Humber Acute Services Programme

Pre-Consultation Business Case

3 July 2023 (v3.1)

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Version Control

Version	Date	Changes	By whom	Where
v0.5	17/12/21	Compile draft chapters into complete master document *(pre-evaluation)*	LC/CH	
v0.6	18/03/22	Integrate feedback on v0.5	LC	All chapters
v0.7	08/07/22	Revise planned care chapter	LC	Chapter 6
		Integrate further feedback		All chapters
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		Addition of chapter outlining proposals		Chapter 4
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		Update performance metrics	LC/BN	Chapters 2, 5, 6 and 7
		Update modelling outputs (following review and sense-check of data)	LC	Appendices
		Update evaluation section to reflect latest position	LC	Appendices
		Update engagement timeline to include additional work undertaken	LC	Appendices
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		Finalisation of evaluation outcomes (inclusion of financial analysis)	LC	Appendices and Exec summary
		Amendments to summary of proposals following outcomes of financial analysis	LC	Chapter 4
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		Update key performance metrics	LC/BN	Chapters 2, 5 and 6
		Update engagement timeline to include additional work undertaken	LC	Appendices
V3.0	30/06/23	Changes to consultation scope – to include UEC and Paeds proposals only	LC	Throughout
		Financial, workforce and activity analysis updated to reflect scope of proposals	LC	Chapters 4, 5 and 6
V3.1	03/07/23	Modelling outputs updated to reflect refreshed scope	LC	Appendices

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Executive Summary

The Humber Acute Services programme commenced in 2018 to address challenges faced by Northern Lincolnshire and Goole NHS Foundation Trust (NLaG) and Hull University Teaching Hospitals NHS Trust (HUTH) and design hospital services that will be fit for the future.

This Pre-Consultation Business Case (PCBC) sets out proposals to provide urgent and emergency care and paediatric hospital services differently across Northern Lincolnshire's main hospitals – Scunthorpe General Hospital (SGH) and Diana Princess of Wales Hospital, Grimsby (DPoW). These proposed changes will be supported by improvements across the Humber that will enable us to provide more care outside of hospitals, in a more joined-up way.

The proposals have been designed to ensure that high quality hospital care can continue to be provided across the Humber now and in the future. They have been:

- developed following extensive engagement with over 12,000 people over the past two years.
- identified following a comprehensive evaluation exercise which has focussed on clinical standards, quality and safety, travel and access, equalities, workforce and financial affordability.

The approach that has been taken over the past two years has been subject to:

- ongoing assurance reviews by NHSE England
- reviews by the ICB Executive Team and Board
- regular overview and Scrutiny Committee reviews
- two Clinical Senate Reviews of the proposed models of care
- an external assurance review by the Consultation Institute of the approach taken to Pre-Consultation engagement.

The external assurance reviews have highlighted:

- **The Clinical Senate** concluded that the current models of care are not sustainable and that the proposed models provide an improvement. The Clinical Senate has provided its highest level of assurance "Reasonable" on the key areas it reviewed.
- **The Consultation Institute** have highlighted an exemplary approach to pre–Consultation Engagement and have not highlighted any significant areas of concern.

Why services need to change

Our two hospital trusts – Northern Lincolnshire and Goole NHS Foundation Trust (NLaG) and Hull University Teaching Hospitals NHS Trust (HUTH) – spend in excess of £1.3bn and employ more than 16,000 people.

On a daily basis:

- 775 people attend our emergency departments.
- 235 people are admitted, as an emergency, to our inpatient wards.
- 377 operations are performed.
- 3,000 outpatient consultations take place.
- 24 babies are born.

As a collective of hospitals working better, together, we can provide improved services and care for all. But to do so, **things need to change.**

We face a number of challenges, including:

- **Rising Demand for Urgent and Emergency Care**
  - Our emergency departments continue to experience significant demand and **we do not deliver national standards** on waiting times or ambulance handovers.
  - The needs of our population are changing, and our models of care are outdated. High levels of deprivation and an ageing population mean that more people are living with one or more long-term condition, contributing to an increase in demand care that needs to be met in a different way.

Last month (May 2023), **only two thirds of patients were seen and treated within 4 hours** in our Emergency Departments (68.3% in NLaG, 62.2% in HUTH) and more than **40 people a day waited for over 12 hours** (854 in NLaG and 386 in HUTH).

- **Delivering Clinical Standards**
  - **Our staff are spread too thinly** across hospital sites, with relatively small services provided from a number of different hospitals; this means that we are not always able to meet clinical standards set nationally.
  - We are **duplicating 24/7 on-call teams** across sites for small volumes of patients and we are unable to provide 7-day consultant reviews, meaning our patients spend longer in hospital to get the same care and treatment than in many other parts of the country. This impacts on ability to manage patient flow and has significant impacts upon our emergency department performance.
  - Many of the patients treated overnight could be seen and treated in a Day case Emergency surgery setting as effectively.

The number of emergency operations undertaken overnight at Grimsby (172/year) and Scunthorpe (196/year) combined equates to around **one patient per night** yet both have fully-staffed 24/7 on-call rotas for overnight surgery.

- **Workforce, Agency and Locum Costs**
  - **We have difficulties recruiting and retaining enough staff with the right skills and expertise** and there are **significant vacancy challenges** in key services. Staffing challenges are not spread evenly between services with some staff groups and teams experiencing much higher vacancy rates (e.g. vacancy rates for Emergency Department specialty doctors in NLaG were 33% in 2022/23, vacancy rates for healthcare assistants in family services departments ranged between 4% and 25%).
  - As a result of our structural challenges we often struggle to recruit specialist skilled staff across multiple disciplines. Many of these skills are in short supply nationally and roles in our hospitals can be seen as less attractive due to low numbers of patients and the consequent lack of opportunity provided for research, education and training.
  - The impact of our vacancy position impacts significantly on our financial performance.
  - The use of agency and locum staff not only impacts on our financial sustainability but also impacts on patient and staff experience as there is limited continuity of care where agency staff are used.

Last year (2022/23) HUTH and NLaG **spent over £55 million on temporary staffing** (agency and locum) and a further £45 million on bank staff, covering gaps in rotas and ensuring services continue to be delivered safely.

- **Ageing estate**
  - Our estate is ageing. Our accommodation does not meet modern clinical standards, a number of our theatres, ward areas have had to be closed. Across both HUTH and NLaG we have a backlog maintenance issue in excess of £200m.
  - Within Scunthorpe Hospital we have in excess of a £69m critical infrastructure risk which means we cannot make any changes to clinical models of care without significant external capital investment
  - This impacts upon our ability to treat patients effectively and also on our ability to recruit and retain staff.

The challenges we face are significant.

The Clinical Senate have identified that our current clinical models are not sustainable and that we need to work differently if we are to continue to meet the acute healthcare needs of our population.

We can improve this situation by working differently, joining up with other parts of the NHS, local councils and other partners, and organising our services in different ways.

Developing the Models of Care

Over the past two years a dedicated team have focussed on developing the potential options for change that could address the challenges faced locally and deliver improved care for patients. The process has been clinically-led, open and transparent throughout. In developing the models of care the team have engaged with over 12,000 people through a mixed approach of workshops, focus groups and speciality one to one discussions. The groups have involved patients, staff and partner organisations.[1]

Over 120 potential options for change were identified in the original Case for Change.[2] These early ideas were carefully considered and, through a comprehensive evaluation approach, were narrowed down to the proposed model of care set out below. The evaluation framework was co-designed through extensive engagement to ensure the models of care were evaluated against the things that matter most to our population and stakeholders.[3]

The evaluation of the potential options for change looked at:

- The potential of different models of care to deliver national standards – with a focus on quality and safety.
- The need to maximise the skills of our existing workforce and the potential of different models of care to support plans to develop new skills and roles and build a resilient local workforce.
- The need to ensure that patients have access to local services for regular and ongoing care.
- The need to make best use of more specialist skills and maximise clinical time available to see and treat patients.
- The need to deliver longer-term more sustainable services which are an improvement on the current models of care.
- The need to deliver financial savings aligned with the need for any future model to be affordable from an internally funded capital pot.

[1] The extensive engagement process undertaken is summarised in chapter 3 and set out in more detail in appendices 10.6 to 10.15.
[2] Humber, Coast and Vale Health and Care Partnership (November 2019) *Humber Acute Services Review Case for Change* Case for Change; see also, *Interim Options Report* (January 2020) – see document library
[3] This process is set out in detail in section 10.4.2

External Assurance and Review

The potential models of care have been through multiple assurance reviews and have been assessed by a number of external and expert bodies including Operational Delivery Networks, Royal Colleges and Peer Reviews and finally by the independent Clinical Senate in March 2023.

The Clinical Senate provided their highest level of assurance (‘reasonable’) in all three areas they considered and supported the proposed model of care:

> *“**The Senate supports the development of an Acute Hospital and Local Emergency Model with consolidation of Trauma on the Acute site.** An Acute Hospital and Local Emergency Hospital affords the opportunity to consolidate specialised skills and expertise on one site.”*

The Clinical Senate concluded:

- ✓ The options for the future models of care have been designed to address the challenges.
- ✓ The proposals have been developed and refined through a robust process including in depth clinical input discussions with Clinical Design Groups, specialty project groups, a citizens panel, focus groups and workshops with elected members, representative groups and other stakeholders.
- ✓ The proposed model affords the opportunity to consolidate specialised skills and expertise on one site.
- ✓ **The proposed models of care are clinically coherent, more sustainable and would provide quality care.**

For Urgent and Emergency Care the Clinical Senate highlighted:

> *“The Senate was reasonably assured that **models of care are clinically coherent, more sustainable and would provide quality care.**” … “It remains concerned about the sustainability of two critical care units from a workforce perspective. Guidance from the Critical Care Network is advised.”*

For Paediatrics the Senate highlighted:

> *“The Senate’s findings on plans for paediatric services provided it with reasonable assurance that **models of care are clinically coherent, more sustainable and would provide quality care**.” …*

The Programme has also undergone multiple Assurance reviews over the past 20 months including monthly NHSE Review Meetings, regular Overview and Scrutiny Committee meetings and an external risk review by the Consultation Institute (tCI) of the Engagement approach undertaken to date. The Consultation Institute review provided assurance that the process undertaken was robust and demonstrated meaningful involvement.

The Consultation Institute risk review concluded:

- ✓ “The HASP team has **delivered an effective pre-consultation engagement exercise**, with significant engagement having taken place over a number of years in preparation for public consultation.”
- ✓ **The pre-consultation business case (PCBC) is robust** and contains a clear summary of the work undertaken to date and there is evidence of influence within this from the public engagement undertaken.

Meeting the key tests for service change

Based upon the work done to date and the assurance received we believe that our approach has enabled us to demonstrate that the Humber and North Yorkshire Integrated Care Board has met its Statutory duties under s242/244/13z2 and 14Q of the NHS Act and follows the relevant NHS Reconfiguration Guidance as set out below.

Four Tests		How we are meeting them	Evidence of approach
☑	**Strong public and patient engagement**	• Extensive engagement of patients, the public, staff and other stakeholders in design of proposals. • Ongoing involvement of public representatives and OSCs.	• c12,000 people engaged in pre-consultation engagement and evaluation. • NHSE/OSC assurance. • Consultation Institute assurance.
☑	**Consistency with current and prospective need for patient choice**	• Extensive clinical and public engagement in design, reflects understanding of communities and impact of any changes on choice. • Detailed population health analysis underpins modelling and engagement.	• CCG/Place/VCSE/Community Rep Group engagement/MVP engagement • Evidence base on engagement substantive if cited in any future challenge for SoS/IRP or JR
☑	**Clear, clinical evidence base**	• Extensive clinical involvement in design and evaluation of proposals. • Models of care reviewed by Clinical and Professional Leaders Group, Clinical Senate, ODN and other independent clinical experts.	• Clinical Senate provided reasonable assurance on evidence base along with options. • Reports and supporting actions from all reviews.
☑	**Support for proposals from clinical commissioners**	• CCG (clinical and managerial) involvement in development and evaluation of proposals • ICB approval required to go to consultation	• Executive Oversight Group and programme governance. • Working Groups/Place Directors/ Place Boards/ICB briefings etc.

What we are proposing to change and what will be the same

Our evaluation and formal external reviews have highlighted a set of proposals – or a preferred option – for the delivery of (hospital-based) urgent and emergency care and paediatric services across Northern Lincolnshire.

The proposed changes would enable us to address critical shortages in workforce, consolidate rotas and improve patient access, waiting times and length of stay, whilst maintaining the majority of services locally.

The proposed changes maximise our recent investment of £58m in our two emergency departments and acute assessment units, whilst also providing an opportunity to consolidate some specialist and inpatient services to improve the quality and safety of services and ensure they are sustainable into the future.

What will be the same?

The proposals recommend that **other services**, including urgent and emergency care for most patients, should continue to be provided as locally as possible and **should remain at both hospitals**.

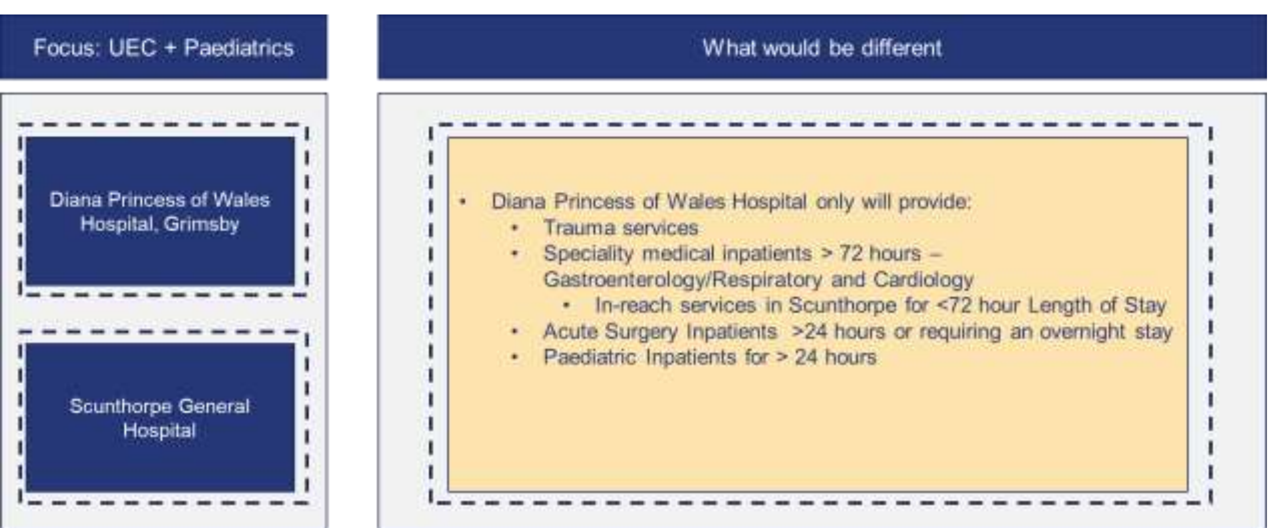
The diagram below highlights what will be the same under our proposals for change.

Services at Hull Royal Infirmary (HRI), Castle Hill Hospital (CHH) and Goole and District Hospital (GDH) would also continue as is.

What will be different?

To improve the quality and safety of services and make sure they are sustainable into the future, the proposals recommend that **some specialist services** at our hospitals in Northern Lincolnshire (Diana Princess of Wales Hospital, Grimsby and Scunthorpe General Hospital) **should be consolidated and in future be delivered from just one site.**

The diagram below provides a summary of the changes that we propose to make:



In evaluating the options we have considered:

- The potential maximum number of patients impacted per day – assuming no other pathway changes
- The travel time impact on patients and staff
- The travel impact on ambulance journeys
- The financial affordability of each option – recognising that we are required to undertake any capital investment from internal resources.

It is important to note that during the evaluation of the Options both scenarios with specialist services being provided at ***either*** Diana Princess of Wales Hospital, Grimsby (DPoW) ***or*** Scunthorpe General Hospital (SGH) were considered.[4]

The "Preferred Option" of providing services at Diana Princess of Wales Hospital Grimsby has been identified because:

- **It is the only option that satisfies the NHSE financial requirement to fund capital investment internally**.
- Based upon the capital affordability analysis, only one of the two site scenarios – where the specialist services are provided at Diana Princess of Wales Hospital, Grimsby (DPoW) – can be delivered within the capital available to the system. The capital cost to deliver this site option is c.£25m, whereas the cost to deliver the site options where services were consolidated at Scunthorpe would cost c.£89m, which cannot be delivered from internal capital resources.[5]

There are some additional advantages to consolidating services at DPoW rather than Scunthorpe, including:

- The travel analysis highlighted that it is closer to more patients from deprived areas, who would otherwise have to travel further, and DPoW provides services for many deprived communities living on the East Lincolnshire coast.
    - Overall, fewer people would be impacted by having to travel to a different hospital site (c.20 per day, compared to c.22 per day if services were consolidated at SGH – based on post code analysis to nearest service).
    - Overall, fewer people would be impacted by longer journeys to hospital (c.10 per day, compared to c.13 per day if services were consolidated at SGH – based on post code to nearest site).
- The ambulance travel and journey time mapping has highlighted that it has the least impact on ambulance services, requiring only ½ of a Dual Crewed Vehicle extra, which could be delivered through productivity/efficiency improvements in the emergency care pathways.

[4] The evaluation process and outcomes are set out in detail in section 10.4.
[5] Details of the financial analysis undertaken are provided in section 10.4.3.4.

A number of potential alternative solutions were also evaluated and discounted, including:

- Creating a new central hospital in Northern Lincolnshire. This idea was considered and discounted due to the impact on patient travel times, the impact on neighbouring providers, the economic impact and the level of capital investment that would be required.
- Providing *all* emergency and unplanned care, maternity, neonatal and paediatric services at one Northern Lincolnshire hospital and all planned care at the other. This idea was discounted due to the significant impacts on patient travel times and the impact on neighbouring providers.
- Consolidating other urgent and emergency care services – specifically, General Medical and Care of the Elderly inpatient care. This was considered and discounted due to the impact of transfers on elderly or frail patients and the potential impact on delayed discharges from hospital.

Pathway changes and services outside of hospital

The proposed changes do not stand alone. The changes proposed will require improvements to be made within a number of community and out of hospital services. We have worked with Place teams and partners to identify out of hospital work programmes that will support implementation, and to identify what needs to be in pace, how it will be resourced and when it can be implemented.

The proposed model of care is underpinned by fundamental **changes to pathways** (in and out of hospital) and supported by a number of **out of hospital enabling changes** that would be put in place across the Humber to maximise the benefits of the proposed changes and help as many people as possible to avoid going to hospital if they don't need to.

These changes include:

- **Clinical assessment closer to home** to reduce conveyance rates to hospital and help more people to access the right service, first time.
- **Co-located urgent care service (UCS)** within the Emergency Department (ED). To treat people with more minor injuries and illnesses more quickly and reduce pressure on the ED.
- **Integrated acute assessment** model and same day emergency care (SDEC) to improve flow within the hospital and reduce overall levels of acute inpatient admissions.
- **Integrated frailty services** across all localities in the Humber to provide more proactive support for people who are frail and help them to stay well and avoid injuries (e.g. falls).
- **Virtual wards, Hospital at Home** and other innovative approaches that will bring more care that is currently provided within our hospitals to peoples' own homes.
- **New staffing models** across a range of services, including the development of new roles to provide long-term sustainable solutions to our workforce challenges.
- **Improved use of digital** to support remote monitoring, provide more responsive services (e.g. patient initiated follow-up) and reduce the overall need for patients to travel to hospital.

Summary of benefits and impacts

The proposed models of care have been assessed by the Clinical Senate, who have confirmed they will **provide better, more sustainable services for our population**. The models of care have also been subject to a rigorous travel and transport mapping exercise aligned to a comprehensive Integrated Impact Assessment.[6]

Proposal	Change	Benefit
The proposed configuration for urgent and emergency care and paediatric services, would: ✓ retain 24/7 Emergency Departments in their current three locations (Hull, Grimsby and Scunthorpe). ✓ deliver a range of benefits – improving quality and sustainability of services. ✓ maximise the benefits gained from the recent £58m investment in our Emergency Departments.	**Co-located Urgent Care Services** would be developed within the Emergency Departments to enable patients with minor illnesses or injuries to be streamed away from ED and treated appropriately within and Urgent Care pathway.	Over 300 people a day who attend our Emergency Departments would be **seen and treated more quickly** within an integrated Urgent Care Service across our hospital sites.
	Trauma services for Northern Lincolnshire patients would be provided at Diana Princess of Wales Hospital, Grimsby (DPoW), with Hull Royal Infirmary (HRI) remaining as the regional Major Trauma Centre (MTC). Patients would be taken by ambulance directly to DPoW or HRI Hospital based on their clinical needs. Patients who self-present to Scunthorpe General Hospital and require trauma services would be transferred to DPoW.	The centralisation of trauma services would **provide access to more specialty skills on the Acute hospital site 24/7** and allow for more rapid patient intervention potentially reducing length of stay and improving the experience for patients. It is estimated this change may impact **up to 2 patients per day,** which could be mitigated though improved ambulance transfer protocol and advice and guidance for crews prior to conveyance.
	Speciality inpatient services (*Gastroenterology, Cardiology and Respiratory*) for Northern Lincolnshire patients who require admission post-72 hours or require a higher level of specialist clinical input would be provided at Diana Princess of Wales Hospital, Grimsby (DPoW).	We would be able to provide **specialist dedicated 7-day per week care** for gastroenterology, cardiology and respiratory medicine improving the quality of patient experience, reducing our lengths of stay and supporting patients to go home more quickly. It is estimated that the number of patients requiring transfer for specialist care would be **up to 3 per day**. This could be mitigated and potentially reduced as many patients could be cared for via a General Medical

[6] Detailed outputs are provided in appendices 10.16 to **Error! Reference source not found.** and contained within the document library.

