under difficult circumstances."
Treatment/ clinical care/diagnosis	41	Effective diagnosis, tests/scans and treatment (including surgery/procedures) that addressed the health issue and supported recovery.	"A diagnosis was made quickly and a treatment plan was formed" "My father has undoubtedly received treatment that has saved his life: sepsis x 2; MI; GI bleed"
Feeling safe/reassured/ 24-hour support	19	Reassurance from being in the right place with professionals available 24/7 – reduced worry for patients and families/carers.	"Care was available from the appropriate professionals 24/7" "High standard of medical care. Felt

			reassured by having experts around to support me.”
Basic needs met (food/meals/pain relief)	14	Being looked after day-to-day (meals, cleanliness, mobility support, pain relief/medication), especially when unwell or unable to manage at home.	“Having regular meals, being looked after, not being in pain” “Someone else cooked my meals, brought my medication and ensured my pain was managed.”
Nothing/ negative/ no positives	13	Some respondents did not identify anything positive (or described the experience as negative), highlighting that perceived benefits were limited for them.	“Nothing” “No good things”

Other recurring themes (outside top 5)

- Communication/involvement: clear explanations, keeping patients/families informed.
- Ward environment/dignity: calm/clean surroundings (including side rooms where available) that support rest.
- Joined-up, timely care: coordination across teams and prompt access to tests/treatment.
- Support beyond clinical care: peer/emotional support on the ward and safe planning for recovery/discharge.

Q5: What was bad/negative about the time in hospital?

Theme	Frequency	What people wanted	Example responses
Waiting/bed delays/ corridor care	22	Timely assessment and treatment; getting an appropriate ward bed without prolonged waits (especially avoiding overnight/corridor waits); smooth admission pathways.	“I was admitted to the RLI and spent 24+ hours in A&E waiting for a bed” “Appalling corridor care.”
Staffing pressure/ missed basic care	18	Enough staff time to meet basic needs (toileting, feeding/hydration, pain relief, personal care) and provide attentive support, particularly for frail people and those with dementia.	“Food poor, nurses so caught up with admin, feeding and hydration of patients, toileting came very low down the priority list.” “Not enough nursing staff”
Communication/ information gaps	14	Clear, consistent updates from someone who knows the case; joined-up information between teams; being listened to; families/carers kept informed.	“Lack of communication between staff” “Not always easy to get update on health from someone who really knows”
Food/dietary needs not met	11	Nutritious, appetising food (hot when served) with suitable options for	“Did not cater for my food allergies or dietary requirements after

		allergies/conditions (e.g. gluten free, diabetic) and support/encouragement to eat.	diagnosis." "The food cold even soup was cold so just ate sandwiches"
Ward environment (noise/ overcrowding/ comfort/ facilities)	11	Restful wards (quiet/dim at night), adequate space, comfort (mattress/seating/ temperature), and functioning facilities (showers/bathrooms).	"My husband said it was very noisy and he didn't sleep." "Overcrowded, everyone too busy, not enough space."

Other recurring themes (not in the top 5)

- Discharge problems: disorganised planning, sudden/early discharge, waiting for take-home medicines, uncertainty about ongoing care/transport.
- Medication issues: missed/delayed doses, wrong/inaccurate meds, timing not as prescribed, delays getting pain relief.
- Cleanliness/infection control concerns: dirty/unclean areas, hospital-acquired infections/COVID, hygiene issues.
- Inappropriate placement/transfers and gaps in specialist rehab/therapy: moved between wards, mixed-needs wards, delayed/absent physio/rehab, poor continuity.

Q6: How was the discharge process?

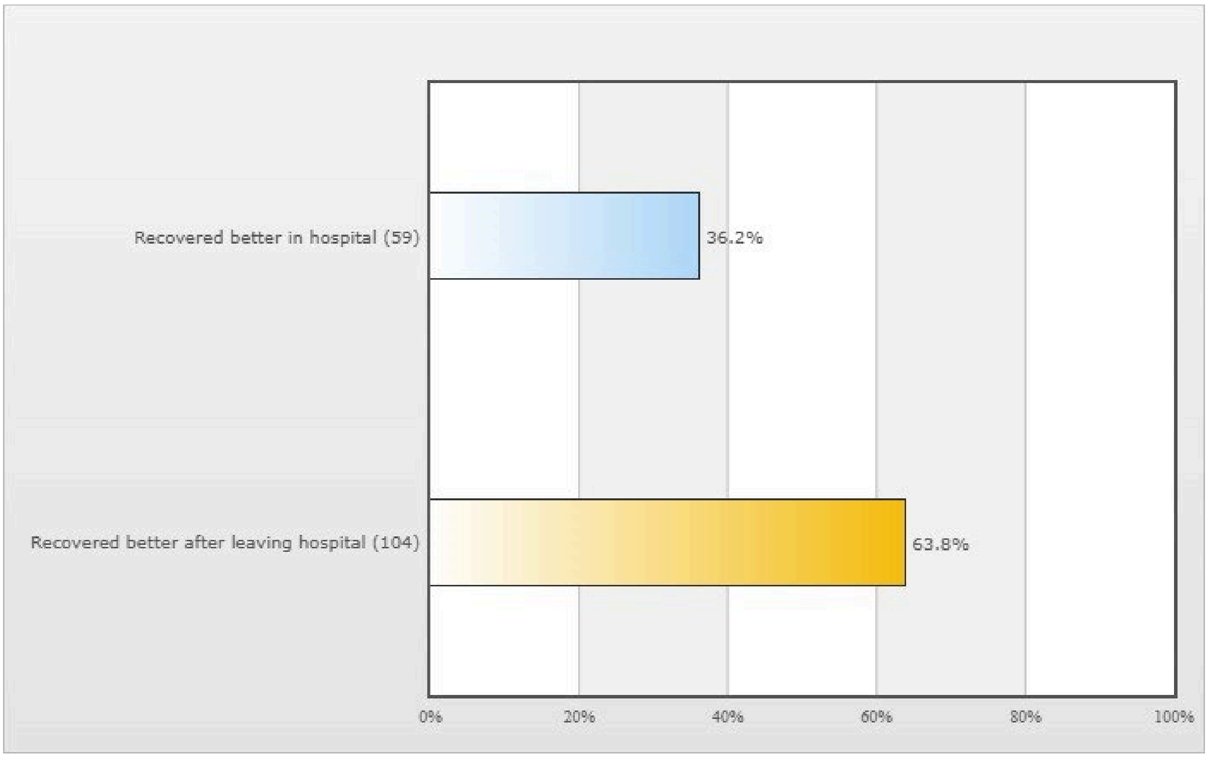
Theme	Frequency	What people wanted	Example responses
Waiting for meds/ paperwork (pharmacy delays)	21	Medication and discharge paperwork ready on time; not having to sit for hours in a discharge lounge or stay extra days; a smoother handover home.	"Slow! In particular the time it took for the pharmacy to provide the medication I needed was extraordinary - I was on the ward for far longer than I needed to as a result of delays from the pharmacy." "Bloody awful had to wait hours for meds"
Rushed/unsafe discharge and poor planning/support	18	Discharge that is safe and planned with the patient/family; appropriate support/equipment/care packages in place; not being sent home too soon or without checks.	"Discharged too soon, no proper support in place, equipment, risk of falls, still in pain, wound infected." "Not good. Felt rushed and without proper checking to ensure patient and carer understood what was needed after discharge."
Communication/ information (clarity, instructions, discharge letters)	12	Clear explanations and follow-up instructions; accurate discharge paperwork; knowing what happens next and who to contact; feeling listened to and involved.	"Excellent communication and follow up instructions." "Poor . Little help or advice , no discharge summary send with relative . No back up help or guidance"

Staff support/ caring/ helpfulness	10	Kind, caring, thorough staff who explain and coordinate discharge; approachable discharge coordinators; sympathy/understanding.	"The ward discharge coordinator was caring, thorough and approachable" "Staff helpful and thoughtful, but just sat for ages waiting for meds and paperwork"
Transport/ transfer arrangements	7	Timely, suitable transport home; reliable arrangements to avoid unnecessary overnight stays; clear eligibility/backup options.	"Was a problem getting transport home to Kendal as live on my own. Eventually agreed to get me a Taxi home." "Fine, although had to wait quite a while for transport home."

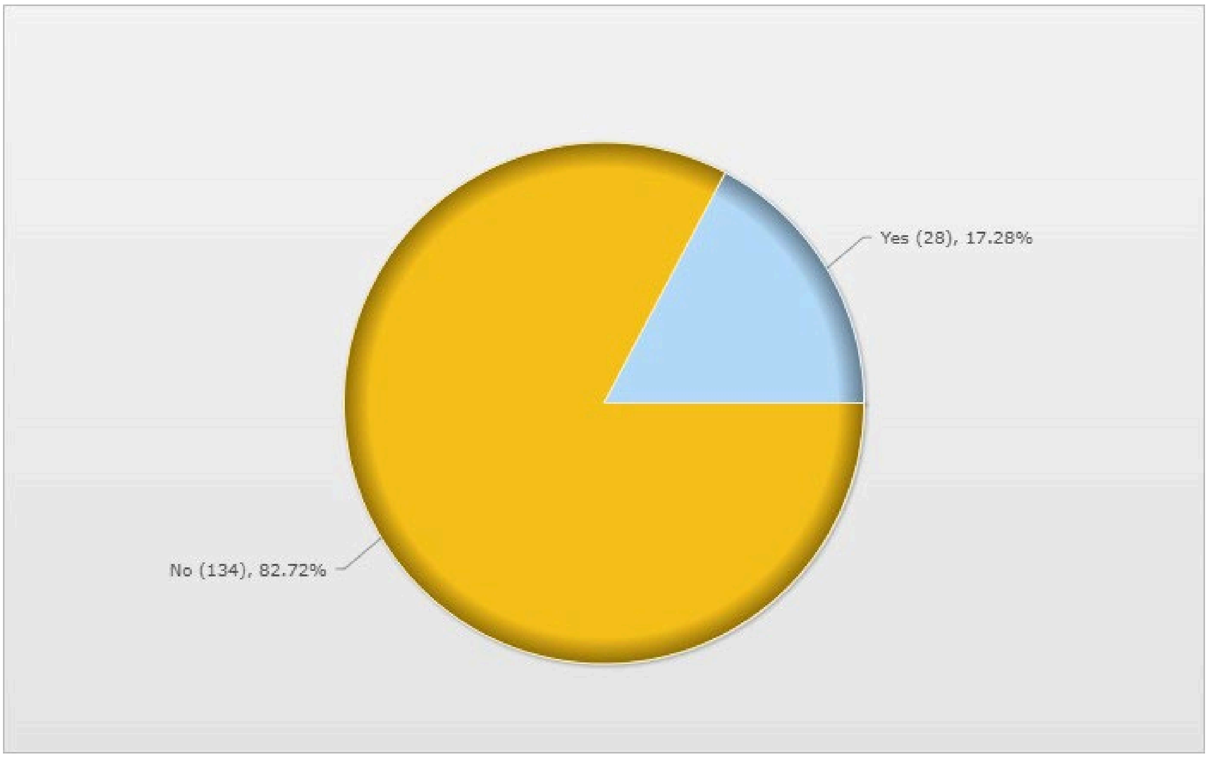
Other recurring themes (not in the top 5)

- Discharge lounge environment: uncomfortable seating, inability to lie down, loud TV, and limited suitability for people in pain or with specific needs (e.g. allergies).
- Weekend/evening constraints: delays or late-night discharge linked to pharmacy/doctor availability and cut-off times for transport.
- Errors/omissions in medicines and records: incorrect meds, missing meds, and inaccuracies on discharge paperwork requiring patients/families to challenge.
- Bereavement/not applicable responses: some respondents said discharge did not apply because the patient died in hospital or shortly before/after planned discharge.

Q7: Did you/your loved one recover better in hospital or when you/they left hospital to return home, or possibly a community setting (sometimes called step down)?



Q8: Do you feel you could/should have accessed any services in the community which may have prevented you from being admitted to hospital in the first place?



Respondents were offered the opportunity to comment further on this question, 88 chose to.

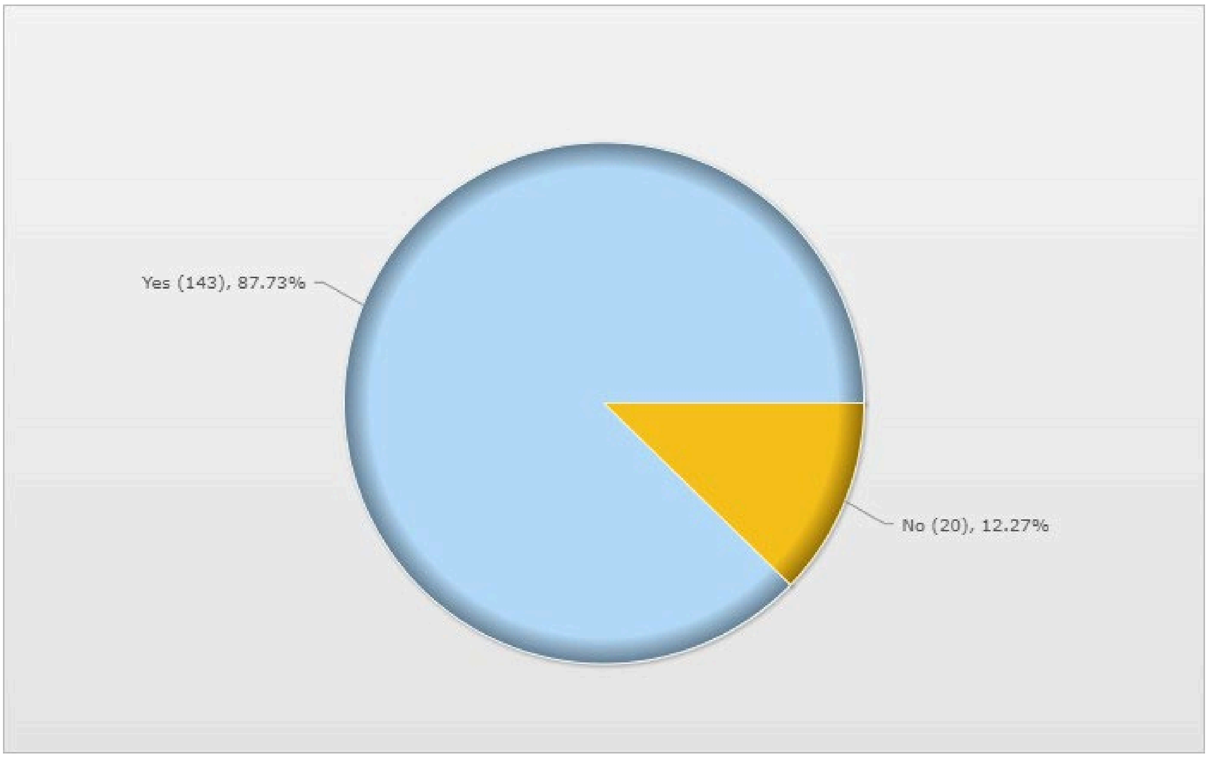
Theme	Frequency	What people wanted	Example responses
Hospital care needed (severity/ surgery /IV/monitoring)	30	Rapid access to specialist assessment, diagnostics, surgery, IV treatments, and close monitoring when needed; reassurance that serious symptoms are treated urgently.	"The situation called for medical intervention at a hospital level of expertise." "No, I required major surgery."
Access delays/limited availability in community/ primary care	13	Timely access to GP appointments and responsive community teams (OT/physio/social work); services available beyond weekday office hours.	"Would like to think so but accessing community services… is not quick." "Community only works Mon-Fri 9-5… even then closed Wednesday Afternoons and go home early on Fridays!"
Perceived lack of community support/ services	10	Knowing help exists after discharge; practical support with care needs and long-term conditions; a functioning community offer rather than coping alone.	"As there are none and noone wants to know" "Not offered any but needed help with care"
GP listening/	8	Being listened to and taken seriously; continuity with a	"Primary care don't listen everything is a battle"

continuity and earlier diagnosis		known clinician; earlier diagnosis and treatment in primary care to prevent deterioration.	“Earlier diagnosis from routine tests by the professionals at the local surgery who should have given earlier treatment”
Community teams positive (home support/ rehab/rapid response)	5	Proactive, joined-up home-based care (e.g. rapid response, frailty, rehab) that supports recovery, reduces avoidable admissions, and gives families confidence.	“…I was taken in hand by the frailty unit and sent home under the care of the rapid response team. Excellent care at home. A wonderful idea which should be supported” “We were supported in this by the Intensive Home Support Service team… a buffer between home and hospital.”

