# Humber Acute Services Review
# Feedback from the Citizen's Panel meeting - Thursday, 21st November 2019

## What is the Humber Acute Services Review?

The Humber Acute Services Review is looking at new ways to provide hospital services for the population of the Humber area, which will meet local needs both now and in the future. The review will also consider how to make best use of workforce, buildings and how technology can innovate how care is provided.

In early 2019, the review focused on five specialities, these being: complex rehabilitation, neurology, stroke, critical care and cardiology. Work to develop clinical models for these specialities is ongoing and any major changes will be incorporated into this phase of the review.

The focus of the review is now on the three fundamental building blocks of hospital-based care:

- Urgent, emergency and acute care
- Maternity and paediatrics
- Planned care

## What is a Citizen's Panel?

The Citizen's Panel is a group of up to 20 independent citizens from across the Humber area, representing various geographical areas and bringing a range of perspectives to discussions. The group acts independently to provide critique, support and advice to ensure the views of patients and the public are considered throughout all stages of the Humber Acute Services Review.

## Purpose of the meeting

On Thursday, 21st November the Citizen's Panel met for the fourth time. The purpose of the meeting was to provide panel members with an update on the progress of the review, seek feedback on the development of public facing communications and finally to involve panel members in developing viable clinical models to be taken forward into fully developed proposals for change.

## Exercise 1: Feedback on the Executive Summary of the Case for Change document

Panel members were provided with draft copies of the Executive Summary of the Case for Change and asked to consider:

- Does the story described ring true? Is it compelling?
- Is anything difficult to understand?
- Is the wording / phrases appropriate?
- Is there anything missing?

Presented below is what panel members said:

***Positive comments:***

- The group felt the document had improved with every iteration.
- The group liked that the document is short, succinct and to the point.
- Refreshingly open and honest and reflects past discussions.
- A lot of people are put off going into these professions and once trained people don't want to stay in our area and this document accurately reflects this.

***Suggested additions / amendments:***

***Page 1:***

- Page 7 – Point 3 – amend to 'Diagnose and evaluate medical conditions'.
- Safety isn't mentioned (e.g. for an individual with allergies who wears a red wristband / specific cognitive conditions and having to re-tell their story could cause high levels of anxiety).
- An easy read version would be useful and inclusive.
- It should say that we need to start considering the social determinants of health and the impact of debt and poverty, for example. There needs to be a reflection on the role of prevention and the need to keep people well so that they don't need to use our hospital services.
- Needs to be something about the need for services to become more integrated and treat people holistically. This would be a better outcome economically and in terms of patient experience.
- Needs to say that care plans should be held in a single place, so that everyone knows the full picture about the patient and they only have to tell their 'story' once.
- It was felt that some areas of care do have the latest IT and equipment, with some being described as cutting edge. Should it say that 'very few services' have the latest?
- 5th bullet – add 'potentially again impacting patients' at the end of the sentence.

***Page 2:***

- The group felt that it should say that people are sometimes going into hospital when they could be better cared for in the community or at home.
- Again, 'medical equipment is old' - it was felt this phrasing didn't acknowledge that there are some services with really up to date equipment now.
- 2nd bullet – give 'HUTH' and 'NLAG' their full organisation names.
- 4th bullet – explain what 'core information' means.
- 4th bullet – change 'online consultation' to 'video link clinical consultation'.
- Last sentence – Put a full stop after 'population of the Humber region' and delete the rest of the sentence.

***Page 3:***

- 1st bullet, 2nd sentence – change to: 'This means seeing skilled, specialist staff who are used to dealing with the illness you have'.

*Other Comments:*

***Page 2:***

- Upon reading about not having technology in place to support care, such as electronic shared records to hold core information – the panel didn't understand as they all know about the Summary Care Record and are seeing that this is being used. They felt it is more about the technology being put in place, but not yet having the systems to facilitate it across services.

## Exercise 2: Review of potential scenarios

Members of the review team presented an update on the work undertaken so far in developing potential models for the three building blocks of a hospital (listed previously on Page 1).

