Hospital Services for the future

Humber Acute Services Review

Patient Workshop Feedback Report November 2019

A report of the Humber, Coast and Vale Health and Care Partnership

Humber, Coast and Vale

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Executive Summary

This report summarises the key findings from a series of workshops with patients, carers and members of the public carried out in October 2019 to support the Humber Acute Services Review.

The Humber Acute Services Review is a collaborative review of acute hospital services across the five main hospital sites in the Humber area – Diana Princess of Wales Hospital in Grimsby; Scunthorpe General Hospital; Goole and District Hospital; Hull Royal Infirmary; and Castle Hill Hospital.

The events were held in various locations across the Humber area, specifically in Grimsby, Scunthorpe, Hull and Willerby.

The events sought to gather the views and perspectives of people who have used hospital-based services in the Humber. Views were sought on potential future models of care for maternity services, paediatric services, planned care and urgent and emergency care.

In addition, participants were asked which aspects of the reviews decision-making criteria were most important to them. The three aspects that were identified as most important were:

- **Clinical Outcomes** – Will the service give me the best possible chance of being well?
- **Staffing** – Will there be the right staff there to provide the care I need?
- **Patient Experience** – Will I have a good experience?

A broad range of diverse feedback was provided by the participants at the events and is set out in detail in this report. Some of the key themes that were highlighted are set out below.

Clinical outcomes

The thing that was most important to most people was getting good quality care and having the best possible chance of getting well. This came through clearly when participants were asked to identify the decision-making criteria that were most important to them. Many of the strengths and weaknesses that were highlighted were focused on the quality of the care that could be provided in each of the different approaches. For example, comments on the different maternity models tended to focus on how they would deliver safe care, particularly in the event of complications during labour. Other issues that were highlighted were linked to the ability to attract enough of the appropriately qualified staff to provide safe and effective care.

The right workforce

The majority of participants were full of praise for hospital staff. In all the workshops it was clear that participants recognised the pressures on staff and empathised strongly with the current workforce.

Participants identified a number of opportunities to develop and make the best use of staff working at our acute hospitals. These included: improving the physical environments staff are working in; making job plans more interesting by enabling staff to work across multiple sites or undertake a wide range of different tasks. Participants also identified the opportunity for local NHS organisations to work with the wider community to help "sell" our local area as a great place to live and work in as well as supporting initiatives to get local children and young people into careers in health and care.

Access and travel

A lot of the participants raised issues around travel and access to services. Many said they were willing to travel further, particularly to access specialist services, as they felt that greater quality of care could be provided by centralised services. However, there was concern about how people living far away from the sites would be impacted by having to travel further to access care.

Participants noted that travelling long distances for a one-off event was generally acceptable (if it meant they were getting the best care) but it was important that ongoing care was available locally, wherever possible. Many participants suggested that services could make better use of technology (including low-tech options such as telephone) to reduce the need for people to travel to hospital at all.

Digital technology

Participants were asked to comment specifically on how digital technology could be used to improve the different models of care, therefore there was lots of feedback on this topic. In general, participants were really positive about the potential of digital technology to improve care and some were frustrated by the sense that health and care services were 'behind the times' in terms of adopting technological solutions.

Sharing information and having access to health and care records was seen as critically important in all of the potential clinical models. In addition, there was significant support for increasing the use of virtual consultations (both with patients and between different clinicians) to reduce the need for moving people around. Participants also suggested making better use of technology to provide more timely information (e.g. live waiting times; digital appointments).

Give patients more information and knowledge

Another common theme to emerge was that participants were keen to receive more timely information about what was happening in their care. Patients were keen to be able to ask questions and have them answered remotely, while they want to have greater knowledge around the choices available to them. Patients were eager for hospitals to manage their expectations around waiting times better. Participants also felt there is the opportunity to improve communication between services and, where possible, standardise communication to patients to help reduce the time it takes for patient to receive correspondence.

Background

About the Humber Acute Services Review

Across the Humber area and beyond, local health and care organisations are working in partnership to improve services for local people. We are working to find new ways of improving the health and wellbeing of local people through transforming care and support in our communities.

As part of this work, we are looking at how to provide the best possible hospital services for the people of the Humber area and make the best use of the money, staff and buildings that are available to us. This may include delivering some aspects of care outside of hospital altogether to better meet the needs of local people.

As a group of health and care organisations we are working together to conduct a review of acute hospital services across the five acute hospital sites in the Humber area, which are:

- Diana Princess of Wales Hospital, Grimsby
- Scunthorpe General Hospital
- Goole and District Hospital
- Hull Royal Infirmary
- Castle Hill Hospital

The review will look at how best to organise the acute hospital services that are currently being provided on the five hospital sites. The input of healthcare professionals, patients and the public in the region is vitally important to the success of the review.

You can find out more about the review and keep up to date on its progress on our website: www.humbercoastandvale.org.uk/humberacutereview

The Review so far

From late September 2018 to summer 2019, the Humber Acute Services Review programme focused on reviewing six clinical specialties, using a clinically-led design approach. This also included a programme of involvement with patients, carers and members of the public. The specialties were:

- cardiology
- complex rehabilitation
- critical care
- neurology
- stroke
- haematology/oncology

The findings of the engagement programme were published on the Review website and have been shared widely with clinical and managerial teams in all partner organisations. Plans are now being developed for cardiology, neurology, complex rehabilitation and oncology and will continue to be shaped through conversations with a wide range of stakeholders.

In summer 2019, the scope of the review was broadened again to look at all the services provided within our acute hospitals. This next phase of the Review is looking at the fundamental building blocks of hospital services:

- urgent and emergency care;
- maternity and paediatrics;
- planned care.

With each of these broad service areas, the clinical design process has involved bringing together doctors, nurses and other clinical colleagues with commissioners and other key stakeholders to generate ideas about the best possible ways to deliver services for their particular service area.

Methodology

In order to gather feedback and ideas from people who use our services locally, we held a series of involvement events in October 2019.

At the events, we heard peoples' views on:

- Care when you need it unexpectedly (urgent and emergency care)
- Planned care (planned surgery or outpatients services)
- Care for pregnant women and children (maternity and paediatrics)

Anyone interested in these services was welcome to attend these workshops to find out more and have their say about the ideas being explored to provide the best hospital care for people living in Hull, East Yorkshire, North Lincolnshire and North East Lincolnshire.

What was the format of the events?

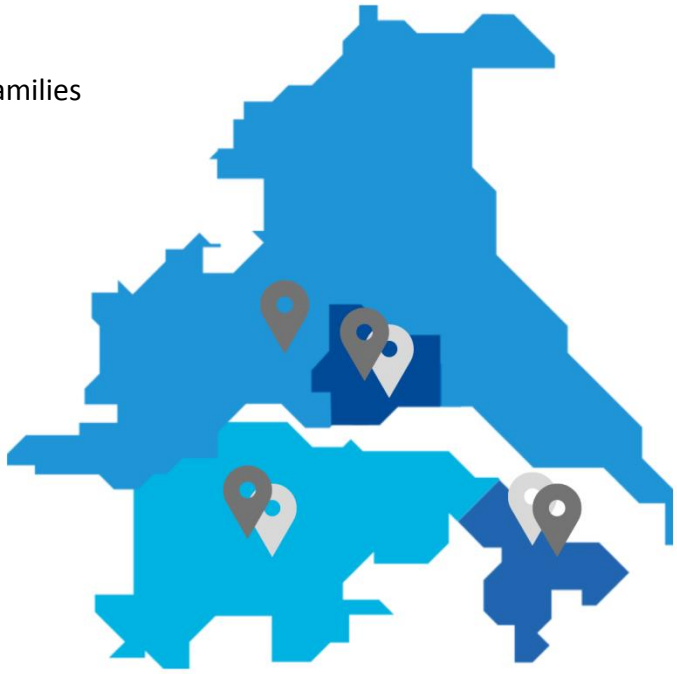
Each of the involvement events followed a similar format, including:

- An overview of the Humber Acute Services Review, including an explanation of the issues specific to the particular service being discussed.
- An overview of the case for change featuring videos that explain why we are having a review and what the clinical design process has discussed so far.
- A discussion of the decision-making criteria used within the review.
- A discussion of potential clinical models for the different service areas, exploring what other areas have done and what the potential ways of delivering the service might be.
- A structured conversation asking for opinions on how these models could be introduced, particularly focusing on: what's good about them (strengths); what might not work (weaknesses); what have we not considered (opportunities); and what impact would they have (impact).

Participants were encouraged to share, from their experience, what is working well and what is not working well in current hospital services in the Humber area. They were challenged to come up with suggestions for how care could be improved for patients in the future as well as how to address some of the current challenges within the services, such as workforce shortages and performance issues.

Where did the events take place?

In order to enable a range of patients, carers, families and friends to contribute, a number of events were planned across the Humber area, close to the existing hospital sites.



The sessions were organised to take place on various different dates and times covering the different specialty areas or populations.

Where patients had to travel to another area to attend, local CCGs supported this by covering travel expenses and/or organising transport if necessary.

In addition, a drop-in session was organised through the Northern Lincolnshire Maternity Voices Partnerships (MVP) group in Brigg, for new mums and their families.

Date	Time	Location	Specialities covered
Monday, 7th October	10am to 12pm	Centre 4, 17a Wootton Road, Grimsby, DN33 1HE	**Maternity care**
	12.30pm to 2.30pm		**Paediatric services**
Tuesday, 8th October	10am to 12pm	The Iron Bar, Glanford Park, Scunthorpe, DN15 8TD	**Adult emergency care**
	12.30pm to 2.30pm		**Adult planned care**
Tuesday, 15th October	10am to 12pm	The Village Hotel, Henry Boot Way, Hull HU4 7DY	**Maternity care**
	12.30pm to 2.30pm		**Paediatric services**
Thursday, 17th October	10am to 1pm	Mercure Hotel, Grange Park Lane, Willerby HU10 6EA	**Adult emergency care and adult planned care**
Sunday, 20th October	1pm to 3pm	Forrest Pines Hotel, Brigg, DN20 0AQ	**Maternity Care (MVP drop-in)**

How were participants recruited?

Participants were invited to attend the workshops by sending invitations with information about the events to a range of support groups and local voluntary sector organisations – via our partner CCGs' communications channels.

Invitations were also extended to key stakeholders, for example: adult social care organisations, local authorities, children's centres, parent's groups and voluntary care sector partners.

These events were open to the public and this was clear in the communication material which promoted these events, which was advertised accordingly. For example, these events were advertised via social media and news releases issued to the region's media outlets.

Who took part?

