healthwatch Wakefield

Real voices, real impact

April to June 2025

Contents

Services can't improve if they don't know what's wrong. Your experiences shine a light on issues that may otherwise go unnoticed.

If you need this report in another format please get in touch.

Registered Company No. 09907848 and Charity No. 1166797 Registered in England and Wales.

Introduction

This report shows how we've been listening to people and using their experiences to improve health and care services.

Every day, people contact Healthwatch Wakefield to share what it's like to use health and social care services — whether through conversations at community events, calls to our office, or messages through our website and social media.

We signpost people to services, contact services directly, and collect and analyse feedback to identify key themes and trends.

Rather than focusing on large numbers, we place high value on the depth and quality of feedback. We are interested in individual experiences, and we focus on personal feedback to help us understand how services impact people on a human level.

These stories often highlight issues that surveys or statistics might overlook.

We then work with services and decision-makers to share what people are telling us and this helps to shape better care for everyone.

This report highlights:

- Where and how we've collected feedback
- What we heard and why it matters
- What actions were taken as a result
- What's changing because of what people shared

Illustration showing how we use your voice to make change happen

Information

How do we hear from people

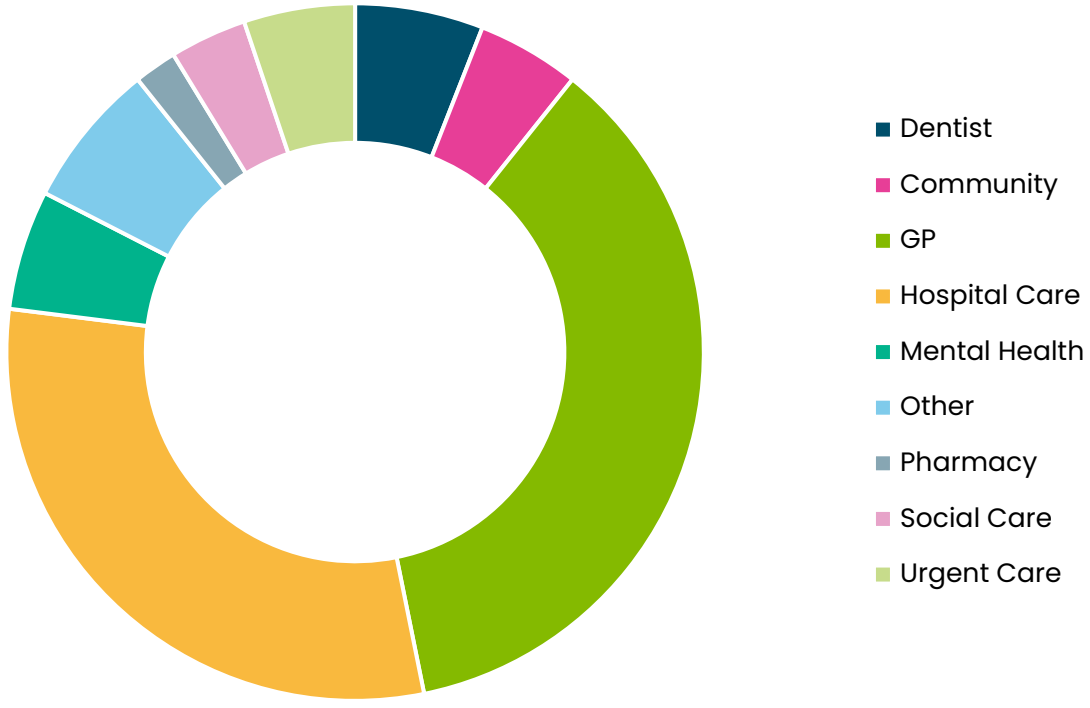
We hear from people in lots of different ways - through engagement, as well as telephone calls, our website, and social media. In these three months we received 252 pieces of information from people who have used health and care services. We talked to people at over 30 different events, meetings, and community locations, including:

- Castleford Cuppa Club
- Wakefield Library
- Aphasia Support Café in central Wakefield
- Fryston Family Fun Day
- Ossett Stroke Support Group
- One Ummah Community Event
- Appletree Allotment Ladies Group
- Pontefract Baby Fayre

We also talked to people at the regular panels and partnerships we run: the Mental Health Community Panel, Adult Social Care Citizen Panel, and Maternity and Neonatal Voices Partnership. We also gather very detailed information from people when things haven't gone to plan or as expected through our independent NHS Complaints Advocacy Service.

