The purpose of this event was to seek the views of our local populations on the proposed models which are being put forward for the five identified services. The Hospital Services Review has now entered Phase Two which runs between January and April. During this time we will be developing ideas and options for recommendations relating to each service and how it could be reconfigured.

The attached document includes:

- Background
- Audience expectations
- Comments and suggestions
- Evaluation feedback

**Post Event Summary and Evaluation**
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EVENT SUMMARY

60 people from across the South Yorkshire, Bassetlaw and Chesterfield area came together on the 8th March to consider the options being presented by the review team in this second phase of the Hospital Services Review. The review team were keen to hear the thoughts and opinions of those present in relation to the proposed models being put forward. During the afternoon each attendee had the opportunity to discuss within their group the options for each service and could seek clarity from a clinical expert. The information was collected from each working group and will be the main feature of this report.

Helen Stevens, Associate Director Communications and Engagement, Health and Care Working Together, welcomed attendees, provided an overview of the aims of the day and asked attendees to tell us what they hoped to see covered during the sessions. (Appendix 1). She committed to coming back at the end of the session to make sure that all of the areas raised had been addressed.

The attendees included wide-ranging representation including members of the public, service users, carers, staff from each trust and Healthwatch.

The feedback received from the first open event held on the 6th December 2017 was used to shape the agenda and format, which was as follows:

- **Prof Des Breen, Medical Director Health and Care Working Together**
  - Introduction to the Accountable Care System

- **Chris Welsh Independent Review Director**
  - Why are we having a Hospital Services Review

- **Alexandra Norrish Review Programme Director**
  - Overview of the Hospital Services Review
  - Reconfiguration options: the approach we have taken, and the vision for South Yorkshire and Bassetlaw

- **Dr Nicola Jay Consultant Paediatrician**
  - Care of the Acutely Unwell Child – options for the service

- **Dr Karen Selby Deputy Clinical Director for Maternity Services**
  - Vision for Maternity Services

- **Dr Nick Mallaband Emergency Care Group Director and Consultant Acute Physician**
  - Vision for Urgent and Emergency Care

- **Gastroenterology and Endoscopy services, Dr Mo Thoufeeq**
Attendees were offered opportunities to ask questions after each session. The questions posed have been used to amend and update the Question and Answer prompt which is available on the Health and Care Working Together website. (Appendix 2). During the afternoon five facilitated sessions took place offering each attendee an opportunity to discuss the proposed models. The questions posed and thoughts relating to each option were captured by a scribe and this information can be viewed in (Appendix 3). The event was live-tweeted (summary at Appendix 4) to reach a wider audience and allow those who weren’t able to attend to also ask questions related to the agenda.

IMMEDIATE IMPACT OF FEEDBACK
The Hospital Services Review team are considering the opinions and thoughts of those whom attended as they prepare to submit a report in April which will outline the vision for each service.

The Review report will lay out the specific areas where public feedback has been taken into account and has helped to shape the recommendations in the Review.

NEXT STEPS
The write up of the event will be used to inform the development of the April report of the Hospital Services Review
Further local events are planned through May and June where local opinions will be sought in reference to the report. We are also planning service specific engagement which will allow recent service users and their family/carers to consider the report findings.
APPENDIX 1 – ‘WHAT WOULD YOU LIKE TO BE COVERED TODAY’

These themes were returned to at the end of the day and an agreement was reached as to how well each of the points had been addressed.

- **I.T – How will different computer systems connect?**
  We recognise that this is a crucial factor in our organisations working together better in the future and have a dedicated workstream that is looking specifically at it.

- **What detail can we give people?**
  The session offered lots of detail about the thinking so far and gave them the opportunity to input into it.

- **How will community services/staff be affected?**
  At this stage, because we haven’t got detailed future service options worked up, we don’t know – but we will revisit and update at future sessions.

- **Will it change again if a different Government is elected?**
  While policies may change, the importance of health and care working more closely together will not.

- **Why is this work continuing given the ‘national’ pause?**
  We are working together more closely to bring health and care services together so that patients are at the centre and there isn’t a national pause on this. The pause that you are referring to is around accountable care organisation contracts, more detail on which can be found here: [https://www.england.nhs.uk/2018/01/consultation-aco-contracts/](https://www.england.nhs.uk/2018/01/consultation-aco-contracts/)

- **How will this affect me, as a pensioner?**
  At this stage, because we haven’t got detailed future service options worked up, we don’t know what the implications are for individuals – but we will revisit and update at future sessions.

- **What has changed since last time?**
  The session offered lots of detail about what has happened since we last met.

- **How are we ensuring accountability?**
  The session described how the Integrated Care System was working and that it doesn’t replace any of the current statutory accountabilities of the partners.