		Physician or Geriatrician on site with specialist in-reach.
	Emergency surgery would be provided across all sites, but on a day case basis at Scunthorpe General Hospital. Northern Lincolnshire Patients requiring out of hours surgery or an acute surgical admission for >24 hours would be treated at Diana Princess of Wales Hospital, Grimsby (DPoW).	The consolidation of emergency surgery with 24/7 teams including surgeons, theatre teams, nursing staff on the Acute site will **reduce out of hours on-call and support future sustainability of workforce**. This could impact **up to 6 patients per day**. A proportion of these patients could be seen and treated on a day case basis (e.g., fractured hip pathway) and therefore the daily impact should be less as surgical pathways and protocols change in line with the model of care.
	Paediatric inpatient care would be provided at Diana Princess of Wales Hospital, Grimsby (DPoW) for Northern Lincolnshire patients. Children and young people could continue to attend their local hospital Emergency Department as required and be treated in the Paediatric Assessment Unit. Children in Scunthorpe who require admission post-24 hours would be transferred to DPoW for ongoing care supported by a dedicated team to ensure safe transfers.	The consolidation of Paediatric inpatient services would improve training and development opportunities and **support the future sustainability of the workforce**. We estimate that this may impact on **up to 2 patients per day.** This could be reduced as the Hospital at Home model of care for paediatric cases becomes embedded. Hospital at Home has been seen in its pilot form to reduce the need for admission and support earlier discharge, reducing length of stay.

Table 1.1 Summary of changes, benefits and impacts

The proposals for change will improve the quality of care, by enabling services to deliver against more of the nationally set clinical standards, reduce reliance on expensive agency and locum staff and ensure services will be more sustainable in the long term. The proposed changes will support us to deliver more services outside of hospitals – in GP surgeries, new facilities such as Community Diagnostic Centres, and in peoples' own homes – in a more joined-up way so that fewer people will have to travel to hospital in the future and their care they receive will be better suited to their needs.

As a result of the proposed changes some patients would need to be transferred to a different hospital to receive more specialist care, either directly by ambulance or by dedicated inter-hospital transport services. A transport action plan has been developed to support timely transfers of patients between

hospital sites, support people to return home after a stay in hospital and to consider ways to ensure relatives, carers and friends can continue to visit and support their loved ones when they are in hospital.

Conclusion and Next Steps

The proposed changes will deliver significant benefit across our health and care system.

Our current models of care are not sustainable. We do not deliver national/constitutional performance standards, we have significant vacancies and struggle to recruit specialist skilled staff, our agency and locum use is significant as a result and we operate from an ever-deteriorating estate. This impacts on our ability to recruit and retain as well as our ability to deliver high quality services to the standards we would like.

We cannot stand still we must make urgent change. The Clinical Senate agree that our services are unsustainable in their current form. We must take urgent action to address our short falls recognising that any change we make has the potential to have an impact on the population we serve and our staff.

Making changes to consolidate some specialist aspects of care will enable us to meet the required clinical standards (e.g. 7-day services), diagnose and treat patients more quickly, improve training and development opportunities for our staff and ensure our services are sustainable in the longer term.

Through improved pathways of care and joint working across the system, we would be able to see and treat patients more quickly and would expect to see 5 fewer patients each day needing to be admitted on an emergency basis at our hospitals (8% reduction).

When taken together across the whole workforce, the proposed model of care would require the equivalent of around 200 (WTE) fewer members of staff than our current position, helping to significantly address the vacancy challenges across our hospitals and make better use of the valuable and highly skilled workforce we do have. The proposed new model of care would also enable us to provide better training and development opportunities and make future roles more attractive helping to secure the workforce we need for the future.

This Pre-Consultation Business Case (PCBC) proposes undertaking statutory public consultation with the public, patients and other stakeholders concerning potential changes to the configuration of urgent and emergency care services (incorporating the assessment, treatment and inpatient care for all patients who access services on an unplanned basis) and (hospital-based) paediatric care across Northern Lincolnshire. So that the NHS Humber and North Yorkshire Integrated Care Board, can make a decision about the best way to provide these services across Northern Lincolnshire on or by March 2024. To allow Northern Lincolnshire and Goole NHS Foundation Trust, Hull University Teaching Hospitals NHS Trust and health and care partners across the Humber **to continue to provide high quality, sustainable and safe, hospital services that meet the needs of patients across the region now and in the future.**

Chapter 1

Our Population and Strategic Context

1. Our Population and Strategic Context

Our population has significantly poorer health outcomes than people living in other parts of the country. Responding to these challenges requires a whole-system approach to deliver prevention, early intervention, self-help and increased support at, or close to, home to improve the overall health and wellbeing of our population.

Deprivation and health inequalities

- Some of the most deprived wards in the country can be found in the Humber region and there are **wide disparities in income, employment, education and training**, which have a strong correlation with poor health outcomes. We are seeking to address these underlying health inequalities through provision of more integrated services and by working in partnership to promote opportunities for people in our deprived neighbourhoods to progress in careers in health and care.
- Due to the **rurality** of much of the region, many of those who live in the most deprived communities also live furthest from existing hospital sites. The programme has undertaken detailed analysis of the travel impacts to minimise the impact on those least able to travel.

Public Health Risk Factors

- A greater proportion of the Humber population has one or more long-term health condition(s) such as heart disease or COPD. Improved pathways of care have been designed to support patients with **multiple co-morbidities** to be treated more effectively in the community and avoid emergency admissions through better, more joined-up care.
- In North Lincolnshire, around 1 in 5 **children are living in poverty** and in North East Lincolnshire it is around 1 in 4 (compared with 1 in 6 nationally), which is linked to poor health outcomes. Working with partners we can develop more responsive service models in local communities to support children and families.

Barriers and inequity

- Rates of **car ownership** are lower than average in the Humber area. We have worked with partners to develop a transport action plan to mitigate any impacts of changes on travel and support people to access care and employment opportunities.
- **Digital exclusion** is an issue for many, particularly those in the most deprived areas. We have developed the proposals in line with the Partnership's digital inclusion principles to ensure everyone can benefit from digitally-enabled changes.

The proposals within this business case have been developed in partnership with health and care providers, local authorities and voluntary sector partners, focusing on specific pathways that will help to tackle underlying inequalities faced by our population.

This pre-consultation business case (PCBC) is built upon a strong foundation of collaboration across the Humber and North Yorkshire Health and Care Partnership. Collaboration between acute hospital trusts, in local communities, places and across the whole system is supporting all partners to deliver the aims and ambitions of the NHS Long Term Plan and other important national and local strategies.

There is commitment from all partners to work together to address the challenges faced by our population, supported through strengthened Place collaborative arrangements. Improved pathways of care, delivered by a more flexible workforce that can move between organisations and sectors, will result in a more integrated, approach to meeting the health and care needs of local people. This, in turn, will help to address the stark health inequalities that are evident within our population, by delivering care that is more tailored to the needs of each individual and reducing the overreliance on secondary care settings that is evident within the Humber health and care system.

Summary Box 1.1

1.1 Background

The Humber Acute Services Programme commenced in 2018 to design future models of care for hospital services that are safe, accessible and meet the needs of local people. The acute hospital services in scope within this Pre-Consultation Business Case (PCBC) are provided by:

- Hull University Teaching Hospitals NHS Trust (HUTH)
- Northern Lincolnshire and Goole NHS Foundation Trust (NLaG)

Map 1.1 Hospital Catchment Area HUTH and NLaG

The map above shows the location of the five hospital sites and combined catchment area (purple line) for both trusts for secondary care services in scope. Hull University Teaching Hospitals (HUTH) also provides a range of specialist or tertiary services for a larger region, serving patients living across East Yorkshire, parts of North Yorkshire and Northern Lincolnshire.

Patients travel from outside of the Humber area, from Lincolnshire County Council area in particular, to access secondary care services at our hospital sites – the combined catchment area with an extended 30km buffer is also displayed on the map (yellow line).

There are residents living within the Humber area who access secondary care services from other hospital trusts, in particular at York and Scarborough Teaching Hospitals NHS Foundation Trust at York, Scarborough and Bridlington hospitals. **These services are not in scope for this programme**.

The programme began with a clinically led review of hospital services which was evidence-based and considered what is working well elsewhere. It also considered local health needs and reflected what has worked, and what hasn't, from similar changes in other parts of the UK. The review was undertaken collaboratively with partners from across health and social care, the voluntary and community sector, patients and the public.

Whilst the starting point for the review was a focus on those aspects of care traditionally provided within acute hospitals, the programme team has worked with partners across the health and care system to align with other aspects of care such as primary, mental health, community and social care. This is essential as changes in one part of the health and care system cannot be made successfully without other parts of the system also changing.

The review led to three inter-linked programmes of work, which sought to design proposals for change over the short, medium and long term:

- **Programme 1** (Interim Clinical Plan): This programme was about keeping services safe in the here and now. During 2020 to Spring 2022, a programme of work was designed to stabilise several services that had been identified as needing to change quickly. The programme's aim was to improve the safety and the quality of these services whilst keeping them as local as possible, given key constraints – especially staff numbers and old estate. This work supported the two trusts in the Humber to put in place some important building blocks for collaboration (see section 1.2.4). The implementation is now being managed operationally within the acute trusts and is referred to as the Humber Clinical Collaborative Programme (HCCP).

- **Programme 2** (Core Hospital Services): This programme is about designing a future model for hospital care that is fit for purpose for our population. The programme has looked at each of the building blocks of the core hospital services – urgent and emergency care (services people need right away), maternity, neonatal and children's services, planned care (operations and other procedures which are booked in advance) and diagnostics (X-rays, CT and MRI scans) – and considered how and where they might be offered in a different way. This Pre-Consultation Business Case sets out **proposals for urgent and emergency care and paediatrics** that were developed through this programme. Other aspects of the work undertaken through this programme (e.g. planned care strategy; maternity and neonatal care review) are continuing in parallel with oversight provided by the Collaborative of Acute Providers (CAP) and the Integrated Care Board.

- **Programme 3** (Building Better Places): This programme is about building the hospitals of the future and using major capital investment as a catalyst for regeneration and revitalisation of our region. Work was undertaken to develop a Strategic Outline Case for major capital investment to address the significant issues with ageing infrastructure across the region. This wider investment is not required to deliver the proposals within this business case but will be required in the future to address issues with crumbling infrastructure across both trusts (see section 2.5).

1.1.1 Principles

The programme was undertaken in accordance with a set of nine key principles, which were agreed at the outset of the Humber Acute Services Review.[7]

- A commitment to provide acute hospital services that are patient-focussed, safe and sustainable, meeting the needs of our population both now and in the future;
- The service review will be clinically-led;
- The review will be evidence-based and take into account best practice;
- The review will focus on hospital services rather than hospital buildings and organisations;
- The review will be cognisant of local developments in out-of-hospital care and work towards solutions that support joined-up care across the system;
- A transparent, collaborative and inclusive approach will be adopted at all stages of the review process, ensuring engagement with key stakeholders from the outset;
- Plans for the future provision of acute hospital services will be developed in accordance with the levels of human, physical and financial resource expected to be available;
- Plans for the future provision will include urgent and emergency care (UEC) and maternity care in Hull, Grimsby and Scunthorpe;
- The review will be undertaken in accordance with an agreed programme plan that sets out objectives, processes, timescales and resources.

The approach taken to the development of the potential future models of care presented in this document has been iterative, based on good practice, data analysis, evidence and independent reviews and has taken on board learning through the COVID-19 pandemic.

Our collective ambition is for everyone across the Humber to have access to the best possible healthcare and opportunities to live healthy, happy lives.

This ambition is why we have developed proposals for change. Optimising opportunities across the Humber unlocks a range of new possibilities for the region and its people.

Summary Box 1.2

[7] Humber, Coast and Vale Health and Care Partnership (2017) *Humber Acute Services Review Principles* Review Principles

1.2 Context – the Humber Health and Care System

1.2.1 Health and Care in the Humber

Every year across the Humber region there are around 280,000 attendances at our Emergency Departments, more than 9,400 babies are born in our hospitals, almost 150,000 operations and procedures are performed and nearly 1.2 million hospital outpatient appointments take place.

These acute hospital services are only a small part of a much wider health and care system. Primary care – GP services, dentistry and optometry – supports the vast majority of the population with their healthcare needs on a day-to-day basis. Across the Humber there are 19 Primary Care Networks (PCNs), which are made up of GP practices working together and with community, mental health, social care, pharmacy, hospital and voluntary services in their local areas to meet the needs of local people. Across the Humber there are around 315 residential care homes, just over 100 home care companies and thousands of voluntary and community sector organisations (c.13,500 organisations and groups across Humber and North Yorkshire).[8] Many people are now living longer with long term conditions or suffer with mental health issues and primary care networks enable more proactive, personalised, coordinated and integrated health and social care to address these needs.

The health and care sector makes a significant contribution towards the local economy across the Humber. Health and Social care jobs account for just over 14% of all jobs in the Humber local authority areas.[9]

1.2.2 The Humber and North Yorkshire Health and Care Partnership

Following passage of the Health and Care Act (2022),[10] the six Clinical Commissioning Groups (CCGs) across the Humber and North Yorkshire merged to form the NHS Integrated Care Board (ICB) on 1st July 2022. The Humber and North Yorkshire NHS Integrated Care Board (ICB) assumed the statutory responsibilities previously belonging to the Clinical Commissioning Groups (CCGs), including responsibility for strategic planning and consultation on major service change.

The NHS Integrated Care Board (ICB) is part of a wider Integrated Care System (ICS), which includes all partners from the NHS, social care, local authorities and the voluntary and community sector who have been working together under the auspices of the Humber, Coast and Vale Health and Care Partnership since 2016. This strong track record of collaboration and partnership working has enabled this Pre-Consultation Business Case (PCBC) to be co-produced with partners from across the whole health and care system in the Humber.

The ambition of the Humber and North Yorkshire Health and Care Partnership is: *“**for everyone in our population to live longer, healthier lives** by narrowing the gap in healthy life expectancy between the highest and lowest levels in our communities by 2030 and increasing healthy life expectancy by five years by 2035.”*

To reach that ambition, our vision is to ensure that all our people ***“start well, live well, age well and die well.”*** The impact of the COVID-19 pandemic has focussed the Partnership further on addressing the health, social care and public health needs of our communities and through wider connections on issues

[8] Chapman, Tony (2021) *The structure, dynamics and impact of the voluntary, community and social enterprise sector* VCSE Sector Impact Report
[9] Nomis (2020) Official census and labour market statistics Local Authority Profiles
[10] HM Government (2022) *The Health and Care Act* The Health and Care Act

such as inclusion, socio-economic development, housing, employment and environment we are supporting our communities and levelling-up opportunities.

The Partnership's priorities are:

- improving outcomes in population health and healthcare
- tackling inequalities in outcomes, experience and access
- enhancing productivity and value for money
- helping to support broader social and economic development

The Partnership is working to bring about a fundamental shift in focus from picking people up when they fall ill, to helping to prevent people from becoming ill in the first place. This means delivering integrated services and organisations that support patients, their families and carers to have a seamless experience, wherever possible, providing care at or close to where people live, through new technologies and flexible local services. For more specialist care and treatments that cannot be offered everywhere, it means providing the highest quality care and supporting people to access it.

The Partnership is also focussed on the role it can play in supporting the communities it serves on wider issues such as supporting the local economy, employment and the environment by working as a collective of anchor institutions.

1.2.2.1 A catalyst for change – our anchor network

Anchor institutions are large, public-sector organisations that are unlikely to relocate and have a significant stake in a geographical area. The size, scale and reach of the NHS means it influences the health and wellbeing of communities simply by being there.[11] One of the goals of our Partnership is to leverage this influence, work closely with partners across each of our places to maximise the benefits we can bring to the health and wellbeing of the populations we serve.

Hospitals are significant players in their local economies, contributing value to the economy through the provision of jobs and wages that can be spent in local businesses, generating demand for (and spend in) ancillary industries, providing training and development opportunities for local people by improving the health and social wellbeing of those accessing the healthcare services provided.

In North East Lincolnshire, Northern Lincolnshire and Goole NHS Foundation Trust (NLaG) is the largest single employer within the district. In North Lincolnshire it is the second largest after British Steel. Across its three hospital sites and community services, NLaG employs nearly 7000 people. Hull University Teaching Hospitals NHS Trust is similarly amongst the largest employers in the Hull and East Riding area, employing over 8000 staff. Across the Humber, 'Human health and social work activities' is the third largest industry by numbers employed (after manufacturing and wholesale trade), except in East Riding of Yorkshire where it is the second largest (above manufacturing).[12]

Research by the Health Foundation explains that access to good quality employment opportunities can significantly improve the physical and mental health and wellbeing of those who take up the roles. Young adults who are unemployed are more than twice as likely to suffer from mental ill health than those in work.[13] In developing the potential models of care, we have worked with partners from across health and care, local government and the private sector to develop models of care that will support

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[11] The Health Foundation (2019) *Building healthier communities: the role of the NHS as an anchor institution* Building Healthier Communities
[12] Nomis (2022) official census and labour market statistics Labour Market Profiles
[13] The Health Foundation (2018) *What Makes Us Healthy* What Makes Us Healthy

new career pathways and enable local people to enter the workforce and provide the staffing our services need now and in the future (see section 8.3.4).

In developing plans for capital investment and rebuilding our estate, we also focused on the wider benefits that could be leveraged for the local economy by working in partnership with organisations across the public and private sectors, who are leaders in education, economic development, R&D and healthcare for our region. By taking a holistic approach to investment and embracing our role as anchor institutions, we can create opportunities for jobs, growth, social impact, environmental protection and innovation.[14]

1.2.3 Health and Care Partners in the Humber

The Humber is served by a complex and diverse health and care economy comprised of a wide range of NHS organisations, social enterprises and other public, private and voluntary sector providers. This diversity creates opportunities to deliver services differently, leveraging the different assets of our social enterprises, voluntary sector organisations and wider health partners.

Health and care partners across the Humber[15] include:

- 19 Primary Care Networks
- 2 Acute hospital trusts[16]
- 4 Community Services providers
- 4 Mental Health providers
- 2 Ambulance trusts
- Social Care providers, supported by 5 Local Authorities
- Secondary Care partners
- Voluntary and community sector partners
- Commissioners
- Neighbouring systems

Health and care organisations work together through Place-based partnerships in each of the four places – North Lincolnshire, North East Lincolnshire, East Riding of Yorkshire and Hull – and through sector collaboratives across the Humber and North Yorkshire area (covering the acute sector, mental health, primary care, community and the voluntary sector). These collaborative arrangements together form the Humber and North Yorkshire Health and Care Partnership or Integrated Care System (ICS). [17]

A wide range of stakeholders were involved in the Humber Acute Services programme.