Other recurring themes (not in the top 5)

- Not knowing who to contact/signposting loops: people described being passed between healthcare professionals, or said there was nobody to contact.
- Transport/access barriers: challenges getting home (and to community settings), and the importance of local services for people who cannot travel easily.
- Social care and home support packages: concerns about delays or lack of funded care packages and the impact on safety/avoidable admissions.
- Coordination between services/hospitals: calls for better communication between hospitals and services to avoid delays, duplication, and deterioration.

Q9: Do you think there are gaps in community and social care support?



Respondents were offered the opportunity to comment further on this question, 129 chose to.

Theme	Frequency	What people wanted	Example responses
Insufficient capacity/ funding/ workforce (carers, district nurses, social care)	31	Adequate staffing and funding for home care, district nursing, social work, and community teams; reliable cover (including rural areas); care that is available when needed rather than long waits.	“Not enough home care staff to enable hospital discharge to be expedited” “Night care is none existent”
Lack of joined-up working/ communication between services	23	Joined-up pathways across hospital, GP, community and social care; timely information sharing; clear ownership and coordination so patients/families are not left chasing.	“No coordination between the two” “There is clearly a connectivity issue and a lack of clarify as to who does what.”
Access delays/limited availability (GP/community services, waiting lists, 24/7)	22	Quicker access to GP and community appointments (OT/physio/district nurses/wound care); availability outside office hours/weekends; early follow-up and continuity.	“The inability to access GP services in a reasonable time frame - average 6 weeks for a routine appointment” “Community services aren't available all the time, only in office hours and not at weekends or on bank holidays.”
Insufficient step-down/rehab/ care home/ nursing home provision	13	Intermediate/step-down options (rehab beds, convalescent/cottage hospital-style settings, day centres) and sufficient care home/nursing home capacity to support recovery and safe discharge.	“A unit like the old convalescent homes would be great as a half way house between hospital and home.” “Not enough nursing homes”
Poor discharge follow-up/ unsafe or inadequate home packages	12	Safe discharge planning with support arranged from day one; monitoring of needs; adequate and practical home support (including equipment, wound care, and ongoing rehab) without undue burden on family.	“On previous admissions I had simply felt I was just been thrown out and was expected to cope” “Care packages are randomly put in place on discharge.”

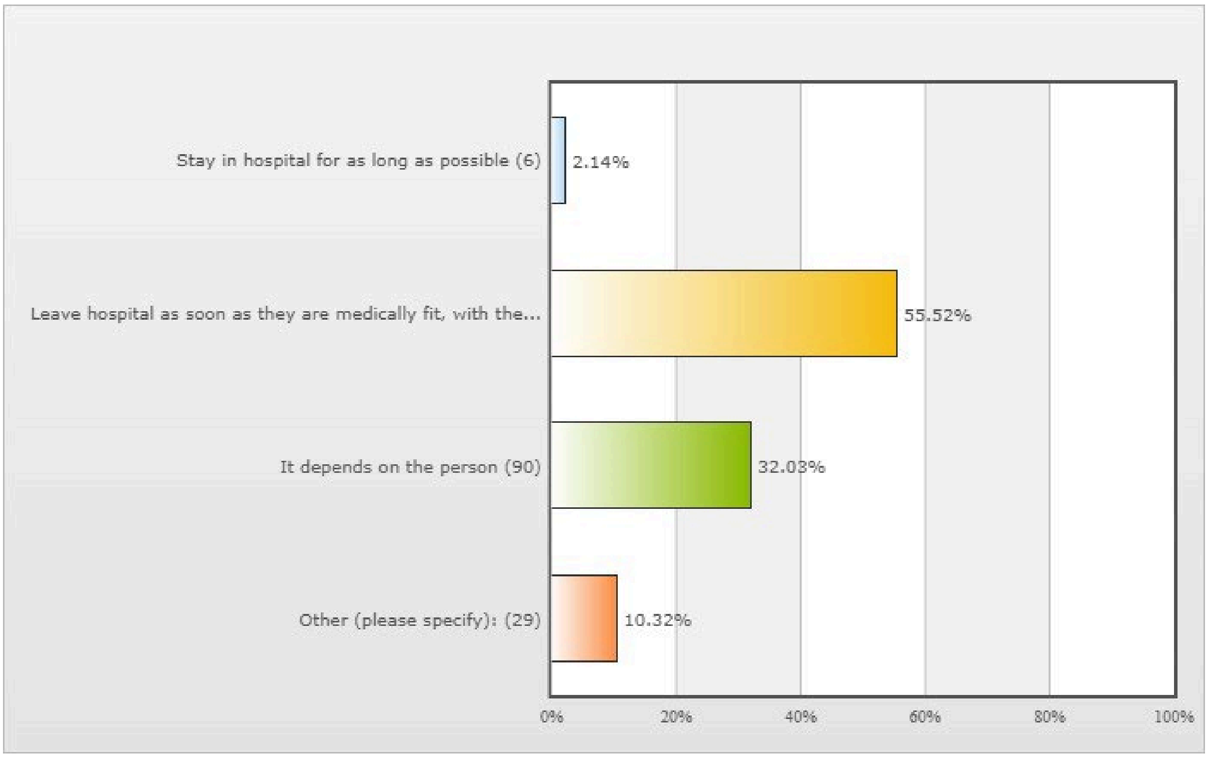
Other recurring themes (not in the top 5)

- Affordability and personal financial burden: concerns about paying for care, lack of affordable provision, and the impact on families (including privately funded care).
- Information/signposting and complexity: difficulty knowing what support exists, who to contact, and navigating complex pathways without advocacy.
- Variation by place and population needs: perceived differences between areas (e.g. East Lancashire vs South Cumbria) and challenges in rural communities with older populations.

- Third sector and community assets: value of voluntary/third sector support (e.g. Age UK) and suggestions for expanding models that build social connection (e.g. day centres).

All respondents were asked the following questions:

Q10: When people spend time as an inpatient in a hospital ward, what do you think helps them to recover best?



The responses received for 'other' can be summarised as below:

Theme	Frequency	What people wanted	Example responses
It depends/ individual needs and circumstances	11	Care decisions tailored to the individual, recognising different needs by condition, age, home situation and available support; avoiding a "one size fits all" approach.	"Depends on many factors: their age, illness, procedures, diagnoses, home circumstances, home location, availability of all sorts of help and care and services etc" "It also depends on the illness"
Assessment needs (mental frailty/dementia/ anxiety and overall needs)	7	Careful, holistic assessment (including dementia, mental frailty/anxiety and carer capacity) so decisions are safe and realistic for patients and families.	"I think dementia is a big factor that doesn't always seem to be fully taken into consideration." "Everyone should be carefully assessed and one size doe not fit all"
Community/	6	Reliable, timely support at home (e.g. reablement and	"Again this will only work if the correct support and

social care support/ capacity insufficient (budgets, overstretched services)		community services) with adequate capacity and funding so patients can leave hospital safely.	budgets are in place." "However the capacity to support particularly elderly people is not adequate"
Safe discharge and not rushed/too early	5	Not being "forced" out before ready; safety checks, realistic planning, and support fully in place before discharge.	"Leave hospital with support like Reablement and to have a safe discharge. Not rushed discharge." "timely high quality care when in hospital and not forced to leave before they are ready."
Coordination/ actioning support properly (joined-up care)	3	Coordinated care that is organised and delivered in practice (not just planned), with clear responsibilities and follow-up.	"The support needs to be tailored to the person and needs to be coordinated and actioned properly" "Hospital at home follow up"

Other recurring themes (not in the top 5)

- Family/carer capacity and support networks: recognition that some people cannot cope at home or may have "no one to welcome them".
- Quality of in-hospital support to prevent deconditioning: e.g. physiotherapy/rehabilitation to maintain strength while waiting to leave.
- Need for human contact during long stays: regular visitors or other forms of contact with home.
- Staff environment/experience: valuing "caring staff" and a more positive atmosphere.

Q11: We know when people, especially older people, stay in hospital longer than they need to, their health can worsen. Below are some of the problems we know people can face. Rank these from 1 to 6, with 1 being the problem you would be most worried about.

Item	Total score	Overall rank
Loss of strength or mobility	1261	1
Risk of infection	1206	2
Loss of confidence or independence	1165	3
Being away from home and family	849	4
Delays in moving on to the next stage of care	831	5
Pressure on hospital beds	589	6

Score is a weighted calculation. Items ranked first are valued higher than the following ranks, the score is a sum of all weighted rank counts.

Respondents were given the opportunity to tell us about any other problems they think people may encounter – 128 people chose to:

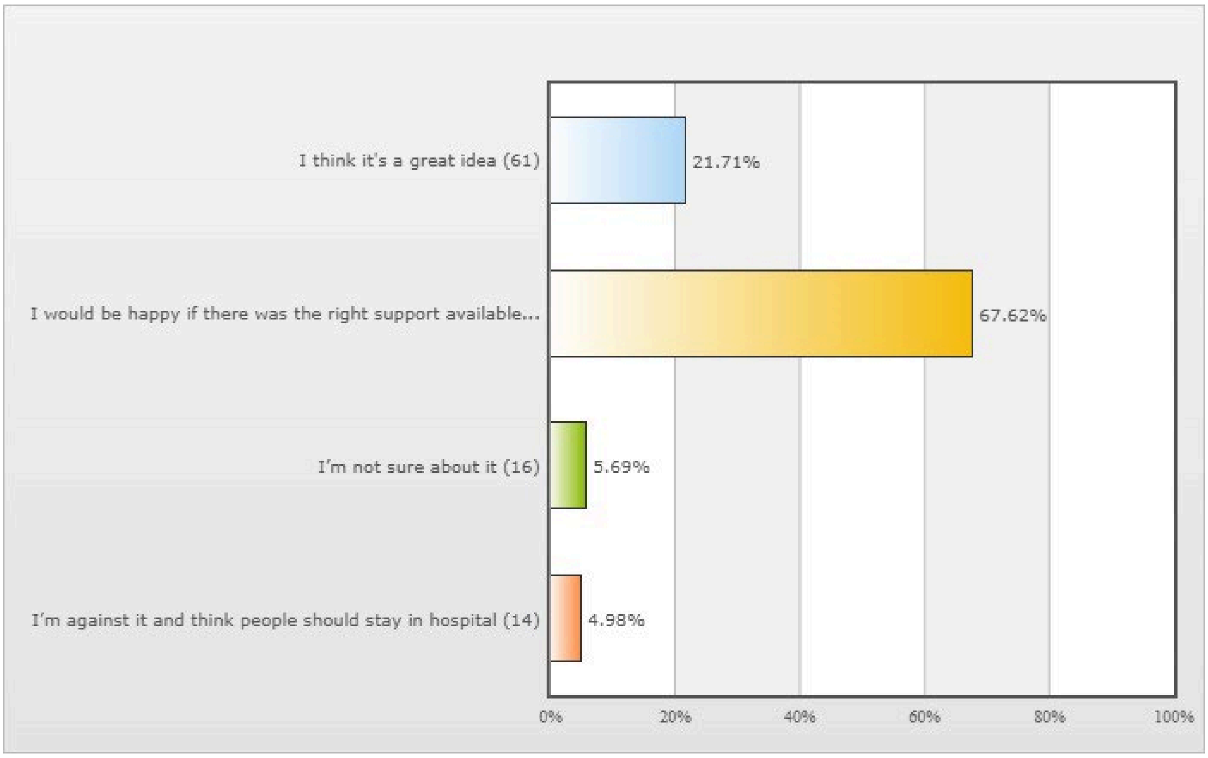
Theme	Frequency	What people wanted	Example responses
Deconditioning/ dependence/	17	Maintaining mobility, confidence, routine and	"People become deconditioned as activity

loss of independence		independence; support that keeps people active and prevents avoidable decline.	and functionality decreases.” “Loss of independence”
Community/ social care capacity and safe support at home	14	Enough carers and community services to enable safe discharge; timely care packages (including overnight care where needed); appropriate step-down/virtual ward-style support.	“AVAILABILITY OF CARERS IN THE COMMUNITY.” “Proper care and support at home is essential.”
Communication/ coordination/ involvement in care and discharge	14	Clear information and updates; involvement of patients/families in decisions; joined-up working between hospital, GP, community staff and social care.	“Little information shared with gp , community staff when planning discharge” “Poor communication about illness, investigations and progress”
Isolation/ loneliness and lack of visitors/family contact	11	Regular contact with family/friends; support to reduce loneliness and confusion; practical help to enable visiting (e.g. transport/parking).	“Feeling isolated and lonely especially if they are in a side ward and don’t have many visitors” “Distance from family”
Food/nutrition/ hydration in hospital	7	Nutritious, suitable meals (including for dementia and medical/dietary needs); support for eating/drinking; better options and quality.	“Poor nutrition and hydration” “Concerns about the nutritional value of hospital meals and adequate provision of a suitable diet for individual patients medical needs.”

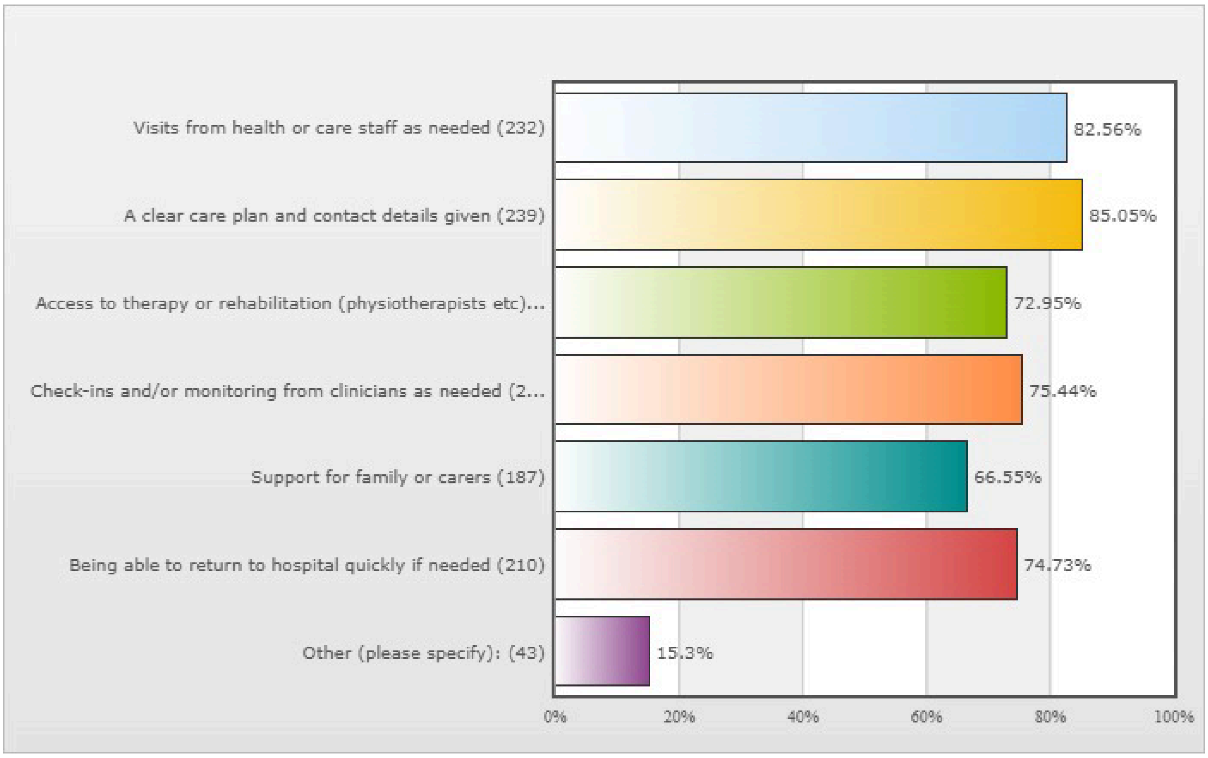
Other recurring themes (not in the top 5)

- Mental health/cognitive decline and distress: including dementia, disorientation, boredom and lack of stimulation linked to hospital environments and lack of engagement.
- Unsafe/rushed discharge and bed pressures: including readmissions, inadequate checks, and services/equipment not in place when people go home.
- Dignity/basic care issues: e.g. toileting/incontinence support, hearing/walking aids, being listened to, and avoiding feeling “helpless” or patronised.
- Financial impacts: paying for care, benefits/income worries, and stress about bills, plus concerns about personal finance affecting choices.