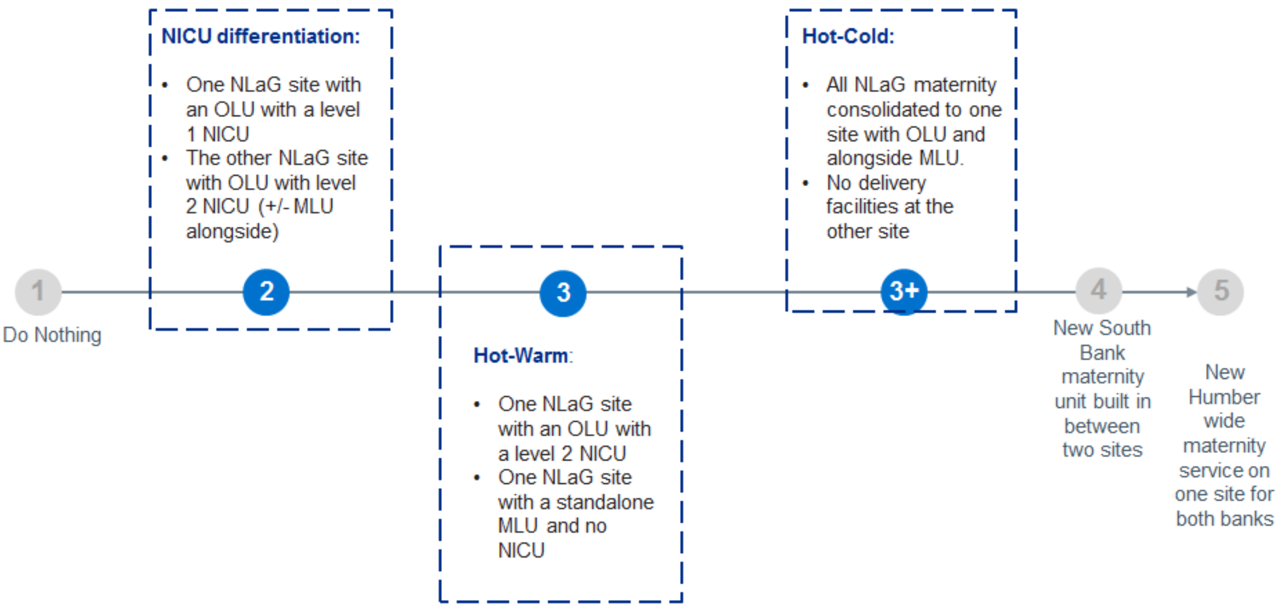
Feedback from both clinical and patient workshops was used to refine initial ideas and preferred models were presented in boxes.

Panel members were then split into four groups asked to discuss the different service models, and provide feedback on the following questions:

- Do you agree or disagree with the statements made?
- What do you see to be the pros and cons of the different options?
- How did you feel the different options would impact on care?

Please see below the proposed service models for each area and the feedback provided by the four groups of panel members:

## Maternity



Definitions:

NLaG = Northern Lincolnshire and Goole Hospital NHS Foundation Trust

OLU = obstetric led unit

NICU = neonatal intensive care unit

MLU = midwife led unit

ED = emergency department

| | 1<br><br>Do Nothing | 2<br><br>NICU differentiation | 3<br><br>Hot-Warm | 3+<br><br>Hot-Cold | 4<br><br>New South Bank maternity unit | 5<br><br>Single Humber-wide maternity unit |
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| Group 1 | | | The group had concerns regarding travelling any distance whilst in labour. Not all deliveries go as planned and travel adds to delay accessing the necessary care.<br><br>You need access to specialist care on hand. | The group had concerns regarding travelling any distance whilst in labour. Not all deliveries go as planned and travel adds to delay accessing the necessary care.<br><br>It works well in Hull as one unit.<br><br>The geography of the area doesn't help as it is so rural – More people will travel further with option 3+. | The group had concerns regarding travelling any distance whilst in labour. Not all deliveries go as planned and travel adds to delay accessing the necessary care.<br><br>Those living in rural areas will have difficulties.<br><br>Those that can travel to other hospitals may choose to do that if things change on the South Bank.<br><br>It works well in Hull as one unit.<br><br>If it was one unit how would you decide where it will be? | The group had concerns regarding travelling any distance whilst in labour. Not all deliveries go as planned and travel adds to delay accessing the necessary care.<br><br>Those living in rural areas will have difficulties.<br><br>Those that can travel to other hospitals may choose to do that if things change on the South Bank. |
| Group 2 | | | Could be a risk to life due to transfer times. Some conditions in the baby present only at birth and will unexpectedly need NICU – long way to travel | Will be affected by the outcome of the paediatrics element. Would you then have all maternity and paediatrics on one site? | We mustn't forget that there were positives expressed regarding options 4 and 5 at the earlier engagement events, however these | Sometimes travel is just not possible – e.g. because of bridge closures, roads closed. |

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| | | | with sickly baby.<br><br>Could an obstetrician/ paediatrician be available on video? | | are now not preferred? | We mustn't forget that there were positives expressed regarding options 4 and 5 at the earlier engagement events, however these are now not preferred? |
| Group 3 | | In the option without NICU, could you upskill obstetricians to be NICU trained?<br><br>Could you combine options 2 and 3? | We have concerns about travelling whilst in labour.<br><br>If a birth is normal, then women would probably choose the MLU, but the disadvantage is if anything goes wrong. Having been a midwife I know sometimes we wait a bit to see how labour progresses rather than act straight away. If we do this it can become more of an emergency and timing is crucial.<br><br>Is it acceptable for women to have to travel? If you are in labour this is not a good experience.<br><br>You can't always predict who will be fine going ahead without obstetric back up. | We have concerns about travelling whilst in labour.<br><br>You might not choose a home birth if there is a long journey to access hospital care in an emergency | We have concerns about travelling whilst in labour.<br><br>You might not choose a home birth if there is a long journey to access hospital care in an emergency. | We have concerns about travelling whilst in labour.<br><br>You might not choose a home birth if there is a long journey to access hospital care in an emergency.<br><br>It is different for things like stroke or ear, nose and throat (ENT), but if maternity it shouldn't be only on one site. |