[14] Humber, Coast and Vale Health and Care Partnership (2020) *Building Better Places – Economic and Social Impact Report* (see document library)
[15] A full list of organisations is provided in appendix 10.1
[16] In addition to the two acute trusts operating within the Humber area (Northern Lincolnshire and Goole NHS Foundation Trust and Hull University Teaching Hospitals NHS Trust), many Humber residents also access acute services at York and Scarborough Teaching Hospitals NHS Foundation Trust
[17] A list of acronyms used within this document is provided in appendix 10.20

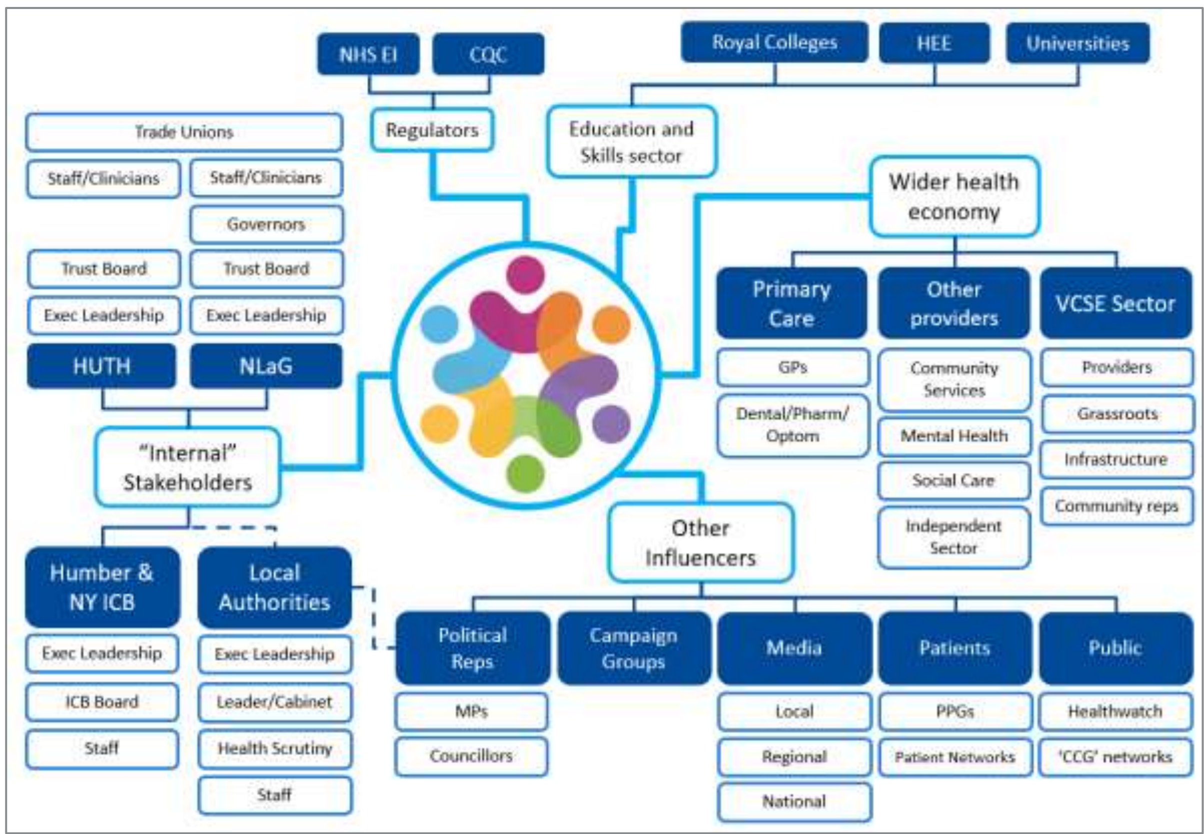


Figure 1.1 Stakeholder Map

1.2.4 Acute Trust Collaboration

Despite operating under different systems of governance, both hospital trusts have increased their levels of cooperation and collaboration over recent years, recognising the benefits of bringing together the strengths of NLaG's position as a Foundation Trust and HUTH's standing as a University Teaching trust and tertiary centre. Both HUTH and NLaG are committed to further increasing collaboration to meet the needs of the population. The trusts have strengthened their governance and leadership arrangements to enable collective decision-making and joint ownership of challenges and solutions. These changes have included, for example:

- The recruitment of a joint Chair to provide joined-up leadership and direction.
- The creation of Committee(s) in Common with delegated responsibility from both Trust Boards for joint working.
- The creation of an Executive-led Joint Development Board to oversee increased levels of joint working, performance management and leadership of fragile and vulnerable services.
- The development and agreement of a Memorandum of Understanding (MOU) and Service Level Agreement (SLA) to enable joint working to take place.
- The appointment to a number of executive joint leads.

In November 2022, the Trust Boards made separate decisions to move to a group structure with a single Executive Team overseeing both trusts. The group executive management model is increasingly being adopted across the NHS and the boards of both organisations agreed that it is the right approach for the two trusts serving the Humber, enabling them to address the challenges both organisations face more effectively. In December 2022 a process began to appoint a Group Chief Executive, with an appointment made in May 2023. Work is planned to take place over the summer of 2023 to finalise the structure of the group, including any shared governance arrangements.

This strengthened governance and leadership has enabled the trusts to develop and implement new ways of working in a number of specialties where workforce challenges and demand pressures were impacting upon the ability to provide safe and effective services for all. For example, from October 2021, the trusts brought together existing neurology teams into a single service to provide more equitable access to neurology services for patients from across the Humber. The service operates with a single patient list and a single point of access for GP referrals, but with key clinics still offered at local hospital sites. Working together in this way has provided greater resilience within the neurology workforce, which can offer a better service to patients, particularly those in North and North East Lincolnshire who previously faced longer waits and a less efficient pathway of care.

The continued development of the group leadership model and work through the Humber Clinical Collaborative Programme (HCCP) to integrate clinical teams and acute hospital services across the Humber will support delivery of the proposed new models of care.

1.2.5 Collaboration at Place

Collaborative working across different sectors – primary, secondary, community, mental health and social care – has also increased in recent years and provides a strong foundation on which to build new models of care that are better integrated and designed around the needs of patients and service-users.

Collaborative arrangements are organised around the four Places, which correspond to the four Local Authority areas: North Lincolnshire, North East Lincolnshire, Hull and East Riding of Yorkshire. Place-based partnerships, incorporating NHS organisations, local authorities and other public, private and voluntary sector providers, are the key mechanism for delivering transformation for out of hospital care as well as helping to shape the future of hospital-based care.

Examples of the positive impact of collaboration and new ways of working that have been developed through Place partnerships, include the **Connected Health Network** model of outpatient care (see section 7.1.3.1.1) that has radically reduced waiting times for cardiology outpatient appointments in North East Lincolnshire, completely eliminating the waiting list in just four months and the innovative approach to managing frailty implemented in Hull through the **Jean Bishop Centre** (see section 5.2.4.2), contributing to a 3% reduction in emergency hospital attendances, an 8% reduction in admissions and a 28% reduction in occupied bed days for patients aged over 80.

Strong Place-based collaboration and shared learning across the region will support delivery of the proposed new models of care. For example, we can reduce unnecessary admissions of frail patients and support them better in, or close to, their own homes by developing effective frailty models across the Humber, learning from the success of the approach in Hull.

This trajectory towards greater collaboration – both between the acute trusts and across the wider health and care system – will support the delivery of new and improved models of care across the Humber.

1.3 Context – Policy and Strategy

The NHS is experiencing some of the most significant challenges since its inception. These were compounded during the COVID-19 pandemic. Pressures within the system include increased levels of emergency demand, shortages in key skills across a number of clinical specialties and increased waiting times for planned care. Despite these challenges, the pandemic was also a catalyst for improved collaboration across the health and care system and provided an opportunity to look at how we can implement new models of care, in particular maximising the use of remote monitoring, virtual care and new and emerging technologies.

The Government has set out its overarching priorities for Health and Social Care in three key documents, which provide the framework within which we must deliver our services for the future:

- the NHS Long Term Plan (2019)
- the NHS People Plan (2020)
- the Health and Care Act (2022)

1.3.1 The NHS Long Term Plan

The NHS Long Term Plan ('the Plan'), published in January 2019, outlined the key ambitions of the NHS over the period to 2030.[18] The Plan focuses on patients taking greater ownership of their care, with improved disease prevention and support, more integrated and joined up care through collaboration, increased use of digital technology and an emphasis on staff health and wellbeing.

The NHS has traditionally provided a hospital-based model of care, which has relied upon people visiting hospitals for tests, clinical assessments and procedures. Advances in technology and clinical techniques mean that significantly more care can be provided out of hospital in other settings or indeed at home, but these opportunities are not being fully optimised at present. Working in new ways requires change, to make improvements to technology and help our staff and service-users develop the skills they need. In making these changes we need to understand the communities we serve and ensure we do not inadvertently disadvantage some communities.[19] The NHS Plan require us to focus on:

- Providing **faster support** to people in their own homes and improved NHS support for care homes.
- Funding new evidence-based NHS **prevention programmes**, including smoking cessation, obesity reduction, reducing alcohol related emergency admissions and to lower air pollution.
- Setting out specific measurable goals and mechanisms by which we will contribute to **narrowing health inequalities** in our region.
- Expanding the number of medical, nursing, midwifery, allied health professional (AHP) and other staff by **increasing training and international recruitment**.
- Making the NHS a more **attractive place to work** with mandatory flexible rostering and increased professional development funding.
- Making widespread **upgrades in technology** to allow clinicians to access patient records and care plans wherever they are, and to allow patients and their carers to better manage their health condition.
- Making **reforms to diagnostic services** including investment in new digital diagnostic imaging services and creation of pathology and diagnostic imaging network

[18] NHS England and Improvement (2019) *The NHS Long Term Plan* The NHS Long Term Plan
[19] See Integrated Impact Assessment (IIA) for detailed analysis (see document library)

The Plan sets out a number of areas of focus relevant to the potential models of care designed through the Humber Acute Services programme.

1.3.1.1 Urgent and Emergency Care

Urgent and emergency care systems have seen unprecedented levels of demand over recent years and face a number of challenges. The NHS Long Term Plan sets out key requirements in relation to urgent and emergency care, including:

- Fully implement the **Urgent Treatment Centre (UTC)** (Urgent Care Services) model by autumn 2020, with the option for appointments booked through NHS 111 (*this was achieved in some areas across the Humber however, the operating model needs to be improved to increase patient access*)
- All hospitals with a major Emergency Department (ED) will:
  - **provide same day emergency care (SDEC) at least 12 hours a day** (*in place*)
  - provide an **acute frailty service** for at least 70 hours a week (*in place)*
  - aim to record 100% of patient activity in ED, UTCs and SDEC units via **Emergency Care Data Set** by 2020 (*partially in place*)
  - test and begin implementing **new urgent and emergency care standards arising from the Clinical Standards review** by October 2019 (*national consultation response not yet finalised*)
  - further reduce delayed transfers of care in partnership with local authorities.
- By 2023, **Clinical Assessment Services** will typically act as a single point of access for patients, carers and health professionals (*partially in place*).
- Develop new ways to treat those with the most serious illness and injury to receive **the best care in the shortest time**.
- Improve responsiveness of **community health crisis response** to deliver services within two hours of referral in line with National Institute of Clinical Excellence (NICE) guidelines.

The Partnership strategic aim for urgent and emergency care is that "when needed, everyone within Humber, Coast and Vale [sic.] will have 24/7 access to information, advice and direct care that will meet their needs and that ***this will be outside of hospital wherever possible***." [20]

Over the coming years, we will streamline access to care, with a focus on NHS 111 and ensuring this is as effective as it can be at directing people to the appropriate service. The aim articulated in the Partnership Long Term Plan was to reduce the number of people attending Emergency Departments (EDs) in hospitals by 10% (by 2024), by offering more joined-up care and directing people to other appropriate services. In developing our potential future models of care, we have been able to push this target further still through the work to redesign urgent and emergency care pathways (see section **Error! Reference source not found.**).

1.3.1.2 Paediatrics

The areas the NHS Long Term Plan highlights a need to focus on within services for **children and young people** include:

- **Expansion of mental health services** for children and young people, growing funding faster than overall NHS funding.

[20] Humber, Coast and Vale Health and Care Partnership (2020) *The Humber, Coast and Vale Health and Care Partnership Long Term Plan* HCV Partnership Long Term Plan

- Action to tackle the **causes of morbidity and preventable deaths in people with learning disabilities** and for autistic people, with reduced waiting times for specialist services.
- Offer all children with cancer whole **genome sequencing** and actively supporting clinical trials.
- Prioritise improvements in **childhood immunisation**.
- Improve primary or community care treatment options to **reduce attendance at ED**.
- **Clinical network** roll out for children with long term conditions, including Critical Care and surgical networks.

We are working together with partners to deliver these aims and strategic objectives through developments in out of hospital care as well as developing the potential future models for hospital care described in this document.

1.3.2 The NHS People Plan

Across the Humber, healthcare organisations employ c20,000 whole time equivalent (WTE) members of staff across a range of disciplines – this includes social enterprise partners who deliver NHS services, primary care networks and those employed by the Integrated Care Board. Our people are our greatest asset. The NHS People Plan – created collaboratively between the NHS and its staff – outlines the NHS commitment to look after its staff and foster a culture of inclusion and belonging, it also sets out actions to grow our workforce, train our people, and work together differently to deliver patient care.[21]

The commitments and priorities within the People Plan have helped to shape our plans for the future. In particular the focus on new ways of working to deliver care has enabled new and innovative approaches to be developed, working across sectors, to deliver more integrated services in the future. These new workforce models and ideas are set out later in this document (see sections 8.3.4). Our proposed models of care look at how we recruit, retain and develop staff along with identifying new skills that could be developed to meet gaps within our workforce for both clinical and non-clinical staff at all grades.

This PCBC is built upon a strong foundation of collaboration across the Humber and North Yorkshire Health and Care Partnership. Collaboration between acute hospital trusts, in local communities, places and across the whole system is supporting all partners to deliver the aims and ambitions of the NHS Long Term Plan and improvements in experience, access and outcomes for our population.

Our plans have been developed in collaboration with staff, patients, elected representatives and the public. They recognise the issues we face, the inequalities in our population base and the need for us to work more collaboratively to **deliver services that are clinically sustainable in the long term.**

[21] NHS England (July 2020) *We are the NHS: People Plan 2020/21 – action for us all* NHS People Plan

1.4 Context – Our Population

1.4.1 The Humber Population

The Humber area has a diverse mix of industrial, urban, rural and coastal areas, encompassing the four main local authority areas – East Riding of Yorkshire, Hull, North Lincolnshire and North East Lincolnshire – and is home to just under one million people (935,900 people in 2021). Taken together, Hull University Teaching Hospitals NHS Trust (HUTH) and Northern Lincolnshire and Goole NHS Foundation Trust (NLaG) serve a population of around 1,045,700 people, including coastal communities within Lincolnshire County Council area. Hull University Teaching Hospitals NHS Trust (HUTH) also provides a range of tertiary (specialist) services for the wider region, serving a population of up to 1.25 million extending from Scarborough in North Yorkshire to Grimsby and Scunthorpe.

The Humber population is growing more slowly than the rest of the country. It is expected to increase by around 1.5% over the next five years, compared with 5.5% nationally and 3.5% for the Yorkshire and Humber region. Like in other parts of the country, our **population is getting older**. But people are not always living well in their older age, with **significantly lower than average healthy life expectancy** – which ranges between 53 and 58 years old across Northern Lincolnshire and Hull.

Summary Box 1.3 – Humber population overview

1.4.1.1 Age profile

The Humber's age profile is trending towards an older population, and this is exacerbated by the slow overall growth in the population and declining birth rate. Hull has a significantly younger population than the national average, with more children and working-aged people. Neighbouring East Riding, however, has a significantly older and aging population. In North and North East Lincolnshire, the older population (65+) is higher in the rural fringes and the urban population is younger.

As the population across Northern Lincolnshire continues to age, it is more important than ever to design pro-active, responsive services in communities to support older people with multiple long-term conditions **to prevent people spending time in hospital** in response to an event. For example, pro-active falls prevention, delivered through multi-disciplinary teams, can support more of our frail population to access support they may not have known about and prevent the expense, stress and inconvenience of travel and a potential admission to hospital.

	East Riding	Hull	North East Lincs	North Lincs	East Lindsey	West Lindsey
15 and under	15.8%	**19.9%**	**18.8%**	17.8%	14.7%	16.9%
16 – 64	57.8%	64.8%	60.3%	60.2%	54.9%	57.9%
65+	**26.4%**	15.3%	20.9%	22.0%	**30.5%**	25.2%

Table 1.1 Age profile by local authority - high level categories[22]

The forecast population change from 2020 to 2030, broken down across the four Humber local authority areas, is as follows:

[22] ONS (2022) *Population and household estimates, England and Wales: Census 2021* Census 2021

- a decrease of 0.22% in Hull
- an increase of 2.96% in the East Riding of Yorkshire
- an increase of 1.57% in North Lincolnshire
- a decrease of 0.68% for North East Lincolnshire[23]

A detailed analysis of the forecast increase highlights a significant increase in the older age range as set out in the graphs below.

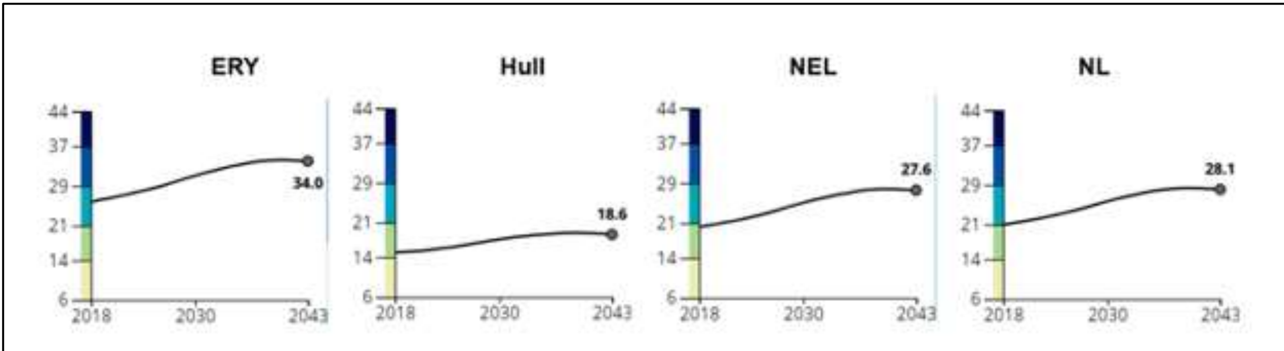


Figure 1.2 Population projection – proportion of people aged 65 years and over by LA, 2018 – 2043[24]

1.4.1.2 Ethnicity

The Humber population is less ethnically diverse than the country as a whole, however, some neighbourhoods have a high concentration of Black, Asian and Minority Ethnic populations. 4.98% of the Humber population is from a Black, Asian or Minority Ethnic background, with the largest group being Asian/Asian British (2.06% overall but ranging up to over 30% in some local areas).[25]

Local Authority	White	Asian / Asian British	Mixed / Multiple Ethnic Group	Black / African / Caribbean / Black British	Other Ethnic Group
East Riding of Yorkshire	97.4%	1.1%	0.9%	0.3%	0.4%
Hull	91.8%	2.8%	1.7%	1.9%	1.8%
North East Lincolnshire	96.2%	1.6%	1.0%	0.5%	0.7%
North Lincolnshire	94.3%	3.3%	1.1%	0.5%	1.1%
Humber	**96.4%**	**2.1%**	**1.2%**	**0.8%**	**0.9%**
England	**81.0%**	**9.6%**	**3.0%**	**4.2%**	**2.2%**

Table 1.2 Ethnicity breakdown by Local Authority[26]

The neighbourhoods (Lower Super Output Areas – LSOAs) with the largest concentration of Asian/Asian British Population are all in North Lincolnshire:

[23] ONS (2020) *Subnational population projections for England: 2018-based* Population Projections
[24] ONS (2020) *Subnational population projections for England: 2018-based* Population Projections
[25] ONS (2022) Census 2021, dataset TS021 Census 2021
[26] ONS (2022) Census 2021, dataset TS021 Census 2021

LSOA	Asian/Asian British Overall %	Area	Post Code	Deprivation IMD Score	Decile (1 = top 10% of LSOAs)
E01013333	33.33%	North Lincs	DN15	12.49	7
E01013332	32.39%	North Lincs	DN15	37.16	2
E01013300	22.63%	North Lincs	DN15	46.74	1
E01013296	21.26%	North Lincs	DN15	55.06	1

Table 1.3 LSOAs with highest %age Asian/Asian British population[27]

The neighbourhoods (LSOAs) with the largest concentration of Black/African/Caribbean/Black British population are all in Hull:

LSOA	Black/African/ Caribbean/ Black British Overall %	Area	Post Code	Deprivation IMD Score	Decile (1 = top 10% of LSOAs)
E01012869	13.16%	Hull	HU5	38.89	2
E01012854	9.61%	Hull	HU1 / HU3	70.60	1
E01012855	7.51%	Hull	HU3	78.37	1
E01012761	6.57%	Hull	HU3/HU5	53.36	1

Table 1.4 LSOAs with highest %age of Black/African/Caribbean/Black British population[28]

Across all Humber localities, the largest minority ethnic group is 'Other White', making up 4.42% of the Humber's population (but ranging to over 30% in some neighbourhoods).

Local Authority	White: English, Welsh, Scottish, Northern Irish or British	White: Other White
East Riding of Yorkshire	94.63%	2.28%
Hull	83.85%	**7.43%**
North East Lincolnshire	92.65%	3.29%
North Lincolnshire	88.72%	**5.04%**

Table 1.5 Ethnicity by Local Authority - White/Other White[29]

The neighbourhoods (LSOAs) with the largest concentration of communities identifying as 'Other White' populations are spread across the region, in Hull, Goole and Scunthorpe.