Over the course of the seven workshops, a total of 77 people attended and took part in the discussions (excluding organisers, clinicians and facilitators).

Total number of attendees: 77	
Grimsby workshops - 7th October	Maternity care: 12
	Paediatric services: 11
Scunthorpe workshops - 8th October	Adult emergency care: 8
	Adult planned care: 9
Hull workshops - 15th October	Maternity care: 13
	Paediatric services: 10
Willerby workshop (combined) - 17th October	Adult emergency care and adult planned care: 14

Only a small proportion of people who attended events completed an equalities monitoring form and therefore some of the demographic information on attendees is incomplete. From the information that is available, participants ranged in age from 36 to 67 and approximately 75% of attendees were female and 25% male.

Feedback on Clinical Models

In each workshop session, a range of potential clinical models or ways of providing care in the relevant service area were described. The ideas presented were based on national and international examples about "the art of the possible", which were provided to stimulate discussion. As was stated in the presentations, no decisions have been made about proposals for change in the Humber. The presentations that were given on the day are available to view on the Review website.

The aims of the session were:

- To find out what matters most to patients (and carers)
- To gather their views on what is not working and might need to change
- To discuss ideas about what might work better – specifically in the context of the challenges identified by the clinical leads in their presentations (written information and infographics were also shared on the tables)

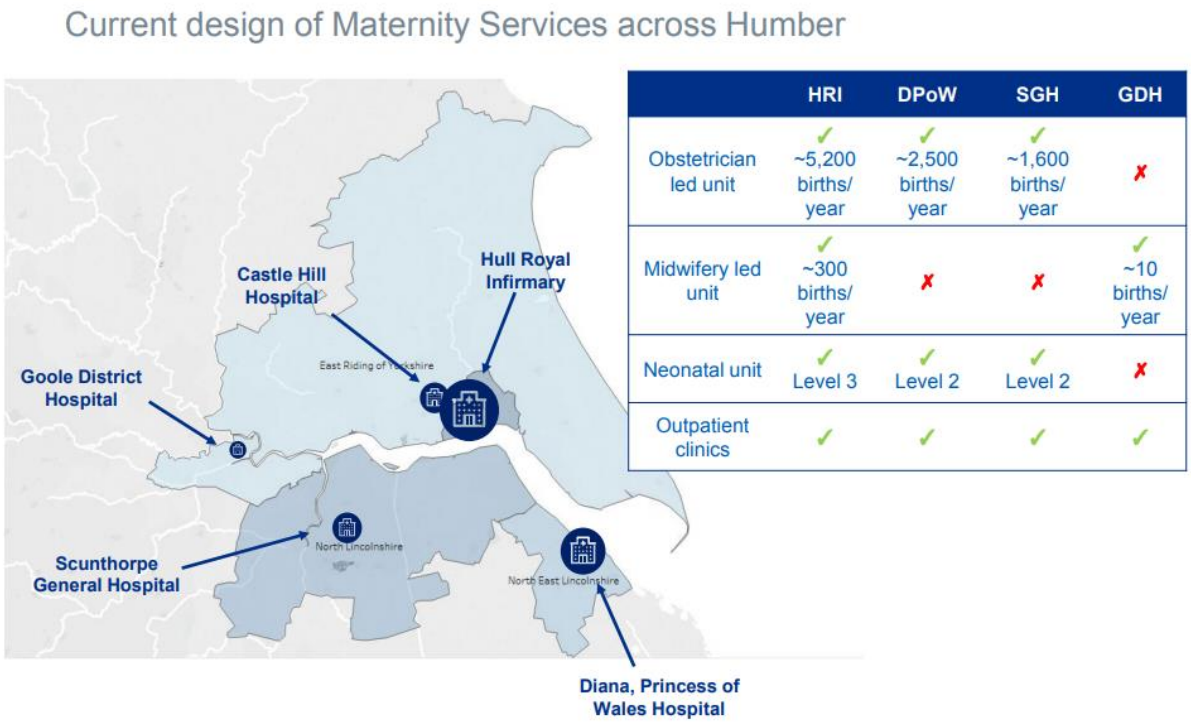
Facilitators were provided on each table. Up to four potential clinical models for each clinical speciality was presented to the attendees, before discussion took place to identify strengths, weaknesses, opportunities and impact of each of these models or approaches. The focus of the discussions was on participants' own experiences and their views and ideas for improving services.

Strengths What is good about this model?	**Weaknesses** What is not good about this model?
Opportunities How could this model be improved (what have we not thought about)?	**Impact** How would this model impact you as a patient/carer?
How could this model be improved using digital technology?	

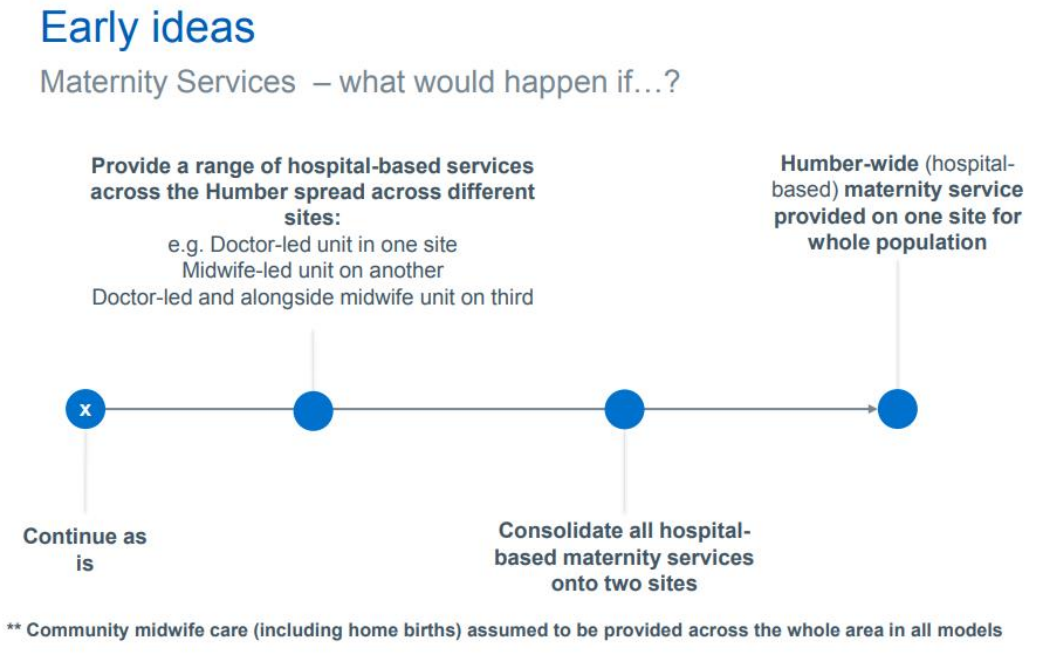
The feedback, comments and ideas were recorded by the facilitators and participants themselves and then collated by the review team. This report has been compiled by analysing the feedback across all sessions and grouping the information by theme.

Maternity Care

Maternity services include care provided for women throughout their pregnancy (sometimes prior to conception), during and after the birth of their child or children. This includes care and support provided by midwives, doctors, health visitors and other professionals in local community settings, at home and in hospital. The current shape of hospital-based maternity services across the Humber was explained to workshop participants:



Participants were then presented with four potential clinical models along a spectrum from least to most change:



The participants were invited to comment on the potential strengths, weaknesses, opportunities and impact of each approach as well as sharing their ideas on how digital technology could be used to improve the models. The comments and ideas shared at all relevant events have been collated and summarised below.

Model 1: Continue as is (no change)

Strengths

- **Quality of care; staff praised for their passion and supportive and caring nature** – level of care at Hull Royal Infirmary is "excellent"; Grimsby was labelled "exemplary"; whatever service you access, the local staff have passion and expertise. Local centres help to maintain skills of midwives and clinicians.
- **Convenience and faith in local services** – You know what you're going to get. Midwife-led unit and obstetric-led unit both located at Hull Royal Infirmary – it gives you peace of mind – lovely for a mum. Having a baby in the town you live in is important to people (support close by if problems). Pre-natal appointments are close by.
- **Choice of services** – Women have a wide range of choices available to them. Good practical choices available.

Weaknesses

- **Staffing issues** – Workforce exhausted because shifts are too long. Not enough staff when in labour at Diana Princess of Wales Hospital in Grimsby - "feel like you have to harass staff". Unsustainable workforce (in relation to number of births).
- **Distance of travel to access services needed** – Rurality of some communities means they are a long way from services. Logistics of coming across the Humber Bridge – there's no alternative if crossing the Humber.
- **Communication** – Lack of sharing information digitally. Query not recorded on notes when you call. Your level of knowledge is assumed when you have your second baby. Communication between services not the best, especially when out of area.
- **Difference in quality of services across Humber region** – 'Continuity of carer' is not available everywhere – only some provision in North/North East Lincolnshire. Needs to be expanded to everybody. Scunthorpe reviews (by service-users) are not as good as at other sites. Not got the capacity to offer home births in some areas.

Opportunities

- **One team, one site** – Create one team from midwives (primary care/community – hospital) for continuity of care for patients – small teams of midwifes (i.e. no more than eight). One site enables you to pool resources. Opportunity to integrate with external services (e.g. doula, breastfeeding support).
- **More flexibility of choice** – A high-risk patient should be able to give birth in a low-risk unit if they wish. Being able to choose your birthing location later in pregnancy would be an improvement.

- **Utilise digital technology better** – Using technology to share information better. Better digital engagement.

Impact

- **Capacity issues** – No bed in delivery ward resulted in delay, which caused stress and anxiety. Cannot guarantee bed is available when needed.
- **Isolation of rural communities would remain** – as they will continue to be far from where services are offered. Cost from travelling from far away can be significant.
- **It would remain closer to home for many communities** – which means they can rely on their families for support (i.e. looking after their other children, for example) and can use public transport. Keeps travel costs down – especially important in deprived areas.

How could this idea be improved by digital technology?

- Women to have their own records/digital notes/paperless records, particularly when women move between areas.
- Translation services and information in different languages.
- Opportunity to link in more with the University to get people to 'buy in' to the local area – to support improved recruitment of workforce.

Model 2: Provide a range of hospital-based services across the Humber region spread across different sites

In this model, a range of different hospital-based services would be available at the different hospital sites. For example, one hospital site would have a midwife-led unit (MLU) only, one site would have a doctor-led unit only and the third hospital site would have a midwife-led unit alongside a doctor-led unit.