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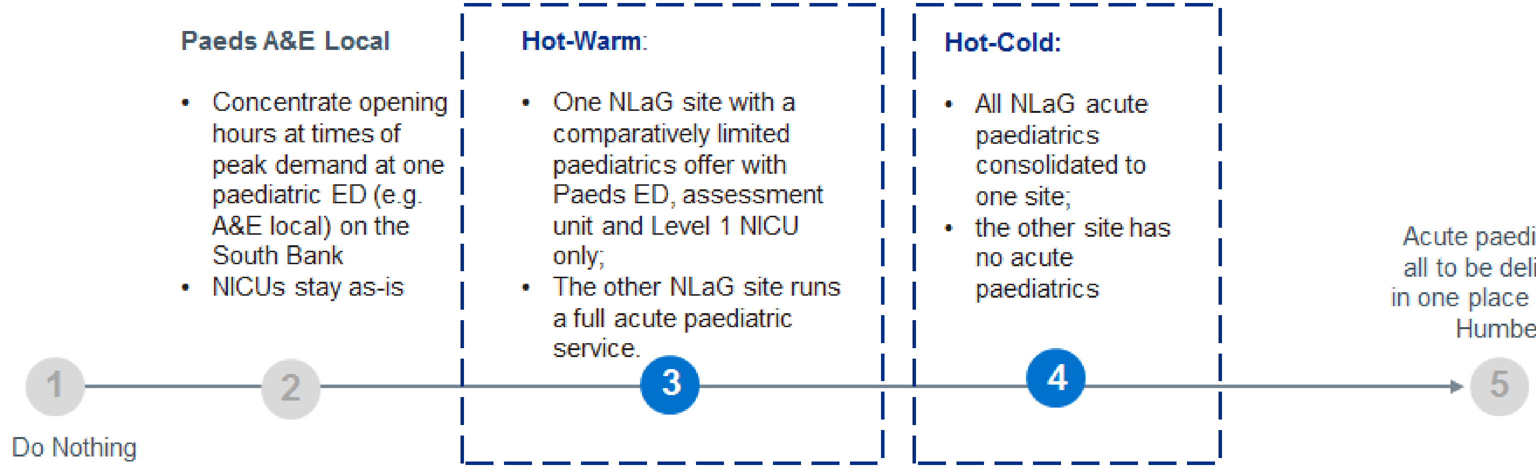
| Group 4 | | Timing is crucial here. There could be blocked roads etc. Should be on two sites to be safe. | No, it is not acceptable to have to transfer mother and baby from a MLU to emergency care, due to the time factor.<br><br>A woman will want to maximise her and her child's chances of a healthy outcome. If there is a lesser unit, if the woman needed a section they wouldn't want to be risking their life and their baby's (therefore demand for standalone MLU will be low).<br><br>At one time, Grimsby was a centre of excellence for maternity, is this something to consider? | Maternity is very unpredictable. It has to be all in one place.<br><br>At one time, Grimsby was a centre of excellence for maternity, is this something to consider? | Timing is crucial here. There could be blocked roads etc. Should be on two sites to be safe.<br><br>They have a helipad in Hull, that's a good idea. | |

**General Comments:**

- The estates vary – not only poor use of estates, but poor condition.
- The model has to maximise the chance of mother and baby doing well.
- You could go from life to death in one journey with maternity, and it is two potential 'patients', rather than one if it was a stroke patient.
- There would be an impact on families without a car, and for close family who will need to visit. Could there be free car parking at the hospitals?
- Model 3 - The Jubilee Centre in Grimsby didn't work before so why would it work now?
- Model 3 - Concerns were raised around safety; if complications occurred during a low-risk birth, a patient would be facing a minimum 30 mile transfer to an OLU.

## Paediatrics




| | 1<br>Do Nothing | 2<br>Paeds A&E Local | 3<br>Hot-Warm | 4<br>Hot-Cold | 5<br>Acute paediatrics all to be delivered in one place across the Humber |
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| Group 1 | Didn't feel the statement reflected the discussions at the engagement workshops. | Set times gives a level of uncertainty, who makes the decision of demand?<br><br>Extra travel time and demand on ambulance staff.<br><br>Seems difficult to understand.<br><br>This model could put patient lives at risk due | Group agree with the statement and had no further comments to make on this model. | Group felt this model could possibly increase the standard / quality of care and patient outcomes.<br><br>The only issue they could envisage was travel. | |