Q12: How do you feel about care being given at home or closer to home, instead of in hospital, when it is safe?



Q13: What would make you feel confident that care outside hospital is safe and works well? (Please select all that apply)



Respondents were given the opportunity to offer other options – 43 people chose to share their views which can be summarised as below:

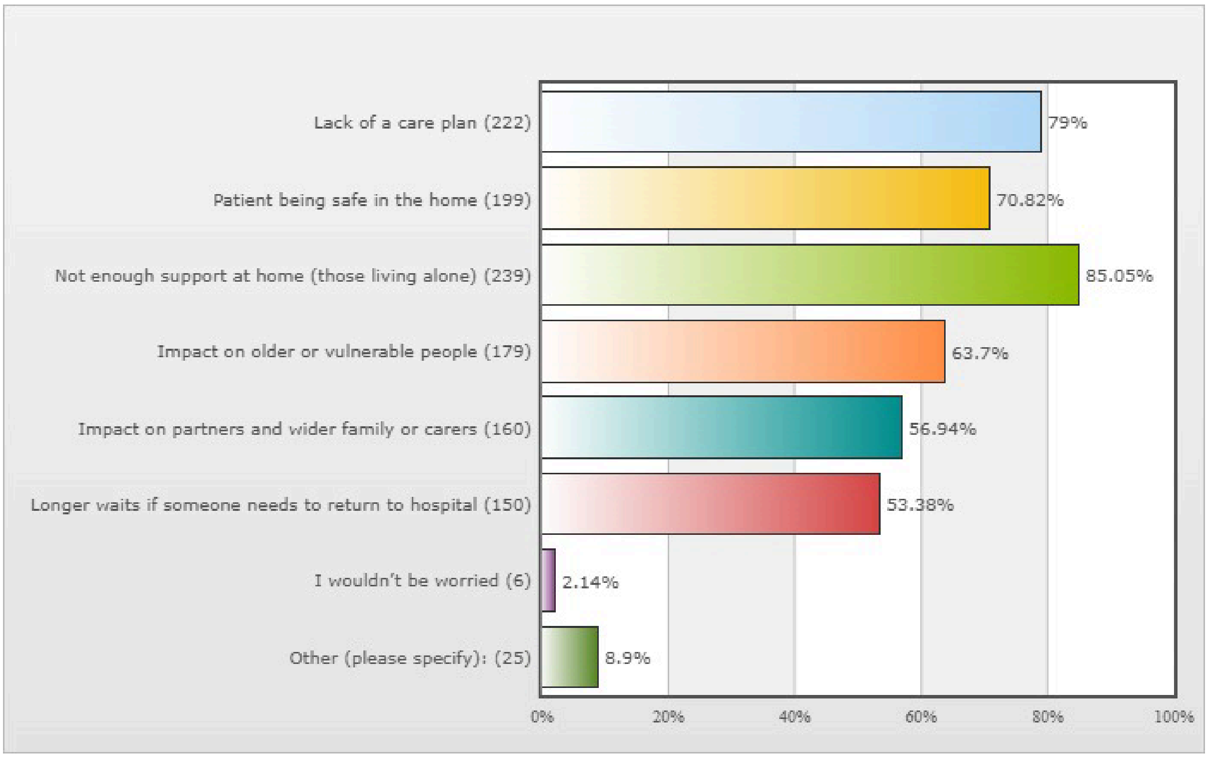
Theme	Frequency	What people wanted	Example responses
Coordination/ communication between services and with patient/family	14	Joined-up working across departments and professions; clear, proactive communication; family/carer involvement; one team/person coordinating so people are not left chasing.	“Communication between depts and care professionals I can not believe the lack of coordination and how people don't know what others have done or said” “Good communication between all disciplines and family members”
Quality/safety of care outside hospital (not a poor substitute)	9	High standards and safety in community care (qualified/accredited staff, monitoring, appropriate clinical back-up); care plans that are real and delivered, not “tick box”.	“ALL CARE OUTSIDE HOSPITAL TO BE OF A HIGH STANDARD WITH ACCREDITED CARERS.” “None of the above if it is just a poor substitute for actual hospital care.”
Named contact/ continuity and rapid access to help (including 24/7)	8	A consistent person who knows the patient; a named contact at GP surgery; quick access to a clinician and an emergency contact number; timely responses.	“having a consistent person to coordinate everything and who knows me” “Good coordination of staff and services, 24 hour emergency contact number”
Discharge planning and practical support in place (meds/equipment /adaptations/ overnight)	7	Medication and support arranged before leaving hospital; equipment and home adaptations in place; overnight support where needed; clear plans tailored to need.	“Equipment to support patient at home provided” “medication provided in advance . all of above services being set up before the patient leaves hospital…”
Scepticism/ preference for hospital as safer	7	Reassurance that care outside hospital is safe and feasible; confidence that services exist and will work; avoiding unsafe moves without back-up.	“Hospital is safer” “I dont feel confident that care outside the hospital would work well”

Other recurring themes (not in the top 5)

- Assessment of family/carer ability and involvement: checking what families can realistically do, and ensuring they are prepared before discharge.
- Funding/costs and NHS–council responsibilities: affordability, state funding, and concerns about “arguing… about picking up the bills”.
- Access and logistics: transport, location/accessibility, and practical facilities to make home/community care workable.

- Need for evidence that the approach works: requests for local data/stories to build confidence and demonstrate outcomes.

Q14: What concerns, if any, might you have when people leave hospital? (Please select all that apply)



Respondents were given the opportunity to offer other options – 25 people chose to share their views which can be summarised as below:

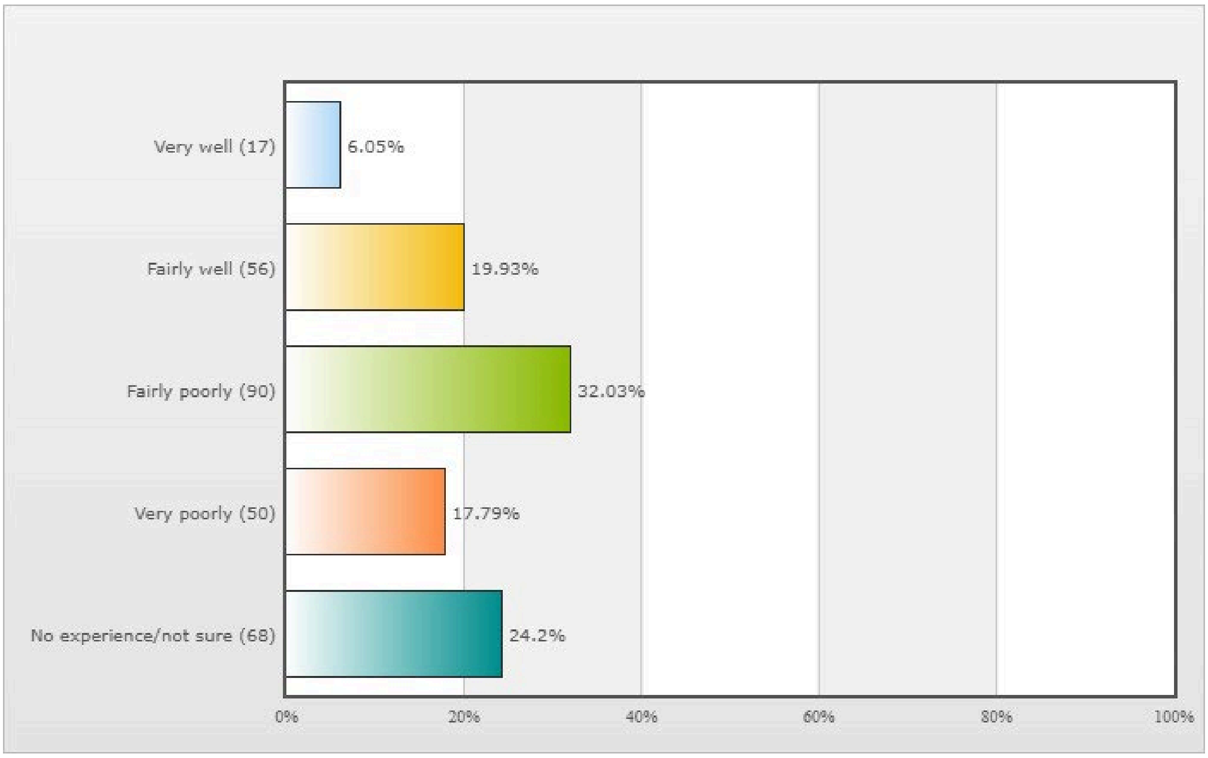
Theme	Frequency	What people wanted	Example responses
Lack of coordination/ accountability and plans not in place (MDT working)	8	Joined-up working and clear responsibility; multidisciplinary teams working promptly; discharge/care plans agreed early and actually implemented (not "promised for later").	"Any discharge plans are drawn up early and are IN PLACE, not promised for later!" "Multi disciplinary teams working together in a timely manner."
Discharge too early/unsafe discharge and inadequate care package	6	Being discharged only when clinically ready; correct care package in place; decisions based on need rather than bed pressures or targets.	"To early discharge and wrong care package." "Being rushed out because the is a bed shortage and not because I am fit to leave"
Deterioration not picked up/insufficient monitoring/ clinical support	5	Proper monitoring and timely specialist nursing/medical support so deterioration is identified early; access to urgent help when needed.	"Any deterioration in a patients condition would not be picked up early" "Person not being properly looked after and monitored properly"

Cost/affordability of social care	4	Affordable care and clarity on funding; reduced financial burden on patients/families; fair access to support regardless of ability to pay.	"cost of social care" "Paying for care (for some people) lack of suitable care homes with vacancies"
Lack of carers/care home capacity and suitable provision	4	Enough suitable, well-trained carers and available care home placements; carers supported and paid appropriately; support for family carers.	"Lack of suitable carers" "Support for families/carers. Supply of well trained and paid carers."

Other recurring themes (not in the top 5)

- Impact on families/partners and need for support: several responses highlighted the burden on relatives and carers if gaps persist.
- Being listened to/individual factors: the importance of personal circumstances being understood and addressed rather than a standard approach.
- Access barriers to community care: difficulty leaving home to access services/appointments, including issues around being "coded housebound".
- Wider service changes and local provision: concern about "Removal of services at local hospitals".

Q15: How well do you think community and social care services support people after hospital?



Patient questionnaire

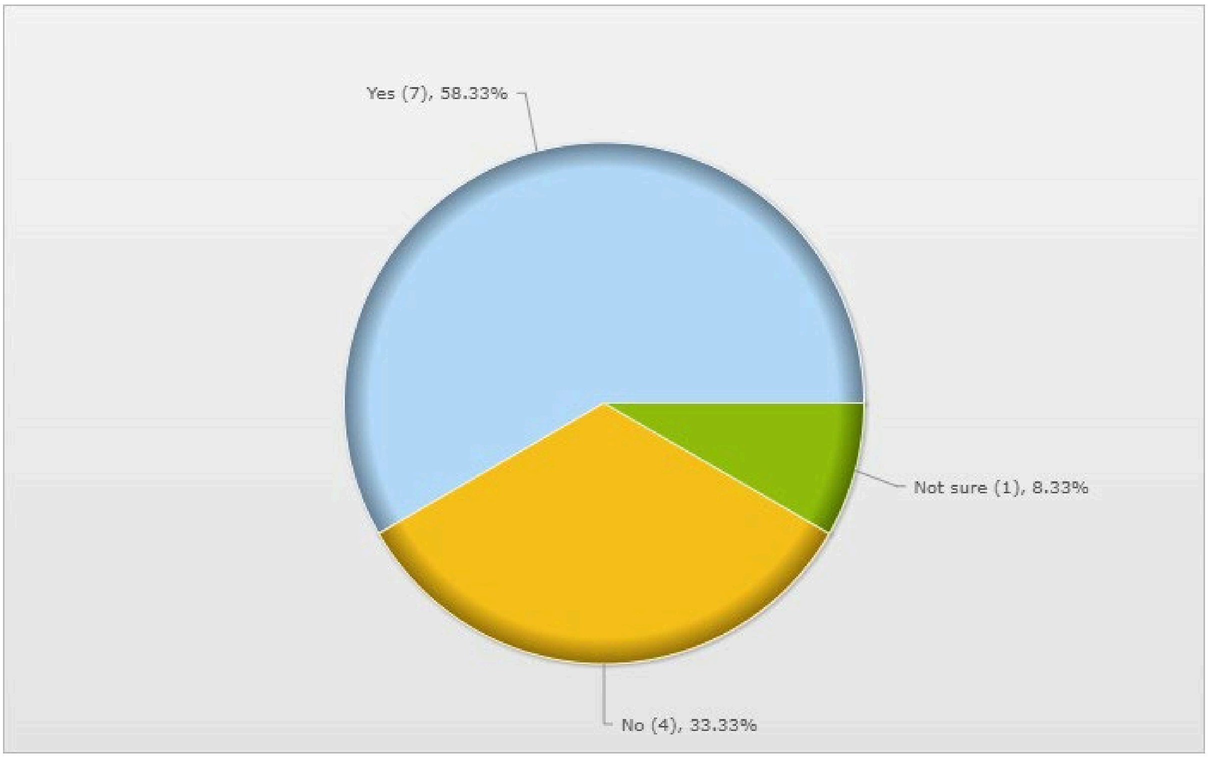
Q1: How are you finding being on this ward?

Eleven people answered this question with eight people reporting a generally positive/acceptable experience. One person commented some staff are nice, some are not, while another said “the ward does not work properly” having experienced long waits to be seen by the right person.