LSOA	Other White Overall %	Area	Post Code	Deprivation IMD Score	Decile (1 = top 10% of LSOAs)
E01012871	35.16%	Hull	HU5	38.94	2
E01012999	32.52%	East Riding of Yorkshire	DN14	29.37	3
E01012997	32.05%	East Riding of Yorkshire	DN14	27.90	3

Table 1.6 LSOAs with highest %age of 'Other White' population[30]

[27] ONS (2022) Census 2021, dataset TS021 Census 2021
[28] ONS (2022) Census 2021, dataset TS021 Census 2021
[29] ONS (2022) Census 2021, dataset TS021 Census 2021
[30] ONS (2022) Census 2021, dataset TS021 Census 2021

The majority of people living within these communities identify their nationality as belonging to an EU country. **Polish, Romanian and Lithuanian** were the most common national identities and are also the most widely spoken languages across the Humber region.

1.4.1.2.1 Addressing Health Inequalities in our BAME Communities

There is strong evidence that people from Black, Asian and Minority Ethnic (BAME) backgrounds face greater health inequalities. This was highlighted through the COVID-19 pandemic, which had a disproportionate impact on BAME populations in terms of incidence of disease and mortality. It is important to understand the barriers and reasons for these structural inequalities. An example of how we are responding as a system to these challenges is the targeted vaccine programme undertaken in North Lincolnshire.

Case Study – North Lincolnshire Targeted Vaccination Programme

Following targeted engagement across communities, we knew we had to take vaccines to the people. We learned some communities only felt safe within those communities and some lacked trust in the NHS. We had to approach this differently to how we had done things historically.

We visited gurdwaras, mosques, homeless shelters and set up pop-up clinics in our most deprived areas. These visits proved extremely successful in terms of vaccine uptake, with a number of strong relationships being produced. Our pop-up clinics in Scunthorpe mosques and gurdwaras were extremely well utilised. The team implemented similar pop-up clinics in workplaces where there is a high number of Eastern European workers. We took an interpreter to build trust and saw hundreds more vaccinated. It proved an opportunity to converse with Polish, Slovakian and Romanian residents. We busted myths and developed relationships.

Thanks to ward-level nationality data, we could target our efforts in communities where uptake was lower, providing information (including promotion videos) in the area's most commonly spoken languages. This was promoted by BBC Radio Humberside and BBC Look North – spreading the message further. We took a GP and the North Lincolnshire Multi Faith Partnership so we could give clinical advice and speak the correct languages tailored to who we spoke with in the street. The initiative led to a surge of vaccinations at the nearby centre.

We quickly learnt that for many people they live in a community within a community. For some, travelling past their local shop was intimidating. For others, leaving their street was intimidating. Only conversations with these people helped us understand why this was. Often mental or physical health issues were at the heart of it. For others, they only felt safe and comfortable in and around their home/place of worship. We adapted to fit the needs of our population.

Following the success of taking the vaccine to the community through pop up sites in our deprived areas, workplaces and places of worship to increase uptake, we are now adopting the same approach with other remits of work such as our cardiovascular disease project to drive population health management by following the blueprint created.

Summary Box 1.4 Targeted vaccination programme case study

1.4.1.3 Life Expectancy

Our population can expect to live shorter and less healthy lives than those living in other parts of England. In each of the Humber local authority areas (except for the East Riding of Yorkshire), life expectancy rates at birth are significantly lower than the England average.

Developing more integrated pathways, with community-based supported targeted in deprived communities across the Humber, will help to address these stark inequalities.

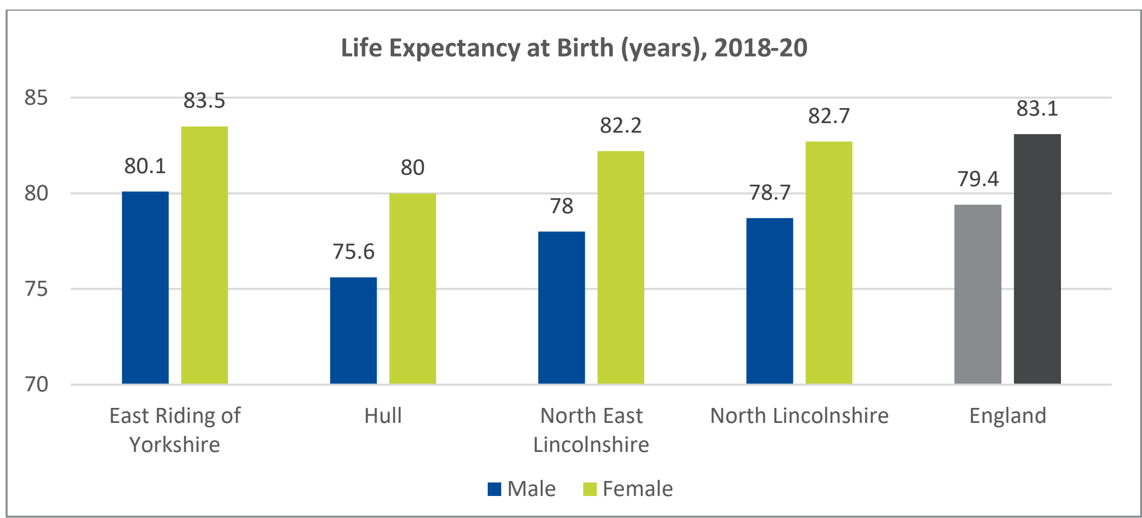


Figure 1.3 Life Expectancy at Birth (years), 2018-2020[31]

Not only do people within the Humber have a lower life expectancy when compared to the England average but they are spending an increasing proportion of their lives living with serious health conditions. The age to which people can expect to live a healthy life currently stands at 63.1 years for men and 63.9 years for women in England. The figures for Hull, North Lincolnshire and North East Lincolnshire show a marked variance for both males and females when compared to the England average, with significantly worse outcomes in our region compared with the country as a whole.

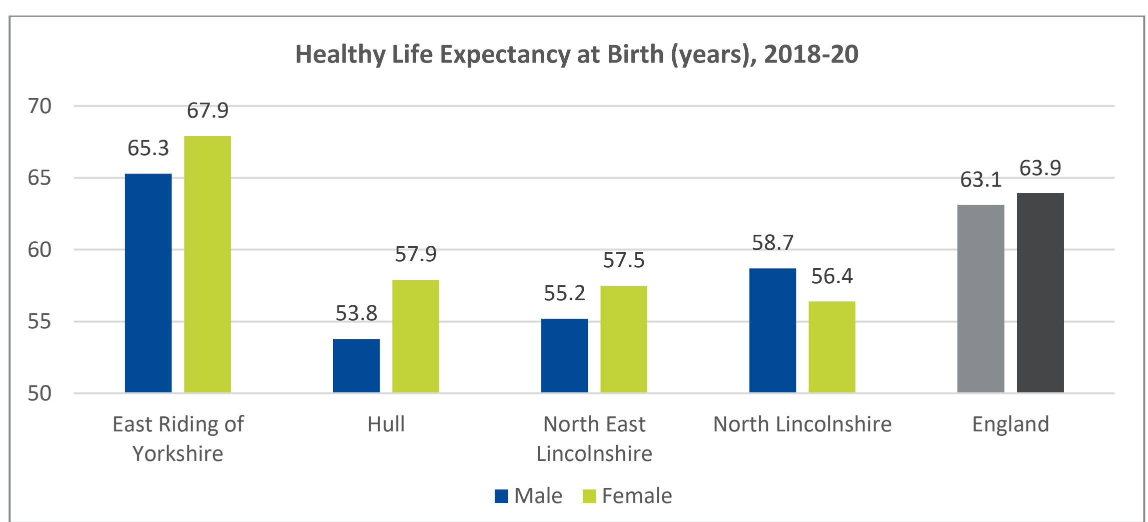


Figure 1.4 Healthy Life Expectancy at Birth (years) (2018-2020)[32]

[31] Office for Health Improvement and Disparities, OHID (2022) *Wider Determinants of Health – Life Expectancy at Birth* Fingertips
[32] OHID (2022) *Wider Determinants of Health – Healthy Life Expectancy at Birth* Fingertips

When looking at 'healthy' life expectancy at birth, women living in North Lincolnshire can, on average, expect to live the last 26 years of their lives in ill health, while men in Hull can typically expect to live the last 22 years of their lives in ill health.

The potential models of care were designed to meet the demographic changes that are forecast, paying particular attention to meeting the needs of an older population with increasingly complex health and care needs.

1.4.2 Deprivation and Health Inequalities

Some of the most deprived wards in the country can be found within the Humber region and there are **wide disparities in income, employment, education and training and levels of crime**. Many individuals and communities across the Humber are disproportionately affected by ill-health and premature death.

Improving the quality and sustainability of hospital-based services will ensure we can better meet the needs of those impacted by poor health in our communities by providing healthcare services that meet nationally-set clinical standards. Our wider work with partners to improve access to skills, training and employment will also **help to address some of the underlying issues that lead to poorer health outcomes** in the first place.

1.4.2.1 Deprivation

The Indices of Multiple Deprivation (IMD) ranks each small area in England (Lower Super Output Area – LSOA) from the most to the least deprived, taking account of many of the wider determinants of health such as income, employment, education, crime, housing and living environment.[33]

The average Index of Multiple Deprivation (IMD) score for the Humber areas combined is 27.4, which is higher (more deprived) than the England average of 21.7. There is also significant variation in deprivation levels between and within the local authorities in the Humber region. The East Riding of Yorkshire is classed within the least deprived areas of England, whilst Hull and North East Lincolnshire are within the most deprived areas overall.

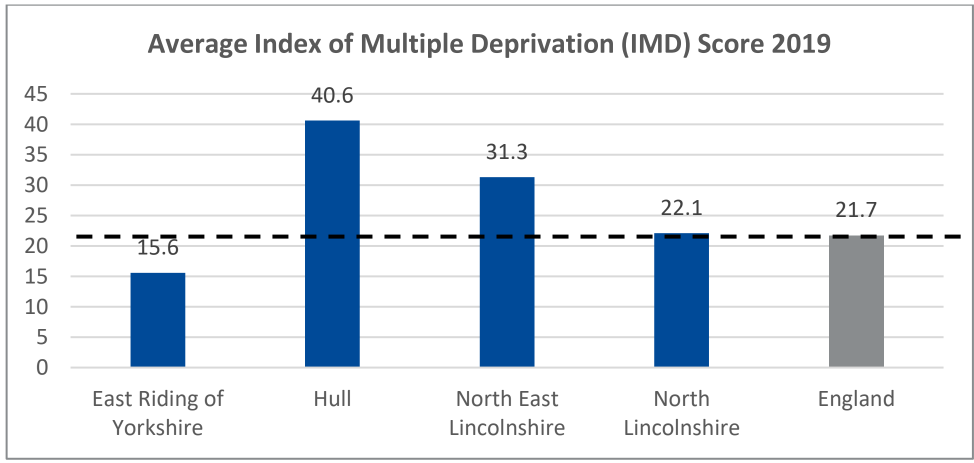


Figure 1.5 Average index of Multiple Deprivation Score (2019)[34]

[33] Ministry of Housing, Communities and Local Government, MHCLG (2019) *The English Indices of Deprivation 2019* IMD 2019
[34] MHCLG (2019) *The English Indices of Deprivation 2019* IMD 2019

Across the Humber, people live in poverty. This has ongoing impacts on their health and wellbeing and use of healthcare services. More than half of all neighbourhoods in Hull (51%) and 40% of neighbourhoods within North East Lincolnshire are classed as being among the 20% most income deprived in England.

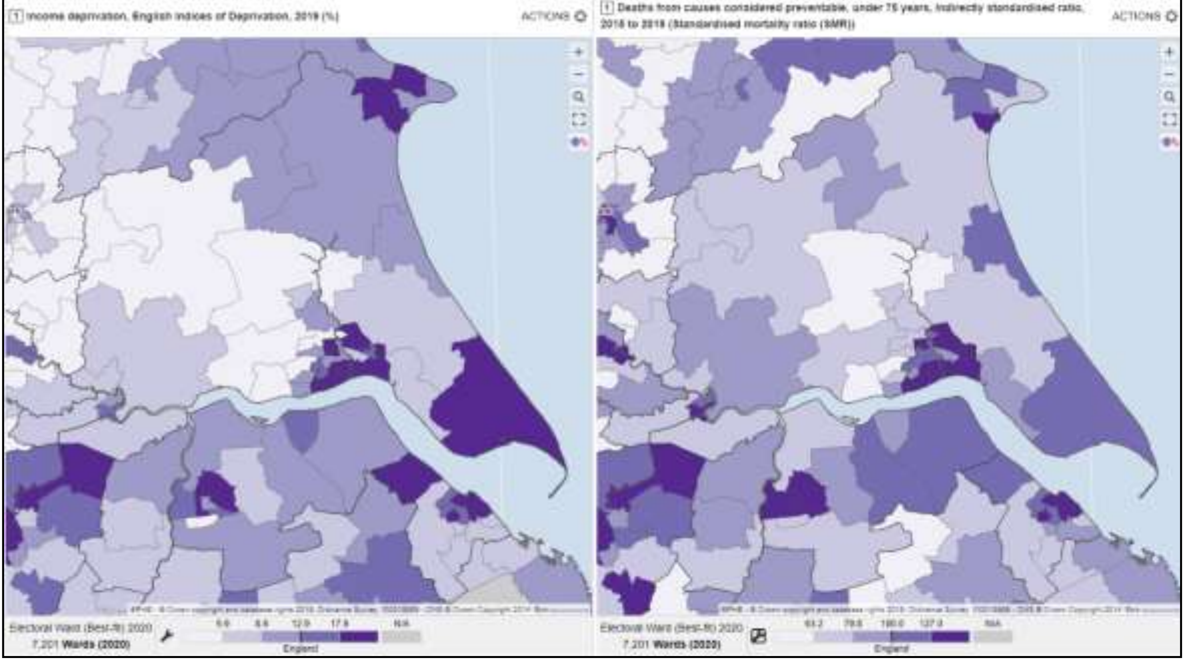
More than half of Hull's residents live in the most deprived quintile meaning a greater number of families are living in poverty and may experience poorer health outcomes. Within our less deprived areas, such as the East Riding of Yorkshire, there is also significant variation across the places with pockets of very deprived communities, notably in Bridlington, Withernsea and Goole.

	Neighbourhoods (LSOAs) within 20% most income deprived	Percentage of population that is income deprived	Local Authority Rank for income deprivation *(out of 316)*
Hull	51%	22.7%	6
North East Lincolnshire	40%	19.0%	26
North Lincolnshire	20%	13.3%	106
East Riding of Yorkshire	10%	9.6%	194
East Lindsey	25%	16.2%	56
West Lindsey	17%	12.3%	123

Table 1.7 Summary of income deprivation across Humber[35]

1.4.2.2 Deprivation and Life Expectancy

Public health analysis highlights a strong correlation between income deprivation and poor health outcomes. When income deprivation across the Humber is mapped against the standardised mortality rate for deaths considered preventable, there is a clear correlation between the two indicators as shown by the darker areas on the maps below.



Map 1.2 Income Deprivation v Deaths from Causes considered preventable[36]

[35] ONS (2021) *Exploring local income deprivation* ONS visualisation
[36] OHID (2021) *Local Health* Local Health maps and indicators

Premature mortality for all causes is significantly worse within the Humber than the national average. The under 75 mortality rate from causes considered preventable is higher in three of the Humber local authority areas, and significantly higher in Hull and North East Lincolnshire.

	Deaths from causes considered preventable, under 75 years (2016-2020)	
East Riding of Yorkshire	82.6	
Hull	162.6	
North East Lincolnshire	125.8	
North Lincolnshire	112.4	
England	100.0	Standardised mortality ratio (SMR)

Table 1.8 Deaths from causes considered preventable, <75 years, Indirectly standardised ratio, 2016 to 2020[37]

High rates of premature mortality, increased incidence of chronic illness and other impacts associated with deprivation mean that there are significant disparities in life expectancy between those living in the most affluent and most deprived neighbourhoods.

	Inequality in life expectancy at birth (years), 2018-2020	
	Male	Female
East Riding of Yorkshire	6.8	3.2
Hull	12.3	9.6
North East Lincolnshire	12.9	8.5
North Lincolnshire	10.9	8.1
England	9.7	7.9

Table 1.9 Inequality in life expectancy at birth, 2018-2020[38]

1.4.2.3 Deprivation and impact on children

Deprivation is unevenly spread across the population and disproportionately affects children and young people – around 16% of the Humber population is classed as income deprived but nearly 1 in 4 (22%) of all children in the region live in poverty. There is also a higher concentration of younger people living in the central wards in the major towns and cities where deprivation is higher and car ownership is lower.

	Percentage of children (under 16) living in poverty	Percentage of population that is income deprived
Hull	28.20%	22.70%
North East Lincolnshire	23.50%	19.00%
North Lincolnshire	21.30%	13.30%
East Riding of Yorkshire	14.80%	9.60%

Table 1.10 Summary of income deprivation and impact on children[39]

[37] OHID (2021) *Local Health* Local Health maps and indicators
[38] OHID (2022) *Public health profiles* Fingertips
[39] ONS (2021) *Exploring local income deprivation* ONS visualisation and OHID (2022) *Child Health Profiles* Fingertips

1.4.3 Public Health Risk Factors

A wide range of factors contribute towards people living within the Humber region being 'less healthy' compared to the national average. Levels of smoking and obesity are higher than the national average in Hull, North Lincolnshire and North East Lincolnshire and levels of physical activity are lower than the national average in all four local authority areas.

We can improve community-based care for people in our communities with long term conditions such as heart disease (CHD) and respiratory conditions (e.g. COPD) if we can release staff and other resources from hospitals to provide more proactive care to help people to stay healthy and on top of their conditions.

More than 1 in 5 adults in Hull and North East Lincolnshire are smokers, 21.8% and 20.1% respectively, compared to 14.4% nationally (2021).[40] In Hull this equates to over 45,000 current smokers and leads to a smoking-attributable hospital admission rate almost twice that of England as a whole.[41] Furthermore, 20.3% of **new mothers** in North East Lincolnshire, 17.5% in Hull, 16.5% in North Lincolnshire and 10.9% in East Riding are **smoking at the time of delivery**, compared to 9.1% nationally (2021/22).[42] This is closely associated with premature births, which are higher than the national average in all four Humber local authorities.[43]

The impact of alcohol and alcohol-related harm on our population is also significant. In Hull, **hospital admissions for alcohol-specific conditions** are significantly higher (858 per 100,000 population) than the England average (587).[44] This equates to 1,990 admissions per year, which when taken together with East Riding admissions (1475) represents a significant source of pressure on hospital services.

Across Yorkshire and the Humber as a whole, **1 in 4 reception age children** (24.1%) and **over 1 in 3 Year 6 children** (35.8%) are **overweight or obese**. Rates are higher still in Hull (and) and North East Lincolnshire, with 28.4% and 26.1% of reception age children and 37.6% and 37% of year 6 children overweight or obese.[45] There are wide inequalities in childhood obesity across our region, closely linked to deprivation. England-wide data shows that in 2020/21, **obesity prevalence was over twice as high for children living in the most deprived areas (20.3% and 33.8%) than for children living in the least deprived areas (7.8% and 14.3%)** at reception age and Year 6 respectively.[46] Childhood obesity impacts on the long-term health outcomes we can expect as those children become older.

Levels of physical activity are lower than the national average across all four local authority areas. The percentage of the population considered physically inactive is worse than the England average in all areas.[47]

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[40] OHID (2022) *Public health profiles* Fingertips
[41] OHID (2022) *Public health profiles* Fingertips
[42] OHID (2022) *Public health profiles* Fingertips
[43] OHID (2022) *Public health profiles* Fingertips
[44] OHID (2022) *Public health profiles* Fingertips
[45] OHID (2022) *Obesity Profile* Fingertips
[46] NHS Digital (2021) *National Child Measurement Programme, England 2020/21 School Year* Deprivation
[47] Office for Health Improvement and Disparities (2022) *Public health profiles* Physical Activity

	East Riding of Yorkshire	Hull	North Lincolnshire	North East Lincolnshire	England
%age of adults considered physically inactive	24.6%	32.4%	31.8%	26.2%	23.4%

Table 1.11 Physically inactive adults (Humber)[48]

The conditions in which people live and work, combined with the impact of deprivation, mean that **a greater proportion of the Humber population have one or more long-term health condition(s) such as diabetes and heart disease**. Our prevalence of diabetes and coronary heart disease (CHD) is higher than the national average in all four Humber local authority areas.