- **Why does the name keep changing?**
  We have been describing our work under the heading of ‘health and care working together in South Yorkshire and Bassetlaw’ as it best describes what the partners are trying to do. National name changes have been put in place to give a better understanding of what is happening.

- **Addressing privatisation of the NHS!**
  Des Breen explained the history of working together and how the 2012 Health and Care Act had encouraged competition rather than collaboration. The thinking behind working together more closely is to encourage more collaboration between public sector partners. A few people in the audience said they were still not convinced the approach was about privatisation at the end of the session.
• **How will people in North East Derbyshire be affected, and what travel implications will there be for specialist care?**

  At this stage, because we haven’t got detailed future service options worked up, we don’t know – but we will revisit and update at future sessions.

• **Have there been any governance changes?**

  The session described how the Integrated Care System was working and that it doesn’t replace any of the current statutory accountabilities of the partners. We will update on this at future sessions.
The Accountable Care System - questions to Prof Des Breen

- Q. Why are you racing ahead when there’s a national pause on ACOs?
- Q. You’ve said none of the SYB work is about privatisation yet NHS111 is currently being prepared for competitive tender (likely to have private sector bidders) will the SYB system not make it easier for more contracts like this to be privatised?
- Q. There’s a patient in Derbyshire for whom it’s almost impossible to get hospitals to transfer her notes between them. Who will get that to happen?
- Q. How can we be sure Drs will use the integrated IT systems? There needs to be more comms around them. And will social care have access?
- Q. We know that you need to integrate - how are you making sure people do it and stop looking at their own bottom lines?

Why a Hospital Services Review. Questions to Prof Chris Welsh:

- Q. The Government’s immigration policy is working against the NHS.
- Q. 52% of NHS staff are administrators. Why do we need our own payrolls/ procurement?
- Q. Why are people not choosing jobs in the care system?
- Q. Have we looked at whether unsociable hours/ lack of flexibility is an issue for the nursing workforce?

Over-view of the Hospital Services Review. Questions to Alexandra Norrish

- Q. Could you go against national rules about healthcare staff training?
- Q. How far along are you with staff passporting?
- Q. In terms of attracting people into the profession are you doing any work with young people pre-uni age?
- Q. What are we doing to make sure we take our workforce and trade unions with us on this journey and don’t affect retention?
- Q: Does the apprenticeship levy apply to the NHS?
APPENDIX 3 – FACILITATED GROUP SESSION DISCUSSIONS COMMENTARY KEY THEMES:

Maternity Services Vision. Dr Karen Selby

Workforce

- General discussions around the local shortages of midwives and consultants, why this is and how it may be addressed in future. Would the recruitment of midwives to a maternity led unit be easier and have we discussed this with staff?
- Further discussions around the staffing levels required for midwifery led units and consultant led units and how the skill mix needed would work given that there are identified shortages would the modelling support or compound the problems.
- Recognition that given the information available in terms of consultant numbers the continuation of six consultant led services would not be sustainable. That it would not seem possible to have the options for six or five consultant led services.
- A feeling that local training of staff and relationship budding with educational establishments will help to train more staff.
- Positive comments relating to staff being able to move more freely but concerns that if service is reconfigured how can we ensure that additional staff don’t leave because they have very clear thoughts around where they would like to work
- Would midwife led units provide better continuity of care?
- Would be useful to see the workforce numbers for midwives as well to have a clearer picture of the number of nursing vacancies for both consultant midwives and general staff. Would also want to see the numbers of community midwives for each place.

Affordability

- Have a better understanding of what the capital expenditure would be in relation to the different models but would also need to understand what the potential savings might be in the long term.
- If these figures relate to capital costs what are the associated infra structure costs.
- Aren’t litigation costs a huge risk to the NHS and would remodelling help to minimise that risk
- If units had to equipped would patients still have access to birthing pods etc in each unit whether consultant led or midwife led and can that cost be covered?

Access

- Travel times are seen as a major risk especially where women may have to move from a midwife led unit to a consultant led unit.
- Travel times would also need to be seen for a transfer when a baby is born in a midwife led unit but need urgent transfer to a neonatal unit.
- If women can choose where they have a baby how does this impact if they always chose a consultant led unit and then have to travel which would also incur costs for their family.
• Would consultants travel to midwife led units if needed to prevent the transfer of mothers. This would be similar to the flying squads we used to have.
• Travel times aren’t just about distance they can be impacted by rush hours and road works
• Are the ambulance service involved with the planning to ensure the ambulance can get the patient in enough time
• Lots of families don’t have access to a car in the baby was to be born in a unit which isn’t local either midwife led or consultant how will this cost be covered?