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| | | to extra travelling.<br><br>High impact on families/carers.<br><br>What happens outside these hours?<br><br>Could be alarming to service users. | | | |
| Group 2 | This is the option the public would choose if you asked them.<br><br>Positive Comments:<br>- Don't have to get used to change.<br>- Close to home.<br>- Close to family/ support at home.<br>- NLAG paediatric assessment works really well to help reduce hospital admissions.<br><br>Negative Comments:<br>- Not sustainable<br>- Doesn't solve workforce/ staffing issues.<br>- Too many patients have to travel out of | Any evidence available that this model works at other sites<br><br>Negative Comments:<br>- Difficult concept for parents to comprehend if A&E is open to adults yet closed to their child.<br>- Extra travel for patients and ambulance staff.<br>- Confusing for patients and ambulance staff knowing where to go. | The group felt the public would be more willing to accept this model.<br><br>NICU has to compliment maternity services.<br><br>Is there a model to work on already?<br><br>Much more emotive when it involves a child or baby. | The group could see the benefits, but did not like this option at all.<br><br>Staff skills could increase with opportunities to specialise.<br><br>Travel would be a huge issue for patients and staff. | NO!<br><br>The only way this would work is to keep the North Bank as it is but build a new hospital on the south bank in Brigg/ Barnetby Top. |

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| | area.<br>- Transport is an issue, especially out of area, and between north and south bank (vice-versa). | | | | |
| Group 3 | No comments made | The group said NO to this option.<br><br>The group would like to know figures before they made a judgment on this option.<br><br>Children are not ill at set times, not convinced this would work.<br><br>Travel for parents/ambulance would increase.<br><br>Travel during the night with a sick child would be extremely distressing for a parent – risky.<br><br>Outcomes could be poor if treatment is 30 miles away e.g. in an emergency with a burst appendix. | This is the best option.<br><br>Could at least be admitted to do the necessary to stabilise the child – would give them a chance at least.<br><br>Puts the child first.<br><br>Seems the obvious choice. | Not safe – a child might not make it to the other site. | Not an option! |

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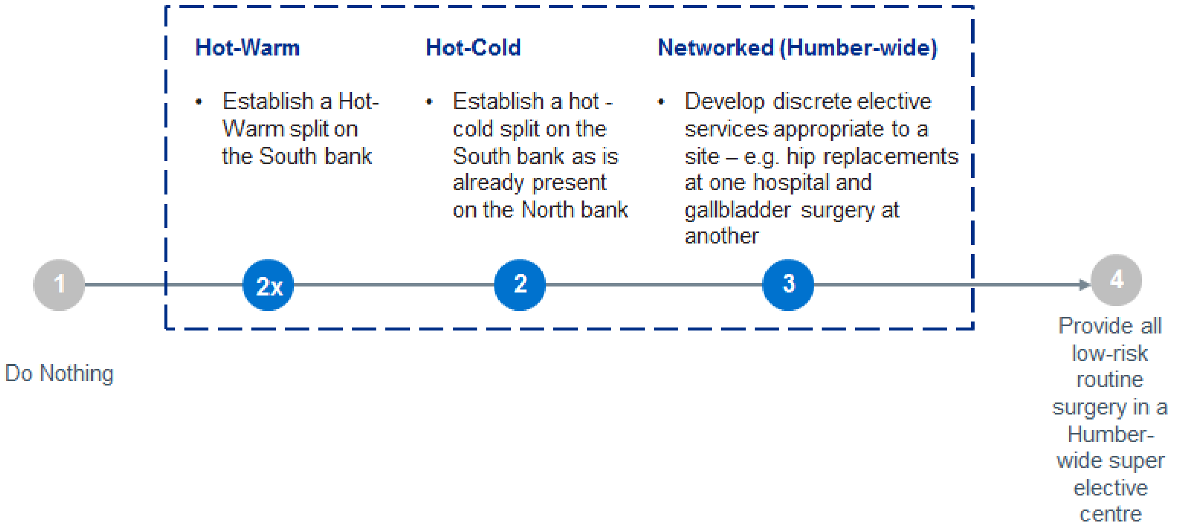
| Group 4 | Not an option. | The group were not keen on this option.<br><br>Lots of time wasted on travelling between sites.<br><br>Confusing and distressing. | Doesn’t address issues e.g. staffing.<br><br>Seems a bit like a botched job / quick fix.<br><br>Confusing for patients. | Bitter pill at the start for the public to accept – but could be more beneficial in the longer term – consistency/quality of care/outcomes could increase.<br><br>Split specialities so not to run down one hospital e.g. maternity and paediatrics at one site; planned and emergency care at the other.<br><br>This is a happy medium, neither site is deprived and it is less confusing for patients. | Not achievable.<br><br>Abolish bridge toll and car parking charges.<br><br>Positives would be:<br>- Potential for greater/ higher grade of care and equipment.<br>- No confusion of where to go.<br>- Simplification of transport issues. |

**General Comments:**

- Transport was an overarching theme throughout the four discussions and it was felt that this needs to underpin any future decisions.