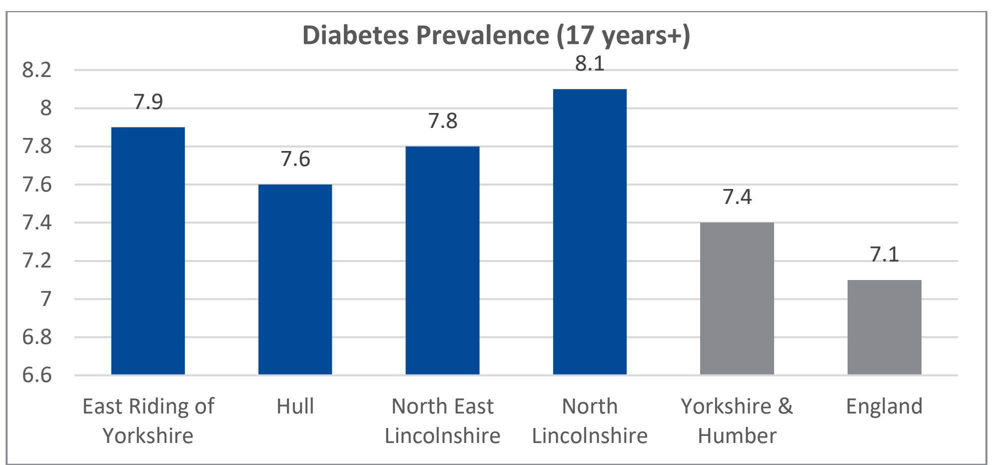

Figure 1.6 Prevalence of Diabetes across the Humber population (17+ years)[49]

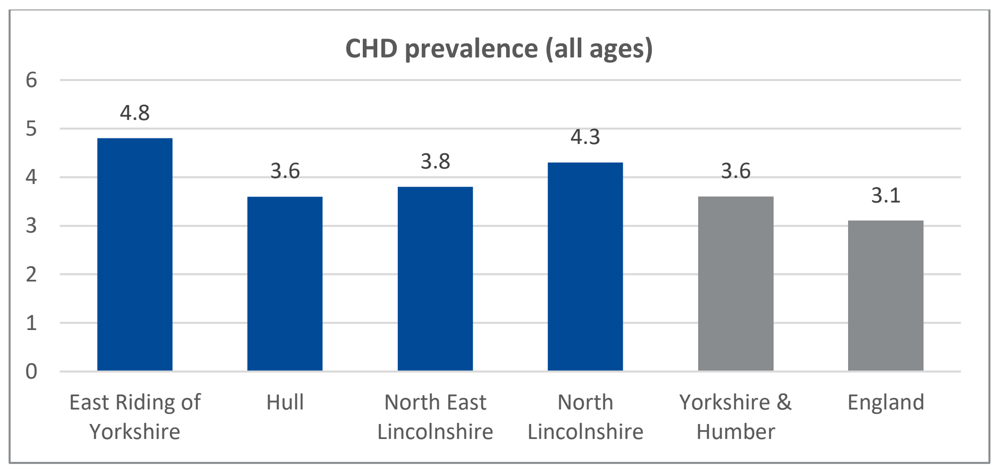

Figure 1.7 Prevalence of Coronary Heart Disease (CHD) across the Humber population (all ages)[50]

The higher prevalence of cardiovascular disease and diabetes puts increased pressure on both hospital services (planned and unplanned care), by increasing the risk for our population of stroke, heart attacks and diabetes-related complications.

[48] Office for Health Improvement and Disparities (2022) *Public health profiles* Physical Activity
[49] NHS Digital (2020) *Quality and Outcomes Framework 2019-20* QOF Report
[50] NHS Digital (2020) *Quality and Outcomes Framework 2019-20* QOF Report

1.4.4 Barriers and inequity[51]

Many groups, families and individuals within our population face additional barriers to accessing health and care provision, which can exacerbate existing inequalities in health outcomes. Our rural and coastal geography, combined with high levels of deprivation, can make it difficult for people to get around to access healthcare, visit loved ones in hospital and access employment opportunities.

Recognising that it is not possible to make changes without some impact, we have mapped travel times to limit the impact on those facing barriers to access and worked with partners across the voluntary and community (VCSE) sector to develop potential solutions (see transport action plan).

Whilst most of the Hull and North East Lincolnshire population lives in or close to a city or large town, **a large proportion of the Humber population lives within rural and sparsely populated areas**, which creates additional barriers to accessing care.

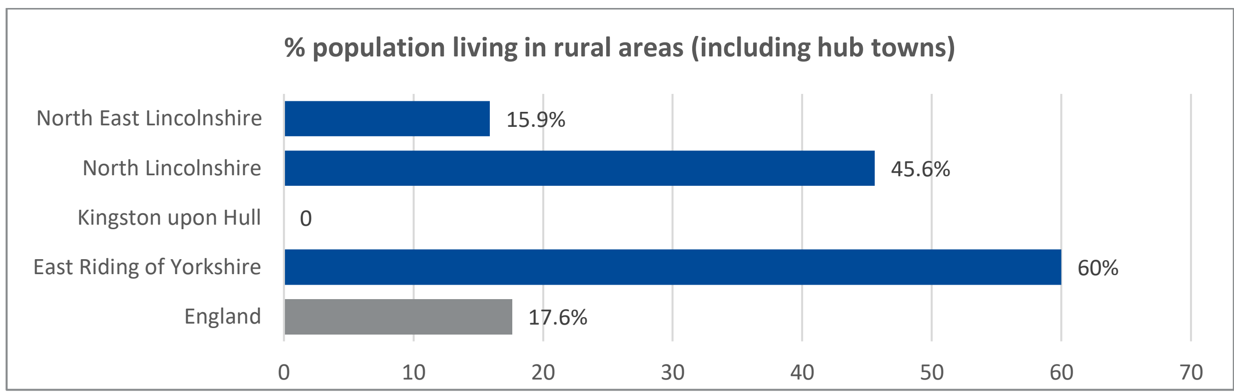

Figure 1.8 Percentage of population living in rural areas[52]

Furthermore, **rates of car ownership are lower than the national average in many parts of the Humber area**. The number of households with access to a car or van varies considerably across the Humber authorities, ranging from just 64.9% in Hull to 84.2% in the East Riding of Yorkshire. Localised variation is considerable and many of the more deprived wards have low household motor vehicle access rates. This has implications for healthcare provision as a great deal of 'need' comes from wards with the lowest car ownership and many people living in these areas are dependent on public transport.

In some neighbourhoods (LSOAs) in North East Lincolnshire, more than half of the population has no access to a car or van and in a number of LSOAs in North Lincolnshire between 40 and 50% of the population has no access to a car or van.[53]

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[51] This is not an exhaustive list and there are many other barriers and challenges that have been identified through our engagement work and have influenced the models of care that were developed.

[52] Department for Environment, Food and Rural Affairs (DEFRA) (2014) *Local Authority Rural Urban Classification* Rural Urban Index

[53] ONS (2022) Census 2021, dataset TS045 Census 2021

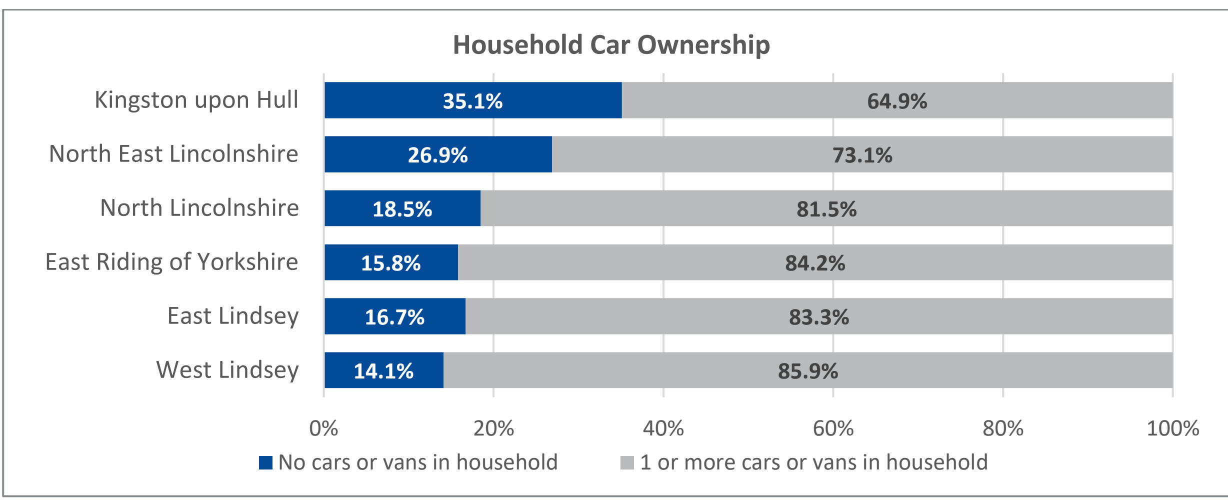
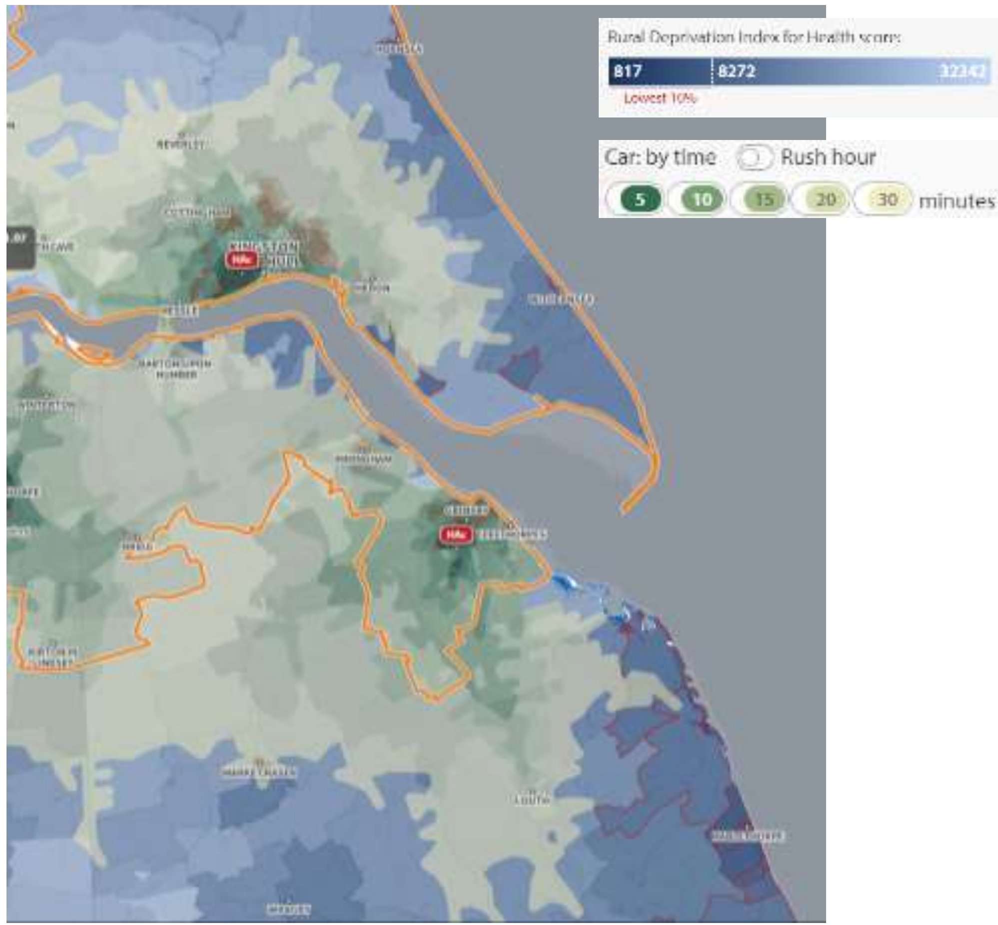


Figure 1.9 Car ownership rates by local authority[54]

Due to the **rurality** of the population, many of those who are living in the most deprived communities are also those who live furthest from our existing hospital sites. This can exacerbate existing healthcare inequalities linked to the difficulties faced by people living in these communities accessing hospital care. This is particularly pronounced in the coastal towns that are served by HUTH and NLaG, such as Mablethorpe, Saltfleet, Withernsea and Hornsea.



Map 1.3 Rural Deprivation and Access Times[55]

[54] ONS (2022) Census 2021, dataset TS045 Census 2021
[55] SHAPE *Strategic Health Asset Planning and Evaluation* SHAPE tool

Within our region, **caravan parks along the coastline** are common and for some residents, despite the restrictions on year-round living, it is their primary accommodation. Static caravan parks present challenges when designing health and care services because these are often the home for older citizens with multiple health needs or migrant workers, but without the service provision to support them. The East Lindsey coastline, for example, is home to more than 200 caravan sites and around 25,000 static caravans, and it is estimated that there are around 3,500 households (6,600 people) who live for some or all of the year in caravans or chalets. This population is often under identified as they are less likely to be registered with a GP or be represented in the Census.

The East Yorkshire and East Lincolnshire coasts are popular holiday destinations, experiencing large visitor numbers, particularly in the summer; East Lindsey, for example, sees over 1.3 million visitors each year.[56] Holidaymakers and seasonal residents create peaks and troughs in demand for hospital services – urgent and emergency care, in particular – where these are often not the best or most appropriate services for their needs. This can put additional pressure on hospital services, particularly in Grimsby.

Rates of homelessness are higher than the England average in some of our areas. The statutory homelessness rate in North East Lincolnshire is 2.9 and in Hull it is 1.3, compared with an England average of 0.8.[57] People without permanent, secure homes are at higher risk of poor health outcomes and face significant barriers to accessing care.

Digital exclusion is also an issue for communities within the Humber, particularly those most deprived areas. Nearly 40% of neighbourhoods (LSOAs) in Hull were classed within the least digitally able in work undertaken to support delivery of the 2021 census.

		HtC Digital				
		Most Able		⇔		Least Able
Local Authority	**Number of LSOAs**	1	2	3	4	5
ERY	**210**	**41%**	**40%**	**9%**	**7%**	**2%**
Hull	**166**	**5%**	**20%**	**13%**	**22%**	**39%**
NEL	**106**	**34%**	**42%**	**11%**	**13%**	**0%**
NL	**101**	**43%**	**47%**	**4%**	**6%**	**1%**
Humber	**583**	**30%**	**36%**	**10%**	**12%**	**12%**

Table 1.12 Digital Exclusion - Digital domain of the Hard to Count (HtC) index for the 2021 Census[58]

Whilst there are many reasons people experience digital exclusion, there is a strong correlation between the LSOAs reporting higher levels of digital exclusion and areas with high levels of deprivation.

The map shows areas of deprivation, measured by the Rural Deprivation Index for Health, overlayed by travel times (by car) to existing hospital sites. The areas outlined in red are the 10% most deprived LSOAs. Many of these deprived communities are also in areas greater than 30 minutes travel time from the existing hospital sites. Further details of the travel mapping undertaken to support evaluation can be found in appendix 0. Further details of our work to develop transport solutions are set out in section 8.4.

[56] Visit Britain (2020) *Destination Specific Research* Local Authority tourism data

[57] Office for Health Improvement and Disparities (2022) *Local Authority health profiles* Fingertips

[58] ONS (2021) *Hard to Count (HtC) Index for the 2021 Census – ability to respond, driven by access and use of digital technology* Census HtC Index – Digital

1.4.5 Reducing Health Inequalities – the 'Core20PLUS5' approach

Core20 PLUS 5 is a national NHS England and NHS Improvement approach to support the reduction of health inequalities at both national and system level.[59] The approach defines a target population cohort – the 'Core20PLUS' – and identifies '5' focus clinical areas requiring accelerated improvement. This approach has helped to shape the focus in developing the potential models of care and, in particular, when evaluating the impact of the potential models on different populations. The aim of each of the pathway changes described within this business case is to contribute to a continued drive to reduce health inequalities within the Humber region and ensure those with the greatest needs have access to the services they need to stay well.

The Core20 PLUS 5 approach identifies the target populations that systems should focus upon to ensure they have equitable access to healthcare and consider targeted interventions to improve healthcare access. In addition, working with partners, systems should seek to deliver improvements to the wider determinants of health such as good quality housing and access to employment for these target populations.

The **Core20** described within this method refers to the most deprived 20% of the national population as identified by the national Index of Multiple Deprivation (IMD). A significant proportion of the population within the Humber region – and in the wider region served by the two hospital trusts – live within areas of high deprivation, as set out in section 1.4.2.1.

Picture 1:A Core20Plus5 Infographic[60]

The **PLUS** aspect highlighted refers to specific population groups identified by Integrated Care Systems (ICSs) because they experience poorer than average health access, experience and/or outcomes. This segmentation should identify population cohorts experiencing poorer outcomes who are not captured in the 'Core20' alone, based on ICS population health data.

[59] NHS England and Improvement (2022) *Core20PLUS5 – An approach to reducing health inequalities* Core20PLUS5
[60] NHS England and Improvement (2022) *Core20PLUS5 – An approach to reducing health inequalities* Core20PLUS5

Work to fully define all population cohorts that fall within this definition is still ongoing within the Humber and North Yorkshire Health and Care Partnership, however, some groups that have been identified initially include **coastal communities** and **people with learning disabilities**. As noted above, people living in coastal communities are impacted by a number of factors that have a detrimental effect on their health and wellbeing, including poverty, ageing populations, lack of educational and career opportunities, low rates of car ownership, poor public transport links, long distances to healthcare facilities, and higher than average rates of co-morbidities and risk factors.

People with learning disabilities have disproportionately poor outcomes and lower life expectancy. Some people with learning disabilities, autism or both encounter difficulties when accessing NHS services and can have much poorer experiences than the general population.[61] Nationally, the rate of treatable causes of death is 403 per 100,000 deaths in people with a learning disability compared with just 83 per 100,000 in the general population. It is important to consider these challenges when designing the models of care for the future of acute hospital services in the Humber.

In developing this Pre-Consultation Business Case, we have sought to engage with different health inclusion groups – including sex workers, vulnerable migrants and asylum seekers, people with learning disabilities and unpaid carers – to ensure a clear understanding of their needs and the barriers they face have fed into service design from the outset (further details of this can be found in section 3.2.2).

The final part of the Core20PLUS5 methodology sets out **five clinical areas of focus**, which are out of scope for the proposed areas of service change.

Adopting the Core20 PLUS 5 framework to inform our approach to service redesign and to Consultation, is helping to ensure reducing healthcare inequalities is at the heart of our proposals for the future shape of hospital services across the Humber. In undertaking the programme, we have aligned with other projects across the Humber and North Yorkshire system to ensure a joined-up approach to tackling health inequalities is in place underpinning all plans as they are developed.

[61] NHS Improvement (2018) *The learning disability improvement standards for NHS trusts* Improvement Standards Report

Our population has significantly poorer health outcomes than in other parts of the country. We need prevention, early intervention, self-help and increased support at, or close to, home to improve the overall health and wellbeing of our population – **we cannot rely on hospital services alone.**

In developing the proposals for change, we have considered the barriers to access faced by many within our population, including physical, cultural and socio-economic barriers to improve access, particularly those most in need of care and support. The pathways and site configuration proposed in this pre-consultation business case (PCBC) will support our health and care system to deliver more prevention, early intervention, self-help and increased support at, or close to, home and provide better, more sustainable hospital services when people do need them.

The proposals seek to improve health outcomes for our population and minimise impact.

- We have developed proposals that will enable services to meet nationally-set clinical standards, providing better care for those impacted by poor health in our communities.
- We have developed proposals for more integrated pathways, with community-based supported targeted in deprived communities across the Humber, that will help to address stark inequalities in health and outcomes.
- We have developed proposals that will help us to deliver more proactive care in communities to help people to stay healthy and on top of their conditions.
- We have worked with partners to improve access to skills, training and employment will also help to address some of the underlying issues that lead to poorer health outcomes.
- We have mapped travel times to limit the impact on those facing barriers to access and worked with partners across the voluntary and community (VCSE) sector to develop potential transport solutions.

Improved pathways of care, delivered by a more flexible workforce that can move between organisations and sectors, will help to address the stark health inequalities that are evident within our population, by delivering care that is more tailored to the needs of each individual and reducing the overreliance on secondary care settings that is evident within the Humber health and care system.

The next chapter sets out the **challenges faced within our hospitals** and why the way we deliver care needs to change.

Summary Box 1.5

Chapter 2

Challenges and the Case for Change

2. Challenges and the Case for Change

Our health and care system, as currently configured, is not always meeting the needs of everyone in the region and is not set up to do so in the future.

Our population and its health needs are changing

- Pressure on urgent and emergency care and planned care services is increasing as more people live longer with multiple long-term conditions and demand is significantly higher from those living in the most deprived areas (c.28% of the Humber population).

We are not providing the standards we should be in all our services

- Our services do not deliver the NHS Constitutional Standards or performance standards, particularly in relation to waiting times and patient access. Too many patients are waiting too long to be seen and treated.
- We are struggling to meet a number of key Clinical Standards, due to workforce shortages and the way in which services are configured – duplicating 24/7 on-call teams across sites for small volumes of patients means we are unable to provide 7-day consultant reviews.

We don't have enough staff to continue to do everything everywhere

- Gaps in rotas put pressure on existing teams and increase our reliance on agency staff, increasing costs and impacting on patient experience – over £55 million was spent across the two hospital trusts on temporary staffing (agency and locum) in 2022/23.
- With over 30% of our staff eligible to retire within the next five to 10 years, it is imperative that we plan for workforce changes now.