Safety
• Prompted the most discussion at all five tables large around the unpredictability of any birth and how this would impact on safety if a mother was admitted to an maternity led unity and then needed consultant care or specialist neo-natal care.
• The potential risks attached to travel times for mother and baby especially when external factors influenced travel times for example ‘rush hour’
• Would this potentially mean more babies were born in ambulances?
• Where then would be the ‘best and safest place to give birth?’
• It would be about offering assurances that should the situation change this is how it would be managed.
• How an assessment would be made of whether it was suitable for a woman to deliver in an MLU. What exactly does an expected ‘normal’ birth mean what are the boundaries when deciding and what percentage of women does this affect.
• Are there safety issues if a large number of consultant midwives are needed for midwife led unit does this create an issue for consultant led unit if the most qualiﬁed midwives are all deployed?

Interdependencies
• How would the systems speak to each other if either the consultant led or maternity units were full in a particular place would there be enough information shared between services to ensure women didn’t arrive somewhere to find it was full and they needed to be diverted.
• How would the information be shared with the community workforce if a woman no longer delivered in her local hospital
• How have the dependencies between neonatal and maternity services been considered when developing these models.
• Would midwifery led units always be placed within a trust setting and if not how would they work with other services for example blood testing

General Comments
• Would like to know more about the apprenticeship schemes and will this apply to midwives and if so how well trained will they be?
• Can we ensure that more data is available for future meetings
• Can we stop using the words ‘high level’
• Why do such a small number of women have home births and what is being done to encourage this.
• Is the intervention higher for example caesarean section arte in a consultant led unit
Vision for Stroke Services  Dr Mo Thoufeeq

Workforce

• Is it necessary to have consultants at ASUs or could consultations be done via telemedicine? If so, you don’t need as many ASUs anyway.
• Could there be a clinical network of consultants to work across the area? Then you don’t need as many.
• The options seem realistic but need more detail around consultant cover and what you mean by “some sites may have to work together.”
• Working on ASUs isn’t attractive to nurses – how can we change this?
• If go for option 3 – will AHPs be able to cope? It’s not all about consultants or nurses. The therapists are vital to getting people better
• Can the NHS provide more flexible working options like other sectors do to make jobs more appealing?

Affordability

• Option 3 seems the most comprehensive but can we afford it?
• Difficult to make a full assessment with limited data
• We only have the additional number of beds needed, not how much this would cost
• Option 3 doesn’t seem to need any extra costs if you’re saying the only cost is beds but what about the knock on impact and costs for the community
• It wouldn’t be fair to ‘save’ money in one area just to cause costs in another (eg, not spend in acute but cause problems with community provision
• Will there be additional costs for transferring people along the pathway?
• It seems like there’ll be an additional cost for the ambulance/patient transport services
• Shouldn’t just focus on the cost of beds

Access

• Learn from HASU criticisms – messaging about travel times should be clear from the start and get people involved to help plan journeys etc
• Could there be a public transport service between the hospitals/DGHs? Like the shuttle buses the combined Trusts have
• Improved transport between the areas would mean there was no impact on already scarce parking
• Can patient transport services cope?
• Having visits from family and friends could help someone’s mental/emotional wellbeing so it’s important people can get there
• Not having an acute unit in each place would be detrimental to family, visitors and carers
• Community services in some areas are already scarce/difficult to access (North Derbyshire cited) – would these changes make this worse?
• Parking at the larger hospitals is really difficult and can be expensive
• It’s important people can visit to help with their loved ones care – particularly if their speech or mobility is affected
• Travel times will be longer for some so might be difficult if people can’t drive
• As people may be travelling further, would we be able to change visiting hours at the hospitals to give people longer with their loved ones or at least a longer time frame to get there?
Safety

• Difficult to comment on which option is the best – just want to know which one is the safest.
• Confusion over option 4 – including this implies that ASUs aren’t really needed. Is that the case?

Interdependencies

• Are local authorities involved as they may be able to help make things work if the systems were more aligned.
• If more rehabilitation care is moved into the community and people’s own home, the impact on social workers should be taken into account – would they be able to help?
• Will there be stronger links to social care? Eg, what about people with no carers or family members close by?
• To enable the workforce to be more flexible, you’d need shared access to health care records across different services so that carers in the community are able to treat you properly.
• Option 2 doesn’t mention community – what happens after leaving hospital? Option 3 seems like you get more care.
• Support for option 3 but when you say, “community rehabilitation” do you mean sending patients home or into community rehab units/step-down facilities? (Clarification on wording needed)
• What’s the availability of interpreters? (For people having speech therapy when English isn’t their first language)
• If hospitals are struggling and we want to move more things closer to home – how are you going to support primary and community care so they can cope?
• How many people who have a stroke have more than one condition? The pathway should focus on individual’s needs.
• Do community centres have access to x-ray and other facilities?
• If you’ve not assessed the impact on community and their bed base, surely option 3 isn’t feasible?
• Would there be any option for family accommodation (more relevant to the hyper acute stroke phase)