Issues shared by service type

Chart showing proportional distribution of service issues



What we heard and why it matters

We analysed the 252 pieces of information that we received and found that four main themes emerged.

1. Digital exclusion and accessibility
2. Dismissive or rushed interactions
3. Communication and coordination breakdown
4. Mental health – poor experiences, missed opportunities

Each theme is outlined in more detail below.

1. Digital exclusion and accessibility

We heard that digital first models exclude vulnerable groups and also that there is difficulty accessing timely care.

- There is a digital divide with many people being excluded.
- There is a lack of alternatives for those without digital access, leaving many patients behind, particularly some people who are older, disabled, have sensory impairments or where English is not their first language.
- Patients from non-English speaking backgrounds reported confusion around how to navigate the NHS system digitally.
- There was also some praise for online systems, with some loving the speed and efficiency.

Examples

A commonly reported issue we heard is people telling us they called their GP at 8 a.m. only to face long queues and often to find no appointments left. People told us about phone queues of over 50 people and extremely long waits. Many older people, and also those without smartphones or internet, told us they struggled to engage with Patchs, the NHS App, and online booking. Walk-in centres often become the fallback when GP access failed, but this isn't suitable for all — especially carers, or those with transport barriers.

"I'm 88. I don't have a smartphone or computer. I have to ring at 8 a.m. and just hope."

We heard from BSL users and Deaf patients who faced frequent barriers due to lack of interpreters or inappropriate appointment times. Some reported missed interpreters, inflexible appointment times, and no video interpreting options. One Deaf person told us that after waiting two weeks for an appointment with an interpreter, when they arrived there wasn't one and they had to cancel. This barrier resulted in an exclusion from care for them.

We did also receive positive feedback. For example, Outwood Park and Maybush surgeries received praise for same day appointments, proactive follow-ups and providing language or disability support.

2. Dismissive or rushed interactions

There was a perception of being treated with disrespect or even being ignored.

- Several older adults in particular, told us that they felt rushed and not taken seriously.
- Some people felt that staff, particularly GP receptionists, were dismissive and disrespectful.
- We heard from neurodiverse people who felt that they hadn't had the time needed to get the best from their appointment.
- Some people also told us that they felt their concerns were dismissed without being fully investigated. This left them feeling anxious and vulnerable.

Examples

Some people also told us that the way they were treated by GP reception staff, left them feeling 'embarrassed' or 'stupid.' Across GP, dental, pharmacy, and hospital services, some patients described interactions where they felt dismissed, devalued, or not listened to. Patients with complex needs, especially people who were elderly, autistic, or recovering from substance misuse, also reported sometimes feeling judged or rushed.

We were told about a patient aged 92, who felt that the dentist was rushing her with the fitting of her new dentures. She told us that the dentist forced the dentures in her mouth, and she felt that as she was elderly, the dentist was not bothered at all.

We also had feedback from deaf, blind, and neurodivergent people who felt especially excluded or not treated with dignity, especially when communication wasn't adapted. For example, we were told about a lady, who is autistic, and her experience of attending A&E. She had not been given the time or space to process and understand what was happening.

"She was moved to a small room but was unable to understand or process the questions being asked about the pain. The doctor and nurse said to her: "If you can't tell us you need to leave"".

3. Communication and coordination breakdowns

We heard that care sometimes feels fragmented and communication across services can be poor.

- There was a theme around feeling that there is a lack of clear coordination, with systems not sharing information efficiently.
- People told us that there is an over reliance on patients or carers to follow things up themselves.
- We again heard that this hits vulnerable groups the hardest.

Examples

We heard from some people about the hospital discharge processes and how it often lacks explanation or follow-up. Patients and carers sometimes felt that they were left uninformed and without follow up plans or adequate handover to community care and that they lacked clarity on the next steps. We were told about a stroke survivor who was moved from Pinderfields Hospital to a care home without his wife being informed.

"No one told us they were moving my husband to a care home. I arrived at the hospital and he was gone."

People reported that there were missed or misdirected referrals, such as patients being sent back and forth between GP's and secondary care, with no clear lead professional or ownership. For example, we were told about a GP who referred a patient to Leeds Dental Hospital, but the referral went to the wrong department. When asked to resend it, the GP refused, citing 'system issues'.

We also heard from carers who described being unsupported and uninformed in managing care for their loved ones, especially when multiple services were involved. For example, we heard from a frail carer who was sent home with his catheter-dependent wife and no advice on how to empty or maintain it. The GP referred him to District Nurses, who told him it 'wasn't their responsibility'.