Some of our buildings and equipment are falling apart and are not fit for the future

- Our ageing estate, equipment and digital infrastructure is not fit for purpose and impacts upon our ability to deliver effective care to meet the demands we face.

We face structural deficits and long-running finance and performance issues

- A structural deficit exists where we are providing the same service across multiple sites, which creates pressure on staff, results in double running costs and low productivity.

To address these challenges we need to substantively change how we provide care for the population of the Humber.

The proposals outlined within the PCBC seek to address these challenges through two main areas of change – improved pathways and changes to the configuration of services (where and how they are delivered). The pathway changes will improve outcomes for patients through better, more joined-up care. They also create opportunities for the development of staff and new roles, working across sectors, to improve recruitment and retention and reduce agency spend. **The proposed configuration changes would enable us to make better use of our highly skilled staff, reduce double-running and provide services that meet key clinical and constitutional targets and that are clinically sustainable in the long-term.** The prosed changes – and estates changes that would be required – can be delivered within existing financial resources, enabling many of the identified benefits to be realised quickly.

Summary Box 2.1

2.1 Organisational Snapshot: HUTH and NLaG

2.1.1 Overview of Service Provision

Hull University Teaching Hospitals NHS Trust (HUTH) and Northern Lincolnshire and Goole NHS Foundation Trust (NLaG) provide a wide range of secondary care services from five hospital sites: Hull Royal Infirmary (HRI), Castle Hill Hospital, Cottingham (CHH), Scunthorpe General Hospital (SGH), Diana Princess of Wales Hospital, Grimsby (DPoW) and Goole and District Hospital (GDH). In addition, HUTH provides a range of specialist (tertiary) services for the wider region and NLaG provides community services in the North Lincolnshire area.[62]

Organisational Snapshot								
Indicator	**HUTH 19/20**	**HUTH 20/21**	**HUTH 21/22**	**HUTH 22/23**	**NLaG 19/20**	**NLaG 20/21**	**NLaG 21/22**	**NLaG 22/23**
Turnover £'000m	£630	£726	£600	£707	£413	£477	£478	£537
Staff (WTE)	8,062	8,390	7,920	8286	6,282	6,595	6,695	6,917
Emergency Dept Attendances	134,590	106,563	126,369	121,689	148,503	123,895	147,849	152,856
Births *(excluding home births)*	4,869	4,828	4,900	4,798	3,955	3,605	3,802	3,652
Elective (day case + inpatient)	88,181	54,572	80,519	90,738	59,453	40,453	54,484	54,452
Outpatient appointments	782,371	634,166	787,872	791,848	416,993	343,952	398,317	449,444

Table 2.1 Organisational Snapshot[63]

Picture 2:A Summary of activity at Humber hospitals

[62] A detailed description of the current configuration of services by site is provided in appendix 10.2.
[63] *Internal Trust data* (updated June 2023)

2.1.2 Overview of Challenges

The Humber Acute Services programme was established in response to a number of key challenges faced by Hull University Teaching Hospitals NHS Trust (HUTH) and Northern Lincolnshire and Goole NHS Foundation Trust (NLaG) in providing effective hospital services for the population of the Humber.

Key challenges:

- **Our population is getting older**, and many people – including children – live in deprived areas with increasingly complex healthcare needs.
    - *We need to join up better with services outside of hospital that can help people to stay well and avoid coming into hospital in an emergency.*
- **We are not meeting national clinical standards** due to the way services are organised.
    - *We need to stop double-running trying to cover multiple small services across different sites so we can deliver better, more sustainable services in the long run.*
- **Our services do not deliver the NHS Constitutional Standards** or performance standards, particularly in relation to waiting times and patient access.
    - *We need to improve our pathways so that we can see and treat people who come to our Emergency Departments more quickly.*
- **Our staff are spread too thinly across our existing services**, and we are not able to recruit and retain the workforce we need.
    - *We need to change the way we deliver care to make roles more attractive and build the workforce we need for the future.*
- **Many of our buildings and much of our equipment is out of date**, and we have limited access to the investment we need to improve or replace them.
    - *We need to maximise the benefit we can derive from recent investments (e.g. new Emergency Department buildings in Diana Princess of Wales Hospital, Grimsby (DPoW) and Scunthorpe General Hospital (SGH) and Community Diagnostics Centre in Scunthorpe town centre) and continue to seek further infrastructure funding where we can.*
- **We face significant financial challenges,** and we are not delivering efficient services due to their site configuration and service models.
    - *We need to reduce the amount we are spending on expensive agency staff to plug gaps in rotas and look at other ways to make services more efficient.*

Summary Box 2.2 - Overview of challenges

Organisational Performance Snapshot							
Indicator	Target/ Benchmark	HUTH 20/21	HUTH 21/22	HUTH 22/23	NLaG 20/21	NLaG 21/22	NLaG 22/23
CQC Rating	Good	**Requires Improvement**			**Requires Improvement**		
Vacancy Rate	8.3%	**7.6%**	**4.4%**	**3.7%**	**10.3%**	**9.3%**	**11.4%**[64]
Emergency Dept (ED) (4hrs)	95%	**78%**	**58%**	**54%**	**81%**	**63%**	**60%**
Ambulance Handover (+60mins)	0	**1221**	**3808**	**7552**	**639**	**5564**	**7088**[65]
ED Decision to Admit + 12hrs	0	**2**	**225**	**17,209**	**106**	**1802**	**12,949**
Diagnostic Procedure wait – 6weeks	99%	**63%**	**37.1%**	**32.2%**	**64.2%**	**69%**	**71%**
Cancer 62 days to treatment[66]	85%	**63%**	**60%**	**24%**	**68%**	**63%**	**52%**
Cancer waits +104 days	0	**83**	**531**	**871**	**32**	**27**	**40**
18 weeks RTT	92%	**52%**	**57%**	**62%**	**65%**	**72%**	**65%**
Inpatient non-elective length of stay	4.59	**8.6**	**5.9**	**6.4**	**4.2**	**3.8**	**3.7**
Inpatient elective length of stay	4.15	**4.2**	**4.1**	**4.1**	**2.0**	**2.3**	**2.2**
No criteria to reside[67]	12%	**10.9%**	**7.4%**	**23.1%**	**10.1%**	**30.7%**	**24.3%**
Bed occupancy	<92%	**82.4%**	**76.8%**	**92.0%**	**82.8%**	**92.5%**	**91.8%**
Backlog Maintenance (£m)	-	**80.5**	**78.3**	**84.6**	**89.8**	**107.7**	**117.0**

Table 2.2 Performance challenges HUTH and NLaG

[64] Vacancy rate at Jan 2023
[65] Data up to Jan 2023 (full year figures not yet available)
[66] An additional standard was introduced in April 2021 for faster diagnosis of suspected cancer (within 28 days).
[67] This is recorded as weekly snapshot data and therefore only represents the situation at a given time not the overall trend. The data provided is for the first week in April 2020 and April 2021, respectively. 2022/23 data is provided as a full year average.

2.2 The Changing Needs of our Population

The nearly 1 million people who live in the Humber face a number of **health-related challenges** and often face **barriers to accessing services** associated with living in rural or coastal communities and/or in areas of high deprivation.

These challenges can lead to poorer health outcomes and increased demand for hospital care – particularly urgent and emergency care services (see section 1.4).

The proposed changes have been designed to enable more care to be delivered closer to home to support an older population with increasingly complex health and care needs and respond to what children and families have told us is most important to them (see section 10.8). The proposed changes will help to ensure we can **deliver high quality care that is sustainable in the longer term**.

Summary Box 2.3 Population health challenges

2.2.1 Changing levels of demand

The growing number of people living with one or more long-term condition is contributing to an increase in demand for urgent and emergency care and planned care services that needs to be met in a different way.

2.2.1.1 Urgent and Emergency Care – rising ED demand

Our hospitals are experiencing a significant rise in demand and acuity in the Emergency Departments. At the onset of the COVID-19 pandemic, services experienced a substantial decrease in ED demand, however, this has increased back to pre-pandemic levels in 2021/22. Overall, the trend has been one of increasing Emergency Department attendances in most hospitals year on year.

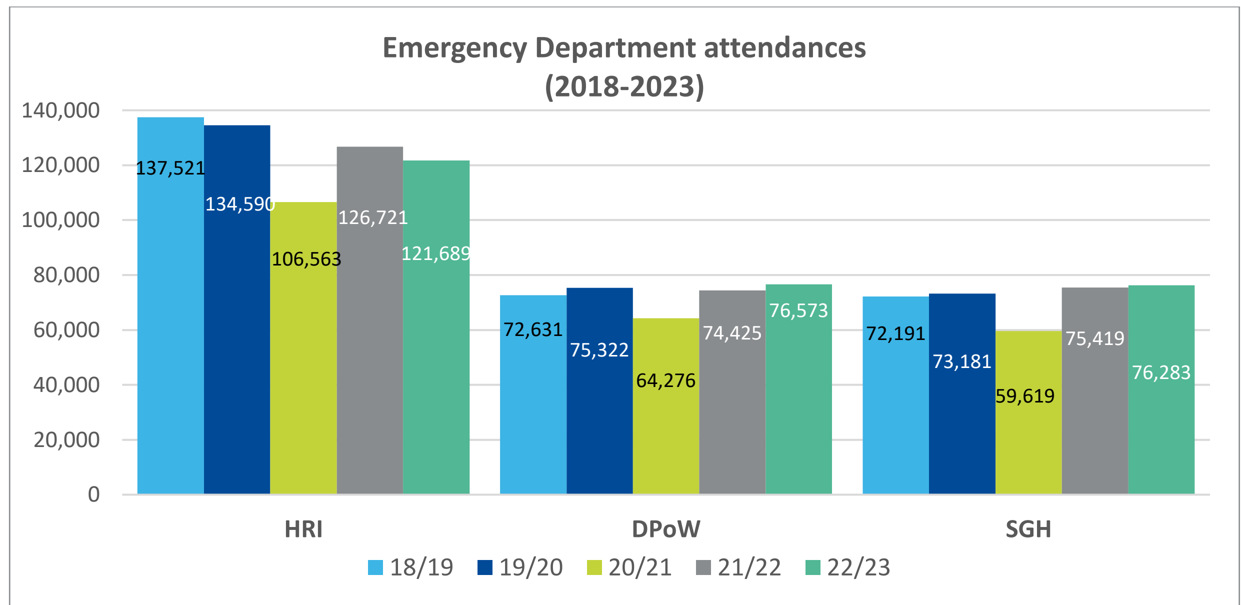


Figure 2.1 Emergency Department Attendances (2018-2023)[68]

[68] *Internal trust data* (updated June 2023)

Furthermore, natural population growth suggests a further rise in Emergency Department (ED) demand across the Humber in the next 10 years, with much of this expected amongst the growing frail and elderly population. Projections are up to a 5% rise in ED attendances by 2026 if current patterns of ED use continue with no change. This equates to approximately an additional 55 patients per day in both DPoW and SGH and 100 patients per day in Hull.

2.2.1.2 Planned Care – rising demand

Planned care specialities across both trusts are experiencing year-on-year increases in referrals. Despite the increase in referral volumes, staff and other resources have not increased in line with demand, putting additional pressure on services.

Speciality	HUTH	NLaG	
ENT	27%	61%	This data is patients who are referred to the two hospital trusts. Independent sector providers also receive significant numbers of referrals especially in Orthopaedics and Ophthalmology without this additional capacity the two hospital providers would have experienced a greater increase.
Gastroenterology	5%	14%	
General Surgery	21%	32%	
Orthopaedics	24%	17%	
Ophthalmology	-15%	9%	
Urology	34%	44%	

Table 2.3 1st OP appointments Change between 2015/16 & 2018/19[69]

Whilst referrals tailed off at the start of the COVID-19 pandemic, they began to rise again in late 2020 and have now returned to pre-pandemic levels. The disruption to planned case services during the pandemic has compounded already high waiting times for many planned care specialties across the Humber region. Long waiting times for planned care can have a knock-on impact on urgent and emergency care if a patient's condition worsens whilst awaiting treatment.

2.2.2 Impact of Deprivation

Across all service areas, the level of acuity of patients and the complexity of their healthcare needs is increasing. This is driven by the population health challenges described in section 1.4 and the impacts of deprivation on health. Deprivation is unevenly spread across the population and disproportionately affects children and young people – around 16% of the Humber population is classed as income deprived but nearly 1 in 4 (22%) of all children in the region live in poverty.

The proposed changes have been designed to ensure those living in the most deprived communities will be able to access high quality healthcare that meets national clinical standards and will continue to have access to a 24/7 Emergency Department when they need care unexpectedly.

2.2.2.1 Urgent and Emergency Care – High Intensity Users

Use of Emergency Departments is closely correlated with deprivation, with those living in the most deprived areas accounting for a higher proportion of overall ED attendances and emergency admissions. Nationally, figures show that there were nearly twice as many attendances to Emergency Departments in England for the 10% of the population living in the most deprived areas (3.1 million), compared with the least deprived 10% (1.6 million) in 2019/20.[70]

[69] *Internal trust data* (June 2021)
[70] NHS Digital (2020) *Hospital Accident & Emergency Activity 2019-20* A&E Activity 2019-20

Across the Humber and North Yorkshire region fewer than 1% of residents accounted for nearly 20% of all ED usage in 2020/21: this equates to just over 5,000 people having around 37,000 ED attendances. National evidence suggests that this small group of people also account for 29% of ambulance transfers to Emergency Departments.

High intensity use – attending Emergency Departments (2021)	East Riding	Hull	North East Lincolnshire	North Lincolnshire
Number of people who attended 5-10 times	1,004	1,735	876	942
Number of people who attended between 11-19 times	57	175	83	80
Number of people who attended more than 20 times	13	66	23	18
Total number of people who attended over 5 times	1,074	1,976	982	1,040
Actual number of attendances that these groups generated	7,112	15,197	7,217	7,407
Total ED attendances (all people) during this period	52,507	67,779	48,068	47,015
% of Populations who attended more than 5 times	0.35%	0.65%	0.58%	0.57%
% of Attendances that were generated by these groups.	**13.5%**	**22.4%**	**15.0%**	**15.8%**

***Table 2.4 High Intensity Users - Humber EDs*[71]**

2.2.2.2 Child poverty

The number of children living in poverty is significantly higher in the Humber than in England as a whole. 1 in 3 children in Hull (30.7%), 1 in 4 children in North East Lincolnshire (24.8%) and 1 in 5 children in North Lincolnshire (20.8%) live in poverty. This impacts on children's health and wellbeing and their future health and life chances.

	East Riding	Kingston Upon Hull	North Lincolnshire	North East Lincolnshire	National average
Children living in poverty under 16 years (2021/22)	14.8%	28.2%	21.3%	23.5%	19.9%
Health and wellbeing of children in area compared to England average	Better	Worse	Mixed	Mixed	N/A
School pupils with social, emotional and mental health needs (2020)	1.8%	2.1%	3.0%	2.3%	2.4%
School children from minority ethnic background	8.3%	21.5%	15.9%	10.1%	33.6%
Levels of child obesity by Year 6	18.2%	23.4%	22.7%	22.6%	21.0%

***Table 2.5 Child health profiles by Local Authority*[72]**

Obesity and a wide range of other conditions that impact upon young peoples' physical and mental health and wellbeing are closely correlated with deprivation. High levels of child poverty and deprivation create higher demand for health services, particularly in Emergency Departments and Paediatric Assessment Units. Services for the future need to be designed to support the wider health and social care needs of children and young people across the Humber.

[71] HNY Urgent and Emergency Care Network (May 2022) *Right Place First Time: How do we make it happen for people who regularly use emergency departments to access health care* Data pack (see document library)
[72] Office for Health Improvement and Disparities – OHID (2022) *Child Health Profiles* Fingertips

We are also working to exploit the opportunities for our hospitals, as anchor institutions, to address some of the wider determinants of health for young people and their families by providing good quality employment opportunities and working with education providers to ensure those from more disadvantaged backgrounds are able to take advantage of those career opportunities. The work we have undertaken with partners in developing this PCBC will enable us to provide better entry routes for local young people to develop fulfilling and rewarding careers in health and care.

2.2.2.3 Long-term conditions – planned care waiting times

The proportion of the population living with one or more long term condition is increasing, putting further strain on our planned care services, with increasing demand for outpatient appointments already evident within our system. Evidence shows that populations living in areas of higher deprivation are increasingly likely to have multiple conditions, more likely to deteriorate while waiting for surgery and are least likely to be able to engage with digital solutions.[73] This puts pressure on our urgent and emergency care services as people are more likely to turn up at A&E if their condition worsens and they need help.

In addition, the impact of the COVID-19 pandemic on waiting times for planned care has been felt disproportionately by those in the most deprived areas. A year after the onset of the pandemic, those living in the most deprived areas were nearly twice as likely to wait more than a year for treatment compared to those living in the least deprived areas.[74]

The growing number of people living with one or more long-term condition is contributing to an increase in demand for urgent and emergency care and planned care services that needs to be met in a different way.

The proposed changes have been designed to ensure those living in the most deprived communities will be able to access high quality healthcare that meets national clinical standards and will continue to have access to a 24/7 Emergency Department when they need care unexpectedly.

[73] GiRFT (2022) *Design and layout of elective surgical hubs – a guide for NHS systems and regions to support planning of effective surgical hubs* GiRFT Report p.6
[74] The Kings Fund (2021) *Tackling the elective backlog – exploring the relationship between deprivation and waiting times* online article

2.3 Meeting Clinical and Constitutional Standards

Our staff are spread too thinly across hospital sites, with relatively small services provided from a number of different hospitals; this means that we are **not always able to meet clinical standards** set nationally and that jobs for our staff are tougher than in other parts of the country. We also spend more on agency and other temporary staffing than many other hospitals.

We are **duplicating 24/7 on-call teams** across sites for small volumes of patients and we are unable to provide 7-day consultant reviews, meaning our patients spend longer in hospital to get the same care and treatment than in many other parts of the country – impacting on the efficiency of our services.

Our services do not deliver the NHS Constitutional Standards or performance standards, particularly in relation to waiting times and patient access. Waiting times for routine surgery are amongst the longest in the country and last year over 30,000 people waited more than 12 hours in one of our Emergency Departments waiting to be admitted or treated and sent home.

Many of our services were not meeting key standards prior to the onset of the COVID-19 pandemic when the Case for Change was written and published. In most areas those **challenges have been exacerbated by the pandemic and the situation has worsened**.

Summary Box 2.4 Challenges meeting standards

There are two key sets of standards that we are required to deliver in our acute hospital services:

- Constitutional standards
- Clinical standards

In both cases, we are falling short across a range of services due to workforce challenges, limitations with our buildings and, crucially, due to the ways in which services are configured and operate.

2.3.1 Constitutional Standards

The growing demand and rising acuity of patients attending our Emergency Departments and waiting for treatment means that we are not meeting the standards we should be across a wide range of hospital services.

The proposed changes have been designed to improve the efficiency and effectiveness of services, through better, more joined-up pathways of care, enabling us to meet key waiting time standards in the longer term.

The NHS Constitution[75] sets out key waiting time and access standards for acute hospital services. **In all service areas, both hospital trusts face significant challenges delivering these standards.**

[75] NHS England (2021) *The NHS Constitution for England* NHS Constitution

- **Urgent and Emergency Care**
    - A maximum four hour wait in A&E from arrival to admission, transfer or discharge.[76]
    - Ambulance trusts response time targets.[77]
- **Elective Care**
    - Patients have the right to start consultant-led treatment within a maximum of 18 weeks from referral for non-urgent conditions.[78]
    - Patients waiting for a diagnostic test should have been waiting fewer than six weeks from referral.
    - All patients who have operations cancelled, on or after the day of admission (including the day of surgery), for non-clinical reasons should be offered another binding date within 28 days, or the patient's treatment to be funded at the time and hospital of the patient's choice.
- **Cancer Care**
    - The right to be seen by a cancer specialist within a maximum of two weeks from GP referral for urgent referrals where cancer is suspected.
    - A maximum one-month (31-day) wait from diagnosis to first definitive treatment for all cancers and a maximum 31-day wait for subsequent treatment.
    - A maximum two-month (62-day) wait from urgent referral for suspected cancer to first treatment for all cancers. [79]

Summary Box 2.5 NHS Constitutional Standards

2.3.1.1 A&E Waiting Times and Ambulance Handovers

Our hospitals are not achieving the expected performance standards. An increased number of attendances combined with new infection control measures have impacted on patient flow. This is also combined with challenges around staffing. As a result, a greater proportion of patients are now waiting for more than four hours to be seen and treated in our Emergency Departments across all three hospitals. Performance was consistently below the 95% target throughout the whole of 2019/20 and worsened significantly in 2021/22, with performance continuing to deteriorate through 2022/23.

The addition of an Urgent Care Service within Scunthorpe General Hospital (co-located with the Emergency Department) has enabled Scunthorpe to perform better than Hull Royal Infirmary and Diana Princess of Wales Hospital, Grimsby, but in all three Emergency Departments, performance has been well below the national average most months.