General comments

• Support for option 3 but is that sustainable?
• Support for option 3 as long as everyone is treated individually and not just moved along a pathway (eg, they move into different care when it’s appropriate for them to do so)
• Support for option 2 or 3
• Confusion over option 4 – including this implies that ASUs aren’t really needed. Is that the case?
• Are there patients in in-patient facilities at the moment who could be looked after at home instead? (Do we have strong stats?)
• More explanation is needed around the difference between HASU and ASU so people know you’re not talking about the emergency care
• It’s okay to create set pathways but care still needs to be tailored to individuals
• Need more evidence/stats/numbers to make an informed decision re: options
• Change word ‘inpatient’ to ‘bedded’
• Will they be NHS ‘community facilities’?
It seems like a “trade off” between getting the best care and being able to have visitors. The best care is the most important thing.

Urgent and Emergency Care Vision Dr Nick Mallaband

Workforce

- Real issue noted to be ‘how can we staff the hospital’; real challenge in getting the staff with the right levels of qualification; services rely on dedicated staff working over and on goodwill.
- Some patients with some conditions need to go straight to place where there is the right kit/staff to treat.
- A&E changed radically from the 1970’s; paramedics can now stabilise; do ECGs; offer advise; but public perceptions have not caught up with the changes (former paramedic).
- Numbers staff needed are based on current patients – will numbers rise in future and how can this be factored in?
- Issues with middle grade gaps and dropout rate; it was therefore noted that we are only likely to have lower figure of staff so do we just work with this. Fundamentally, if we don’t have enough consultants; we have to work with what we have.
- We need to think about the future/future guidance and ways of working – ie 5 years from now - what impact?
- Do we need consultants on all sites 24/7?
- Impact on rota gaps- for example, if there is no mid-grade to cover night shift, this could be covered by consultant, which would impact when they were not then available the next day.
- What are services doing to recruit but if those present think that there is an easy solution ie training more staff; this may be something to address.
- Unlikely to have consultants to manage 6 units 24/7 – start from there.
- Assumptions – that staff recruitment/retention/current demand/working practices will all stay the same - not likely to- impact?
- A&E seen as ‘glamorous’! - high profile, fast paces (TV dramas etc). Bigger units attract more staff; full A&E attract more than urgent care/minor injuries units. – currently happens; Sheffield pull more than other areas.
- Can we offer attractive re-location packages?
- Can we have better system for staff working across the area.
- Hospital accommodation/quality and availability?
- Experience recounted – Derbyshire – felt two separate injuries were treated/counted separately- one person for one injury; another person for second – both fractures – could this have been more efficient? Waste of staff and patient time?
- Staffing projection thought to be optimistic- assumes same working patterns.
- Staffing for UEC is higher than others because of nature of work/patients, and no of hours the service needs to cover. Currently service busies t 3-8 pm; not elective so can’t be managed. 2 consultants needed – one to manage /overview whole dept. consultants need to sign off all children/ chest patients.
- A&Es have better outcomes when consultants are there.

Affordability

- Even if more staff available, would still be a money issue.
- People wanted to know the different costs – ie what is needed for service reform and what can we save by doing things differently.
• If people were to see these figures without understanding the context, they would say ‘do nothing’ - vital to explain in the right way
• Numbers are confusing – where are the running costs?
• If additional funding is needed, where will this come from – Issues re PFI noted – would there be government funding?
• If the ambulance service are transferring more patients, this will need reflecting in their contract/payment – wanted this to go back as clear message
• Need to look at running costs as well as capital costs- potential savings or additional costs

Access
• What could be done differently? Ie are there conditions that could be taken out of A&E; heart attacks straight to specialist service
• If more patients transferred (ie in the ‘front door’ at one unit; then sent on to another); what would be the implications for the ambulance service- will this increase pressure when service already at capacity issues with ambulance handover waits etc space needed in units for this to happen – ie not waiting in ambulance. Will only work if ambulance transfers work
• What will be the impact on ambulances- in terms of capacity to transfer patients.
• People go to A&E when they could go to the GP- 111 send people to A&E when not needed.
• Also access in rest of system – ie GP capacity – full Poor access to G.P’s drives people to A&E’s
• Would closing some units put pressure on other parts of systems ie Walk in Centres
• Noted that though people might think travelling is bad, in SY it’s not that much an issue in comparison with some parts of the country – perspective?
• Should be able to deliver primary care next door to A&E – ie some units now streaming to primary care from front door at A&E
• Concerns about closing A&Es- not intending to close any A&E; but discussion is round if everything is treated all the time everywhere – do we need all services 24/7 in all locations? Example, surgical patients may arrive at Bassetlaw A&E, but be transferred to Doncaster.
• Concerns for some parts of the communities – further travel may be an issue ie single parents
• Public transport – likely to be an issue for some – cost/frequency etc.
• Car parking - most hospital sites already struggle with capacity, for both patients and staff. Would there be additional car parking if some services moved/consolidated?
• Is there conflict between too many people going to A&E and putting in GPS – are these conflicting messages? To an extent the A&E brand is too successful, too well known, so people will use it. It’s a bit like shops etc commercial businesss work with customer flows, not try to change them
• Walk in centres are a mid point between primary care and A&E, but are being closed
• Concerns around access for family/visitors – would be repatriated as soon as possible to local hospital