Strengths

- **Choice** – Perinatal mental health improved by having choice and feeling more comfortable. You have a choice of all potential options for giving birth.
- **Midwife-led units (MLUs)** – Midwife-led model works well because there are fewer medical interventions in MLUs. Lots of benefits to MLU approach – breastfeeding, tears, birth times, the birth experience. Cost of delivering an MLU is cheaper.
- **Reduced travel time for each appointment** – as some will be closer to home.

Weaknesses

- **Could be confusing for some patients** – Unclear what was being offered where. Would patients understand what an MLU is and if this would be appropriate for them?
- **Too much choice** – People might consider this to be a bad thing (too many options to choose from).
- **Costs of reconfiguring services** – Money would need to be spent on reorganising services to this model of care.

- **Transport and communication would still be an issue** – what about people who don't want to travel out of their own communities to access a particular service? Would services communicate with each other (when managing care of the same patient between them)?
- **Concern about safety** – could complications be managed in MLUs? What would happen if there were complications during labour?

Opportunities

- **Primary Care Networks** could allow parents to link in with maternity services via GP surgery – low risk births.
- Access to **smoking cessation** and healthy lifestyle support.
- Opportunity for some mothers to use private midwifes and doulas to support **home births**.
- MLU makes roles more desirable for community staff more comfortable with births – to avoid staff migration to bigger cities (such as Leeds and Sheffield).
- **Education and communication** – so patients know what each unit offers. True choice – patients fully informed of services available (raising awareness). Make it clear which unit has which level of neonatal care.

Impact

- **Transport and travel** - impact on patient and carers if they have to travel further away to receive care. This issue is compounded in areas where car ownership is low. Public would object to services being moved.
- **Ambulance services** - cost of ambulance service to transfer patients. Ambulance availability and crew required to have skills and equipment required to deal with negative outcomes during travel from one site to another.

How could this idea be improved by digital technology?

- Using and sharing learning and expertise of Humber, Coast and Vale maternity programmes.
- Doctors monitoring remotely and video consultations.
- One IT system within trusts/areas. One patient record.
- Skype between MLU and OLU if concerns about patient.
- Need reliable and widely available Wi-Fi coverage.

Model 3: Consolidate all hospital-based services into two sites

In this model, hospital-based services would be available at two hospital sites rather than the existing three. Home births and other community-based services would continue to be offered across the region as they are now.

Strengths

- High quality care in one place.

- Less travel for wider range of choice –everything is there in one place. Travelling just to give birth is acceptable when there is a range of support nearer to home for other aspects of the maternity journey.
- Good for people who live locally to the two units, (but not for the ones who live far away). Maybe more attractive to medical staff, less so for midwives. More attractive to future staff?
- Patients more comfortable knowing there is a doctor onsite if needed – travelling from a MLU to an OLU can be stressful.

Weaknesses

- Impact on staff and travel – potentially more time spent travelling to sites.
- Impact on continuity of care where staff are trying to deliver this
- Parking - bigger sites mean parking is more difficult.
- Reduces choice
- How does this achieve 'continuity of carer' – particularly for midwives? How does this impact staff (and how do they feel about this)?
- Ambulance staff stretched. Would more try home births and how would this impact the 999 emergency services?
- People in North and North East Lincolnshire would still prefer local services. Poor transport links in these areas.

Opportunities

- More opportunities for family to stay in larger units.
- Could Labour, Delivery, Recovery, Postpartum model be delivered at both sites?
- More investment in community services.
- Purpose-built centre in the middle of the North Lincolnshire/North East Lincolnshire region (Brigg or Barnetby Top) – this would potentially solve transport/travel issues, is equitable and provides easy access to Level 3 care.
- Become a specialist centre as population increases.
- Training and links to universities in area would increase workforce.

Impact

- Cost of travel and concerns about travel time. Free bus travel for pregnant women. Would travel further to visit an OLU or MLU. People willing travel to get the best care.
- Local knowledge needs to be utilised to ensure this model would be successful.
- Investment in ambulances required.
- What is available outside of the Humber region (particularly for those people on the borders)?

How could this idea be improved by digital technology?

- Skype would support follow-up appointments (to save patient need to travel). Same provision at primary care centres – such as community clinics.
- Being seen at a local maternity hub – for example, to check foetal movements – with advice and guidance from specialist (provided remotely) would save patient travel.

Model 4: A Humber-wide (hospital-based) maternity service provided on one site for the whole population

In this model, hospital-based services would be consolidated onto a single hospital site rather than the existing three. Home births and other community-based services would continue to be offered across the region as they are now.

Strengths

- Quality standards would be great. Better service for some patients. Specialised service with highly-skilled staff.
- Help with recruitment and retention of staff. Excellent training potential for doctors and midwives. Bringing workforce together will promote better expertise, safety, outcomes, training, and career development.
- Makes sense (although not practical in reality).
- Improve communication between departments.
- Hull Royal Infirmary building will not last forever – so new purpose-built building may be necessary.

Weaknesses

- More people will have to travel longer distances to receive care they require. How would you access the site if the Humber Bridge is closed, for example? Road network issues.
- Staff might not be willing to work in this way – they might need to travel further for work.
- Personal identity – people from Yorkshire/Lincolnshire wanting their children to be born in Yorkshire/Lincolnshire.
- Parking issues.
- Removes the opportunity for patient to choose where they receive care, and (potentially) their opportunity to receive personalised care.
- Loss of community care.

Opportunities

- Would investing in community services mean fewer people access hospital care?
- If all other aspects of maternity services were local, would travel to one ‘super’ centre be less traumatic?
- Could this model bring skills/excellence back to our area – so patient doesn’t have to go to Sheffield, for example, to receive required care?

- Primary Care Networks could include teams of midwives.
- This model could improve home birth rates, as these services improve.
- Would need regional/community support to minimise travel problems. Doulas and external agency support/funding.
- Opportunity for Hull to become a maternity centre of excellence.
- Making a number of private rooms available.

Impact

- Potential to lose staff expertise if people go to different areas where they identify.
- Anxiety for people who live far away from the site. Anxiety that babies may die because services are located a longer distance away than before (but more babies may survive due to better quality of care).
- Cost of travel (bridge tolls, for example), poor public transport (so people need to stay in hotels the night before admission). Parking and traffic also issues.

How could this idea be improved by digital technology?

- Making use of video communication from where 'super consultant' is based.
- The idea needs integrated technology to improve community care.
- Pre-conception care – would this be in primary care/local community?

Common themes and issues

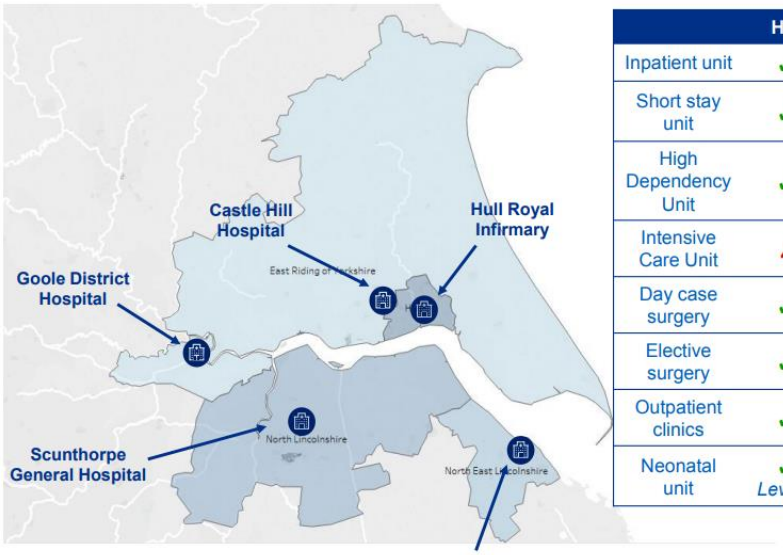
In addition a number of common themes and issues were raised throughout the discussions that apply to more than one of the models or approaches. These include the following:

- Concern about having to travel to one centre from Lincolnshire to Hull/East Yorkshire (or vice versa) to receive care (travel time and distance)
- Greater quality of care provided by more centralised services
- Ability to ask questions and have them answered remotely (via digital technology) can improve care, across all models
- Staff retention and opportunity to upskill staff
- Better awareness of what services each unit offers required (communication is really important)

Paediatric Care

Paediatric services include care provided for children from birth to adolescence and sometimes into early adulthood depending on the condition and individual circumstances of the patient. The services being considered through this element of the review include neonatal services (care for new-born babies, including those born prematurely), children's urgent and emergency care services and most planned care for children that takes place in hospital settings. The current shape of hospital-based paediatric services across the Humber was explained to workshop participants:

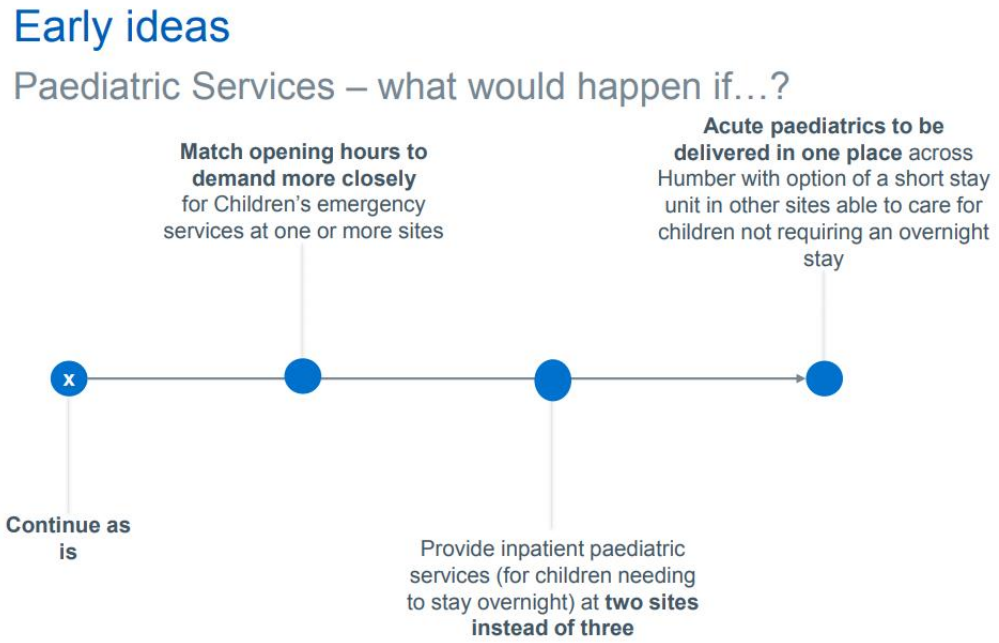
Current service design of Paediatric Services across Humber



	HRI	CHH	DPoW	SGH
Inpatient unit	✓	✗	✓	✓
Short stay unit	✓	✗	✓ *In A&E*	✓
High Dependency Unit	✓	✗	✓	✓
Intensive Care Unit	✗	✗	✗	✗
Day case surgery	✓	✗	✓	✓
Elective surgery	✓	✗	✓	✓
Outpatient clinics	✓	✓*	✓	✓
Neonatal unit	✓ *Level 3*	✗	✓ *Level 2*	✓ *Level 2*

*Castle Hill Hospital provides a small number of outpatient clinics, such as those for children with Cystic Fibrosis

Participants were then presented with four potential clinical models along a spectrum from least to most change:



The participants were invited to comment on the potential strengths, weaknesses, opportunities and impact of each approach as well as sharing their ideas on how digital technology could be used to improve the models. The comments and ideas shared at all relevant events have been collated and summarised below.