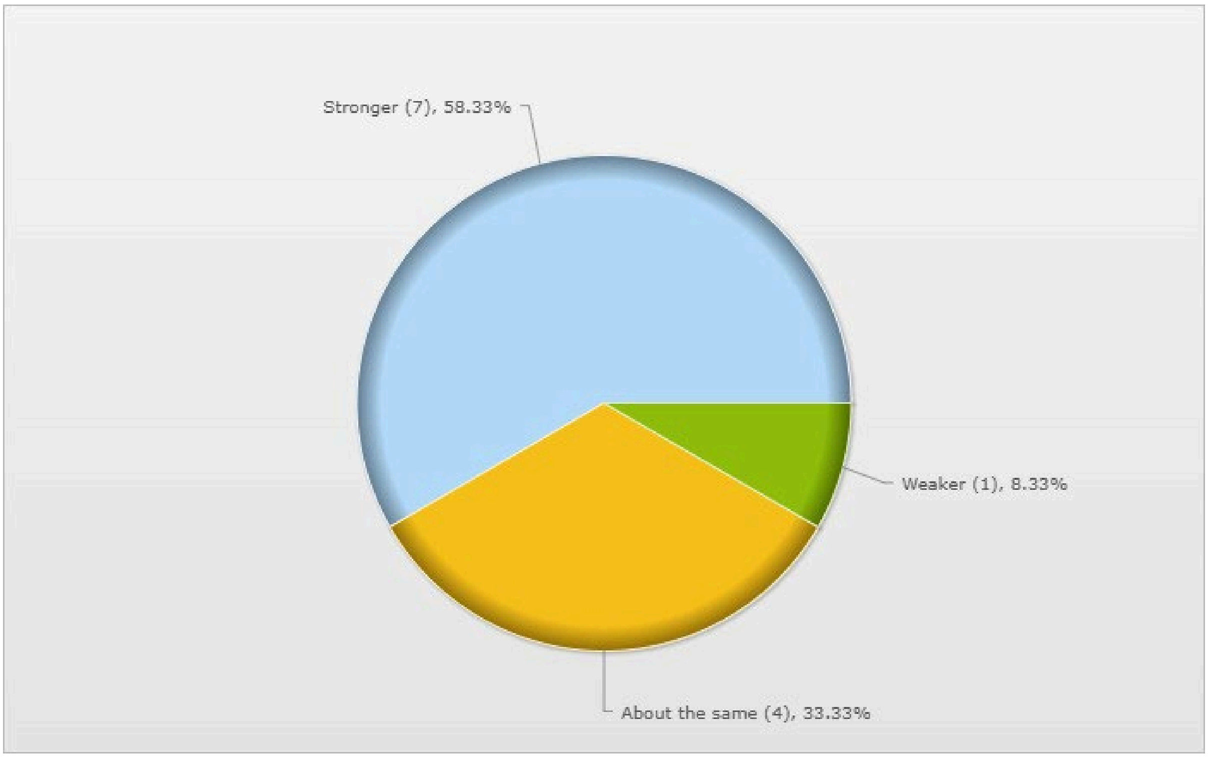
Q2: Is there anything that has been particularly good or particularly difficult for you?

Nine people answered this question, two people said no, two people reported the ward to be noisy, and two people reported a lack of access to rehab. One person said their breathing had got worse and another struggled to get on an off the bed.

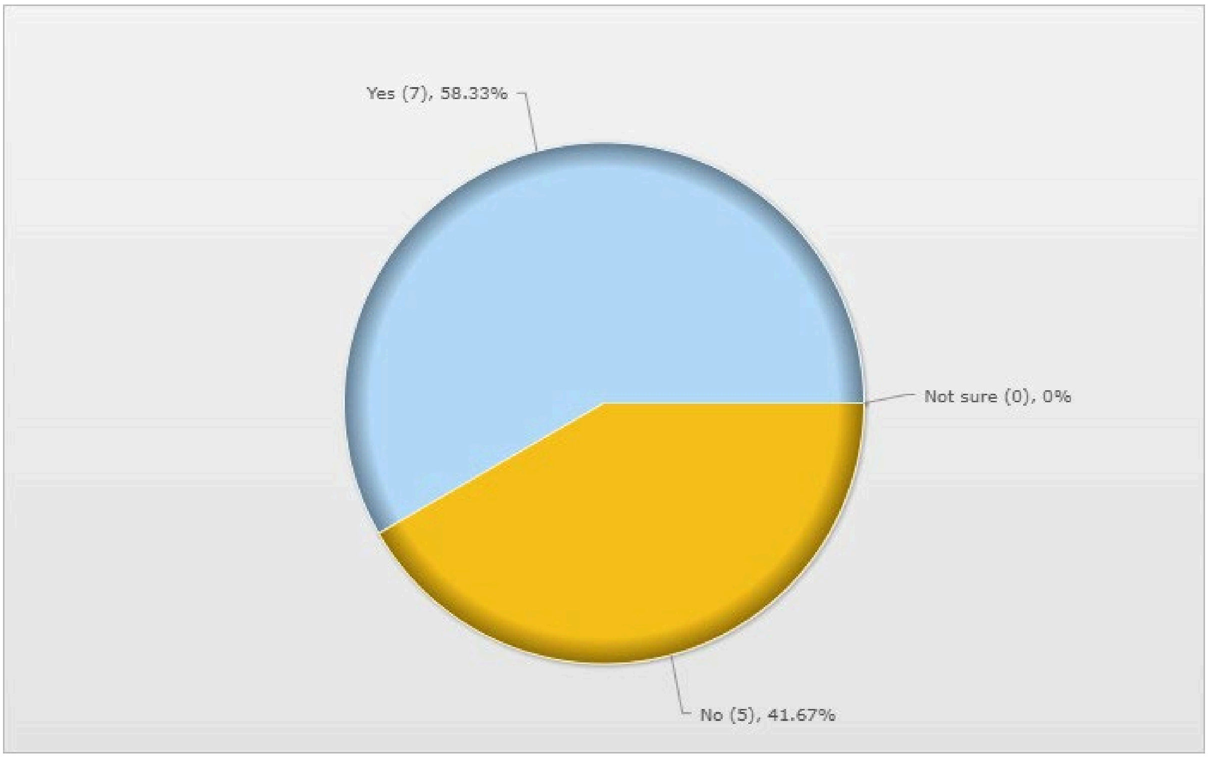
Q3: Do you feel being in hospital is helping your recovery right now?



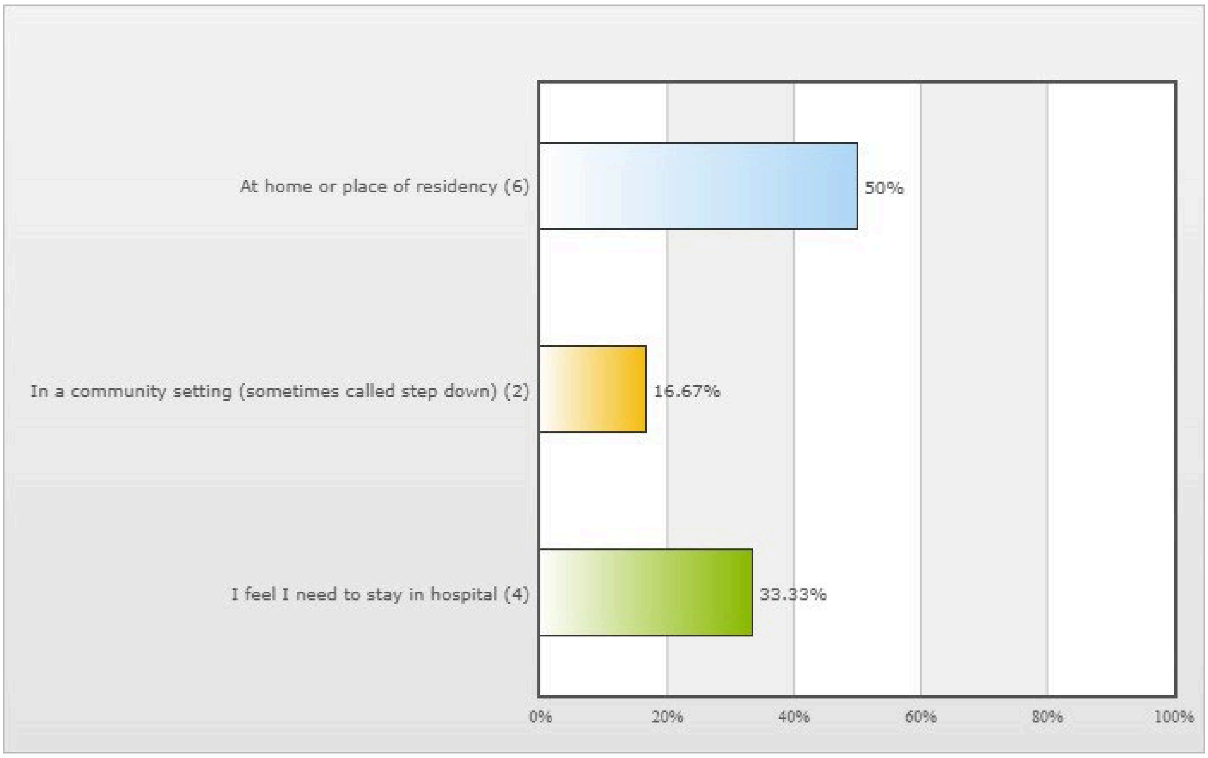
Q4: Since being here, do you feel:



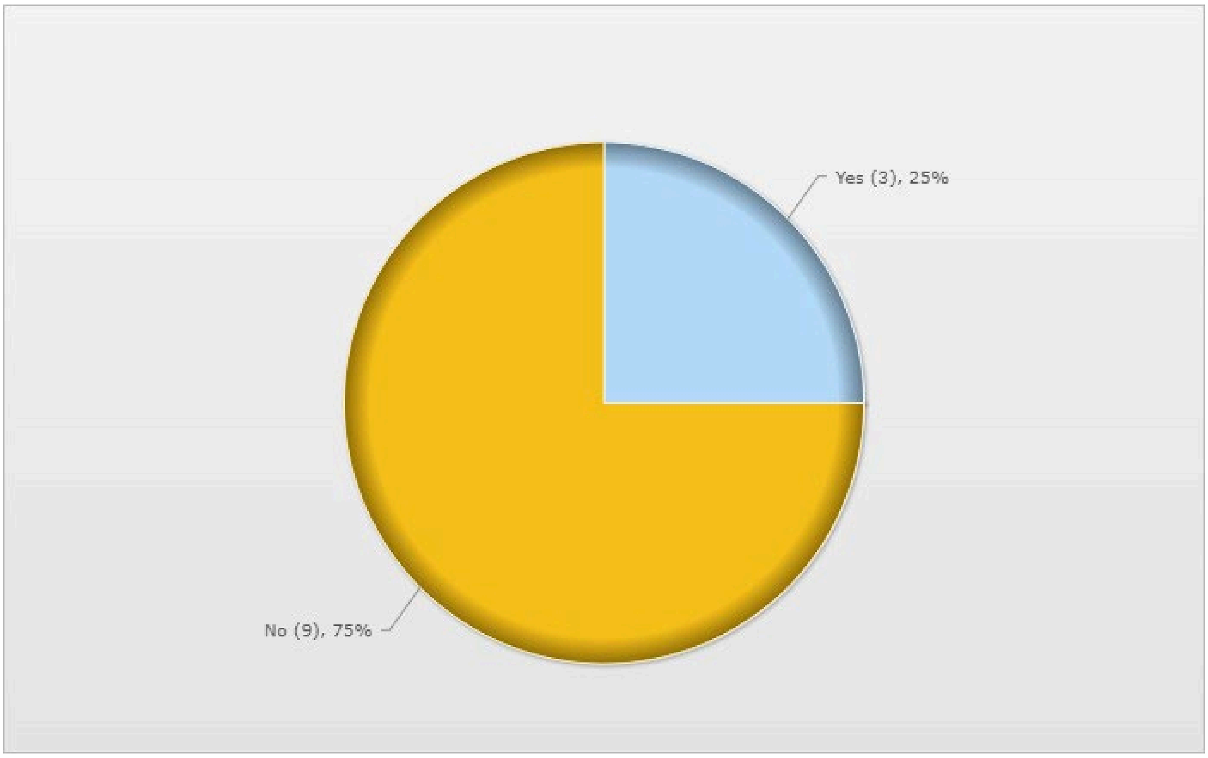
Q5: Do you feel ready to leave hospital if the right support was in place?



Q6: Where would you most like to be recovering?



Q7: Have staff explained why you are still in hospital?



Of the three people who responded yes to this question, all three said the explanation made sense to them.

Q8: If you could speak directly to the decision makers – what one thing would you like them to understand about being in your position?

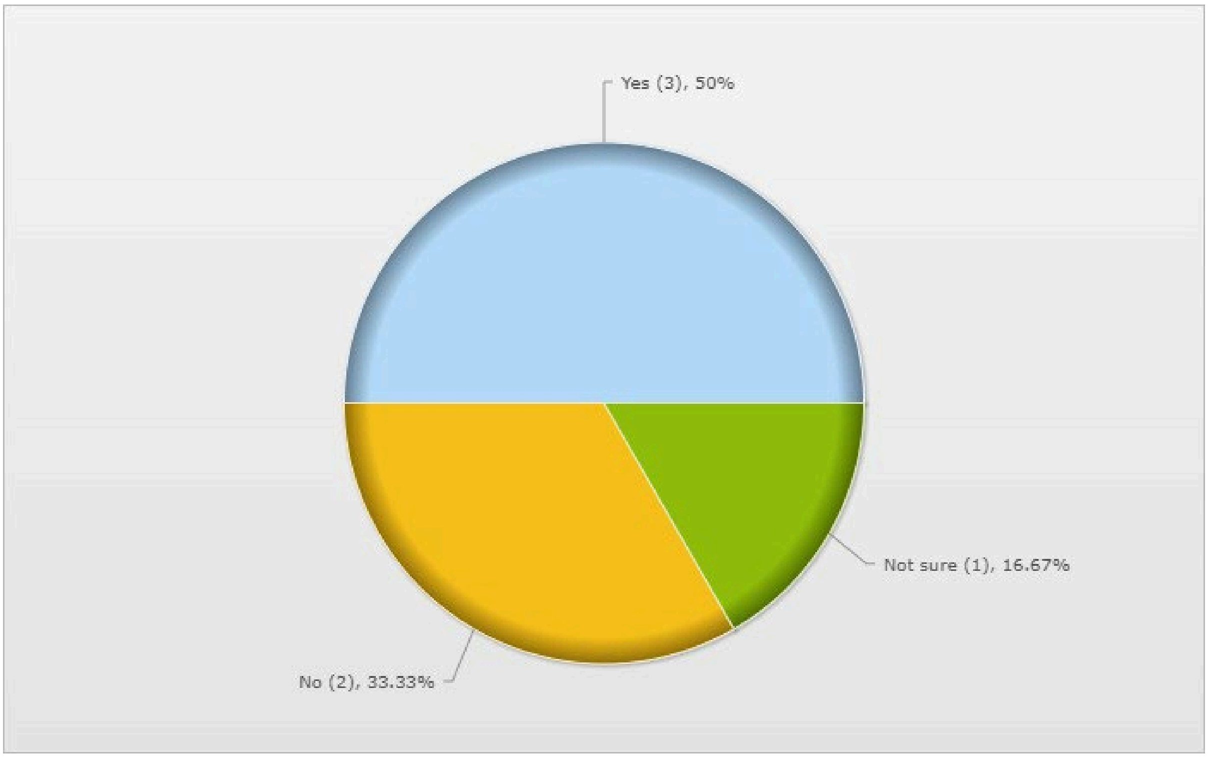
Five people answered this question. Two people cited a lack of communication, one said they had been out of bed in a month and two felt they could leave with the correct support in place.

