

Review South Yorkshire, Bassetlaw and North Derbyshire

Feedback form

General comments

Chesterfield PPG Network Group – 11 people representing 10 GP Practices

Members had already been circulated with the slides from a recent presentation recently provided by Sheffield CCG which AB had attended. AB said that this was an extremely valuable event that succinctly outlined the things that were being looked at in the Review. She said that a follow up event was due to take place at the Source Conference Centre at Meadowhall in March, and would circulate dates to people on the group once she had them.

AB provided a resume of the key points outlined in the presentation that covered the following 5 services and the problems being experienced:

- Poorly children who need hospital care
- Pregnant women and mother and baby
- Stroke Services - **2 people had experience of this within the last 2 years**
- Urgent and Emergency Care Services – **2 people had experience of this within the last 2 years**
- Investigation Stomach and Intestine conditions - **2 people had experience of this within the last 2 years**

A discussion took place regarding views, observations and thoughts on the problems outlined.

Themes

- Reduction in nursing study bursaries will put people off from taking up Nurse training.
- Distance to travel to an alternative hospital. Concerns about being required to travel to another hospital if Chesterfield is not able to receive mothers about to give birth – more people could give birth on their way to hospital.
- Nursing supply, is a fundamental problem. Need to create other nursing roles that contain the skill set required to undertake the task. Not always a degree trained nurse required. Pleased to say that Chesterfield Royal is already working on the Productive Ward initiative putting in other staff roles to undertake tasks.
- Need to accept that sometimes there is going to be a conflict between matching choice with people's rights. People may prefer a local service but it is not always possible to provide services in "every back yard".
- Urgent Care - Need to find the correct balance between services offered from GP

Practices and Emergency Departments in hospital. More to be offered in the community or acknowledge that people are going to make their way to the local hospital if they can't get an appointment and deal with them appropriately there.

- Bring some specialist services into CRH on a day basis.
- Have access to out of hours on call specialists eg gastroenterologists to operate locally.
- Train other people to undertake tasks such as Endoscopy.
- Stroke services – Want to acknowledge the developments in stroke care over the last 10 years and the excellent responsive service that is now available to patients at Chesterfield Royal.

Concerns

People acknowledge the problems outlined. There is a worry about taking procedures/services away will make their local hospital Chesterfield Royal, unviable.

About the session

Please capture as much demographic detail as possible.

What group or meeting was it? Chesterfield PPG Network Group

How many were there? 11 people

Sex, age, ethnicity, disability etc

6 female

5 male

Age: 65+

White British



Hospital Services Review South Yorkshire, Bassetlaw and North Derbyshire

Feedback form Feedback from NDCCG PE Team

General comments

Agenda item at a Meeting of **Dronfield, Eckington and Killamarsh PPG Network** – Quarterly meeting of patient representatives **from 4 GP Practices. 6 people present.**

- Poorly children who need hospital care

- Pregnant women and mother and baby
- Stroke Services
- Urgent and Emergency Care Services - **All had experience of this within last 2 years**
- Investigation Stomach and Intestine conditions

A discussion took place regarding views, observations and thoughts on the problems outlined.

Themes

- Promote the use of pharmacists to take pressure away from visits to A&E
- Access to patient records – Attention needs to be given to the use of IT and systems talking to each other. Derbyshire GP needs to be able to access the hospital record if their patient has visited a hospital outside their county. Different services need to be able to view the patient's record.

Concerns

- Concerns about extra travelling times to a hospital other than Chesterfield eg research saying that if relatives are involved in their family member's care they are more likely to make a better recovery sooner. Make sure that as soon as the urgent care is dealt with patient is transferred back to their own hospital.
- Families not familiar with travelling to out of region hospitals. Public need to know where their relative might be sent so that they knew where to go to find them.

About the session

Please capture as much demographic detail as possible.

What group or meeting was it? **Dronfield, Eckington and Killamarsh PPG Network Group**

How many were there? **6 people**

Sex, age, ethnicity, disability etc

2 male and 4 female

White British

Age range – 30-40 **1** 40-50 **1** 50-60 **1** 60-70 **3**



Hospital Services Review South Yorkshire, Bassetlaw and North Derbyshire

Feedback form Feedback from NDCCG PE Team

General comments

Agenda item at a Meeting of **Dales PPG Network** – Quarterly meeting of patient representatives from **9 GP Practices. 6 people present.**

- Poorly children who need hospital care

- Pregnant women and mother and baby
- Stroke Services
- Urgent and Emergency Care Services - **All had experience of this within last 2 years**
- Investigation Stomach and Intestine conditions – **1 person**

A discussion took place regarding views, observations and thoughts on the problems outlined.

Themes

A&E – Could stop people attending by campaigns on use of pharmacies and using gps more and 111.