Model 1: Continue as is (no change)

Strengths

- **Existing Humber children's A&E services (facilities) received good feedback** - Hull Royal Infirmary children's emergency department is fantastic, particularly the separation of children from adults. Waiting room has good facilities, tailored communication (physical environment is important). Easy direct access to Disney ward at Scunthorpe General Hospital – pleasant place to be.
- **Paediatric staff also praised** - Emergency staff for children's A&E are good – long-standing paediatric consultants know children well.
- **Good specialist services out of the region (good link-up between sites)** - Patients like the local clinic provided from Leeds. Problems or complex cases can be quickly escalated to Leeds/Sheffield.

Weaknesses

- **Lack of appropriate service in particular areas** – Nowhere on west side of Hull for urgent care (for anyone), lack of gastroenterology consultancy (needed to go on a Saturday to see particular consultant), Hull Royal Infirmary closes children A&E in evening/overnight – adult A&E 'not a nice place to be' especially on Friday/Saturday night. Lack of intensive care unit in the area and lack of access to specialist care.
- **Lack of local paediatric expertise** – Participants experienced the lack of understanding of different conditions (specialisms) as child was put in over-stimulated environment. Doctors having to 'Google' when they are presented with new conditions. Generalised paediatricians in the region lack the specialist knowledge and need input from specialist centre in Sheffield.
- Waiting times are too long and there is insufficient accommodation (e.g. beds) for parents when their child is admitted.
- **Inconsistency of service** – service varies depending where you live. Lack of continuity of care across some sites because staff leave the area for better jobs in larger centres (e.g. Leeds/Birmingham/Sheffield).

Opportunities

- **Having access to the right staff** - More consultants could come from out of area. Most people will wait to see the right person who can help them. Improve education of healthcare providers particularly on mental health and autism. Having care workers/specialist nurses to keep those with complex needs out of hospital. Learning disabilities nurse funding – they help us access services more easily.

- **Harnessing digital technology** - Online consultations to keep people out of A&E. E-notes and better communication between different services.

Impact

- Mental health of parents waiting for child's diagnosis needs to be considered
- Impact on child's education and family life
- Junior doctors have not always got expertise (i.e. ignoring classic signs)

How could this idea be improved by digital technology?

- It could standardise communication for patients – which could reduce the length of time it took for communication to reach patient.
- Electronic notes being sorted across organisation for all to see and access. This takes the responsibility away from parents who feel they have to remember lots of clinical information.
- Using technology to engage children – apps for education and what to expect when you come into hospital.
- Video consultations used for the overnight patients (eg: autism/complex needs to help children stay in their own environment).

Model 2: Match opening hours to demand more closely for Children's emergency services at one or more sites

In this model, opening hours for children's emergency services would be matched to peak demand, reducing over-staffing at quiet times and improving staffing for predicted busy periods. Children with complex needs (i.e. those with the most admissions) would be better supported by community based teams to avoid admission altogether.

Strengths

- If it worked properly, waiting times may be reduced or could increase.
- Could help with staffing issues, helping the staff plan around their time – making it more attractive/flexible for the workforce.
- Works well but only if opening hours are clearly communicated so parents know when they can access each service.

Weaknesses

- Does not address communication issues.
- Challenge of travelling to the open site if the more local service is closed.

Opportunities

- GP access to emergency paediatric appointments (usually same day) keeps us from needing to go to A&E – this is really valuable

- Create neuro disability areas – Patients could have passports so that people are aware of the problem with over-stimulation in A&E environment, which can exacerbate autism/behaviour issues.

Impact

- If we close A&E (children's) overnight, how does this fit in with planned care/adult care, would they also be closed?
- Would consolidating services make waiting times increase?
- Those who do not live locally would be impacted by having to travel to access services at an alternative site.

How could this idea be improved by digital technology?

- Could live waiting times for emergency departments be viewed on an app or website?

Model 3: Provide inpatient paediatric services (for children needing to stay overnight) at two sites instead of three

In this model, in-patient services for children (i.e. wards where children who need care can stay overnight) would be available at two hospital sites rather than the existing three. Other community-based services would continue to be offered across the region as they are now.

Strengths

- This idea could save money (resources which could be reinvested in other areas).
- Staffing problem could be alleviated (to some extent), could help with workforce recruitment and retention.
- Help to improve quality of care and provision of specialist care.

Weaknesses

- Environment surrounding Sunshine House (in Hull) is difficult/not always conducive to families in need of paediatric care.
- Some families will need to travel further to access care and this is an issue when there is less of a transport infrastructure in rural areas
- Communication between sites needs to improve
- Will this model be enough to keep skills locally, or make it attractive enough for staff?

Opportunities

- Opportunity to provide an environment for paediatric services all in the Queen's Centre at Castle Hill?
- Opportunity to create a bespoke, child-centred service.
- Need to provide a nicer environment for parents to stay overnight.
- Opportunities to specialise for staff (to help improve retention).

- Could you keep three A&E departments and two inpatient services, transferring children to the relevant inpatient service if they needed admissions?

Impact

- Travel impact for those people living far away from the site (especially those in rural areas - no infrastructure for transport).
- Impact on accommodation for parents who live far away. Supporting family and parents with their broader needs.

How could this idea be improved by digital technology?

- Digital technology (e.g. apps) could connect peer support groups.

Model 4: Acute paediatrics to be delivered in one place across the Humber

In this model, hospital-based children's services would be consolidated onto a single site for the Humber. This could include keeping a short stay unit on one or more of the other hospital sites to care for children who do not require an overnight stay so that they could still be treated in their local A&E department in an emergency or other urgent situation.

Strengths

- Lots of support for this idea – described as the 'holy grail' by some participants
- This model helps to keep A&E free for emergencies. Can be used as a triage before emergency services.
- All the experts under one roof should you require them (particularly for those with complex needs). Better learning/research for staff. Staff will maintain skills in this model.
- Better communication between services

Weaknesses

- Moving children between step-up and step-down care can be challenging.
- Travel and distance – major issues for those that live some distance away. Impact on outcomes for a child that lives the furthest from the central site and has a time-critical medical emergency (could be life or death).
- Does having one unit increase infection risk?

Opportunities

- Is there the opportunity for a 'one-stop shop' - with services coming to see the patient, not the other way around?
- Therapies need to be more joined-up – relevant staff being able to look at the whole problem.
- Local units would be integral to this model happening.
- Accommodation for parents who live far away from the main centre.

- Access to IV medications closer to home (on the short-stay paediatric assessment units, for example) to avoid or reduce hospital admissions.

Impact

- **(Positive impact)** Benefit for NHS budgets – economies of scale.
- **(Positive impact)** Better for staff, have a choice of larger centre and also smaller short-stay paediatric assessment units.
- Everyone would have to travel (some long distances).
- How does this impact on ambulance services?
- People have different thresholds for seeking care so potential for confusion.

How could this idea be improved by digital technology?

- Using the NHS 111 online would be good for the peer group to link up and live chat
- Assists people who are anxious about using the phone.
- Consultants could make better use of Skype (for patient consultations).

Common themes and issues

In addition a number of common themes and issues were raised throughout the discussions that apply to more than one of the models or approaches. These include the following:

- Consultants should look at streamlining letter writing.
- Getting into doctors' surgeries to raise awareness - this is a challenge for some of the condition-specific support groups.
- GPs v specialists – specialists listen more.

Planned Care (for adults)

Planned care services include care provided for patients over the age of 18, for any routine or planned procedure. This includes outpatient appointments, diagnostic tests, planned surgery and other types of treatment across a range of specialisms. The majority of planned care across the Humber takes place on an outpatient or day case basis with a small, and decreasing, proportion of treatments or procedures requiring an overnight stay in hospital. The current shape of hospital-based planned care across the Humber was explained to workshop participants, with a focus on six high volume service areas:

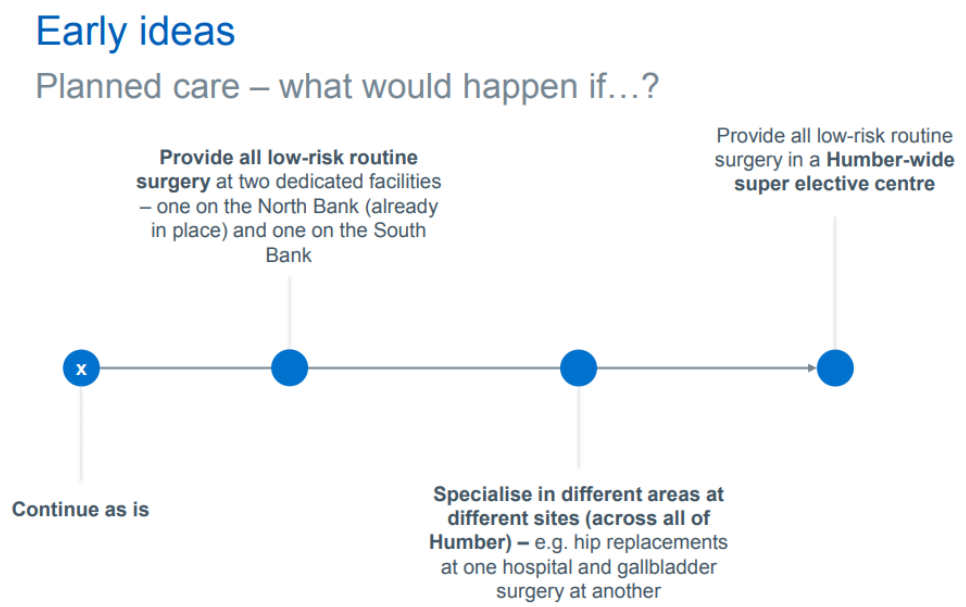
Early ideas

Current service design of Planned Care across Humber

		HRI	CHH	DPoW	SGH	GDH
Orthopaedic surgery	Inpatient ward	✓	✓	✓	✓	✓
	Day case ward	✓	✓	✓	✓	✓
General surgery	Inpatient ward	✓	✓	✓	✓	✓
	Day case ward	✓	✓	✓	✓	✓
Gastroenterology	Inpatient ward	✓	✗	✓	✓	✗
	Endoscopy unit	✓	✓	✓	✓	✗
Ear, Nose and Throat (ENT)	Inpatient ward	✓	✗	✓	✗	✗
	Day case ward	✓	✗	✓	✓	✗
Urology	Inpatient ward	✗	✓	✓	✓	✓
	Day case ward	✗	✓	✓	✓	✓
Ophthalmology	Inpatient ward	✓	✗	✓	✓	✗
	Day case ward	✓	✗	✓	✓	✓

*Outpatient clinics are provided at all locations, except ENT and Ophthalmology which are provided at HRI, DPoW and SGH. Additional Ophthalmology clinics are also h

Participants were then presented with four potential clinical models along a spectrum from least to most change:



The participants were invited to comment on the potential strengths, weaknesses, opportunities and impact of each approach as well as sharing their ideas on how digital technology could be used to improve the models. The comments and ideas shared at all relevant events have been collated and summarised below.