Family/friend/carer questionnaire

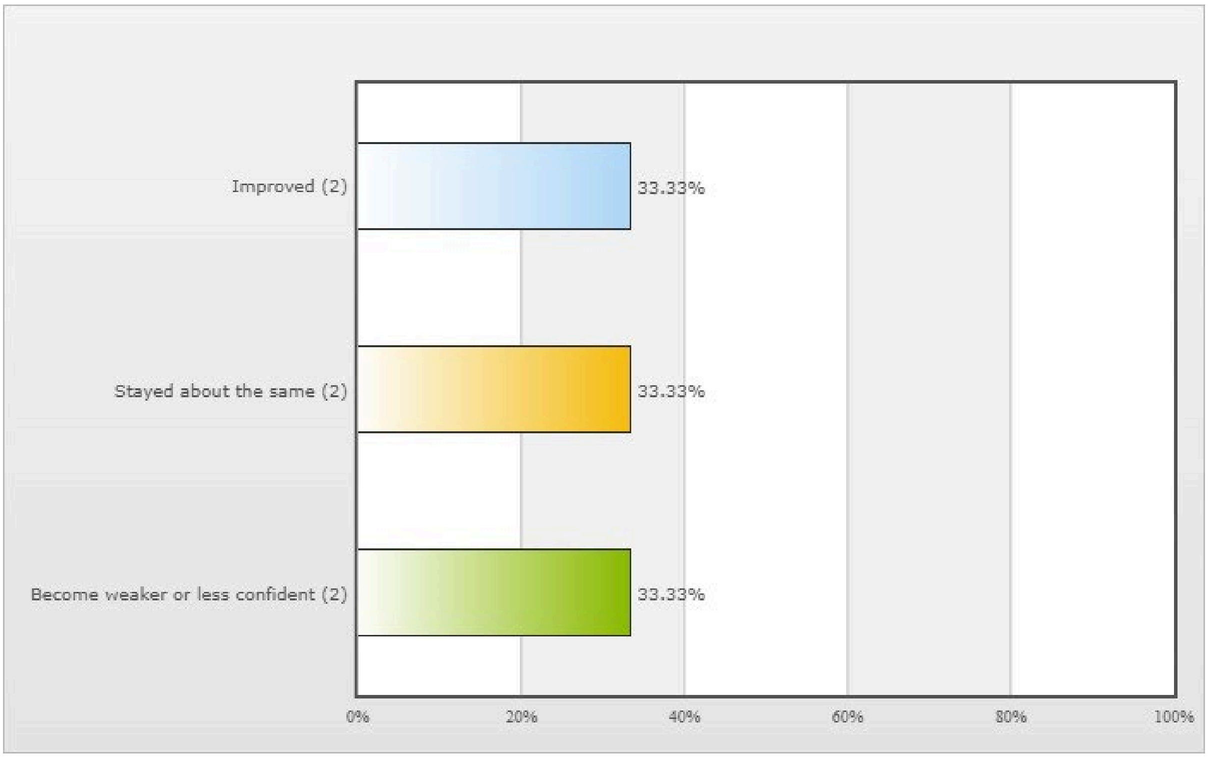
Q1: From your point of view, how has your loved one's stay in hospital been?

Six people answered this question. Three reported a positive experience, while three reported a less positive experience, with one reporting the environment was poor, and another believed their loved one had been moved onto the ward too soon.

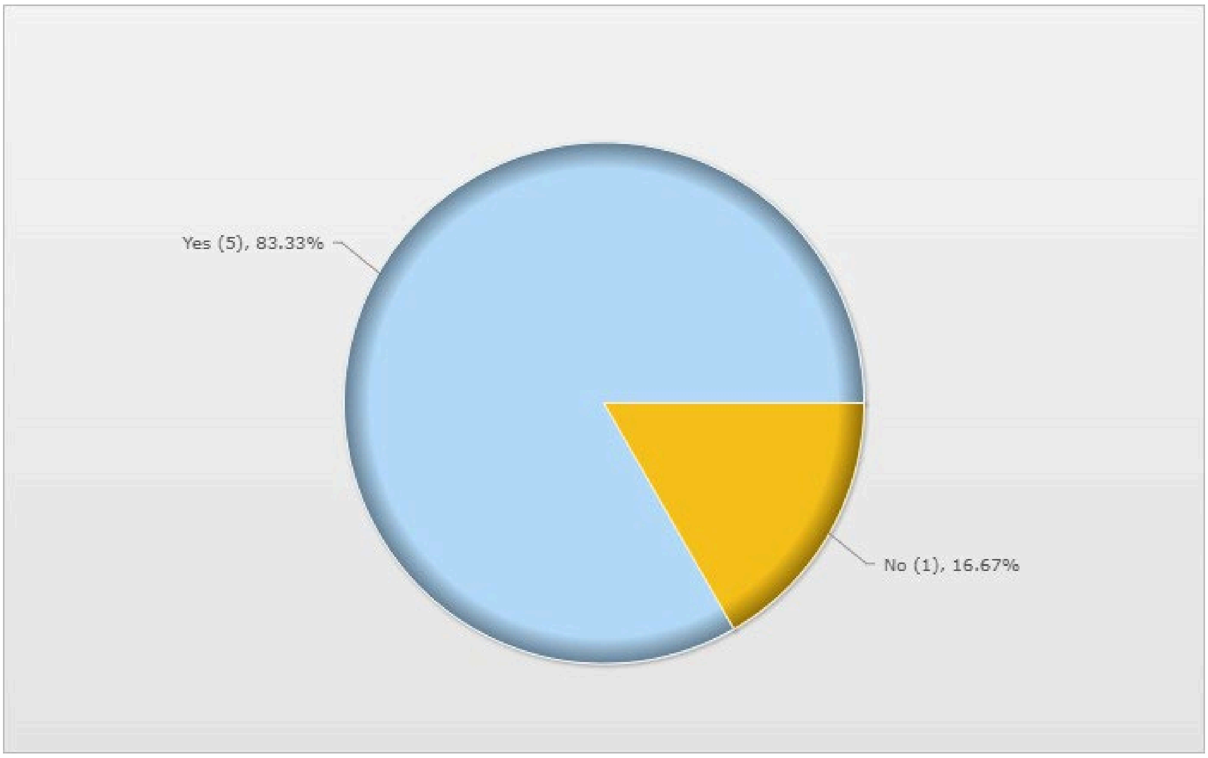
Q2: From your point of view, is being in hospital helping your loved one recover?



Q3: Since being in hospital, do you feel your loved one has:

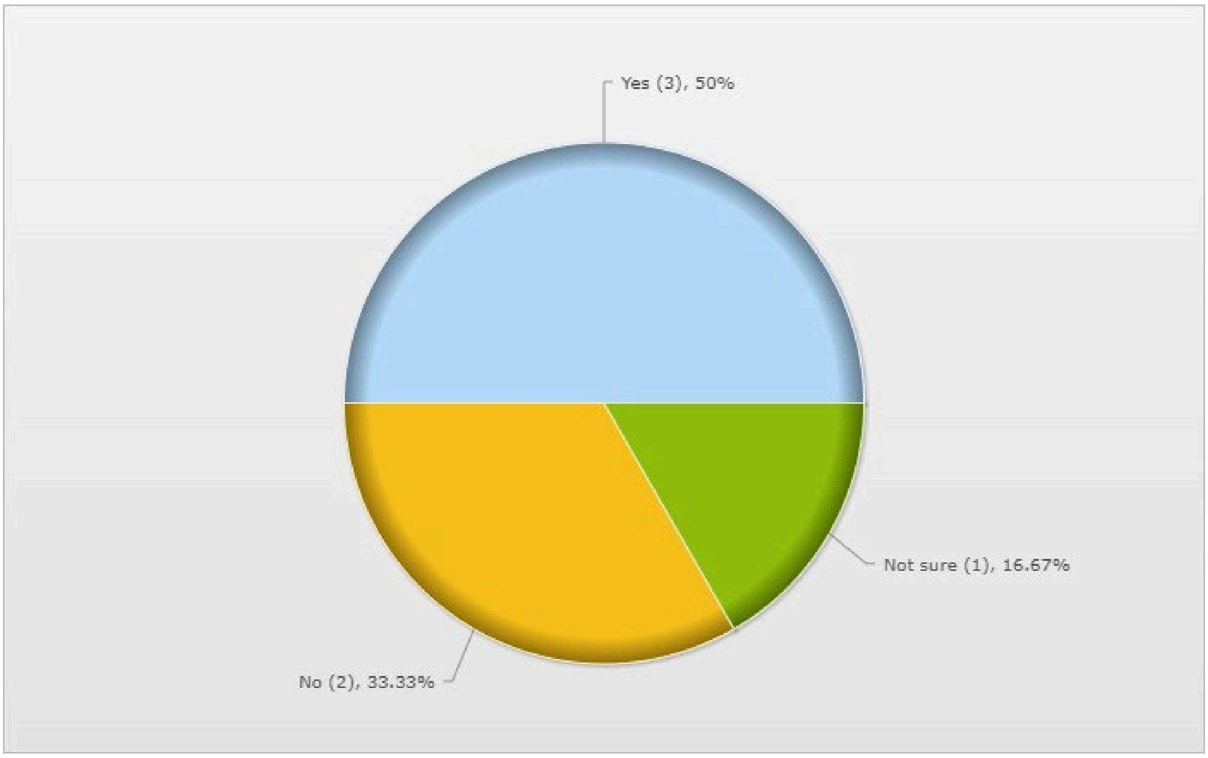


Q4: Have you noticed any changes in their mobility, independence, mood, or confidence?

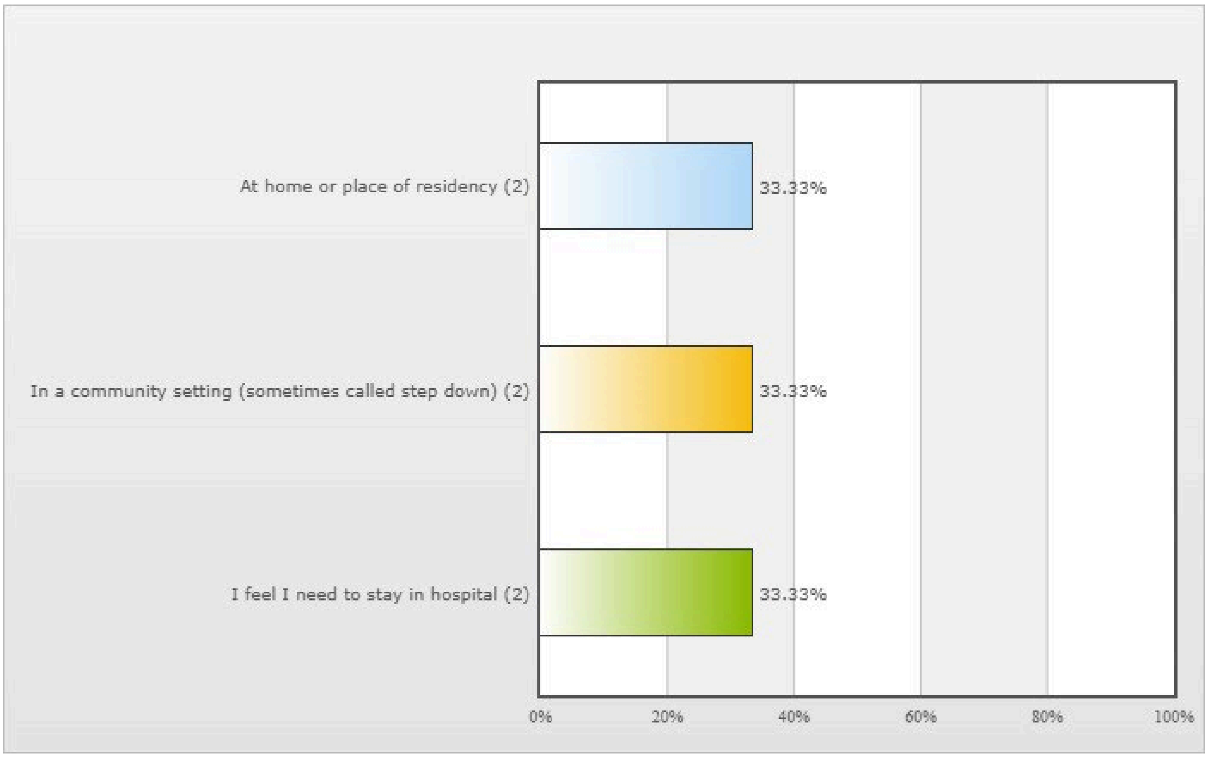


Four people chose to comment further on this question. One cited their loved one needs 1:1 care, another a lack of communication, one reported their loved one had been in bed too long and the fourth said their loved had lost weight.

Q5: Do you feel your loved one could leave hospital if the right support was in place?



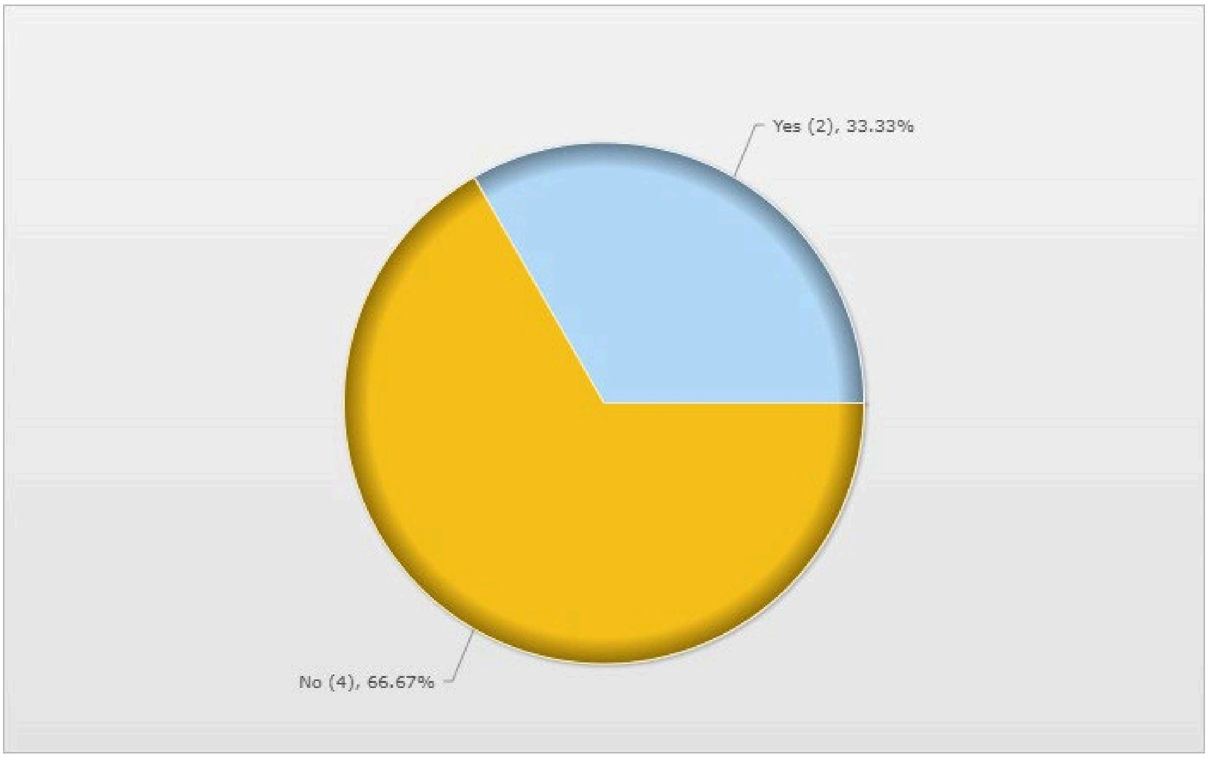
Q6: Where would you most like your loved one to be recovering?



Q7: What are your main concerns about them leaving hospital?

Four people answered this question. Two reported supported would be needed and concerns about falls, one cited communication and aftercare and one talked about not being able to manage as a carer for two people and a lack of communication about what is planned.

Q8: Have staff explained why your loved one is still in hospital?



Of the two people who responded yes to this question, both said the explanation made sense to them.

Q9: If you could speak directly to the decision makers – what one thing would you like them to understand about your loved one's situation?

Three people answered this question. One cited a lack of communication, one said they had seen a decline, and one raised going home package.

What we have learned

What people have told us

Selected quotes (illustrative)

- “Staff are amazing. They listen show respect and values and nothing is ever too much.”
- “No beds, patients left on corridors or in waiting room in A&E.”
- “Awful had to wait hours for meds.”
- “It really isn't joined up.”
- “Again, this will only work if the correct support and budgets are in place.”

Conclusion and recommendations

Feedback from this pre-consultation engagement reinforces that people understand the case for reducing unnecessary hospital stays and support care closer to home when it is safe. This was consistent across questionnaire responses and targeted community outreach conversations, where people emphasised the need for reliable, joined-up community health and social care before any reduction in bed capacity at RLI.