[76] A&E 4-hour standard requires that 95% of patients are seen and treated within 4 hours and that no patient should be in the department for longer than 12 hours.
[77] Emergency Departments are expected to enable ambulances to hand over patients within 15 minutes (100% target).
[78] RTT standard requires that 92% of patients begin treatment within 18 weeks of referral.
[79] Cancer 62-day target requires 85% of patients begin treatment within 62 days of urgent referral.

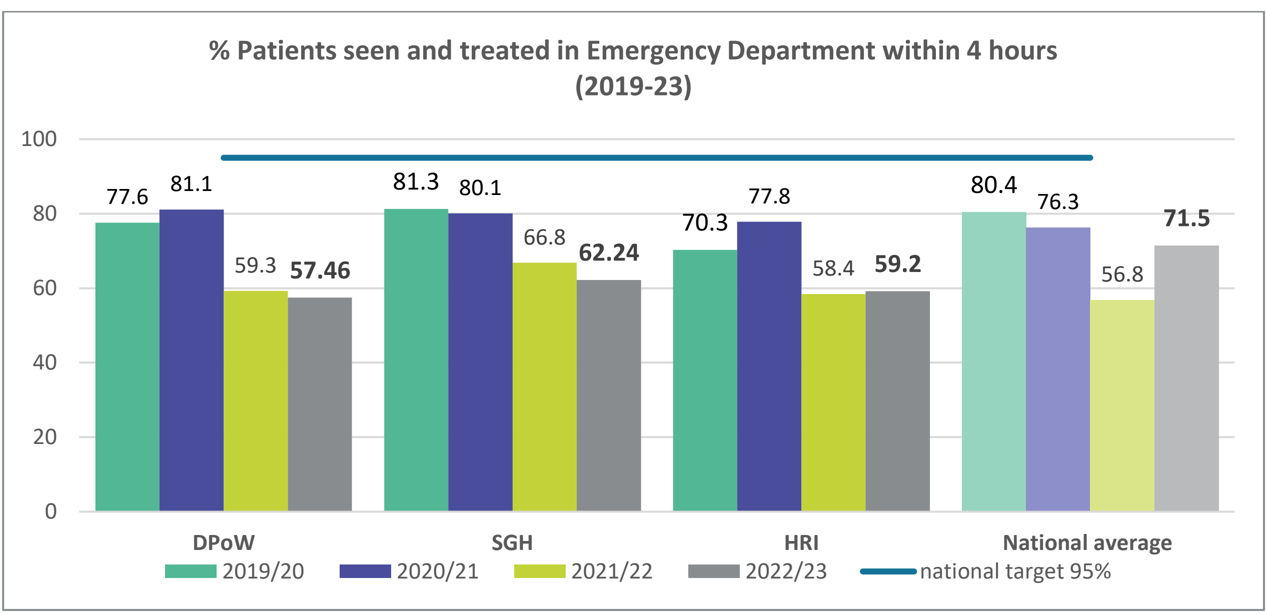


***Figure 2.2 Patients seen and treated in Emergency Department within four hours*[80]**

There are instances where patients have waited more than 12 hours in our Emergency Departments due to various factors from complicated clinical acuity, awaiting a bed to be admitted to a ward, transport to either go home or be conveyed to another hospital. This is not good practice and does not support our ambition to provide a positive patient experience. The position has deteriorated significantly over the past 12 months and continues to be a challenge for Grimsby and Scunthorpe hospitals in particular.

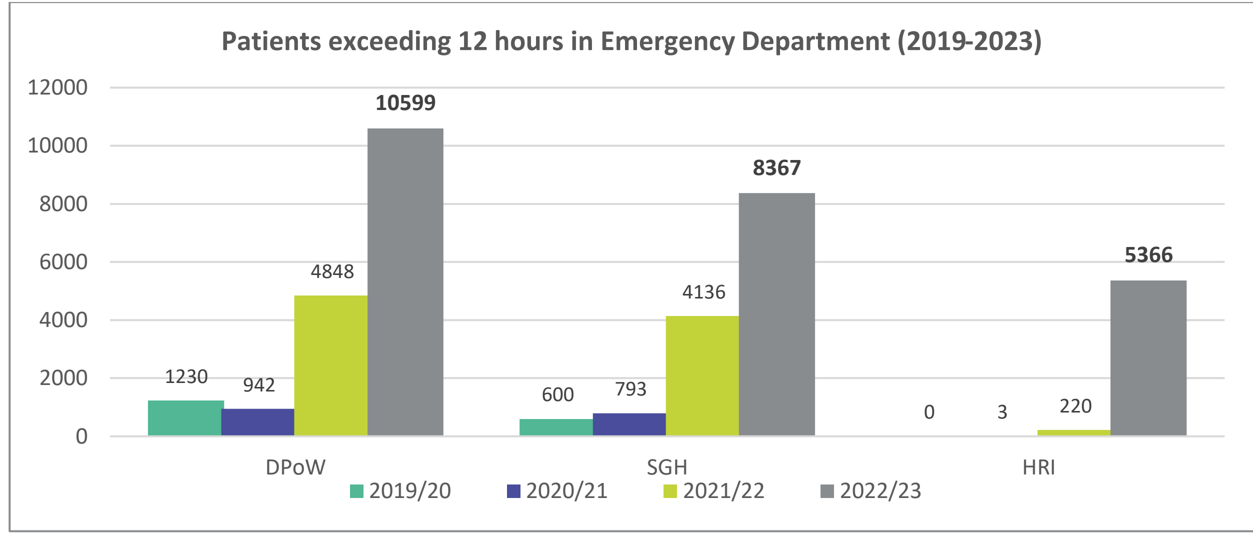


***Figure 2.3 Patients exceeding 12 hours in ED (2019/20 to 2021/22)*[81]**

Pressures within the Emergency Department have a knock-on effect on ambulance handover times due to space and staffing, which consistently fall below the 15-minute target in all three Emergency Departments. This impacts on the ability of ambulance providers to meet their constitutional targets in relation to response times to incidents as their crews and vehicles are tied up in hospital Emergency Departments.

[80] *Internal trust data* (updated June 2023)
[81] *Internal trust data* (updated June 2023)

All three hospitals have seen a spike in ambulance handover delays in the past year, worsening performance, which was already well below the expected level in 2019/20. This is predominantly due to excessive demand, workforce shortages and the departments being at full capacity.

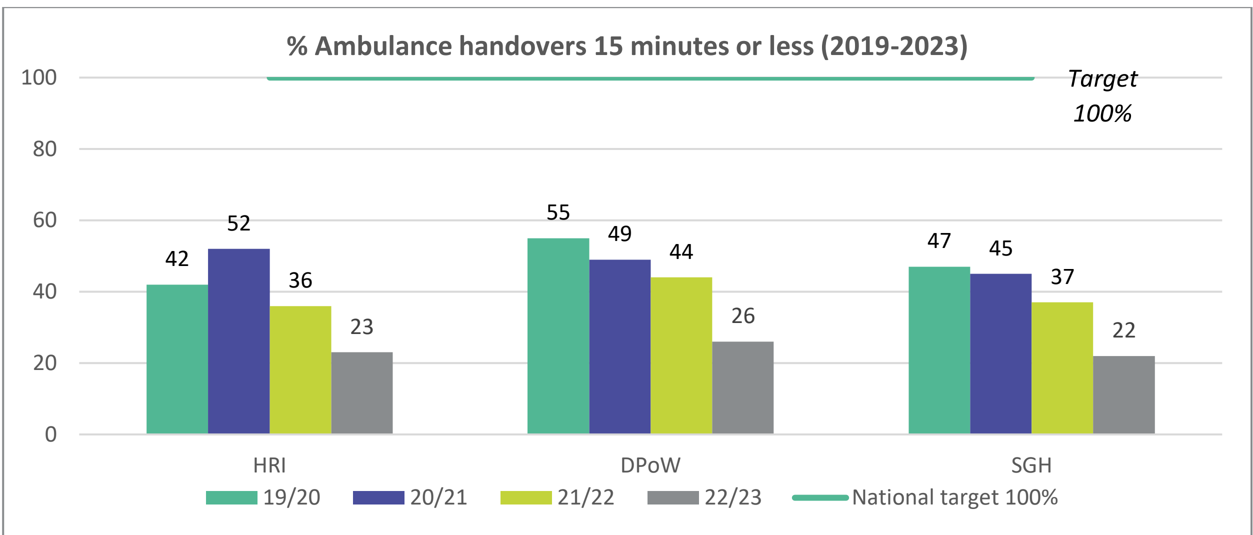


Figure 2.4 Ambulance handovers within 15 minutes (2019 - 2022) [82]

The development of integrated assessment pathways within the hospitals will help to improve the flow of patients and tackle long waits at the front door. Improved pathways and interventions outside of hospital will help to reduce the overall demand for our Emergency Departments and wider hospital services.

2.3.1.2 Referral to Treatment (RTT) Performance

Similar challenges also exist in relation to meeting the constitutional standards for planned care. When the Case for Change was published in 2019, both trusts were in the bottom quartile for performance against the referral to treatment time (RTT) standard and had not met the standard for treating patients within 18 weeks of referral from primary care in any of the six specialties identified within the Case for Change for five years or more.

The situation has worsened significantly since 2020 and the impact of the pandemic. The total waiting list size and numbers of patients waiting more than 52 weeks for treatment has grown significantly as a result of the pandemic. Specialties that were previously meeting or getting close to delivering the RTT standard are now consistently falling short.

As a result, people living in the Humber region are waiting longer for treatment than those in other parts of the UK. This means, often, that they are living for longer with pain and/or uncertainty as well as the knock-on effects waiting for treatment can have on an individual’s quality of life, mental health and ability to be economically active. It also puts additional pressure on urgent and emergency care services should a patient’s condition worsen whilst they are waiting for treatment. Waiting for treatment can also impact on an individual's ability to work or learn and for older people it can make it harder to maintain independence.

[82] *Internal trust data* (updated June 2023)

	Total waiting list size				Patients waiting >1 year			
	Nov 2019	Nov 2021	Nov 2022	May 2023	Nov 2019	Nov 2021	Nov 2022	May 2023
Hull University Teaching Hospitals	52,843	61,513	69,066	69,236	0	5,558	5,362	3,848
Northern Lincolnshire and Goole	25,138	30,149	35,281	37,505	9	380	411	673

Table 2.6 Total waiting list size (HUTH and NLaG) – Covid impact[83]

In addition, we do know that there are "hidden" waiting lists due to delayed referrals and people putting off seeking treatment. It is estimated that nationally there could be as many as 10 million patients who might have otherwise come forward for treatment but did not.[84]

Enabling plans and principles developed for planned care will help to ensure the impact of surges in demand for urgent and emergency care is lessened in the future – enabling the system to better meet constitutional targets for waiting times for care.

2.3.1.3 Cancer Waiting Times Performance

Pressures on our diagnostic services also impact on performance against key Cancer waiting time targets, which is significantly below national targets in both HUTH and NLaG.

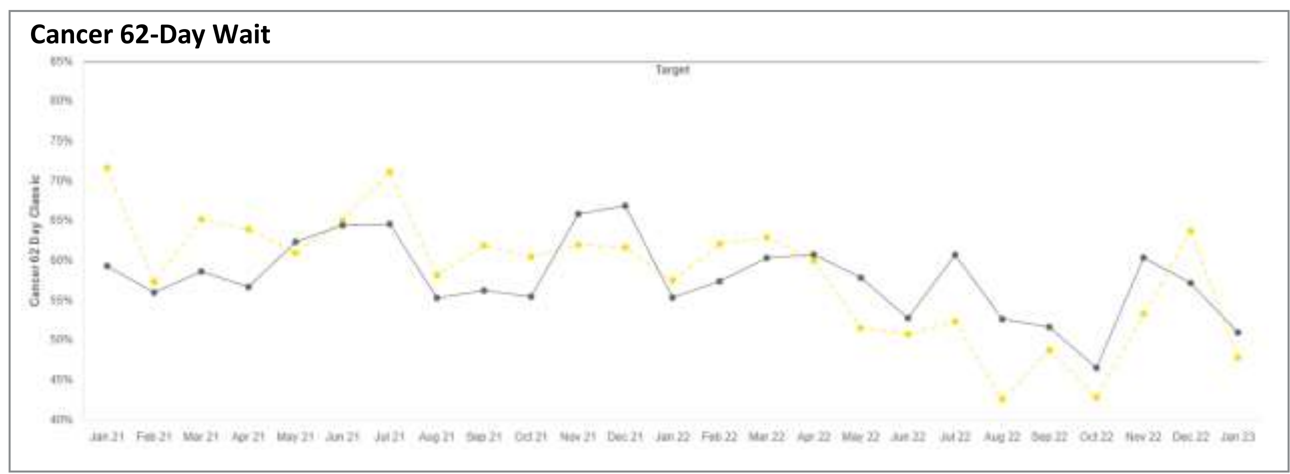


Figure 2.5 Cancer 62-Day Wait (HUTH and NLaG)[85]

Enabling plans for diagnostics will help to improve access to diagnostic services – enabling the system to better meet constitutional targets for waiting times for care.

[83] NHS England (2023) *Consultant-led Referral to Treatment Waiting Times* (*monthly snapshot data*) RTT waiting times data
[84] NHS England (2022) *Delivery plan for tackling the COVID-19 backlog of elective care* Delivering Elective Recovery
[85] NHS England (2023) *Cancer Waiting Times* (*monthly provider snapshot data*) Cancer waiting times data

2.3.2 Clinical Standards

Our staff are spread too thinly across hospital sites, with relatively small services provided from a number of different hospitals, which means that we are **not always able to meet clinical standards** set nationally. For example, specialty medical services currently provide senior review for patients approx. 3 to 4 days a week only because they are spreading their rotas across two sites. This can lead to delays to treatment and longer lengths of stay for those patients.

There are many important clinical standards that need to be met to ensure services can continue to be provided safely on an ongoing basis. These can include services caring for a specific number of patients or doing a set number of procedures or operations to ensure staff maintain the necessary level of skill and competency. They can also relate to staffing levels, ratios of staff to patients and/or the skill mix of teams caring for patients.

Clinical Standards are set by a range of organisations including Royal Colleges, regulators and advisory bodies (such as NICE). Across the Humber region, many of our services are struggling to meet key clinical standards, some or all of the time. Many of our services need trained staff to cover rotas 24/7, 365 days a year and we don't have enough staff to do this for all our services, all the time. This means that some staff are on the rota more than we would like them to be and gaps have to be filled with agency or locum staff, increasing the risk to delivering services safely on an ongoing basis and also having a potential negative impact on the quality of care that can be provided with unfamiliar or transient staff. Current services are failing to consistently achieve the standards required across a range of indicators.

Achieving	*Partially achieving*	*Not achieving*

Clinical Standards - Urgent & Emergency Care	**HRI**	**DPoW**	**SGH**
Patients to be seen and treated within 4 hours (95% standard)	Not achieving	Not achieving	Not achieving
Ambulance handovers within 15 minutes	Not achieving	Not achieving	Not achieving
Consultant assessment within 14 hours of admission to determine the person's care pathway	Achieving	Partially achieving	Partially achieving
Daily consultant review, including weekend and bank holidays	Not achieving	Not achieving	Not achieving
More frequent consultant review, based on clinical need	Not achieving	Not achieving	Not achieving
Royal College workforce recommendations (Emergency Medicine, Acute Medicine, Emergency Surgery)	Partially achieving	Partially achieving	Partially achieving
Fractured neck of femur (hip fracture) to be operated on within 36 hours	Achieving	Partially achieving	Partially achieving
Suspected stroke – thrombolysis within 60 minutes of arrival for eligible patients	Achieving	Partially achieving	Partially achieving
Adults with non-ST-segment-elevation myocardial infarction (NSTEMI) or unstable angina who have an intermediate or higher risk of future adverse cardiovascular events who are having coronary angiography *(with follow-on percutaneous coronary intervention [PCI] if indicated)*, have it within 72 hours of first admission to hospital	Achieving	Partially achieving	Partially achieving

Support services to ensure transfer to community, primary and social care and response to urgent and emergency mental health care 7 days a week			
Patients aged over 65 and frail or 80 or over should have multidisciplinary input that includes early involvement of geriatrician teams			
Trauma Standards – CT within 30 / 60 minutes			
Clinical Standards - Paediatrics	**HRI**	**DPoW**	**SGH**
Consultant led care service seven days a week			
Royal College workforce recommendations (e.g. Paediatrics - facing the future)			

Table 2.7 Summary of performance against clinical standards (UEC/MNP)[86]

2.3.2.1 Urgent and Emergency Care – key standards

We are not currently providing 7-day consultant-led services for all specialties, which means that patients get a different response depending on whether their emergency occurs during the day or overnight. This means that some patients stay longer than they need to and have poorer outcomes.

Changing the way in which the workforce is deployed, will enable us to deliver more of the key clinical standards and improve outcomes for patients.

Emergency Departments are complex settings managing a wide range of patients and patient needs and are required to deliver on a number of key clinical standards published by Royal Colleges, NICE and other regulatory bodies.[87] Many clinical standards relate to specific conditions (e.g. fractured neck of femur or stroke, which need to be treated within a specific time window) and others to specific patient cohorts (e.g. patients aged over 65 and frail or over 80). For example, patients who require angiography following a heart attack (NSTEMI) or because they are at increased risk should be treated within 72 hours, according to national guidance.[88] Currently such patients are admitted and monitored (often for several days), because 7-day consultant cover is not available on either site. The proposals have been designed to enable 7-day services to be provided, enabling patients to be reviewed by a consultant and treated within this time window.

There are other clinical standards that relate to staffing levels, experience and skill mix of those working in Emergency Departments.[89] Within our existing Emergency Departments, services are not always meeting these standards and other best practice guidance. In particular, it is extremely difficult to meet the workforce requirements and deliver the right skill mix and level of specialist input within all three Emergency Departments on a 24/7 basis. For example, within the Emergency Departments at Grimsby and Scunthorpe, providing sufficient specialty doctors to run the departments requires three shifts per day, seven days a week. Between the 14 staff currently employed in these roles, they are required to work 1 in 4 (or 5) weekends and 1 in 4 (or 5) night shifts, which makes some of these rotas

[86] *summary table collated from internal trust data* (updated June 2023)
[87] Royal College of Emergency Medicine (2022) *RCEM Clinical Standards* RCEM Guidance
[88] National Institute for Health and Care Excellence – NICE (2020) *Quality Standard [QS68] – Acute coronary syndromes in adults* Quality Standard
[89] Royal College of Nursing and Royal College of Emergency Medicine (2020) *Nursing Workforce Standards for Type 1 Emergency Departments* RCN Report

unsustainable and impacts on training. The rota should be aiming for 1 in 8 to safely staff and reduce the risk of tiredness and subsequent low morale.

The situation increases our reliance (and spend) on agency and locum staff to cover shortages and leaves services more vulnerable and at risk of failing should existing members of staff become ill and unable to work or move to another job. This has happened on a number of occasions in recent years within both HUTH and NLaG due to the number of services operating with shortages in key specialisms. We have, often at short notice, had to make changes to the way in which particular specialties are delivered to ensure they can continue to operate and keep patients safe.

2.3.2.2 Facing the Future standards for Paediatric services

It is getting increasingly challenging to deliver key clinical standards for 7-day consultant-led services for children and young people across our hospital sites. Meeting the requirements for training rotas and ensuring trainees have sufficient exposure to enough complex cases is difficult to deliver in smaller units.

Changing the way in which services are organised will enable us to deliver more of the key clinical standards, improve training for staff and improve outcomes for patients.

The publication of the 'Facing the Future' standards in 2010 presented a vision of how paediatric care can be delivered to provide a safe and sustainable, high-quality service that meets the health needs of every child and young person, both in hospital and closer to home.

The report *Facing the Future: Standards for Acute General Paediatric Services* marked a move towards services being delivered 24 hours a day, seven days a week with services organised around the child, ensuring quick access to an expert opinion.[90] The Royal College of Paediatrics and Child Health (RCPCH) accepted that implementation of the standards would necessitate a greater degree of consultant presence than had previously been the case but believed that these standards would bring a level of consistency to what is currently quite a variable pattern of practice.