Model 1: Keep current model in place

Strengths

- Familiar to the public (as it's already in place). Local staff and local specialist care (for local people). Some people find change difficult.
- Lots of choice.
- Goole and District Hospital is "fantastic" – caring staff, clean, modern, evening appointments, minimal cancellations, plentiful parking.
- Planned clinics away from centres – so less travel for patients.
- Staff seeing a variety of conditions (developing their skills in the process).

Weaknesses

- Not an equitable service. Not delivering patient-focused care (still not patient responsive).
- Long waiting times: need to manage patient expectations better - patients told they'll be seen in six months, but don't get appointment for 12 months. Wait for a letter but when it arrives you then can't make appointments. Appointments not flexible and don't take into account patients' needs. Appointment cancellations. Not providing timely care, results in poor outcomes.
- Communication between hospital and patient and between hospital and GP is poor – should be seamless.
- Staffing issues. Nurses are working with patient groups they are not being trained for (eg: medical outliers in surgical beds).

Opportunities

- Improve patient transport in general, but also particularly between hospitals (dedicated transport system) and transport to out-of-area appointments.
- Immediate communication across systems and organisations. Better collaborative working with partners, hospitals and providers. Improve staff communications skills. Manage expectations better (timescales of care). Timely clinic appointment letters.
- Provide more in-the-community clinics (more accessible, less daunting).
- Raise awareness of voluntary care service.

Impact

- Not sustainable – poorer care. More likely to have an adverse incident.
- People will travel for specialist care
- Will choose to go to Goole and District Hospital as less likely to get cancelled.

How could this idea be improved by digital technology?

- Can use technology to minimise physically going into hospital for outpatient appointments (especially for long-term conditions and regular checks).
- But IT can't be the only method (as not everyone has smart phones).
- Use IT for appointment systems. E-letters (to save on postage and paper costs).
- Advice and guidance for GPs to seek input from hospital specialists.
- Virtual appointments and clinics.

Model 2: Provide all low-risk routine surgery at two dedicated facilities – one on the North Bank (already in place) and one on the South Bank.

Strengths

- Care all under one roof. Pathways standardised.
- Easier to staff, consultants have to devote less time to travel to clinics.
- Reduced risk of cancellations.
- Calmer and nicer experience/environment.

Weaknesses

- Patients want choice (the group felt that they did not have choice with this model).
- Travel to appointments would increase significantly for some patients (time and cost factors). Issues would arise around transport and access to these sites, as well as parking issues. Public transport is not good enough.
- Specialist planned care for those with additional needs (eg: muscular dystrophy) is lacking and patients need to go out of area
- Why not have follow up clinics in same place?
- Take away that local feel which people value.

Opportunities

- Two specialist centres in North Lincolnshire and North East Lincolnshire – rather than just one site.
- Work with local authorities to improve transport infrastructure. Improve transport between hospitals in Scunthorpe, Grimsby and Goole (dedicated hospital transport system).
- Services with higher demand to be in major centres, while services with less demand could be in satellite centres.
- Nurse specialists and/or junior doctors could run community clinics for low risk patients, leaving consultants free to run complex clinics, resulting in more patients being seen, and upskilling staff. Community based investigations to take pressure off hospitals and getting to hospitals.
- Opportunity to stop patients going out of area as their choice (as will be better patient experience with lower waits).

Impact

- Participants more happy receiving care under this model. Happy to travel if patient receives the care they require. However, issue remains around bridge closure and transport concerns.
- If primary care being relied upon to deliver service more locally, are they set up appropriately?
- People need to be supported to access these services.

How could this idea be improved by digital technology?

- Phone calls with consultant could replace check-ups if everything was okay (doesn't need to be a video consultation, phone calls work well in primary care). Technology should be used for pre-assessment appointments (which would free-up consultant appointments and also solve transport issues).
- Technology could be used to support nurses and/or junior doctors at low-risk community clinics (call/video call a consultant if they have a question or concern).

Model 3: Specialise in different areas at different sites across all of Humber (eg: hip replacements at one hospital and gallbladder surgery at another)

Strengths

- Clinicians would be able to see patients on one day. Staff become ultra-specialised.
- Fewer visits for patients (potentially).
- Better quality of care. Clinical outcomes would improve. All consultants would adopt same standards with standardised pathways.
- Supports specialist training requirements. More attractive to new staff.

Weaknesses

- Difficult to implement within Humber geography (transport costs, Humber Bridge closures. Is their capacity to implement this model?
- What happens if a patient has multiple/complex needs? There may not be the expertise available as it is at a different site.
- The location of these sites could become totally unreachable for some patients (particularly those living in extreme rural locations).
- Potential impact on staff – eg: nurses who specialise in orthopaedics at Scunthorpe General Hospital, but are then required to work a Diana Princess of Wales Hospital in Grimsby. Impact on local economy if staff groups have to move,
- For routine ops, specialising a site doesn't make much difference. If emergency operations still carried out at this site there's still the risk of planned procedures to be cancelled.

Opportunities

- Selling the benefits of working (and living in) East Yorkshire and Lincolnshire.

- This approach could break down barriers within trusts – better communication about certain patients as they would talk to each other more effectively.
- Junior doctors could specialise and progress (staff retention therefore easier). Roles within the area could potentially become more attractive.
- However, staff would need to be continually trained and not become stagnant in one area. How would this happen if services were concentrated in one area?

Impact

- Making people from Grimsby travel to Hull (and vice versa) would be a barrier. Long transport times. Public transport links not adequate (also people might not be able to afford public transport costs, which would place added pressure on patient transport and ambulance services).
- Would need staff and buildings to meet demand at one centre.
- Access for carers and wider (psychological) impact on patients.

How could this idea be improved by digital technology?

- Could still do the assessment locally and use technology more?

Model 4: Provide all low-risk routine surgery in a Humber-wide super elective centre

Strengths

- Fewer visits to the hospital (if everything is on one site).
- Clinical outcomes would be better. Patient confidence. More specialities within teams.
- Concentration of staff. More opportunity to talk across speciality.
- Better buildings (fit for purpose). Transport to one site might be easier to get right.

Weaknesses

- The scale of the model seems “incomprehensible”. Some participants thought that, from a geographical perspective, this model would not work.
- Transport would still represent a major issue.
- More strain on GPs if diagnostics are close to home.
- Narrows options for staff – less local employment?

Opportunities

- The idea was dismissed completely by the East Yorkshire participants, due to the geographical obstacles discussed in the weaknesses section.
- For the model to work, the diagnostics would need to be closer to home.
- Employment would have to be attractive to the staff who would have to travel to work there – offers such as free parking (and other support) would help.

Impact

- Public transport is poor – so patients might need to travel further. There is a lack of rural transport so the infrastructure needs to improve.

How could this idea be improved by digital technology?

- Digital technology could be used for pre-op consultations (to share information) instead of face-to-face appointments.

Common themes and issues

In addition a number of common themes and issues were raised throughout the discussions that apply to more than one of the models or approaches. These include the following:

- Familiarity is important – people are uncomfortable with change until they understand where to go and what is available. With any change, communications will be key. Provide more in-the-community services where possible (especially for long-term conditions or conditions which require regular monitoring).
- Put the patient first - more emphasis needs to be on patient outcome. Look at where planned care is working well currently. What do people value so much about the GDH model, for example?
- The East Riding group really didn't like model three (Specialise in different areas at different sites across all of Humber) or model four (Provide all low-risk routine surgery in a Humber-wide super elective centre) due to issues around geography.
- Use technology to reduce unnecessary visits to hospital sites. Those than can use technology will – this will reduce some pressure.
- Consultants adopting the same standards and pathways across the patch are seen to be important.
- Dedicated planned care facilities mean fewer emergencies to deal with and therefore fewer cancellations. Better patient experience.
- The model adopted has to appeal to the workforce, has to boost recruitment and retention.