4. Mental health, poor experiences, missed opportunities

We heard that mental health issues are often misunderstood and mishandled.

- People experiencing mental health challenges often feel judged, dismissed or blamed for their symptoms.
- People also felt unsupported during mental health crises, often due to a lack of trauma-informed care and a system that defaults to 'physical health first'.

Examples

We received feedback that in emergency settings, there were issues in supporting some people in acute distress, particularly those with autism, Post traumatic stress disorder (PTSD), or sensory processing needs. One person reported being dismissed by a doctor. She had PTSD and had to wait six hours for psychiatric liaison to get involved before feeling that she received compassionate support for her mental and physical health. Another person told us she had been left waiting and threatened with sectioning instead of being supported. She described herself as being frozen due to sensory overload. From the feedback we received from some carers, there was also a sense that people with dementia or long-term conditions are seen as 'nobody's priority' and are also misunderstood.

"They wrote violent, but he was just scared. That label will follow him forever".

What did we do

Advice, information, and signposting

We give people advice and information about numerous things including how to find services and what to expect, knowing their rights, how to raise concerns or complaints, self-help, advocacy and where to go for reliable health information.

We also signpost people to a huge range of organisations, websites, helplines, and services. This signposting makes a real difference to people as the examples below show.

One person, who had received support and signposting from our NHS Complaints Advocacy service, summed it up well:

"Thank you so much again, you find all the contacts!"

Signposting for support for people with Fibromyalgia

In April, we posted and signposted on social media about a new pilot project being provided by Conexus Healthcare, via text, for Fibromyalgia patients. One person shared the following:

"This is exactly the service that I needed but did not know I needed! Since using the app, I have now planned to do my journaling three times this week and that has lifted my mood."

Signposting and support for people whose loved one is nearing end of life

We met with a young woman who shared that her mum, aged 60 is terminally ill and at end of life. She explained she felt her parent is in denial about dying. She asked how she could she prepare herself and her two young children for the death of her mum. Healthwatch signposted her to Star Bereavement who are running drop in grief cafés in the area, they work with children, and also reached out the Pontefract Hospice, who have a wellbeing team, they have offered to meet with her.

Signposting and support for people with disabilities and isolation

We visited the Wakefield District Sight Aid Drop In Café at Horbury and spoke to a woman who had previously had a stroke and moved house shortly afterwards, from Bradford to Horbury. She was left blind in one eye and with a weakness down one side. She was happy walking to Horbury but was nervous to go on the bus and going somewhere new. We put her in touch with Connect at St George's Community Centre, whose aim is to help people struggling to get out and about. The Connect team are now going to go with the lady to a Sight Aid Group and also a Stroke Support Group in Ossett. Because of this signposting, she is now able to access these additional services which offer her great support.

Quality Intelligence Group

Each month we take all our information to Wakefield District Health & Care Partnership's NHS Quality Intelligence Group. This is an important monthly meeting which captures experiences of health and care – both positive and negative. This meeting is organised and Chaired by the NHS Senior Head of Quality.

Feedback is gathered from a range of sources, including Healthwatch Wakefield, the Partnership website, the NHS website, engagement activities, complaints, social media, and service walkabouts. Healthwatch Wakefield produce a monthly report which is shared with Quality Intelligence Group, this report is usually the main source of feedback for the group.

Each month, after considering and discussing all of the intel, three or four themes are identified by the group members, and relevant actions are agreed, with the ultimate goal to make experiences of services better for everyone.

Feeding into decision making meetings

In addition to direct feedback and signposting, Healthwatch Wakefield regularly shares insight at a wide range of strategic meetings across the district. This ensures that the voice of local people influences decisions at every level of the health and care system.

These meetings include:

- Wakefield District Health and Care Partnership Board and workstreams
- NHS Wakefield Quality Intelligence Group
- Adult Social Care Strategy Group
- Mental Health Provider Collaborative
- Learning Disabilities and Autism Partnership Board
- Experience of Care Network
- Wakefield Safeguarding Adults Board

At these meetings, we share current themes, lived experience, and emerging concerns. This enables system partners to respond quickly to public feedback, spot service gaps, and consider where deeper engagement or service changes may be needed.

What changed

Real stories, real impact

Here are some examples of the difference we have made.