## Planned Care




| | 1<br>Do Nothing | 2x<br>Hot-Warm | 2<br>Hot-Cold | 3<br>Networked (Humber-wide) | 4<br>Humber-wide super-elective centre |
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| Group 1 | | Planned care is easier to reconfigure as it is 'planned' and all options apart from 'do nothing' should reduce the time wasted by doctors and nurses travelling up and down the A180 to clinics/wards. | | | |
| | | | | People will have more confidence about going to a dedicated 'centre of excellence' and it will be a way to attract professionals in to learn and gain expertise. | |

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| | | | | Need to consider impact on staff if based in one centre for their specialty which is a distance away from their home and therefore increasing travel times after long 12/13 hour shifts. | |
| | | | | When considering impact on care must also factor in mental health and impact of patient, carers and family if care is not accessible to them.<br><br>This may result in longer and lengthier journeys for the patient transport service provider and therefore it is likely that more rigorous application of the eligibility for patient transport (medical need) will be applied. | |
| Group 2 | | | | Options 3 and 4 present opportunities for staff to come to a centre of excellence to learn/hone their craft.<br><br>Travel will be a problem for some people and we must ensure that poorer people don't miss having the treatment they need because they can't afford to get to it. | It is easier to maintain one set of high quality kit/equipment in one site than try to make do across multiple sites.<br><br>Travel will be a problem for some people and we must ensure that poorer people don't miss having the treatment they need because they can't afford to get to it. |

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| Group 3 | | | | | Will be able to attract staff to a shiny new facility with prestige.<br><br>People will travel to get the best care but we need to be aware of poorer people and find ways to help them access their care.<br><br>Option 4 will mean treatment and care is quicker and better. |
| Group 4 | | | | People want to go where the expertise is and in the case of planned care people can plan for travel. | Option 4 will mean better equipment if all one centre. This may attract a higher grade of staff as a new, modern building will be a more attractive place to work and therefore reduce current staffing recruitment and retention issues.<br><br>Also help to alleviate transport issues with all planned care transport going to and from one place. |

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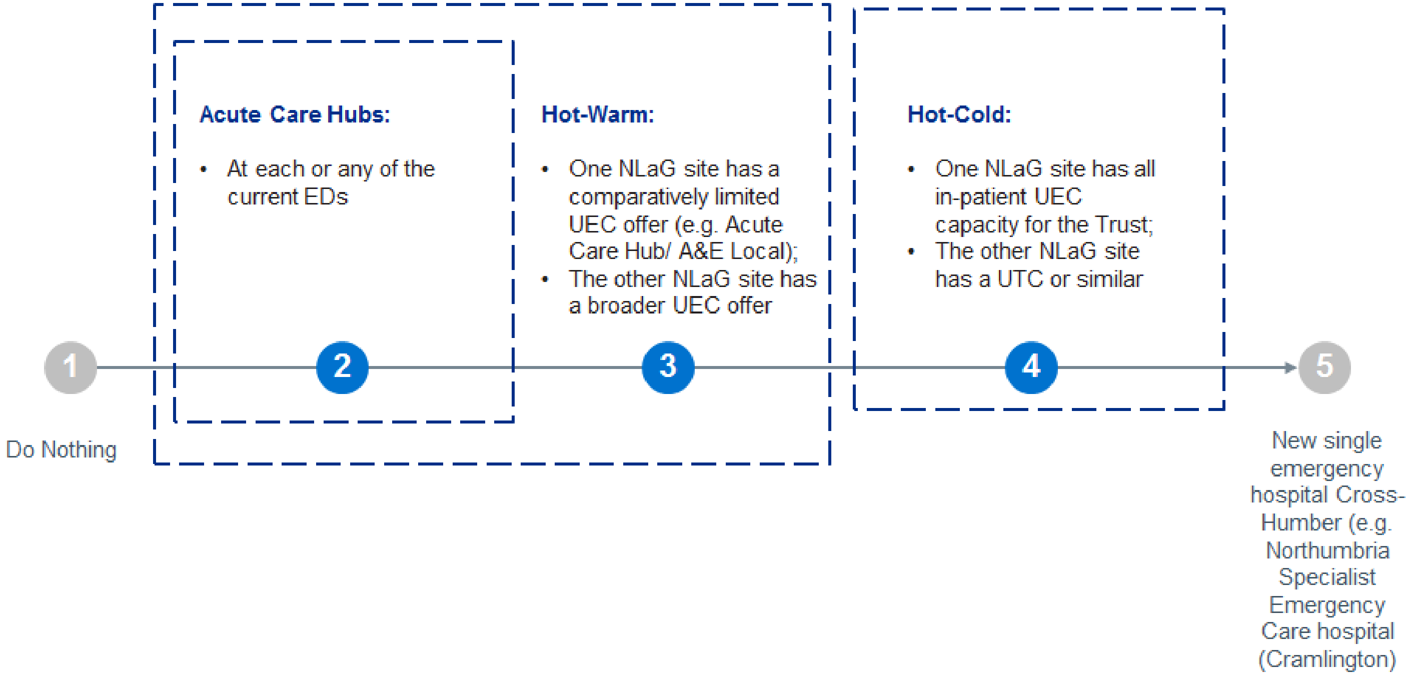
| | | | | | More outreach to patients locally. Need to be more honest about follow-up appointments and appointment times.<br><br>The technology in use now is not the best – improving technology and communications will enable patients to take back control. |

**General comments**

- Planned care is less emotive than the other specialties.
- People are used to and happy to travel if they thought it is better for them to do so.
- South Bank people have been travelling to Castle Hill for specialist treatment for some time now and have come to accept it because they will get the best consultant and nursing care.