Across the feedback, the strongest risks to confidence were the perceived lack of capacity and resilience in community and social care (including carers, district nursing, therapy and equipment), delays accessing services (including out-of-hours), and a lack of joined-up working and clear ownership between organisations. People also raised concerns about hospital flow and discharge, particularly delays linked to take-home medicines and worries about rushed or poorly planned discharge without adequate follow-up. The PCBC should therefore set out clearly how safe alternatives and strengthened discharge pathways will be delivered and monitored before any ward closures progress.

Recommendations

- **Demonstrate community and social care readiness before reducing beds:** set out what capacity and resilience will be in place (including carers, district nursing, therapy/rehab, equipment and step-down provision), how it will be sustained, and how impacts will be monitored as beds reduce.
- **Strengthen discharge planning, safety and flow (including take-home medicines):** improve end-to-end discharge processes, reduce delays linked to pharmacy/discharge paperwork, ensure early and proactive planning with clear safety checks, and strengthen handover/follow-up once people leave hospital.
- **Improve communication and involvement for patients and families:** provide consistent updates, involve relatives/carers in decisions, and ensure people understand why they remain in hospital and what support will be in place after discharge.

- **Build confidence through named contacts, clear ownership and responsive support:** provide a named coordinator/single point of contact, a clear care plan, and timely access to help (including out-of-hours), with responsibilities agreed across organisations.
- **Use engagement insights to shape the PCBC and consultation materials (if required):** address key concerns directly, explain what will change for patients and carers, and set out how feedback will continue to be gathered and used.

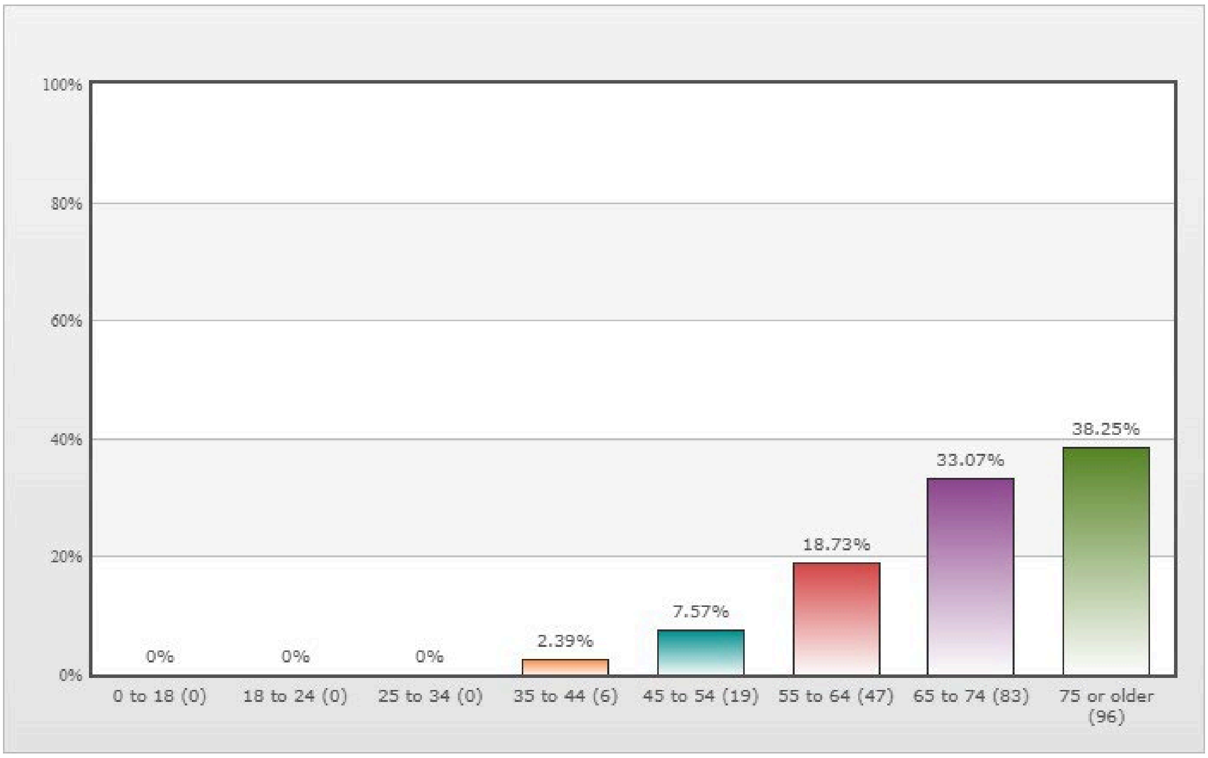
These recommendations will inform the development of the PCBC and the approach to consultation if required, including the evidence required to demonstrate safety, quality and deliverability of community alternatives before any staged reduction in bed capacity is implemented.

Appendices

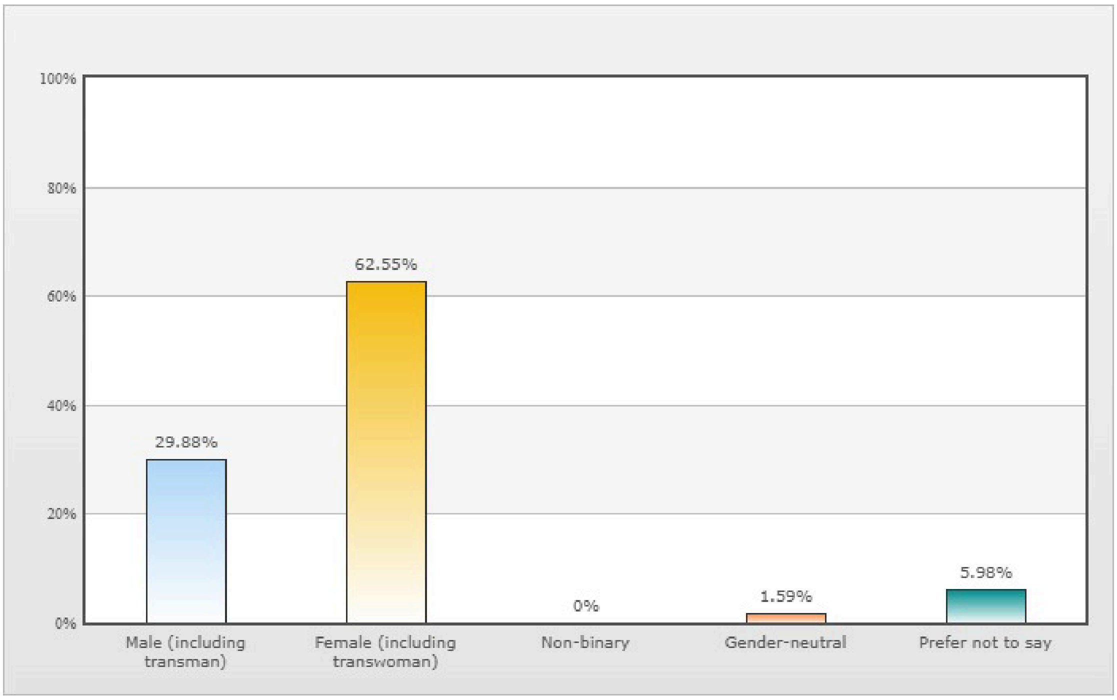
Appendix 1: community engagement questionnaire – demographics

Responses to the demographic questions were optional, 251 people chose to answer them.

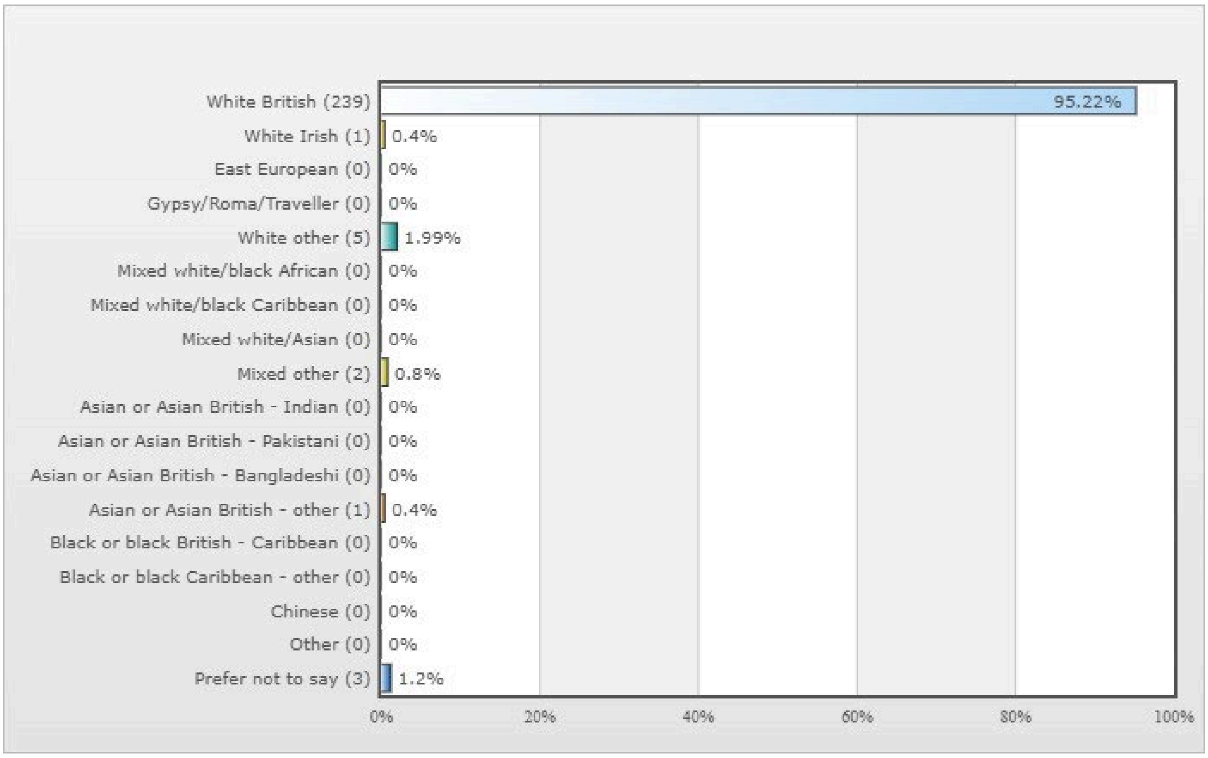
What is your age?



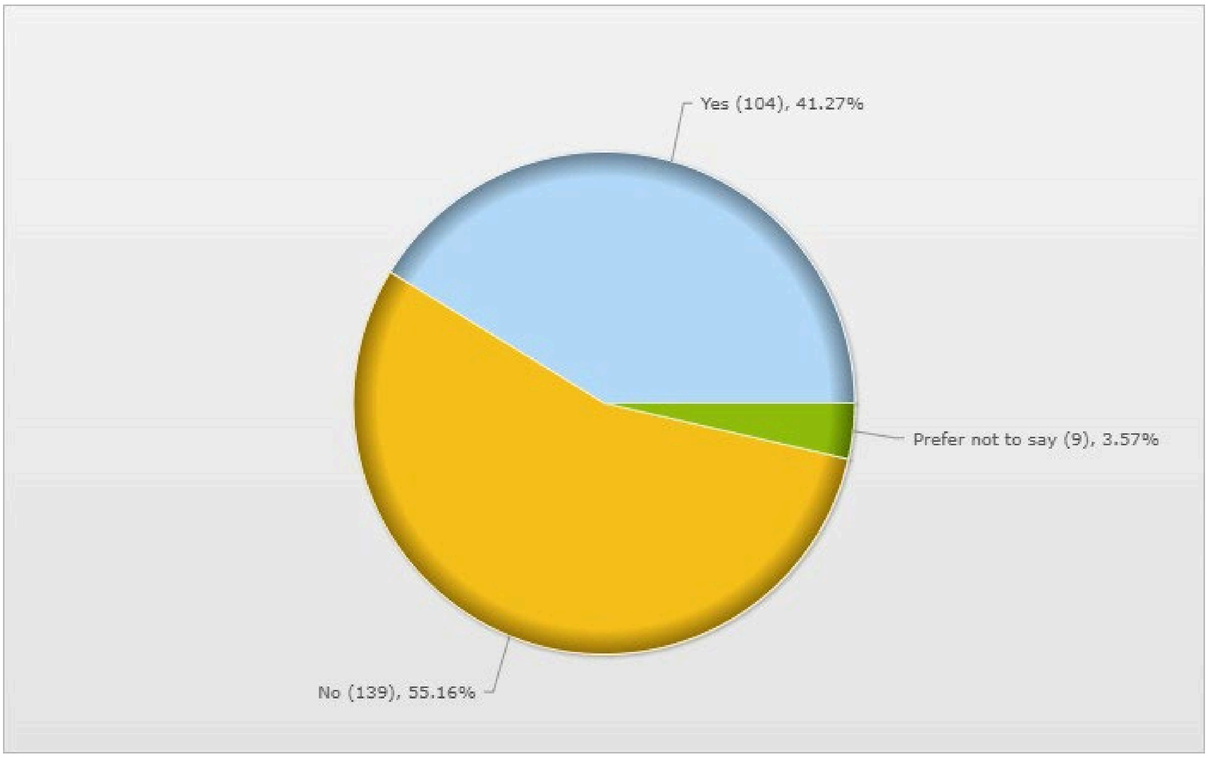
Which of these best describes you?



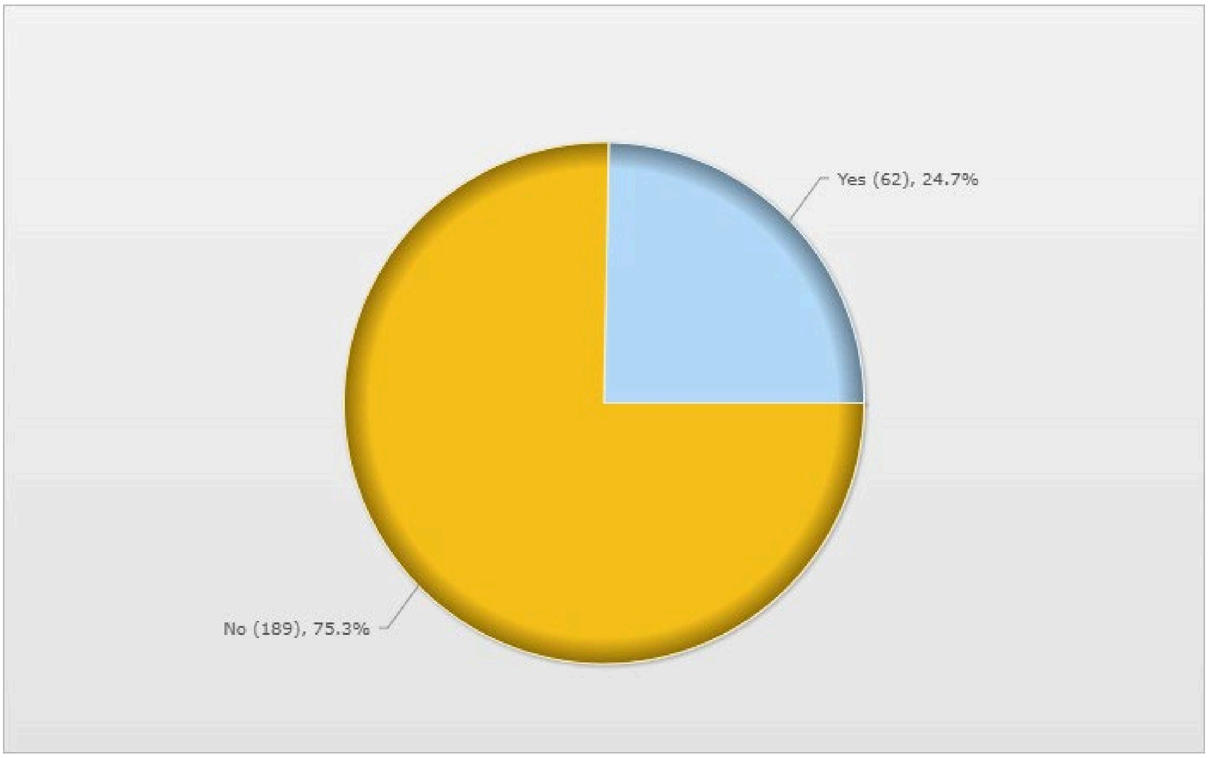
Which of these best describes your ethnicity?