Focus on access to primary care services for Deaf patients

A Deaf patient told us that they had visited their GP surgery in person to ask about an out-of-hours appointment. Staff refused to assist them, saying that they had to phone the practice. The patient explained they couldn't use the phone or automated system due to their hearing loss, still, the staff insisted they must phone.

Eventually, the patient attempted the call but couldn't hear the automated menu. When they walked back over to clarify face to face, the staff member accused the patient of "hanging up" and appeared angry. The patient was told to email management. They felt dismissed, humiliated, and disbelieved.

"I am deaf. I was right there in front of them asking for help, and they made me call from 30 feet away. It was like they didn't believe me."

The patient told us that "protocol" was used as a reason to deny reasonable adjustments — leaving them without care.

Healthwatch took this feedback to Quality Intelligence Group where it was discussed and then followed up by the Senior Quality Manager and also by Healthwatch who met with Connexus Healthcare. The key actions and learning for Connexus Healthcare following the meeting were:

- The member of staff involved contacted the patient to apologise.
- The member of staff also received dedicated training to improve their understanding of access protocols; this was followed up with them to ensure understanding.
- Learning was shared across the whole team and a service-wide communication was sent, reinforcing the importance of reasonable adjustments for patients where needed. This included reiterating that patients can request appointments in person.
- The service has started to explore the implementation of an SMS-based online booking system for patients who are unable to communicate via telephone.
- We discussed the potential to involve patients with lived experience in reviewing access protocols in the future.

We have also heard from other deaf people who have struggled to access British Sign Language (BSL) interpretation services at the GP. Healthwatch had oversight of the new interpretation service specification and following this up, we spoke to the ICB Senior Primary Care Manager who was responsible, alongside West Yorkshire colleagues, for the procurement of a new GP interpretation service. We asked specific questions from deaf service users about this new service and were given

reassurance regarding the service user consultation that had taken place, the number of BSL interpreters employed and their registration level. These were specific questions that we had been asked at Healthwatch. The new contract started on the 1 April 2025 and we will be monitoring further feedback from deaf clients about this service.

Focus on better care for inpatients who are breastfeeding

A patient attended A&E four weeks after giving birth, she had her baby with her. She appreciated the quiet space and breastfeeding support but felt anxious about whether her baby could stay with her in hospital as the staff were unclear about this. On Ward 36, she felt that staff were dismissive and lacked breastfeeding knowledge. A side room was offered, but she told us that the process felt overwhelming, especially when she was asked to sign paperwork about risks to her baby. On a later readmission, she again faced resistance to having her baby with her and was advised to consider bottle-feeding. She found the overall experience stressful due to inconsistent staff responses. We shared this experience with the Infant Feeding Lead Midwife, who committed to create a clear Standard Operating Procedure. Some weeks later, the patient attended hospital again and stayed on Ward 40. She reported a much more positive experience this time.

Focus on supporting access to health and care for trans and non-binary people

Following the Supreme Court ruling that legally defines the term "woman" as referring to biological sex, we recognised that some transgender and non-binary people might feel uncertain about their rights or hesitant to access health and care services.

In response, we created and shared a practical support guide to help transgender and non-binary people understand how to access inclusive, respectful care in Wakefield and beyond. The guide also highlights their rights when using NHS or social care services.

We received strong, positive feedback on this resource:

- The Equality, Diversity, and Inclusion Transformation Lead at NHS West Yorkshire ICB described it as a “fab resource.”
- The Coordinator at West Yorkshire Voice also praised its clarity and usefulness.

Additionally, our resource will be featured in an upcoming edition of *Daisy Chain* — a regional magazine co-produced by LGBTQ+ people — which focuses on creating safe and welcoming spaces in health and care. We’ve provided them with an explainer about Healthwatch and a QR code linking to the guide.

We wanted people to know that we believe in their right to safe, respectful, and inclusive health and care. Their identity is valid, and they deserve to be treated with dignity, always.

How to access support for trans people

Focus on improved support for parent waiting years for a SEND diagnosis

Healthwatch attended an engagement session at Wakefield Diagnostic Centre. One person shared with us that she had chosen to home educate her daughter as her needs were not being met in school. She said that they had started the process of getting a diagnosis for SEND for her daughter

when she was six years old, she is now 15 and still has no diagnosis. We contacted commissioners to ask if they could help this parent, who had chosen to home educate and thought this was the reason that her daughter's case was being delayed. The commissioners replied saying that they would look into the daughter's case and see what was going on. The mum was so grateful that Healthwatch listened and were willing to go the extra mile for her.