## Urgent and Emergency Care




| | 1<br>Do Nothing | 2<br>Acute Care Hubs | 3<br>Hot-Warm | 4<br>Hot-Cold | 5<br>New Single Emergency Hospital for Humber |
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| Group 1 | Most members of public are less adamant than clinicians that things need to change – if you ask them, most would like Hull Royal Infirmary-style A&E model everywhere. | Seems eminently sensible – should just do anyway.<br><br>Need to explain impact and evidence better – need for good communication. | Would be more acceptable to local people – having local option for short-stay then only moving if you have to for specialist care.<br><br>People like the reassurance of having a front door locally that they can walk through. | Some concern regarding closure of one A&E due to heavy industry in both communities.<br><br>Older people and carers need to be a consideration – minimising travel where possible for routine things/conditions associated with frailty. | South bank residents are getting more used to and more accepting of travelling for care – most serious patients are already taken to Hull. |

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| Group 2 | Things can't stay as they are - "Waiting 6+ hours to get to the assessment ward is inhumane." | Co-located UTC is improving triage in A&E.<br><br>Good suggestion – removes "us and them mentality". | | What about more than one UTC not just on the hospital site?<br><br>Can we offer more walk-in centres and more non-acute options for people, so that only the sickest need to travel for hospital care? | Can see some benefits to this approach, however, this will inevitably disenfranchise someone.<br><br>Would this leave the other hospitals with poorer staff? High grade consultants won't go to the small hospitals. |
| Group 3 | Agreement that something does need to change. | Good model.<br><br>Should we be considering a geriatric hospital?<br><br>Will it still be clear to patients where they should go? Current system can be confusing (UTC/A&E/GP?). | | Concern around one community being disenfranchised in this model.<br><br>Would people know where to go – would it be clear which hospital deals with which conditions? Could people turn up at the "cold" site with serious conditions which could delay treatment? | Geography and rurality makes this really challenging.<br><br>Could this improve the medical training offer? Can we look at how to improve the medical training offer associated with all models? |
| Group 4 | | Most popular option for the population.<br><br>This should be a given.<br><br>Can we quantify the | No real concerns about transferring for specialist care but would be very concerned about not having an "open door". | Model 3 is better than 4.<br><br>Psychological impact of not having an available service – people will worry if their A&E is no | Choose one centre of population or the other, not the middle where nobody lives. |

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| | | outcomes? Are we clear it will have a significant impact on making things better? | People like the reassurance of having a front door they can walk through, if they need it. | longer there. | |