Urgent and Emergency Care (for adults)

Urgent and emergency care services include care that is provided on an unplanned basis – when not expected or pre-planned. The services being considered through this element of the review include services provided at our existing Accident and Emergency departments, (hospital-based) urgent care, assessment for acutely ill patients (including medical assessment and surgical assessment) and trauma services. The current shape of hospital-based urgent and emergency care services across the Humber was explained to workshop participants:

Early ideas

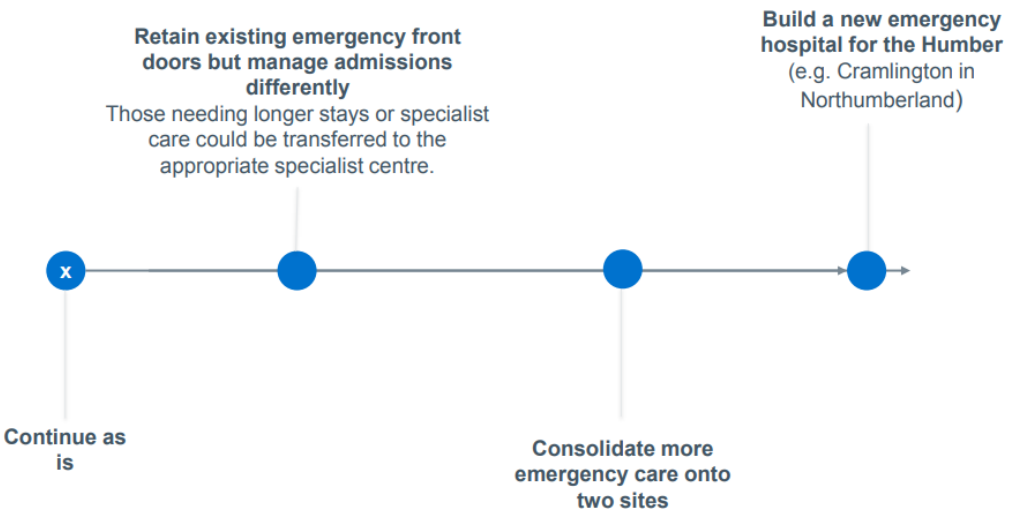
Current service design of Urgent and Emergency Care across Humber

	HRI	CHH	DPOW	SGH	GDH	ERCH	Brid	Brans
A&E	✓	✗	✓	✓	✗	✗	✗	✗
Dedicated Children's A&E	✓	✗	✗	✗	✗	✗	✗	✗
Major Trauma centre	✓	✗	✗	✗	✗	✗	✗	✗
Trauma unit	✗	✗	✓	✓	✗	✗	✗	✗
Ambulatory Care Unit	✓	✗	✓ (surgical)	✓ (medical)	✗	✗	✗	✗
Urgent Treatment Centre	✗	✗	✓	✓	✓	✓	✓	✓
Acute Medical Unit	✓	✗	✓	✓ (CDU)	✗	✗	✗	✗
Surgical Assessment Unit	✓	✗	✓	✗	✗	✗	✗	✗
Specialist emergency cardiology	✗	✓	✗	✗	✗	✗	✗	✗

Participants were then presented with four potential clinical models along a spectrum from least to most change:

Early ideas

Urgent and Emergency Care – what would happen if…?



The participants were invited to comment on the potential strengths, weaknesses, opportunities and impact of each approach as well as sharing their ideas on how digital technology could be used to improve the models. The comments and ideas shared at all relevant events have been collated and summarised below.

Model 1: Keep current model in place

Strengths

- Familiarity: People understand how current model works (people like familiarity). People know where to access services.
- Quality of existing staff: Staff are good and already provide good care.
- Good local services already embedded into the community: It's local, closer to where you live. Clinical expertise if local. Service embedded in the community it serves.
- Transport links are good to hospitals in cities and large towns.
- Good connection between primary and secondary care: GP services at front door of hospitals on both sides of Humber. Medical notes available when you arrive at the emergency department.

Weaknesses

- Current model is not sustainable - Pressure is going to increase on services, inappropriate use of A&E is high (because open 24/7), current infrastructure is struggling (no room for expansion at current sites), not enough staff (issue around workforce sustainability), longer waiting times (particularly on Friday and weekends), inefficiencies in joined-up care at weekends, quality of care can be variable.
- Barriers around access to services - Transport is poor in rural areas. Not equitable access for East Yorkshire residents. Do not attend instances are high because people cannot access the service and public transport and parking is expensive.

Opportunities

- Develop and support workforce – Increase staff training and development. Expand roles in emergency care. Specialist staff recruited in all areas of Humber region (not just at hospitals). Specialist staff supporting and teaching more junior staff. Invest in admin staff (to take admin duties away from clinicians so they can focus on treating patients).
- Empower the patient - patient passports to be properly delivered (important for patients/carers). Patients to have better control of medical records. Educate patients more about their care options.
- Hospital trusts could become more joined-up. Improve partnership working between providers and partners.

Impact

- Some patients have 4 or 5 people involved in care, and nobody can access information (stressful for patients and carers).
- Services need to provide greater support to those that have not got family support.

How could this idea be improved by digital technology?

- All health systems to have same capability across the area so patient information is available at every site.
- Utilise IT technology to improve communication.
- Digital records that are shared across sites and with ambulance services.
- Virtual follow-up clinics, either at home or at a hub (for those that can't use technology).

Model 2: Retain existing emergency front doors but manage admissions differently

In this model, the existing A&E departments in the three localities would remain as they are, but alternative staffing models would be put in place behind the front door to manage the care of patients attending A&E. Patients expected to be admitted for up to 48/72 hours, would be admitted to an acute care hub, rather than specialty wards. Patients needing longer stays or more specialist care could be transferred to the appropriate specialist centre for treatment, following assessment in the local unit.

Strengths

- Still the same front door, but quicker access to specialist care (people with greatest need would see specialist quicker (aid quick diagnosis).
- Better clinical outcomes as initial triage is done by an A&E specialist.
- This model would help with recruitment and retention of staff. Jobs would be more attractive to specialists (good for workforce development).
- Post-op care would be closer to home.

Weaknesses

- Too many assessments (patient having to repeat themselves multiple times to different healthcare staff).
- Location of sites key. Facilities aren't suitable in some places, such as East Yorkshire (where community bed capacity keeps on being reduced).
- Lack of bed capacity could prevent people from being repatriated to their local hospital.
- Staffing issues would still remain (can we staff this model?). Pressure on ambulance staff to transfer patients.
- Smaller sites don't always have specialists available. Could an expert generalist miss something that a specialist might see?
- Rural transport lacking (so travel to sites could be difficult).

Opportunities

- Appoint staff to the whole Humber region, not just Hull Royal Infirmary, for example. This could solve the recruitment issues in East Riding and North Lincolnshire.
- Repatriation for rehabilitation could be moved to local community hospitals instead of acute hospitals.
- Single point of access could be used to improve access to the right care, faster
- GPs being able to access specialist advice – quicker access to advice earlier through primary care.

Impact

- Travel issues (length of journey and cost) - family may have to travel to wherever the patient is transferred to (which could be from one end of the patch to the other). Parking issues.
- Demand for ambulance services could increase (because people struggle to get to hospital themselves).

How could this idea be improved by digital technology?

- Use technology to link the specialist to the patient on other sites (so could be available in an emergency).
- Live A&E waiting times to help patients make decisions about where to go for care.

Model 3: Consolidate more emergency care onto two sites

In this model, most emergency care would be consolidated onto two sites, rather than the existing three. Smaller urgent treatment centres could continue to operate locally to provide care for a wide range of urgent care needs.

Strengths

- This model is more sustainable. You might be able to receive care nearer your home more quickly.
- Better clinical outcomes – good quality care at two sites serving Humber population. Increase capacity (2 A&Es to serve population).
- Better quality staff at bigger centres - patient flow could be improved as a result.
- Easier for workforce to get there (would help with recruitment and retention). More chance of offering seven-day-a-week services as staff are concentrated.
- Public transport to central locations already well developed.

Weaknesses

- Would be difficult to implement in North Lincolnshire and North East Lincolnshire – as the current sites (Grimsby and Scunthorpe) are not viable and there is no central location in this area. Not viable without a new facility.
- Emergency care would be less local – patients need timely access for emergencies so cannot travel too far. This could impact on safety. Ambulance delays around Hull Royal Infirmary during rush hour could have a negative impact on patient outcomes.
- Public transport is poor – time taken to travel to hospital can be lengthy. Roads poor in rural areas.
- Who diagnoses need for emergency care? Assessment needed to be made whether emergency care is required.
- Staff might not want to move to work at these sites, so workforce need might not be met.

Opportunities

- A new centre could be better positioned on the North Bank than where Hull Royal Infirmary currently is.
- Whatever model is implemented needs to be future-proofed.
- Could offer free car parking for relatives having to travel.
- Appoint staff to the whole Humber region, not just Hull Royal Infirmary, for example. This could solve the recruitment issues in East Yorkshire and North Lincolnshire.
- Opportunities to work with local community to address workforce issues (encourage locals to work in healthcare).

Impact

- How many patients would actually get an ambulance? How many would not survive the ambulance journey to hospital? Could ambulance service with this extra travel?
- Travel from end of each area to the other (eg: Scunthorpe to Grimsby).
- Air ambulance needed more often.

How could this idea be improved by digital technology?

- Would enable staff to work remotely (might help with recruitment)
- Local tests available to the specialist centres.

Common themes and issues

In addition a number of common themes and issues were raised throughout the discussions that apply to more than one of the models or approaches. These include the following:

- Staff parking affects all ideas. There needs to be guaranteed parking for staff and patients taken into account in when implementing any of the models.
- Keeping same front door was regarded as a good approach – but changing the pathway could improve how clinicians can work (might be good for keeping workforce).

- Families might have to travel to follow patient to emergency care, so for short time this could impact them. However, if the quality of care was better this could be acceptable.
- If patient gets to see the right person / specialist care quicker, then the impact on family is reduced.
- North Lincolnshire and North East Lincolnshire has no central point to base one of the two emergency department sites, if consolidated. Lots to consider (travel/infrastructure/capacity) to support local population.
- Use technology to support access to specialist advice.

Feedback on Decision-making Criteria

Background

During the sessions, we also asked participants for their feedback on the decision-making criteria that have been developed to guide decisions that will be made later on in the review process. The decision-making criteria was set at the beginning of the review process by the review steering group in discussion with key stakeholders, which included clinicians, local NHS leaders and local authority representatives.

The criteria have been developed to help decision-makers to understand and therefore take account of the various trade-offs that are presented by different scenarios or proposals for change. The purpose of discussing them with the patients and carers who attended the workshops was to gather their feedback on which things are most important to them as people using services, so decision-makers are aware of this when making decisions about future service models.

Specifically, participants were asked to read through the criteria. They were asked to discuss whether the questions posed were the right ones when thinking about future service models; whether any important criteria were missing; and whether there were any areas where further clarification would be helpful.