Focus on advocacy outcomes

Sandal Castle Surgery

A client had made a complaint to the practice as she requested an appointment, but instead received a prescription for a medication that she had already tried. The client made a complaint in August and was told that she would receive a response in 28 days, however she didn't receive anything. She complained again in November and again didn't receive a response. With support from our NHS Complaints Advocates, this was fed back to the Surgery, who now have a Duty Manager who deals with any complaints received each day and responds on the same day. In addition to this, they now have a complaints tracker where all complaints are logged and then discussed on a weekly basis during their complaints meeting.

Dewsbury District Hospital

The client's wife was transferred to Dewsbury District Hospital from Pinderfields Hospital following a suspected stroke. The client went to visit his wife in the evening and his wife's buzzer was continually buzzing. She told him that she wanted to go to the toilet and that she was frightened of having an accident. The client stated that the nurses were being unprofessional and just 'standing smirking at his wife' rather than taking her to the toilet. Therefore, he took things into his own hands by taking her to the toilet. Following this complaint, audits will now be carried out at random intervals on the ward to monitor response time when buzzers are activated.

Actions and outcomes from Quality Intelligence Group

The table below shows the themes identified at the NHS Quality Intelligence Group for April, May, and June 2025, and some of the agreed actions. It shows how the intel we receive at Healthwatch Wakefield helps to recognise good practice and also helps to influence change at a strategic as well as individual service level.

April 2025 themes	Some actions taken
Negative attitude of staff	• Share the feedback with the Head of Patient Experience at Mid Yorkshire Teaching NHS Trust. • Ask Conexus to consider developing customer services training for clinical staff, which is already offered to administrative staff.
Long waiting time in A&E	• Patient safety walkabouts undertaken to Emergency Departments at Dewsbury and Pinderfields Hospitals in Q4 24/25. Positives noted including clinician on the reception area to help triage and support vulnerable people with waiting. Clear pictorial wall chart of 'what to expect' during attendance.
Positive feedback for fast and easy access screening and diagnostic services	• Share positive feedback with the relevant services.
Processes not being followed in GP practices	• Primary Care Team will review the feedback and look into this theme – this is currently an ongoing action.

Additional actions in April based on Healthwatch Wakefield feedback
Feedback about Diabetic Eye Screening at Glasshoughton was fed back to the NHSE screening and immunisation team.
Feedback about information missing from the NHS app was shared with the medicines optimisation team to use as an example for the Quality, Innovation, Productivity and Prevention Scheme, which has a focus on efficiency savings whilst maintaining quality, for structured medication reviews.
Feedback about repeat prescription for stoma bags shared with medicines optimisation team and used as a case study for proposal to move stoma products off FP10 (medicines) prescriptions.

May 2025 themes	Some actions taken
Positive feedback from Eastmoor Medical Centre	• Positive feedback shared with the service.
Positives for Maybush Medical Centre, including suicide awareness training	• Positive feedback shared with the service.
Positive feedback about care and treatment in Pinderfields Emergency Department	• Positive feedback shared with Head of Patient Experience. • Ask the trust to consider signposting patients the A&E patient journey displayed in the entrance of Pinderfields Emergency Department – this action is ongoing.

June 2025 themes	Some actions taken
Negative feedback about Patient Transport Services	• From April 2025, updated national eligibility criteria for non-emergency patient transport services was implemented in West Yorkshire. • Patient feedback was provided to contracting and involvement commissioning leads. • Feedback was shared with the Head of Quality for Yorkshire Ambulance Service. • West Yorkshire Healthwatch met with the commissioner for transport services and shared useful information regarding the new criteria, including how patients can appeal the decision. We will also be involved in the upcoming review taking place in the next few months and will promote this new information.
Negative experiences noted for various services around care, treatment, and access for elderly people	• Quality Intelligence Group data for the last 3 months reviewed and shared with relevant services.
Lack of communication about transfer between wards / hospitals	• Feedback shared with Head of Patient Experience – feedback to be brought to future meeting. • Patient ward transfers out of hours guidelines have been updated.

Additional actions in June based on Healthwatch Wakefield feedback
Concerns about unsafe equipment being installed by Wakefield Council, grab rails etc, was fed back to Wakefield Council Adult Social Care's Community Equipment Service.

Looking back

At Healthwatch Wakefield, we carry out several pieces of in-depth work over the year. Below we look back at a piece of work carried out between 2022 and 2024 and focus on revisiting this and looking back at changes and impact as a result of the work.