Safety
• What information is available about distance travelled and outcomes – noted that there are 2 correlations- very generally, outcomes are worse the longer it takes to get to treatment; but also worse longer it takes to get to the right specialist treatment. Its not just about get a patient to any location, but to the right place.
• How much are systems driven by non-clinicians? Clinicians should drive working to ensure safety/quality
Inter-dependencies

- Capacity in community also an issue – better capacity may reduce demand.
- What will be the impact on ambulances in terms of capacity to transfer patients.
- IT systems important – giving info only once – better for patients and less chance of missing vital info.
- If one/more units closed at night or didn’t take some patients; what would be the impact? Would other services not be needed/be underused there/overused in other places?
- GPs in A&E - good way of streaming people – more now doing this – but not enough GPs.
- Doncaster – have work on frail elder pathway - can be shared – ‘Rapid Response’ supports older people in to community living.
- Bassetlaw noted as example where surgical patients coming in through the ‘front door’ are sent to Doncaster – it’s the systems behind the front door that are important.
- Relationship with this workstream and WICs - is this as linked as it could be/should be?

General

- Urgent care – is the most emotive of all subjects; consider the press coverage over the winter – the main message is that the NHS can’t deliver a reliable service – not enough resources/staff.
- If we start to change things, there will be public concern – example cited – Sheffield reconfiguration of hospitals years ago - local headlines stated ‘people will die’ – but they didn’t.
- Vital that the public have confidence in services and in any changes.
- Ongoing issue in terms of educating people – people who turn up when they don’t need to, generally most of the people do need to be in A&E; most areas are deflecting where needed via triage/streamed to GP.
- Vital to think of this in terms of delivering modern 21st century healthcare, not a model from the 1960’s.
- Public perception informed by Holby city etc – we need to get ‘real’ information and stories out there.
- People are generally unclear and confused about what is emergency care and what is urgent care - where this impacts on where they need to go, the messages and language need to be very clear.
- Do we know what patients mean when they say A&E? do we need to look at this more?
- Its vital to get patients to the right bit of the system.
- People will want a local unit.
- Some CCGs have already done a lot of work around this – assurance that this will be used where possible.
- People don’t have much faith in call centres (111); but people do have faith in seeing a clinical 1:1 - nhs brand.
- How does mental health fit in/impact? Most A&Es have MH/crisis teams working alongside - will this be same in all future units?
- Will one of the 6 units close –
- How can we lose any services when all A&Es and inpatient beds are full?
- Vital to educated public on how to use health services correctly - alternative is to design a system that follows the way patients use it.
- General issue is about not having all 6 working in same way – key points are – clarity about what each provides/doesn’t provide; assurance that if people are transferred away; they will be back as close to home as possible as soon as possible.
- All A&Es triage/stream; ie to GPs or direct to a medical service.
• Query re major incident – noted that there are really tight protocols across health services, with ways of pulling in additional services as needed
• Need to look at need in 2032 not 2022
• Vital that patients know where to go – is there a role for in hospital volunteers/ or the vol/com sector?
• Engagement/consultation – ask a simple question that require a simple response
• Everyone in SY&B should be aware of what is going on, more public engagement necessary T.V/Radio/Media
• Like all the public engagement sessions I have attended / You wouldn’t think the NHS was in crisis
• Use Facebook and Twitter to get the positive messages out
• Today is another box ticking exercise like the Healthwatch engagement sham exercise
• Evening sessions to engage staff and the public across South Yorkshire and Bassetlaw please. Always provide some incentives, travel costs and refreshments, publicise across South Yorkshire and Bassetlaw and through Vol/Com sector