Would you consider yourself (or the person you are answering for) to have a disability? (Described in the Equality Act 2010 as ‘a physical or mental impairment’ of which has a ‘substantial and long-term adverse effect on your ability to carry out normal day-to-day activities)



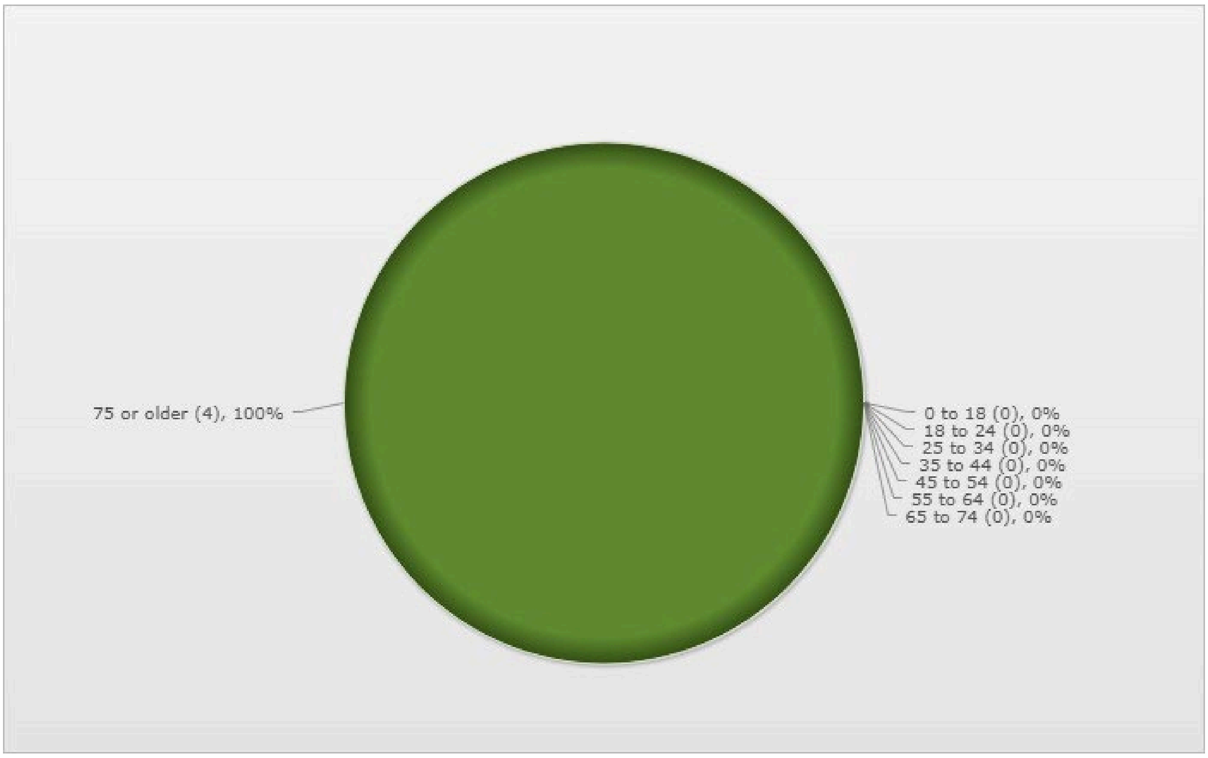
Are you a carer?



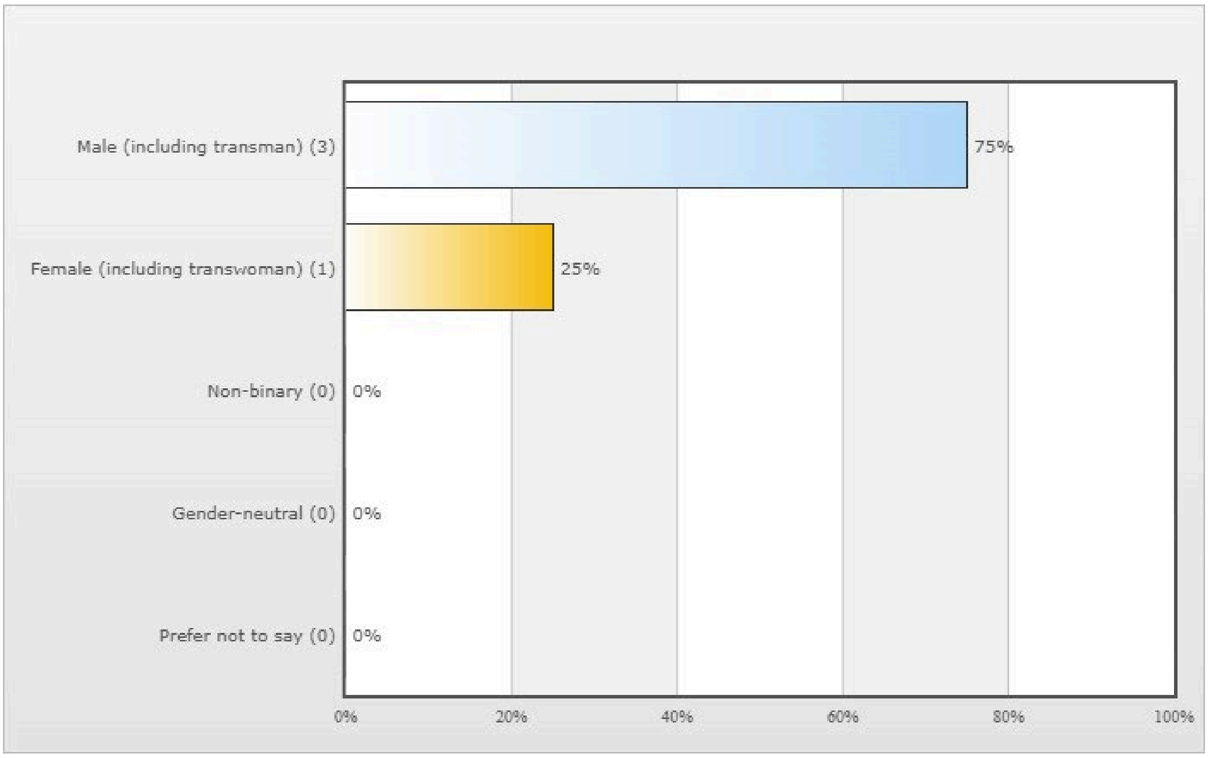
Appendix 2: patient questionnaire – demographics

Responses to the demographic questions were optional, four people chose to answer them.

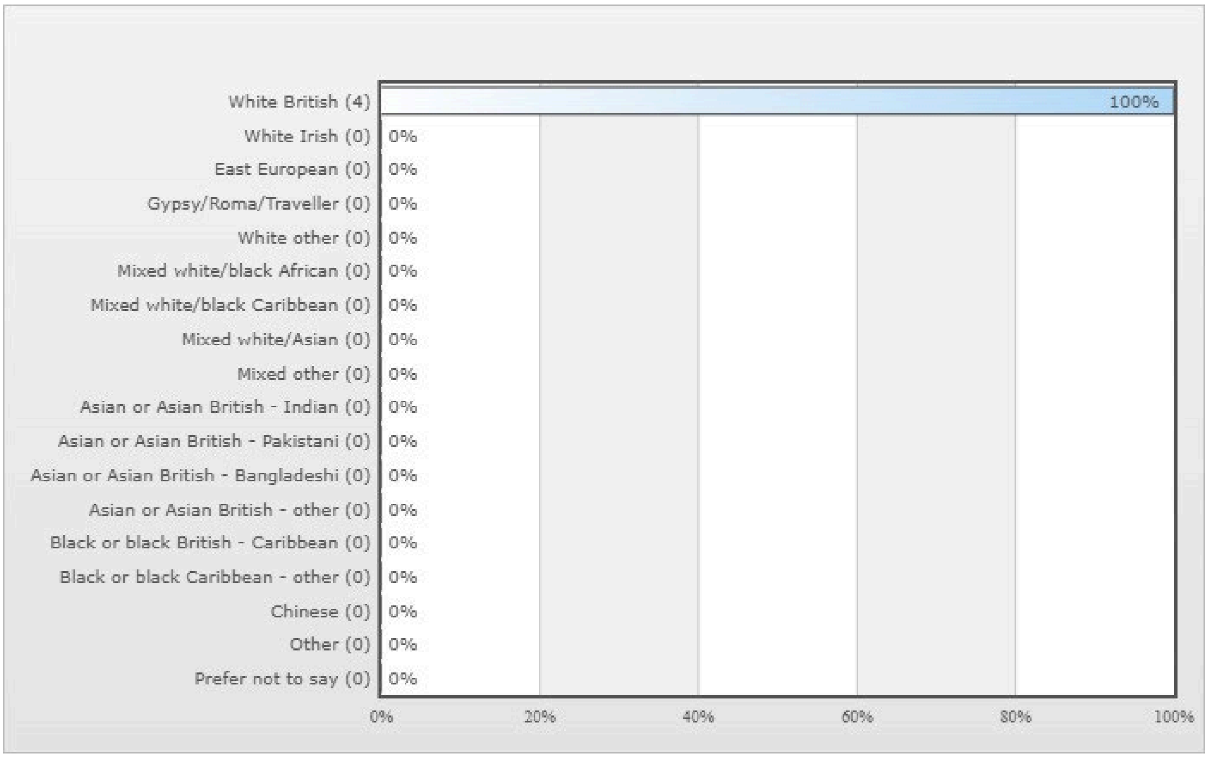
What is your age?



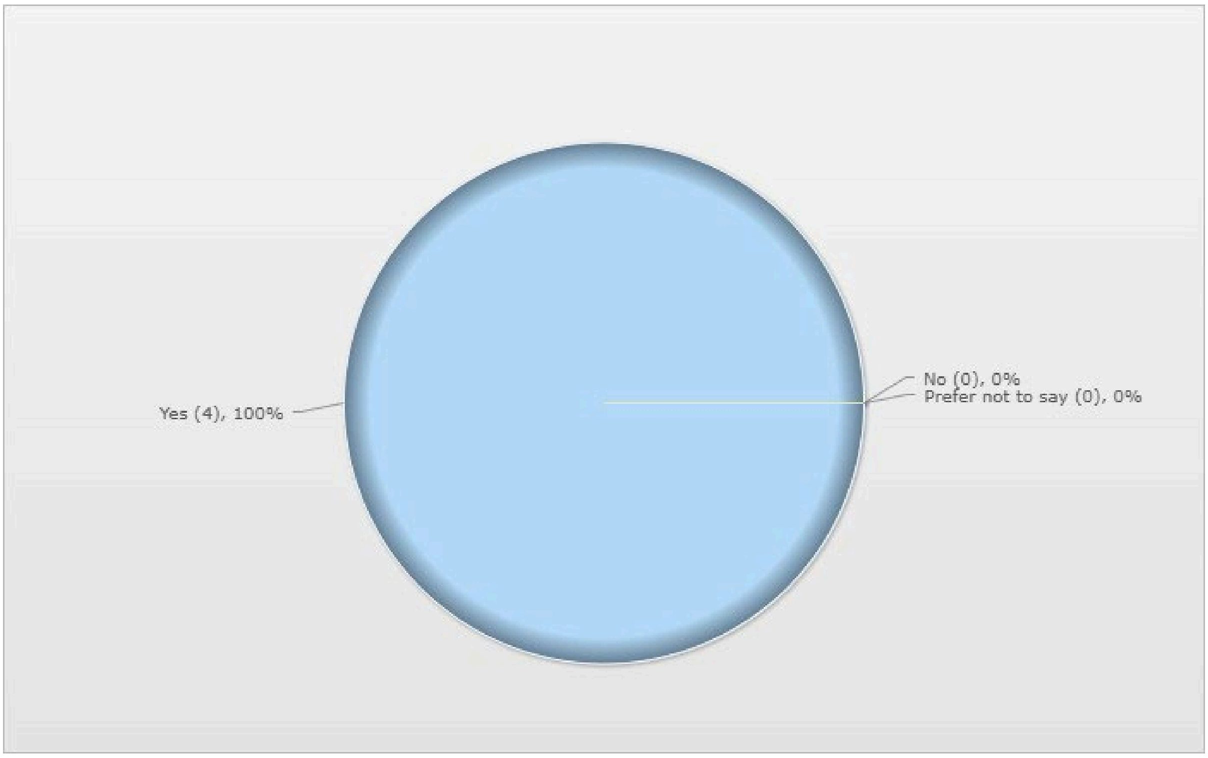
Which of these best describes you?



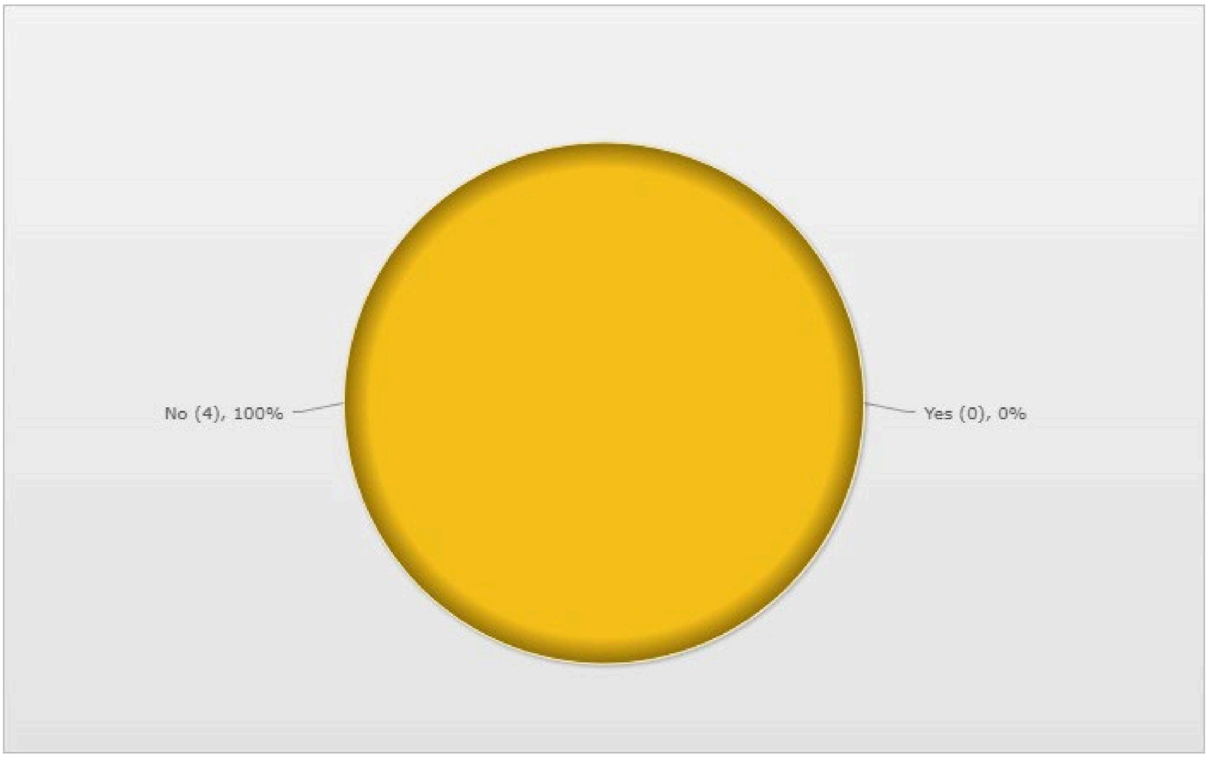
Which of these best describes your ethnicity?