Decision-making criteria

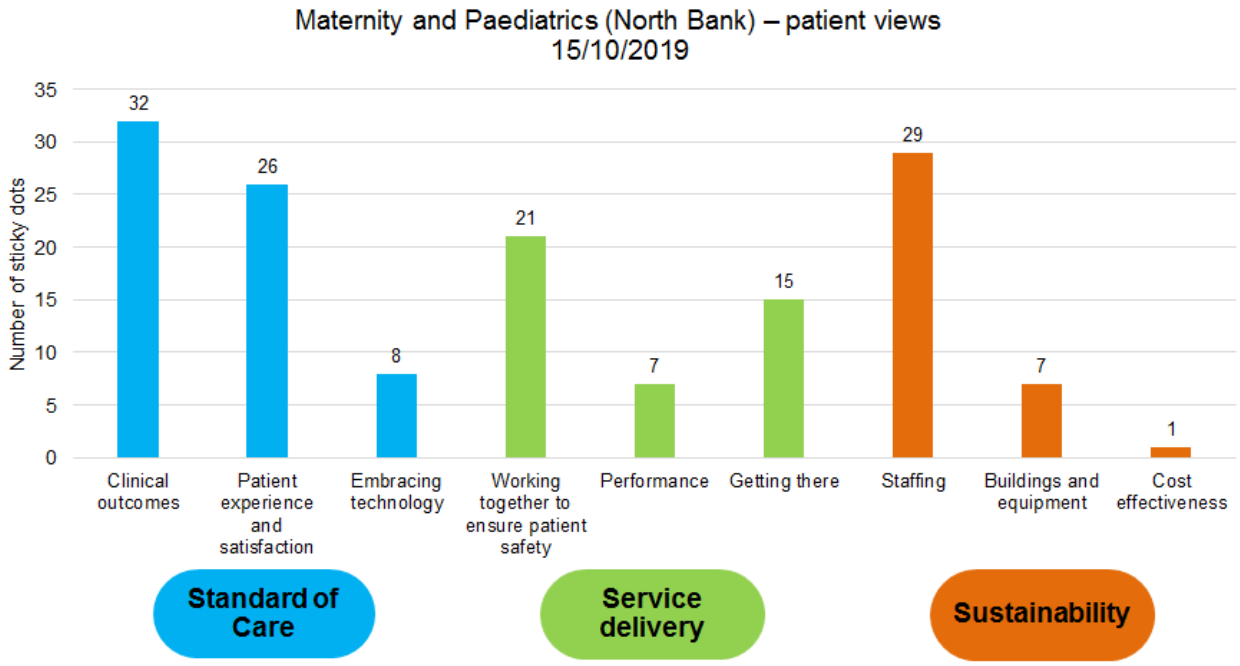
Feedback on the Decision-making Criteria

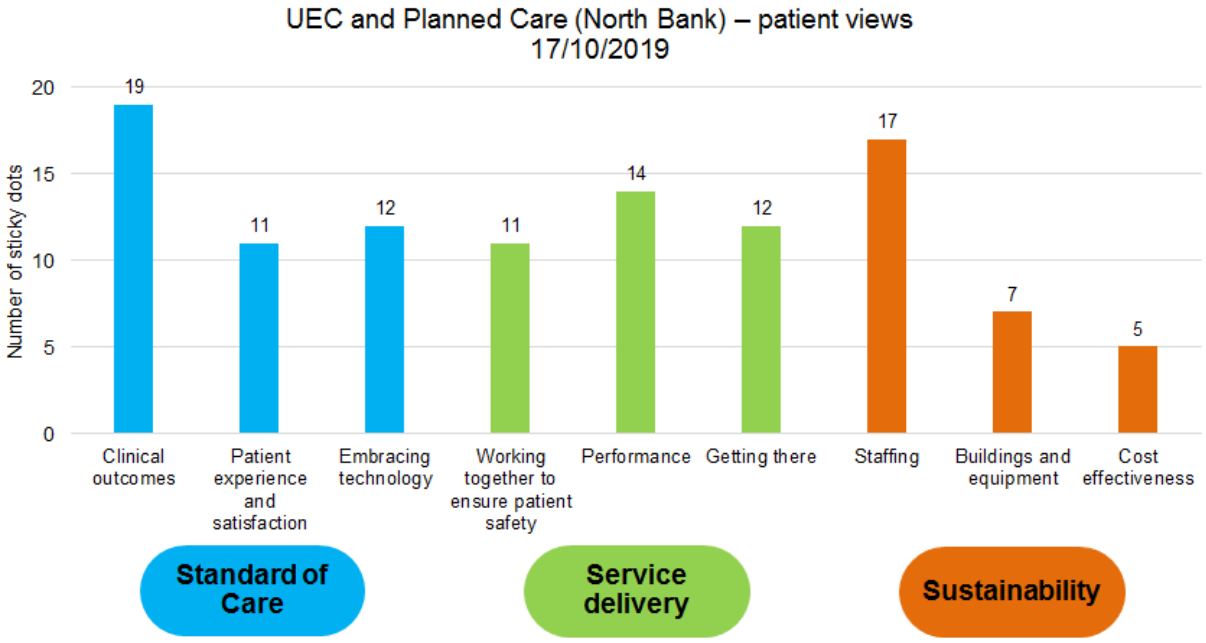
The decision-making criteria are grouped into three themes:

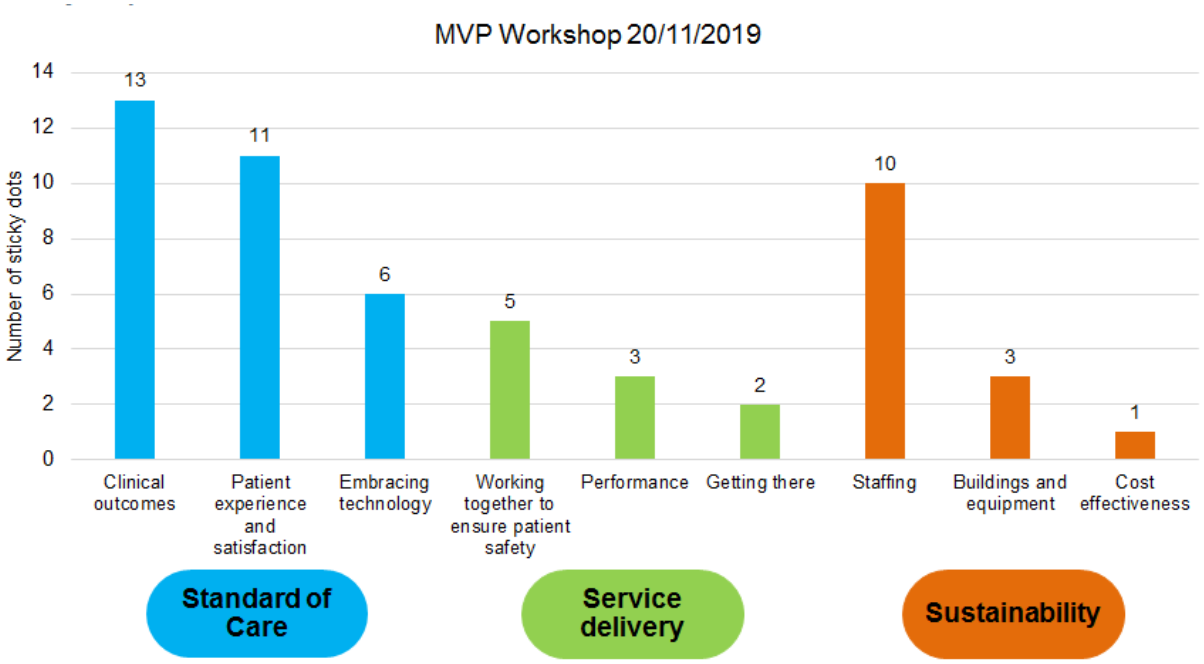
- **Standard of care** – clinical outcomes, patient experience and satisfaction, embracing technology
- **Service delivery** – working together to ensure patient safety, performance, getting there and parking
- **Sustainability** – Staffing, buildings, cost effectiveness

At each workshop, participants were given nine red stickers and were asked to stick these next to the criteria most important to them (or the people they were representing). They could choose to put as many or as few red dots next to each criterion (i.e. they could use all nine dots on one thing if it was extremely important, or use one dot per criterion if each were of equal importance).

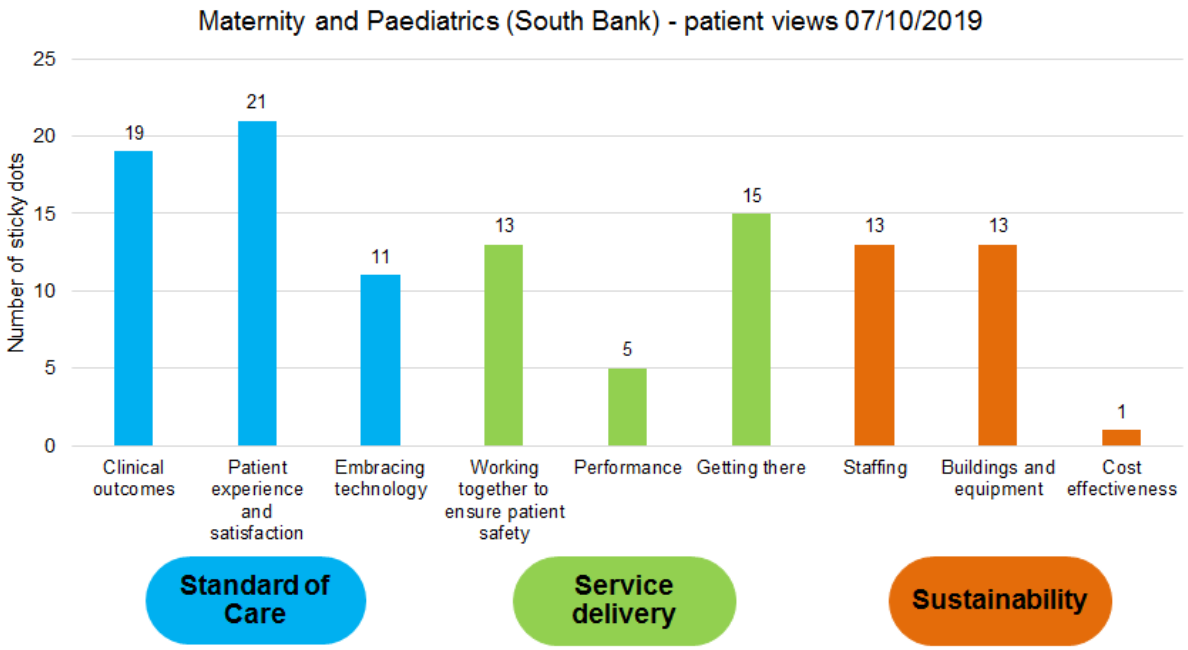
Clinical Outcomes was considered to be the most important of the decision-making criteria at the Hull workshops on maternity care and paediatric services (15th October), the East Riding workshops on adult planned and emergency care (17th October) as well as the Maternity Voices Partnerships (MVP) drop-in session on maternity services (20th October). Having the right staff available and good patient experience were also ranked highly by all three groups.