Staffing – is at the heart of all 5 issues. Concentrate on how we can better recruit to posts. Eg if young people not accepted to medicine signpost them to some other health/social care qualification. Hold onto that caring quality that made them look to medicine. If people who want to be a nurse are rejected then signpost them to a lower level of nursing and caring. Need to get people to see caring as a career and promoting that – not just about being a high level nurse or practitioner. **Use a “Cool to Care” slogan.**

Widen the promotion of caring – having positive stories about being a carer – a campaign about being surrounded by passionate caring staff.

Try to entice people to stay within the caring profession and not just linked to medicine or nursing.

Concerns

About the session

Please capture as much demographic detail as possible.

What group or meeting was it? **Dales PPG Network Group**

How many were there? **people**

Sex, age, ethnicity, disability etc

6 – Over 65 Male 4 Female 2

White British



Hospital Services Review South Yorkshire, Bassetlaw and North Derbyshire

Feedback form from NDCCG PE Team

General comments

This was placed as Agenda item at the January **NDCCG Patient Reference Group** – A key group that acts as critical friend to the CCG. Unfortunately due to bad weather the meeting was cancelled and members were asked to provide their comments using email for collation

and feedback.

The group consists of 18 patient members from across North Derbyshire and Hardwick and they had already been circulated with the slides from a presentation recently provided by Sheffield CCG which Amanda Brikmanis, Patient Experience and Engagement Manager (NDCCG) had attended, as well as a copy of AB's notes of key points made at the meeting. From this information 6 people provided comments as outlined below.

Themes

Lay Rep 1

There can be no argument against the principles of better use of staff and resources to achieve better outcomes for patients in a given catchment area. Within the document the case is well made. The general public (or rather that minority who will show any interest) don't want to be consulted on principles, they really need some firmed up (but NOT finalised) proposals to consider.

Lay Rep 2

1) Regarding staffing, we have a severe shortage of specialised medical and nursing staff, and any scheme to retain, recruit and bring qualified staff back into practice is to be welcomed. There are some examples of these from other places that seem good eg midwives in Australia. S Yorkshire (and N Derbyshire) need to be seen as attractive places to work, and staff are often concerned with conditions of work, feeling valued etc as much as actual pay. It's a great place to live - are we emphasising that to prospective staff??

2) Regarding public information, it is essential when any changes are being made, especially to acute services, that the public are informed about the changes ahead of time, and reasons explained. People (and the media) often get hold of planned hospital closures, for example, and start a protest campaign before they have understood what alternative provision is being made and why the alternative is much better (ie not just to save money, although it might also do that). IT/comms staff need to engage with the media proactively, not just firefight when news breaks

Urgent care - I would support rationalisation of A&E departments so that not all are open 24 hours, as long as public are adequately informed and travel times are not too great. As a Chesterfield resident, for example, I can get to hospitals in central Sheffield in 30 mins, whereas Chesterfield RI takes 15 minutes. The difference is not so great except in real life-threatening situations, when an ambulance would probably be called anyway and care can be given on the journey. Social care needs much more funding and integration into health services, so that A&E departments are not blocked because of lack of beds in the hospital. This is a national problem, but some health areas such as Greater Manchester and North East England seem to be improving integration by better overall management. The example from Cambridge and Peterborough about keeping mental health patients away from A&E seems excellent - urgent mental health services need to be prioritised, but a busy A&E department is NOT the best place for an acutely ill mental health patient.

I would also suggest A&E overcrowding would be eased by a network of Walk-In Centres/GP units that are available out of hours and available for urgent appointments

Stroke - I would agree with promoting larger, specialist units for acute stroke care (even though they may be further to travel), followed by supported rehabilitation close to or in the patient's own home, Services need to be standardised across the region.

Gastroenterology and endoscopy - nothing to add. I would support training of nurses/technicians to do routine endoscopy

Maternity services - choice for women is very important, so that they can give birth in the way they choose subject to medical constraints. My daughter, for example, was a low risk pregnancy but chose to give birth in hospital rather than a midwife-led unit because the latter would have meant a much longer drive during labour. But generally midwife-led units are a good idea provided there are enough midwives, and special care facilities are available nearby for babies born with any problems. Are we encouraging home births where appropriate?

Training/recruiting/attracting back more midwives (as in 1) above) seems essential

Care of the acutely ill child - I agree children's services have changed a lot while hospital provision hasn't. I would support putting all acute/intensive children's beds on one specialist site (ie Sheffield) but having a network of paediatric assessment units in strategic places in the community staffed by trained GPs and nurses, providing assessment, short-stay care and specialist advice. Again, public information as to where to turn with a sick child is essential.

Lay Rep 3

Running through this is the usual narrative; excess demand, capacity constraints and staff shortage.