Vision for Gastroenterology and Endoscopy Dr Mo Thoufeeq

Workforce
• Is the current figure of 42 staff a continuous number of staff across all six sites?
• If the numbers of sites are reduced would it limit the number of hours consultants spend with patients reduce due to travelling from site to site etc.? This is something that needs taking in to consideration.
• Are consultants overstretched now? Do we need more consultants to cover the amount of work that needs doing?
• What are the workforce plans after 5 years? Has retirement etc. for 10, 15+ years been taken in to consideration?
• Looking at the predicted staffing (of 50) there would easily be enough staff to cover 5 sites.
• Is training nurses up as Endoscopists part of this plan? Will they be able to do the emergency bleeds?
• We need to see the facts and figures for each endoscopy unit (staffing, skillsets, equipment, number of cases etc.) before we can give an informed decision on workforce.
• If the number of units are reduced and you have to go elsewhere for specialist treatment, even if it isn’t your local hospital, is fine as long as you are treated by the right staff and you are moved back to your local hospital to recover.
• The slide pack is misleading as it mentions general medicine which is different to an emergency endoscopy service. (NB: A lot of people questioned whether we were referring to the whole endoscopy service)
• Has anyone spoken to the existing staff to see if any of them would rather do just the night time shift? This may reduce the number of staff you need on rota.
• Is the demand for the service stable or increasing?
• You need to be proactive in managing patients’ conditions and medications so that less people need urgent endoscopies.
• You won’t be able to run 6 sites with 50 consultants, maybe not even 5.
• Who makes the decision about if the patient requires overnight treatment or not?
• The number of staff to cover 5 sites is less than you have now – why?
• Has Rotherham not having a substantive gastroenterologist post had an effect on the population of Rotherham?
• A lot of people are wrongly referred to gastro, does this have an impact on consultant figures?
• The important thing for the patient is to have quick diagnosis and treatment by a specialist whether that’s on 2, 3 or 6 sites.

Affordability
• Are costs per annum?
• Are these local or national costs?
• Would you have a reduced staffing cost?
• Has a time element been included in the costing?
• Will spend on new equipment deter money from other areas or specialties?
• Why does it cost more for less sites? Where are the savings?
• The affordability needs to be shared – will each trust have to build it in to their budget? It’s difficult for lay people to understand who is going to be paying for it.
• Are these all capital costs?
• What is the service costing at the moment? We don’t have anything to compare it to.
• What is the most affordable and manageable option?

Access/Transport
• It will put a lot of pressure on the ambulance service
• It’s not going to be fair because some people will have to travel further for an emergency endoscopy
• Things like shuttle busses should be put in place for visitors to get to visit their families
• Existing shuttle busses (like a Sheffield) should be extended across SYB and run during visiting hours
• Travel times and public transport options need to be fully researched before a decision is made.
• Could visiting times change to make it easier to get there etc.?
• Rush hour traffic can affect travel times so this needs to be taken in to consideration
• It’s not only the time getting there, it’s the time it takes to park as even where there is a park and ride (Doncaster) it is far away so adds time on.
• Are we certain that the ambulance service will be able to cope with fewer sites? They are struggling with capacity as it is.

Safety
• If the numbers of sites were reduced would it be detrimental to the patients’ health for them to travel further for urgent endoscopy?
• Do all the sites currently have ‘gold standard’, 24/7 service for urgent endoscopy or is it just Sheffield that has it? If you reduce sites will it be sites that don’t currently offer a night time service?
• How often do you see emergency bleeds?
• Does the GI work stream flow with the emergency care work stream?
• Do patients have a choice which hospital they go to in an emergency situation? For example, if a patient needs an emergency endoscopy but they don’t want to go to the hospital where the specialist/equipment is will they be forced to go?
Interdependencies

- Is Chesterfield Royal Hospital included in the number of sites being taken in to consideration?
- It will require a lot of co-ordination to get transport right
- Options have to be co-ordinated, it needs a co-ordinator that liaises between private and NHS transport services.
- What about the conditions that bowel screening picks up? Do these present at Gastro via GP referrals?
- Is it likely to be the same sites for each speciality? If so what are the impacts on the hospitals that take on more or lose services?

General Comments

- It's important to take in the population size of each area when making decisions on which areas to close or merge.
- It is a huge decision based on only a 5 year plan.
- Do demographics affect the prevalence of GI bleeds?
- There isn't enough time to go through everything in the group sessions (regarding group activity)
- There isn't enough info on each service
- Mental health should be included in the Hospital Service Reviews
- Will there be a consultation on accountable care systems?

Vision for care of the Acutely Unwell Child Dr Nicola Jay

Workforce

- Retention of children’s nurses/consultants. Training of paediatric nurses need enough places to free up middle weight doctors.
- Group discussed harvesting potential and removing barriers not pigeon holing people. Moving resources around. Challenge the norm in this review looking at now and in the future to ensure sustainability
- Recruitment: Is workforce an issue for the private sector
- If there were reduced numbers of staff needed would we still have staff retention/staffing issues?
- Discussed that during the night there are minimal children admitted. There is an aim to have more wrap around care e.g. nurses going into the home to do follow ups/checks and offer support after initial 4-6 hour observations
- Using the workforce differently – need closest cooperation from CCG
- More paediatricians needed in primary care – to keep them out of A&E. The same applies for adult services
- Discussion about sustainable staffing and thinking 15/20 years ahead
- If we have 6 sites now then what is happening? How are they staffed?
- A discussion about how they could make DBH more attractive/provide passport.