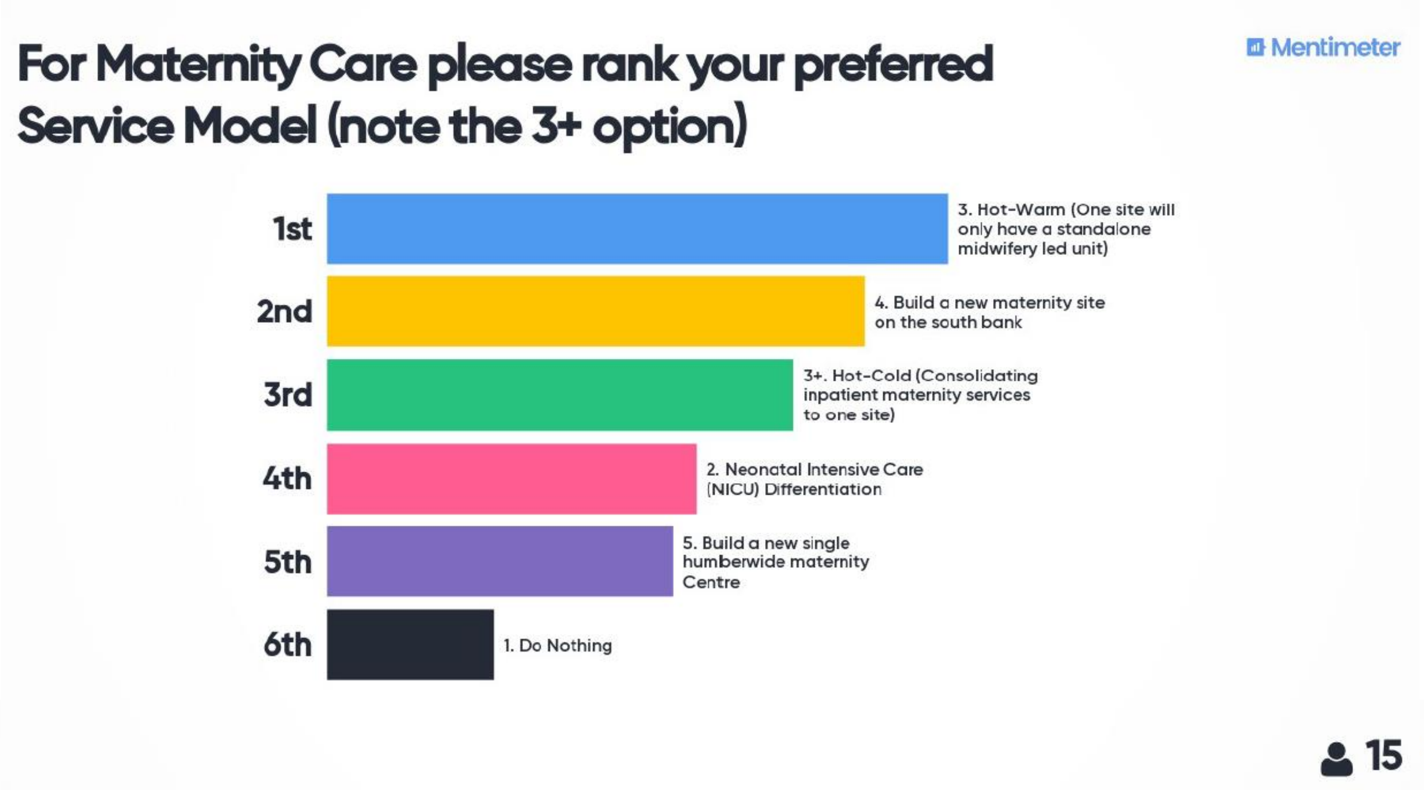
**General comments**

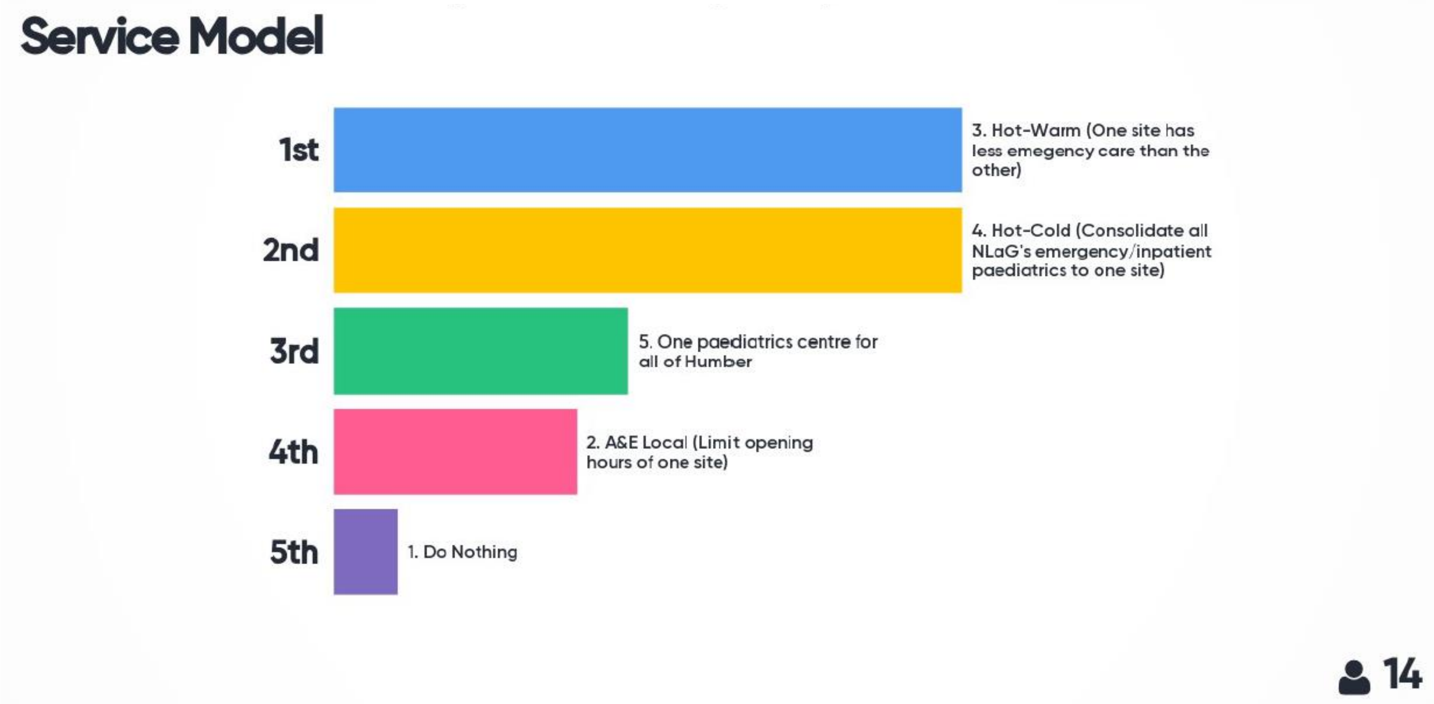
- Being able to see accurate medical records anywhere is critically important irrespective of the model adopted – putting in place shared care records need to be a priority, investment in improving digital shouldn't be ignored.
- More needs to be done outside of hospital to stop people coming in at all
- Need to look beyond Humber – e.g. to Doncaster
- Consider impact on carers and families