Would you consider yourself (or the person you are answering for) to have a disability? (Described in the Equality Act 2010 as ‘a physical or mental impairment’ of which has a ‘substantial and long-term adverse effect on your ability to carry out normal day-to-day activities)



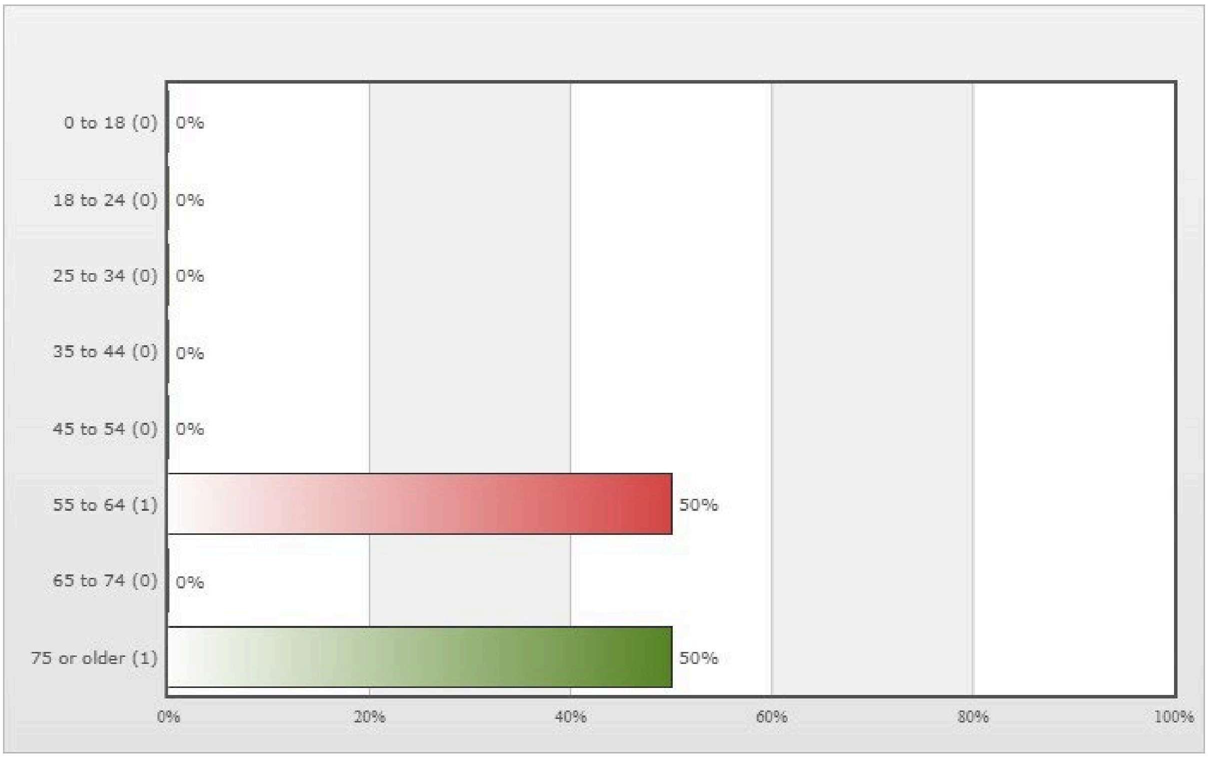
Are you a carer?



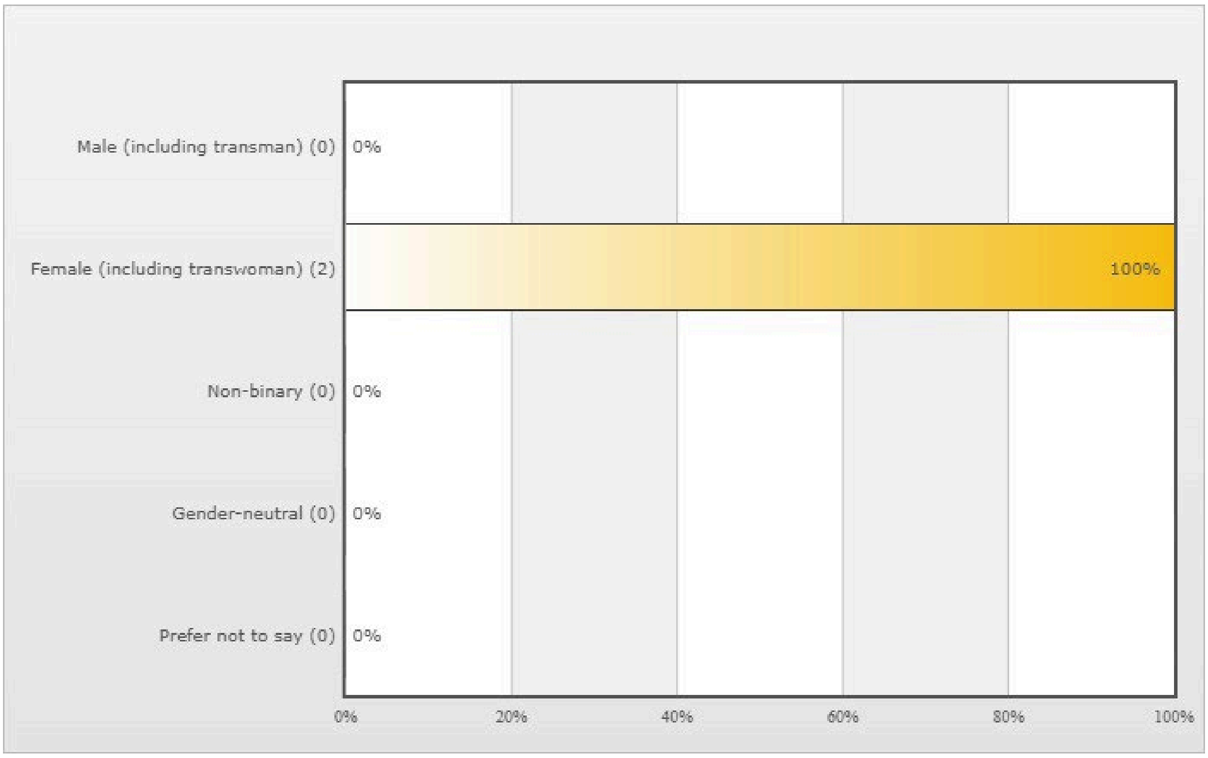
Appendix 3: family/friend/carer questionnaire – demographics

Responses to the demographic questions were optional, two people chose to answer them.

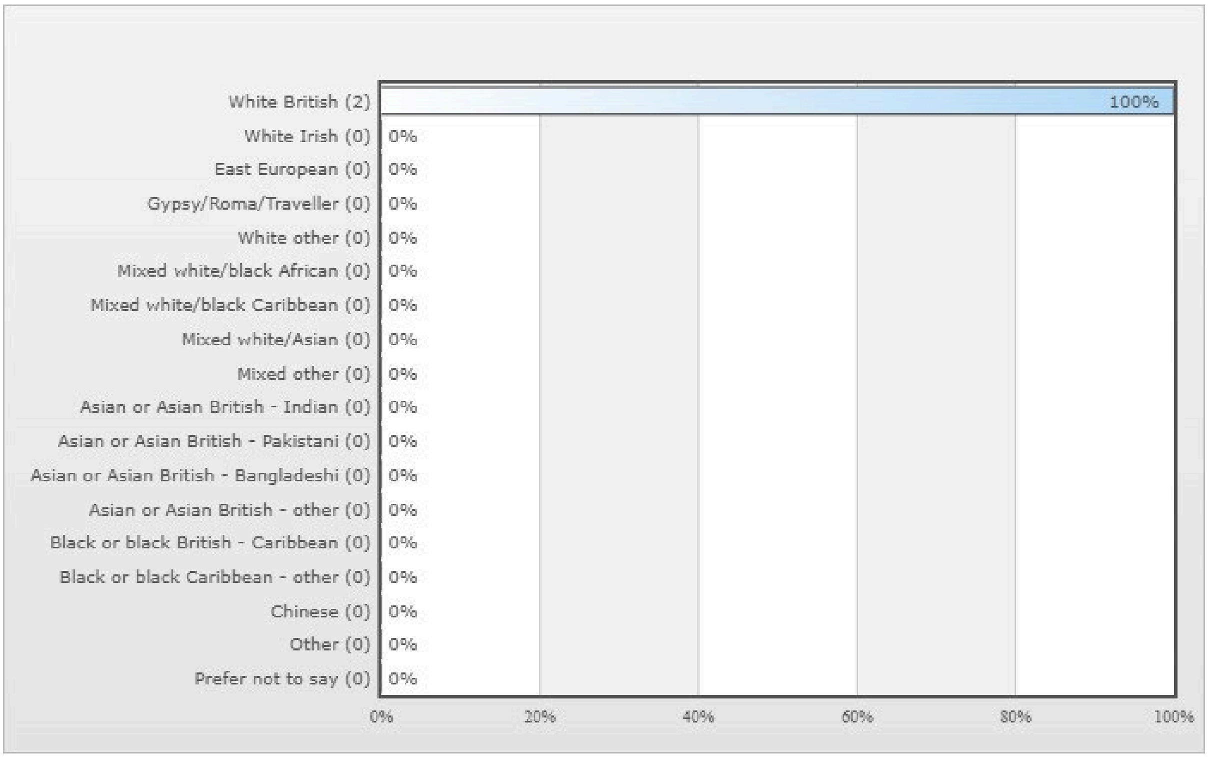
What is your age?



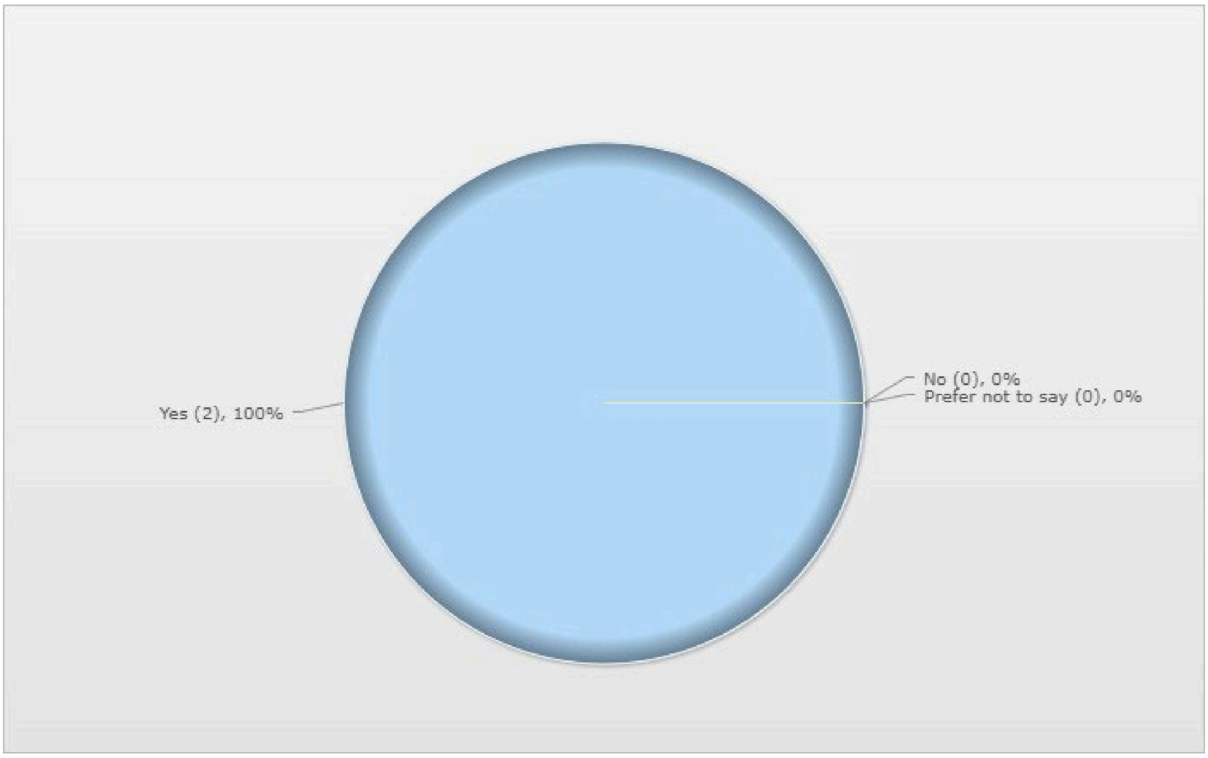
Which of these best describes you?



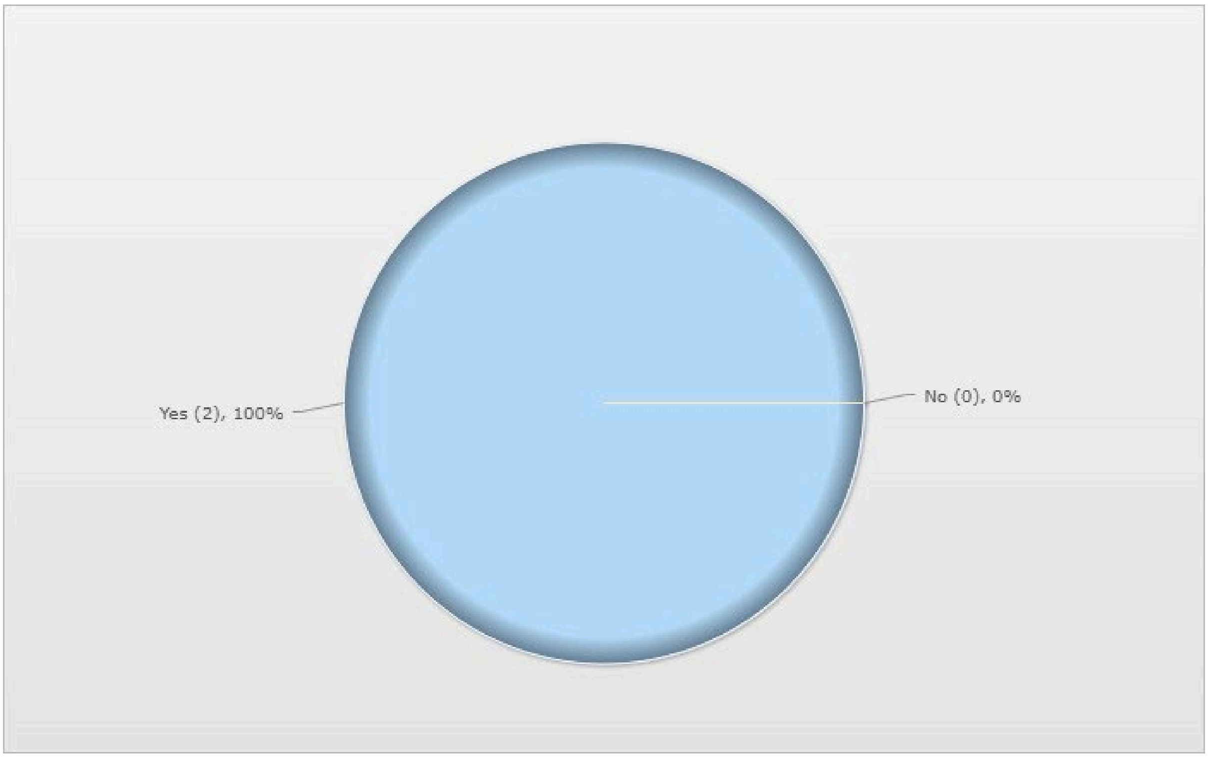
Which of these best describes your ethnicity?



Would you consider yourself (or the person you are answering for) to have a disability? (Described in the Equality Act 2010 as 'a physical or mental impairment' of which has a 'substantial and long-term adverse effect on your ability to carry out normal day-to-day activities)



Are you a carer?


Yes (2), 100%
No (0), 0%