Affordability

- We also need more funding put into the community so children and young people are ensured a GP appointment
• The group said it was important that children and young people go for the best care/treatment
• Do our costs decrease but other partners’ increases?

Access
• How will sites be decided?
• A man and lady had moved to Sheffield from the South many years ago but they stated that we were very lucky in this region to have so many ‘specialist’ services and the closeness we have to these experts should be acknowledged. They argued that even if this was reduced to 3-6 in a radius this would still be very good compared to many areas in the country.
• Accommodation for family/adults must be taken into consideration (Nicola did clarify that bed/chair at the side of the bed is made available for parent)
• Poverty: affording the cost of public transport for families without a car
• What are families with other children supposed to do if they have to travel out of town?
• We want our services where they are. Car parking, poverty and austerity are all issues for many local families who couldn’t afford this expense.
• Many still thought we were in a better position than some and you almost expect to go to Sheffield for some specialist care/diagnostics. They also went on to discuss that having listened to presentations that it wasn’t feasible to have specialists in every area but it is necessary to take appropriate action in terms of transport/logistics for families.
• Do mid yorks have less travel time than across SYB?

Safety
• A discussion that people won’t know where to go/what to do if there child is unwell at night (and if you knew what do you’d be a Doctor) so needs clear communication/education so people understand the system. You go local and then you are triaged. Also needs clear guidelines about transfer.
• Logical to have less services (looking at the model) but assurances needed for when something goes wrong and avoid unintended consequences.
• Discussion about what would happen out of hours.
• It’s all well until it’s your child who is ill in the middle of the night

Interdependencies
• A conversation about appropriate visits. What groups are going to A&E before their GP? More empowerment of patients/education and continuity of care. More around ‘choose well’/PH/Appropriate use of services. Need to consider all the different groups. Have we undertaken an audit of out of hours visits? Is this weekend/seasonal - assured this data will be used.
• Communication/Information will be required to support the implementation of any changes. Must also communicate that this means your child will receive better care.
• Who is going to coordinate the services – so many different bodies involved in this work
• Wanted to know that all partners have been involved e.g. social care and YAS?
• Ensure wrap around care is in place as this won’t work in isolation

General Comments
• This is an emotive argument
• This is a social issue and impacts on perceived disadvantage
• Would be useful to see the communications work undertaken by mid-yorks – have any reports/data about the changes they have made been published?
• Have you looked into how Pontefract are doing it
• Discussed the surgical care for children consultation is on pause until this work is finalised.
• Quality – queried what the outcomes for mid Yorks are?
• The group said that of all the topics this was the most straightforward – it’s just the logistics to sort and we can’t disadvantage one community over another.
• The group felt they hadn’t had enough time or information
• Is this about being reactive rather than pro-active?
• Challenges with quality in south Yorkshire – admitted for same condition but stay for different lengths of time/sending home after 6-8 hours/observations
• Children’s mental health is also a significant issue and this could make a potentially vulnerable child suffered increased anxiety. Ongoing issues with CAMHS and children are often assessed by Adults team.
EVENT EVALUATION

What did you enjoy most about the event?

- Being able to network with people from other areas
- Comparing notes with other attendees
- The variety of information
- Being able to talk to and ask questions of relevant experts
- Clear accessible discussion suitable for lay people to understand
- Opportunities for meaningful group discussions regarding the possible options
- God clear input from speakers
- Ability to participate being involved
- Well organised and professional
- Lunch and group work
- The afternoon where we discussed each service in more detail in smaller groups
- Informal style
- The initial introductions to the event
- The information to take back to practice to improve Services
- it seemed to be repeating the information from the August and December meetings
- I was able to take part more than previous meetings because I now have more knowledge of the subject
- The variety of questions from attendees was good but responses along government lines less so

What could we do to improve future events?