I would like to suggest yet again that the hospital(s) consider entering into a partnership with a care supplier (not an existing one but preferably a budget hotel chain) to design, build and run a nursing home next to the hospital which is efficient, affordable and comfortable with the nursing care supplied by the hospital on a bespoke basis. Every patient in acute care can be discharged immediately their condition is stabilized, in default of an immediate discharge home, to a facility entirely financed, apart from the nursing care, by the Local authority. The patient, their relatives and social services can then decide at their leisure and at their own expense whether they can survive at home or remain in a pleasant, safe and affordable facility.

If you were to do this then a huge amount of money, hospital beds and staff can be freed up. But you have to start thinking out of the box!

Lay Rep 4

Although I have not needed to use the SY hospital services I appreciate that many patients in our area are dependent upon them. All public services have found that they have to deliver more with less and the NHS is no exception this. The problem for the NHS it is literally delivering a life and death service.

I am in favour of finding better ways working in urgent care and I could go on about making better use of paramedic practitioners in the community.

I do not disagree with any of the examples given but until there is a more integrated care system between NHS and social care services I see these proposals sadly as a 'sticking plaster' on the problem.

Lay Rep 5

Mental Health - like the Cambridge model Avoid hospital admission - particularly Walton

Stroke - understand the rationale BUT to local beds asap Like Hyper Acute Units BUT not all staff will want outreach work so needs to be carefully managed to avoid high staff turnover

Endoscopy - why the increase in volumes Not a procedure without risk so should not be a first resort. Do schemes like bowel screening err on the side of referrals Is there a perverse incentive to refer? It does sound sensible to look at rationalise BUT care will be necessary about locations and patient experience.

Like the idea of mixed skill teams BUT nurses are also in short supply A new brand of technician perhaps?

Screening - similar comments re perverse incentives - separate funding sources and specialisms (work shall expand to fill the time available).

Like the idea of Midwifery refreshers must be user friendly locations and not involve cost to the individuals

Don't we already have a paediatric specialist unit to support GPs etc in Chesterfield - like the W Yorks model?

Like the idea of the default position being 24 hour care and then discharge.

Lay Rep 6

1. Whatever the discipline the problems are similar – increasing demand, too few trained staff and a patchwork of provision across the piece. Instead of getting together and planning for a whole area, health service facilities have invested in provision for which they feel they will attract sufficient takers to 'make a profit'.

Shortage of trained staff and a general shortage of resources have simply served to highlight the shortcomings inherent in this way of going on. Today the pressures and the staff shortages are such that there has to be central planning and hospital and other health resources involved have to provide what is asked of them – no more and no less.

Interesting, isn't it, that austerity is highlighting two basic issues that have dogged the Health Service since its inception:

a. We don't have one single NHS. What we have is a collection of service providers (who want funding to provide what they want to provide) and an arm of government that makes money available for its bureaucracy to purchase services, attempting in the process to do so in a sensible way which is rarely possible if for no other reason than that the purchasers (be they CCGs or whatever) rarely cover sufficiently large areas. Do you provide for localities, regions – or the country? Frankly, we have reached the point at which, guided to some extent by the data localities provide, in large part the provision of different services has to be designed top-down.

b. Decentralisation or centralisation..... People want to be treated at home or as near to home as is feasible; they also want the best possible treatment. They cannot have both. In most instances, especially nowadays when the average hospital stay should be short and the strain on visitors reduced to fewer days than in the past, all disciplines should have places to which patients go and at which they are treated that do not cease at 8.0 or 10 p.m. and that have the full gamut of specialists able to deal with their morbidity whatever turn it takes.

This pattern, concentrating provision for individual disciplines rather than allowing that provision to continue as it has grown up with its separate elements dotted, scatter gun, across the piece will be easier for everyone in urban areas; to ensure equality there needs to be a revolution in the way NHS transport is provided and thought of with subsidies for patients and visitors to use taxis to reach treatment centres otherwise several hours away. This has significant consequences for the Ambulance Service of the future.

2. At present GPs send 'their' patients to hospital. The hospital makes its input and returns 'the' (or is he now 'their'?) patient to the community with a covering letter to the GP and in the expectation that there will be an adequate and an adequately staffed service of care in the community. It doesn't work. Those patients are still receiving follow-up care for the morbidity which was the cause of their initial referral and the hospital hasn't yet completed its job. It needs the daily feedback from field staff so that it can respond and make sure that the treatment available near to home really is good enough. The hospital should be running the teams of community workers.

From personal experience (heart failure nurses) I can tell you that training nurses up to deal with certain limited condition has its value but these nurses require a lot of support and very wide training if they are to fulfil their limited function.

3. Final thought – and it has a bearing on the centralised planning and purchase of provision that I believe necessary..... we have to be boundary blind. No county, district, hospital or any other boundaries can be allowed to figure on the map NHS (England) planners use to draw up their plan of health provision.

Concerns

About the session

Please capture as much demographic detail as possible.

What group or meeting was it? Patient Reference Group

How many were there? 18

Sex, age, ethnicity, disability etc

Female 11

male 7

Age: 30-40 **1** 65+ **17**