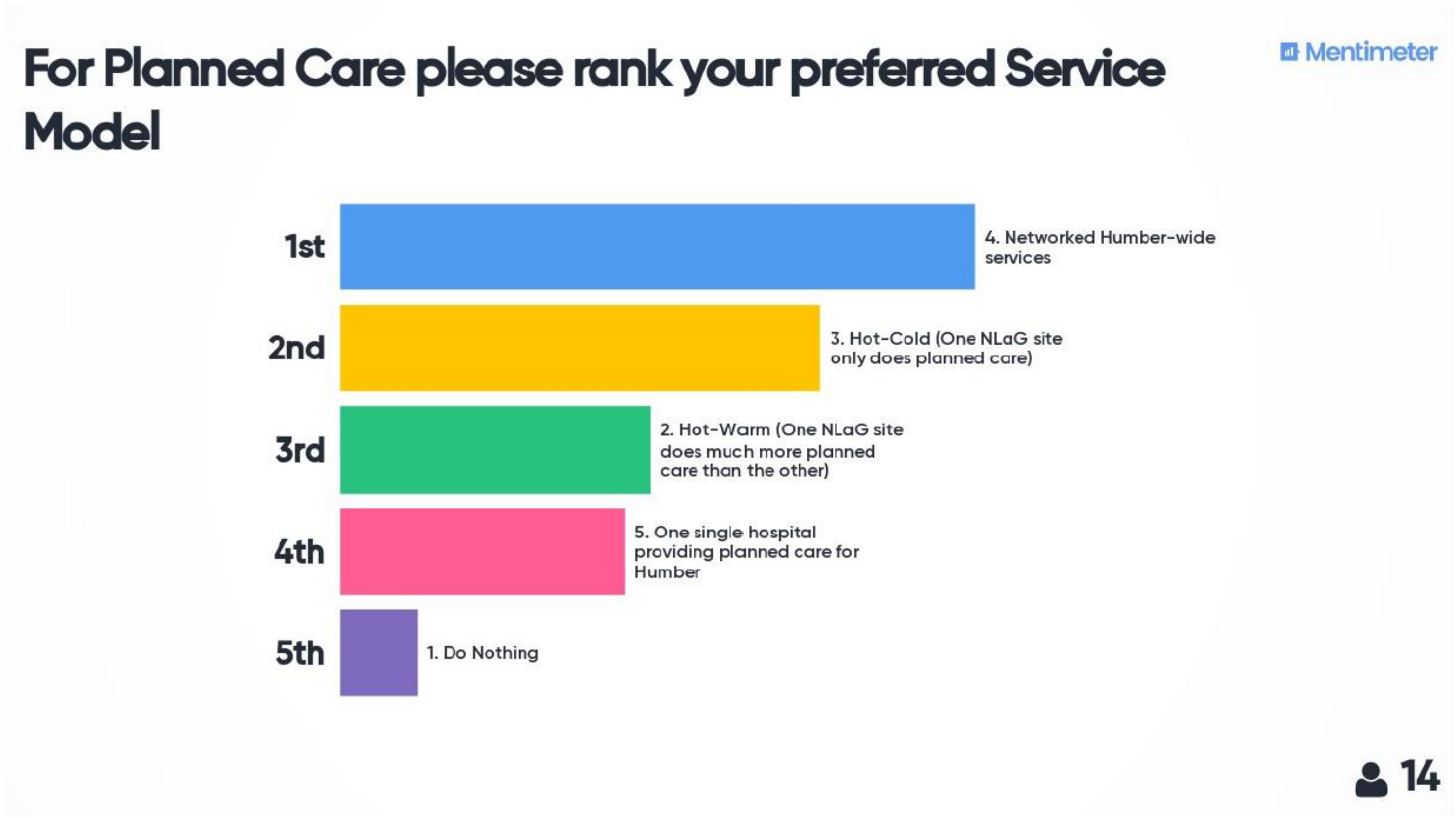
## Identifying preferred service models

For the final task of the day, a real-time voting exercise was undertaken, asking Panel members to rank the potential clinical models based on their preferences. This was done by logging onto [www.menti.com](http://www.menti.com)

*NB: Some panel members were not able to properly access the vote via their smartphones, so the results should not be considered conclusive and should be read alongside the qualitative feedback already provided above*.







## Date of next meeting

The Citizen's Panel will next meet in January 2020.