- Allow more time for discussion perhaps fewer workshops – format was very repetitive
- Paper agenda so I can let PPG know what transpired
- I would like you to change the time so the public can get to these events. 9.30 seemed too early
- Stop repeating what has been covered at previous events and start to actually provide answers on how the issues we raise will be solved
- More time for questions it felt a little rushed
- More roving microphones so that questions from the floor can be heard by all
- Tabled questions which we can have more time to answer
- Longer events
- Make sure the lift is working
- Lacked representation of people form minority groups – need to see a wider demographic
- Pre-reading was repeated should have had more time to think about the proposals
- Ensure speakers have some instruction in how they should speak publicly and affectively
- Less jargon
- More interactive activities
- Need more data and information for each service required and more evidence of what happens now and how things may change in the future
- Better chairing of early session we were out of time and many of the questions were covered later
- Decaffeinated coffee please and biscuits
- Publicise the event more
- Need more comfort breaks
• Provide more information to be discussed so everyone is up to speed and comes prepared with their questions

Additional comments or suggestions:

• He lift wasn’t working on arrival which created an issue for those with mobility problems
• Not inspired to believe that the government will or need to take any notice of the recommendations when published
• Have social care ambulance, community so we can see there is engagement across the ICS
• Enjoyed the breakout sessions as everyone had a chance to air their views
• This was much better than the first event
• More data and statistics for the ‘big’ five.
• Present a service users perspective
• Approach other patient/community groups need to create better links
• Wish I had been involved earlier. This is the best session I have attended. Interesting and very different to other events
• Need to align programmes of work for example integrated urgent care work in Sheffield and UEC hospital service
• A very good central venue
• Group work could have been longer twenty minutes didn’t give enough time
• I hope that we shall be able to identify some effective result for the information gleaned from us today., even if things can’t be done we would need to hear why not
• Handout information was good but too similar more specific information relating to the services would have been good.
• Choices could have been reduced to pairs as an exercise to make it easier to give responses
• Better catering some of the flasks weren’t full during the mid-morning break
• If the work streams split I would like to be involved more closely in both EMU and Stroke
• Thank you for the event I could see that some progress has been made
• Ensure adequate contrast in presentations please don’t use white text on a light blue background
• The NHS doesn’t seem to be concerned about cash but about recruitment and time
• The programme illustrated a wish list but didn’t cover enough on the significant problems such as long waiting times
• Terminology is very important so choose how you phrase and explain what you are proposing Consultation and engagement are two very different things
• Stop cuts and closures to our hospital services
• Narrow focus questions restricted the scope for discussion
•
APPENDIX 4 – SOCIAL MEDIA COVERAGE

Social media is an effective way of communicating and engaging with a variety of audiences to:

- Disseminate information and signpost
- Raise awareness
- Collect demographic data
- Demonstrate willingness to engage in dialogue with a target audience
- Speak to a large number and variety of audiences in real-time

We therefore ‘live-tweeted’ the event via our @SYBhealthcare account and saw:

3,387 Impressions (how many people’s timelines we reached)
181 Engagements (link clicks, picture clicks, likes, retweets)
16 Retweets
25 Likes

Full Twitter coverage from the event can be seen at the following Storify page:
https://storify.com/SYBhealthcare/public-event-8-march-2018

APPENDIX 5 – ATTENDANCE

Publicising and Promoting the Event
Promotion of the event began in January and a series of materials and resources to support this were developed through the communications team. This included narrative, posters and web design. The event details were regularly circulated through each trust, CCG, Healthwatch and those voluntary and community groups where links have been developed including South Yorkshire Community Foundation and South Yorkshire Housing Association. Repeated targeted marketing was undertaken throughout the intervening months.

**Demographic Information**

The event had:

- 60 people attended (this does not include the presenters or organisational staff of which a further 15 people were involved)
- A significant number of people cancelled on the day this was largely due to the snow which particularly impacted on those travelling from Bassetlaw and Barnsley from where the highest number of people rang or emailed to say they were unable to attend due to the weather or didn’t ‘show on the day.

Attendees included representatives from acute providers, patients and service users, members of the public, consultants, nurses, Healthwatch and managers.

Each place (Barnsley, Bassetlaw, Doncaster, Rotherham and Sheffield and Chesterfield) was represented.

Attendees were invited through approaches to Healthwatch, Engagement Place Leads, Voluntary and Community Sector, Trusts and other network contacts.

Of those who attended, 8 delegates did not supply which of the ‘places’ they were from while some gave the organisation (‘NHS’ or ‘Healthwatch’) rather than the place. This means we cannot provide an accurate coverage of the representation breakdown of those who did identify where they came from was as follows:

<table>
<thead>
<tr>
<th>Place</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sheffield</td>
<td>11</td>
</tr>
<tr>
<td>Doncaster</td>
<td>15</td>
</tr>
<tr>
<td>Bassetlaw</td>
<td>2</td>
</tr>
<tr>
<td>Barnsley</td>
<td>6</td>
</tr>
<tr>
<td>Rotherham</td>
<td>3</td>
</tr>
<tr>
<td>Chesterfield</td>
<td>7</td>
</tr>
<tr>
<td>NHS staff</td>
<td>6</td>
</tr>
<tr>
<td>Healthwatch</td>
<td>2</td>
</tr>
</tbody>
</table>