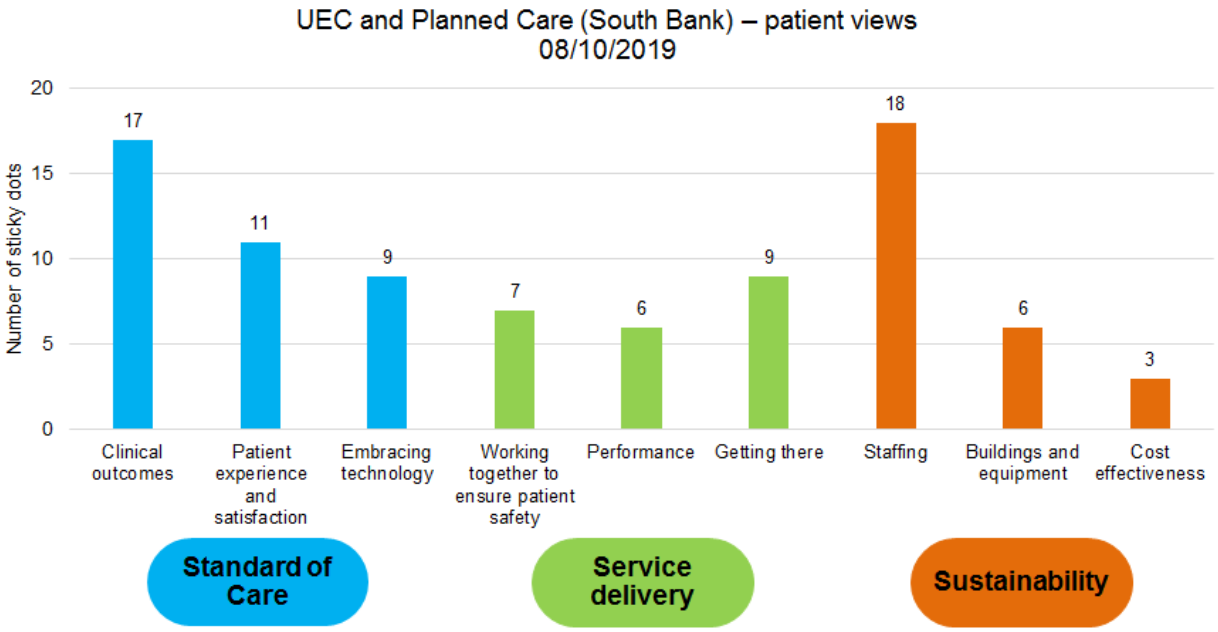

UEC and Planned Care (North Bank) – patient views
17/10/2019
Number of sticky dots
20
15
10
5
0
19
11
12
11
14
12
17
7
5
Clinical outcomes
Patient experience and satisfaction
Embracing technology
Working together to ensure patient safety
Performance
Getting there
Staffing
Buildings and equipment
Cost effectiveness
Standard of Care
Service delivery
Sustainability


MVP Workshop 20/11/2019
Number of sticky dots
14
12
10
8
6
4
2
0
13
11
6
5
3
2
10
3
1
Clinical outcomes
Patient experience and satisfaction
Embracing technology
Working together to ensure patient safety
Performance
Getting there
Staffing
Buildings and equipment
Cost effectiveness
Standard of Care
Service delivery
Sustainability

Patient Experience and Satisfaction was ranked the most important at the maternity care and paediatric services workshop held in Grimsby (7th October).

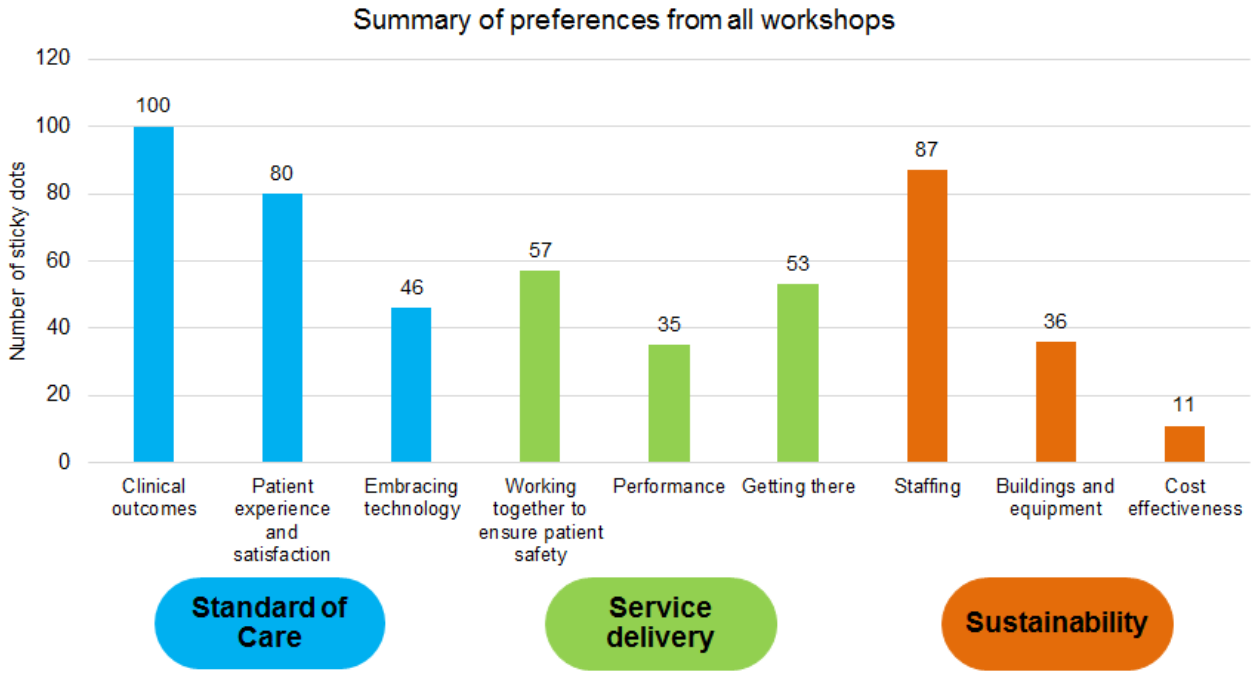


Having the right **staffing** available was considered to be most important at the adult planned and emergency care workshop in Scunthorpe (8th October).



When taken together across all workshops, the criteria that were considered the most important to the patients, service-users and carers we engaged with were: **Clinical Outcomes** (100), followed by **Staffing** (87) and **Patient Experience and Satisfaction** (80).

1) Clinical Outcomes **(100)**
2) Staffing **(87)**
3) Patient Experience and Satisfaction **(80)**
4) Working Together to Ensure Patient Safety **(57)**
5) Getting There **(53)**
6) Embracing Technology **(46)**
7) Buildings **(36)**
8) Performance **(35)**
9) Cost Effectiveness **(11)**



Key Themes and Next Steps

There was a broad range of diverse feedback given from participants over the course of the eight events and, therefore, it is difficult to summarise everything said without losing the richness of the feedback.

Nevertheless, it is possible to identify some key themes and common issues raised by many participants. These also reflect the priorities that were expressed in relation to the decision-making criteria. The three aspects that were identified as most important to those taking part in the events were:

- **Clinical Outcomes** – Will the service give me the best possible chance of being well?
- **Staffing** – Will there be the right staff there to provide the care I need?
- **Patient Experience** – Will I have a good experience?

Key Themes

Some of the key themes that were highlighted throughout the discussions are set out below.

Clinical outcomes

The thing that was most important to most people was getting good quality care and having the best possible chance of getting well. This came through clearly when participants were asked to identify the decision-making criteria that were most important to them. Many of the strengths and weaknesses that were highlighted were focused on the quality of the care that could be provided in each of the different approaches. For example, comments on the different maternity models tended to focus on how they would deliver safe care, particularly in the event of complications during labour. Other issues that were highlighted were linked to the ability to attract enough of the appropriately qualified staff to provide safe and effective care.

The right workforce

The majority of participants were full of praise for hospital staff. In all the workshops it was clear that participants recognised the pressures on staff and empathised strongly with the current workforce.

Participants identified a number of opportunities to develop and make the best use of staff working at our acute hospitals. These included: improving the physical environments staff are working in; making job plans more interesting by enabling staff to work across multiple sites or undertake a wide range of different tasks. Participants also identified the opportunity for local NHS organisations to work with the wider community to help “sell” our local area as a great place to live and work in as well as supporting initiatives to get local children and young people into careers in health and care.

Access and travel

A lot of the participants raised issues around travel and access to services. Many said they were willing to travel further, particularly to access specialist services, as they felt that greater quality of care could be provided by centralised services. However, there was concern about how people living far away from the sites would be impacted by having to travel further to access care. Participants noted that travelling long distances for a one-off event was generally acceptable (if it meant they were getting the best care) but it was important that ongoing care was available locally, wherever possible.

Participants highlighted a number of potential opportunities to improve the experience if they do have to travel to access care:

- Expand car parking provision at hospitals (for staff as well as patients/visitors).
- Improve public transport links (including between hospitals).
- Ensure people living in rural areas are able to travel to access the care they need.
- Services could make better use of technology (including low-tech options such as telephone) to reduce the need for people to travel to hospital at all.
- Consolidate appointments to reduce the frequency of travel.

Digital technology

Participants were asked to comment specifically on how digital technology could be used to improve the different models of care, therefore there was lots of feedback on this topic. In general, participants were really positive about the potential of digital technology to improve care and some were frustrated by the sense that health and care services were 'behind the times' in terms of adopting technological solutions.

Participants were keen for hospitals to harness digital technology more, especially to overcome some of the challenges facing these services (eg: demand for services, workforce shortage). Some of the recommendations included:

- Sharing information and having access to health and care records was seen as critically important in all of the potential clinical models.
- Offer video consultations for pre-assessment and follow-up appointments (to reduce times patient has to travel)
- Staff at local sites could use video consultations to speak to specialist when they need advice
- Use digital technology to improve communication between clinicians/departments involved in a patient's care (so patient doesn't have to repeat their story several times)
- Digital apps could connect people to support/peer groups better and provide live information about waiting times (at A&E departments, for example)

Give patients more information and knowledge

Another common theme to emerge was that participants were keen to receive more timely information about what was happening in their care. Patients were keen to be able to ask questions and have them answered remotely, while they want to have greater knowledge around the choices available to them (what services are available and where).

Patients were eager for hospitals to manage their expectations around waiting times better. Participants also felt there is the opportunity to improve communication between services and, where possible, standardise communication to patients to help reduce the time it takes for patient to receive correspondence.

Next Steps

The detailed feedback that was shared about each of the potential clinical models will be shared with the review team and used as part of the evaluation process to refine possible clinical models for acute services in the Humber.

In addition the feedback will be shared with the Citizen's Panel, which is a group of 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.

Further involvement opportunities will be available throughout the review process, details of which will be shared on the Humber Acute Services Review website.