Revisiting our Hospital Discharge Project

Background

Between 2022 and 2024, Healthwatch Wakefield carried out engagement work with people who had recently been discharged from our local hospitals. This was part of a larger piece of work being carried out by the System Discharge Group under the lead of Wakefield District Health and Care Partnership. The overall aim was to understand and improve hospital discharge experiences across Pinderfields, Dewsbury, and Pontefract hospitals.

We conducted two phases of engagement involving over 160 telephone interviews with patients and carers post-discharge. Our findings highlighted challenges with communication, emotional readiness, and delays with medication and planning. From this, we made a series of recommendations.

Six months later, we followed up with a second phase of engagement to assess changes and understand the impact of our recommendations.

Recommendations for change

Our initial report made 8 recommendations.

1. Review systems to ensure that patient information and contact details are up to date.
2. Review communication at time of discharge in order to ensure that people feel as ready as possible, both practically and emotionally. Particular focus should be on information that people are given about their discharge; the follow up and support they may need; and allaying any concerns that they may have regarding whether they require further care in hospital.
3. Review systems on wards for keeping family up to date, with a particular focus on dealing with telephone calls and messages from family members and procedures for keeping family up to date when wards are closed and visiting is not allowed.
4. Consider what is in place to keep family members up to date where patients are unable to keep in touch themselves.
5. Put systems in place to ensure that no patient is transferred to a different hospital without their family being informed prior to the transfer.
6. Review systems that are in place to ensure that patients and / or their family have clear communication around expected length of stay in hospital.

7. Review the information leaflet given regarding discharge, including how it looks, when it is given, how it is given, for example are patients talked through the booklet, are the telephone numbers pointed out, is this information reiterated on discharge.
8. Review medicine discharge procedures and communications with patients in this area in order to manage expectations.

So what?

Based on the findings, and recommendations of our report, several changes have been made by Mid Yorkshire Hospital Trust, including the following.

Improved communications for patients

Introduction of several new written communications for patients and families. These include the 'My Discharge Plan' leaflet which is a small leaflet given to patients shortly before they are discharged. This has sections to be completed alongside a health professional, such as any appointments planned after discharge. It has been seen to be particularly useful for vulnerable patients as it allows their families to stay up to date with their discharge process.

The Trust have produced a new 'Getting Ready to Leave Hospital' booklet – this provides the patient with details of what will happen during their discharge process and provides them with contact information if they wish to raise a concern or complaint relating to their own discharge experience.

Welcome letters have also been introduced. These provide patients with information regarding a long term stay in hospital and provide details of what they might expect whilst there. Since these have been implemented, the Integrated Transfer of Care Hub have noticed a big decrease in the number of complaints regarding the discharge experience.

Videos explaining the discharge process to patients and carers have been created and these videos are now played in the discharge lounge. This allows patients and relatives to understand a patient's discharge journey, the different stages they may encounter and what to do if they have questions or concerns.

There is ongoing work on improving ward and hospital transfer communication with patients and their families. For example, families can now 'opt out' of not being contacted after 10pm and instead will receive updates at any time

Improved waiting areas

The discharge lounges also now have beds and seating areas for those who have been discharged but may have to wait a long time before going home.

Improved feedback methods

Once a patient has been discharged, they will be sent a 'calling card' otherwise known as a 'Discharge feedback card'. This will either be sent to the patient or their family and is a way of gathering feedback and finding out about their experience. This allows the Integrated Transfer of Care Hub to continue to make improvements based on up to date feedback.

What was the impact?

Our follow-up interviews, six months later, with patients who had been discharged from hospital confirmed meaningful progress.

93% of patients felt practically ready for discharge (an increase from 70%)

Satisfaction with discharge communication increased from 45% to 53%

Post-discharge care satisfaction rose from 70% to 96%

The changes made to improve hospital discharge show Mid Yorkshire Hospital Trust's strong commitment to acting on public feedback. Many suggestions are now part of daily practice, making discharge safer, smoother, and more focused on patients' needs.

We want to hear from you

We report every three months on what we have done and the difference it has made.

The stories, concerns, and experiences shared in this report came directly from people in our community — and they've already helped to shape better health and care services across Wakefield District. But there's always more to do. We're here to keep listening, keep sharing, and keep pushing for change — and we need your help to do it.

If you've had a good or bad experience with local health or social care services, we would like to hear about it. Your feedback helps to shape better services for everyone.

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