The standards for *Acute General Paediatric Services* include:

- *A consultant paediatrician is present and readily available in the hospital during times of peak activity, seven days a week.*
- *Every child who is admitted to a paediatric department with an acute medical problem is seen by a healthcare professional with the appropriate competencies to work on the tier two (specialty doctor) paediatric rota within four hours of admission.*
- *Every child who is admitted to a paediatric department with an acute medical problem is seen by a consultant paediatrician within 14 hours of admission, with more immediate review as required according to illness severity or if a member staff is concerned.*
- *At least two medical handovers every 24 hours are led by a consultant paediatrician.*
- *Throughout all the hours they are open, paediatric assessment units have access to the opinion of a consultant paediatrician.*
- *All general paediatric inpatient units adopt an attending consultant system, most often in the form of the 'consultant of the week' system.*

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[90] Royal College of Paediatrics and Child Health (2015) *Facing the Future: Standards for Acute General Paediatric Services* Facing the Future

- *All general paediatric training rotas are made up of at least ten whole time equivalent posts, all of which are compliant with the UK Working Time Regulations and European Working Time Directive.*

For children and young people requiring care outside of hospital, *'Facing the Future – Together for Child Health'* contains standards which apply across the unscheduled care pathway to improve healthcare and outcomes for children. They focus on the acutely mild to moderately unwell child. These standards aim to ensure there is always high-quality diagnosis (safe, effective and caring) early in the pathway, providing care closer to home where appropriate (right care, right time and right place).

The standards aim to ensure specialist child health expertise and support are available directly into general practice services, where the needs of the child and their family are known; and to build good connectivity between hospital and community settings; primary and secondary care; and paediatrics and general practice.

The standards for 'Together for Child Health' are:

- *GPs assessing or treating children with unscheduled care needs have access to immediate telephone advice from a consultant paediatrician.*
- *Each acute general children's service provides a consultant paediatrician-led rapid access service so that any child referred for this service can be seen within 24 hours of the referral being made.*
- *There is a link consultant paediatrician for each local GP practice or group of GP practices.*
- *Each acute general children's service provides, as a minimum, six-monthly education and knowledge exchange sessions with GPs and other healthcare professionals who work with children with unscheduled care needs.*
- *Each acute general children's service is supported by a community children's nursing service which operates 24 hours a day, seven days a week, for advice and support, with visits as required depending on the needs of the children using the service.*
- *Acute general children's services work together with local primary care and community services to develop care pathways for common acute conditions.*

The impact of the Facing the Future Standards for paediatric services across the Humber is significant, with a need for increased Paediatric Consultant resource to meet all of the recommendations. For example, in HUTH in 2019 it was identified that, for a medium sized unit like that at HRI, the number of consultants that exclusively provide acute general paediatric services would need to increase to 9.3 WTE, based on the assumption that all consultants would provide 7.4 programmed activities of acute general work and no sub-specialty services. At that time, the shortfall in programmed activities identified to ensure compliance with the Facing the Future Standards was 29.5 programmed activities.

Given the geographical isolation of the Humber and its impact on recruitment, and the shortage of Consultant Paediatricians nationally, the continued provision of paediatric services from three hospital sites would require significant expansion in consultant paediatric cover in order to maintain Facing the Future compliant medical rotas. This requirement comes on top of existing difficulties in recruiting to vacant consultant posts.

2.4 Workforce Challenges

We have difficulties recruiting and retaining enough staff with the right skills and expertise and there are **significant vacancy challenges** in key services, such as cancer care and midwifery, which are often made worse by national or international shortages. Whilst for many years both trusts have invested significantly in recruitment and retention initiatives, some of which have been very successful, workforce challenges persist across the Humber's hospital services.

Our staff are spread too thinly across hospital sites, with relatively small services provided from a number of different hospitals; this means that we are not always able to meet clinical standards set nationally and that **jobs for our staff are tougher than in other parts of the country**.

We are **duplicating 24/7 on-call teams** across sites for small volumes of patients, which increases cost and puts additional pressure on staff, limiting opportunities for training, research and development.

Last year (2022/23) HUTH and NLaG spent **over £55 million on temporary staffing** (agency and locum) and a further £45 million on bank staff, covering gaps in rotas and ensuring services continue to be delivered safely.

We do not have enough staff to continue to do everything everywhere.

Summary Box 2.6 - Workforce challenges

2.4.1 Workforce profile

Together HUTH and NLaG employ approximately 13,500 whole time equivalent (WTE) members of staff, spanning a range of core skills.

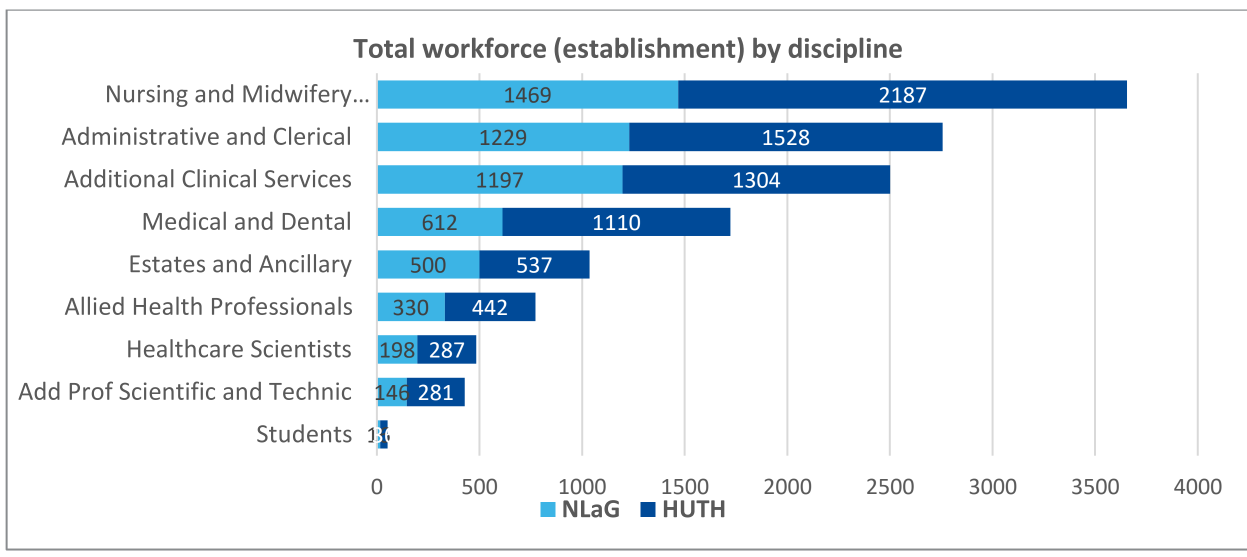
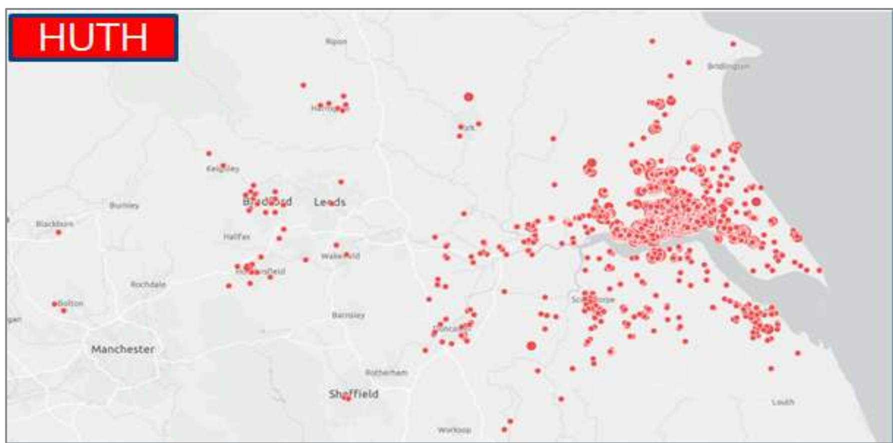


Figure 2.6 Total workforce (establishment) by discipline[91]

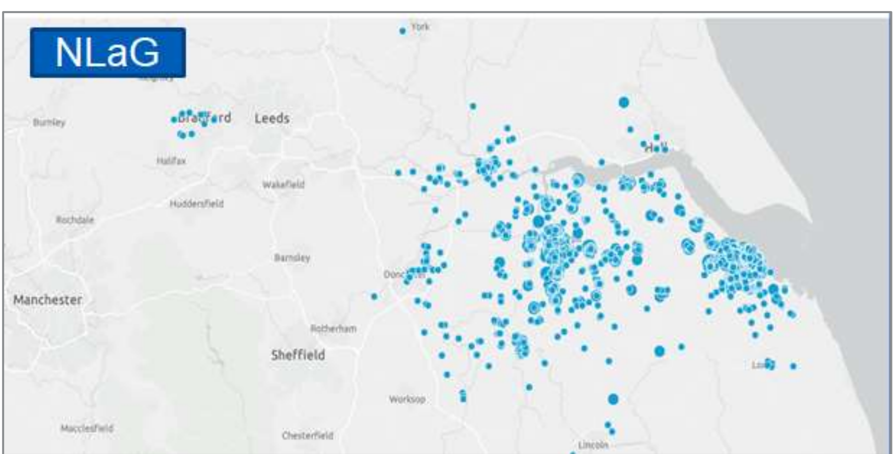
This workforce is drawn primarily from the immediate population, with most residing within easy commuting distance. This is especially true of NLaG where its teams come from the immediate North and North East Lincolnshire communities. In contrast HUTH draws its workforce from communities both to the north and south of the Humber estuary. Recruitment into the sector is drawn mainly from the

[91] *Internal trust data* (updated June 2022)

local population but there are some in senior or professional roles who do relocate into the area to take up employment – this is especially true for many medical and Allied Health Professional (AHP) roles.



Map 2.1 Map of workforce by home postcode – HUTH[92]



Map 2.2 Map of workforce by home postcode - NLaG[93]

The age profile of staff across both trusts is such that a large proportion of staff (over 30%) are eligible to retire within the next five to 10 years. 32.8% of NLaG workforce are 50yrs+ and 29.6% of HUTH workforce are 50yrs+. Some professions are eligible for retirement at 55 years.

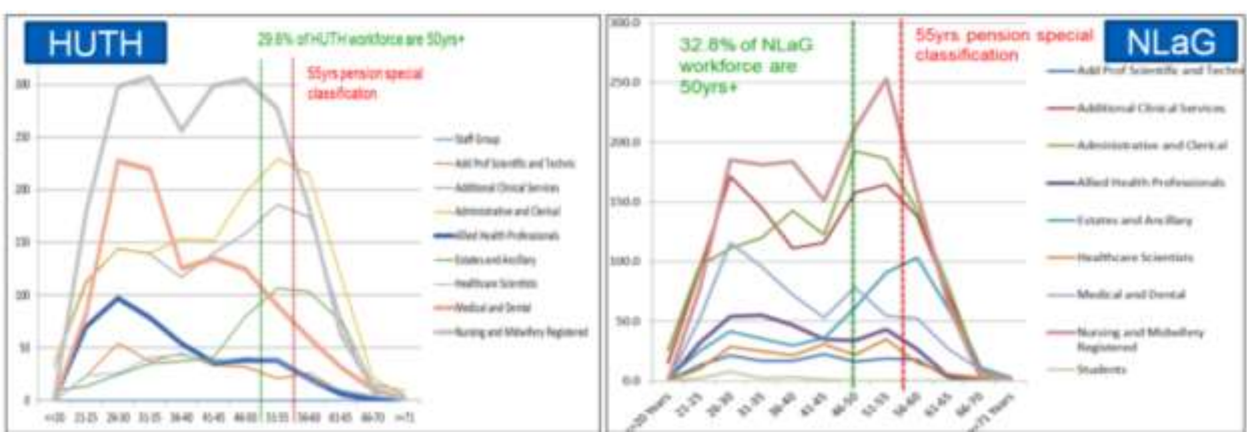


Figure 2.7 HUTH and NLaG Staff Group Age Demographics (2019/20)[94]

[92] *Internal trust data* (mapped May 2022)
[93] *Internal trust data* (mapped May 2022)
[94] *Internal trust data* (March 2022)

Some services may be just about managing to deliver services now; however, we must plan now to ensure we can recruit and retain sufficient workforce to deliver services in the future. On average it takes three years to train a nurse and at least 13 years to train a consultant, so targeted action to address shortages is critical to ensuring the sustainability of services over the long term.

2.4.2 Vacancy rates and skills gaps

We have difficulties recruiting and retaining enough staff with the right skills and expertise and there are **significant vacancy challenges** in key services, which are often made worse by national or international shortages. Where consultant posts are vacant, gaps in rotas are covered by SAS grade doctors or locums, potentially impacting on the quality and sustainability of those services for the longer term.

We need to organise our workforce differently to ensure we are making best use of the skills and expertise we do have.

Whilst for many years both trusts have invested significantly in recruitment and retention initiatives, some of which have been very successful, workforce challenges – vacancies and turnover of staff within key skills areas – persist across the Humber's hospital services. For example, last year (2022/23) there was a vacancy rate of 39.8% within the Cardiology clinical team at Diana Princess of Wales Hospital, Grimsby (DPoW) and a vacancy rate of 23.3% within the Gastroenterology clinical team at Scunthorpe General Hospital (SGH). Trust-wide there was a vacancy rate for registered and unregistered nursing staff of 12% within the medical specialties. Taken together these gaps put significant pressure on existing teams to deliver high quality care on an ongoing basis.

Too often the staff we do have are spread too thinly, trying to cover multiple rotas across multiple sites and are not always matched to the demand for services across the system. Duplication of services across multiple hospital sites is not the most efficient or effective use of resources and dilutes the skilled workforce. For the three main emergency hospitals, the majority of services for all specialities are provided 24/7 on each of the hospital sites. Providing the specialist workforce needed across both Grimsby and Scunthorpe sites for relatively small services, requiring duplicate rotas 24 hours a day is difficult and makes it extremely challenging to ensure that senior decision makers/consultants are present to provide care seven days per week. As a result, it is not uncommon for patients to be admitted whilst they wait for review by a specialist. If services were consistently provided on a 7-day basis, those patients could be assessed and treated the same day, significantly shortening their length of stay and improving their outcomes.

We need to change how we organise services to maximise the number of patients existing staff can see and treat. Our plans have been developed to ensure that we are looking to fill the areas of core skill gaps, maximise the potential of new roles and to recruit locally where possible.

2.4.2.1 Urgent and Emergency Care

Vacancy rates for posts within the Emergency Departments, medical and surgical specialities fluctuate over time but there continue to be challenges ensuring all posts are filled and that services are fully staffed with the right grades and right skill mix at all times. Smaller departments like Scunthorpe and Grimsby are often more difficult to recruit to due to more onerous on call rotas and less exposure to more complex cases.

		Vacancy Factor – Emergency Departments			
		Consultants	Specialty Doctors	Registered Nurses	Unregistered Nursing (HCAs)
HRI	2019/20	16%	42%	13%	14%
	2021/22	6%	30%	7%	-1%
	2022/23	6%	0%	0.5%	0%
DPoW	2019/20	-8%	33%	18%	10%
	2021/22	34%	28%	7%	4%
	2022/23	13%	30%	15%	15%
SGH	2019/20	34%	-6%	25%	11%
	2021/22	20%	14%	23%	27%
	2022/23	18%	16%	12%	-25%

Table 2.8 Summary of Emergency Department vacancy rates (HUTH and NLaG)[95]

2022/23	Medical Staff Vacancy Factor – Acute Specialties		
	DPoW	SGH	Trust-wide (incl. Goole)
Cardiology	39.8%	19.7%	28.7%
Gastroenterology	-0.5%	23.4%	10.2%
Respiratory	19.1%	-10.3%	5.5%
Surgery and Critical Care	12.2%	9.9%	11.4%

Table 2.9 Summary of Acute specialty medical vacancy rates (NLaG)[96]

Our hospitals seek to compensate for these high vacancy rates by using temporary locum and agency staff, which impacts on continuity of care and results in a significant financial pressure on the system. In 2021/22, NLaG spent £12.5 million on agency and locum cover for its two Emergency Departments. The spend was lower in 2022/23, but still represented a significant cost pressure at £7.6 million, with a further £2m spend over the same period on bank staff. When considering all medical and surgical specialties, the spend across the organisation on agency, locum and bank staff was significant over the past two years.

£000s	Spend on temporary staffing (£k) – UEC					
	2021/22			2022/23		
	Medicine	Surgery	TOTAL	Medicine	Surgery	TOTAL
Agency Staff (Nursing and Medical)	19,481	11,049	30,530	12,544	6,672	19,216
Locum Staff (Medical)	6,163	3,476	9,639	3,296	1,780	5,076
TOTAL (Agency and Locum)	25,644	14,525	40,169	15,840	8,452	24,292
Bank Staff (Nursing and Medical)	11,001	23,337	34,338	12,590	17,072	29,662
TOTAL (all temporary staffing)	36,645	37,861	**74,506**	28,430	25,524	**53,954**

Table 2.10 Summary of spend on temporary staffing (NLaG) 2021/22 to 2022/23[97]

Our services are also supported by the good will of substantive members of staff working overtime. This is not sustainable in the long run and leads to higher stress-related sickness due to overworked staff.

[95] *Internal trust data* (June 2023)
[96] *Internal trust data* (June 2023)
[97] *Internal trust data* (June 2023)

Our nursing staff sickness rates were higher than the national average (5.5% during 2022/23) in both Grimsby and Scunthorpe Emergency Departments.

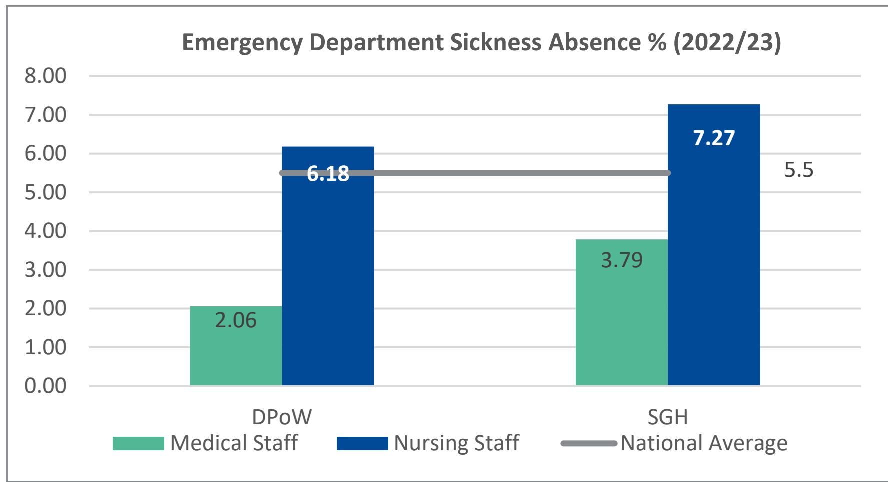


Figure 2.8 Emergency Medicine Staff Sickness (2022/23)[98]

The accumulation of workforce issues has a significant impact on patient flow resulting in long length of stay and deconditioning of patients' health, waiting times, and the ability to meet the required standards of care.

Workforce pressures within social care (affecting both residential care and domiciliary care) also have an impact on the effective provision of urgent and emergency care due to the close interdependencies between sectors. The latest data available shows that across the Humber local authorities, the vacancy rate within the social care workforce ranged from 8.4% to 9.8% throughout 2021/22. There continues to be high turnover of staff within the sector, ranging from 18.8% in North East Lincolnshire to 39.1% in North Lincolnshire in 2021/22, posing a major risk to service delivery.[99] Feedback from the sector suggests that high turnover is due to a range of factors, including post-pandemic burnout and a sense of being undervalued, combined the availability of jobs in other sectors such as retail where staff can earn as much, or more. To address this, the Humber and North Yorkshire Integrated Care Partnership are focusing on recruitment as a key objective, with social care being a critical area of focus.

2.4.2.2 Paediatric services

Within the Paediatric workforce there is also a range of workforce challenges. The workforce is not static, and vacancies fluctuate over time. The most pressing issue at present is a significant gap in training grade doctors. Not only does this put strain on the consultant workforce but it also creates a challenge for the long-term sustainability of the service as there are fewer new doctors coming through the pipeline.

In 2019/20, there was a 19% vacancy rate within Paediatric training grade doctors on the South Bank, which has improved slightly to an overall vacancy rate of 12% in 2022/23, however, these vacancies are not spread evenly between the sites and an overprovision at DPoW masks the 35% vacancy rate within training grade doctor roles in Scunthorpe. There are also gaps within the nursing workforce and in specialist roles, such as play specialists (where there was a vacancy factor of 44% in 2022/23).

[98] *Internal trust data* (June 2023) and NHS Digital (2023) *NHS Sickness Absence Rates* Data Dashboard
[99] Skills for Care (Oct 2022) *Adult social sector and workforce – Local area comparison* Workforce Intelligence

2022/23	Staff Vacancy Factor – Children's Services		
	DPoW	SGH	Trust-wide (incl. Goole)
Consultants	-8.0%	-0.1%	-4.5%
Training Grade Doctors	-4.6%	35.3%	12.4%
Nursing (Registered)	5.6%	2.8%	4.4%
Nursing (Unregistered)	23.5%	8.5%	17.4%

Table 2.11 Summary of Children's services vacancy rates (NLaG)[100]

These vacancies and gaps make covering paediatric services at two hospital sites problematic and it becomes increasingly difficult to ensure compliant medical rotas and to meet clinical standards (see section 2.3.2.2). For those staff in post, there is increasing pressure to work over and above their contracted hours, which can impact on retention of staff and make posts less attractive to future applicants.

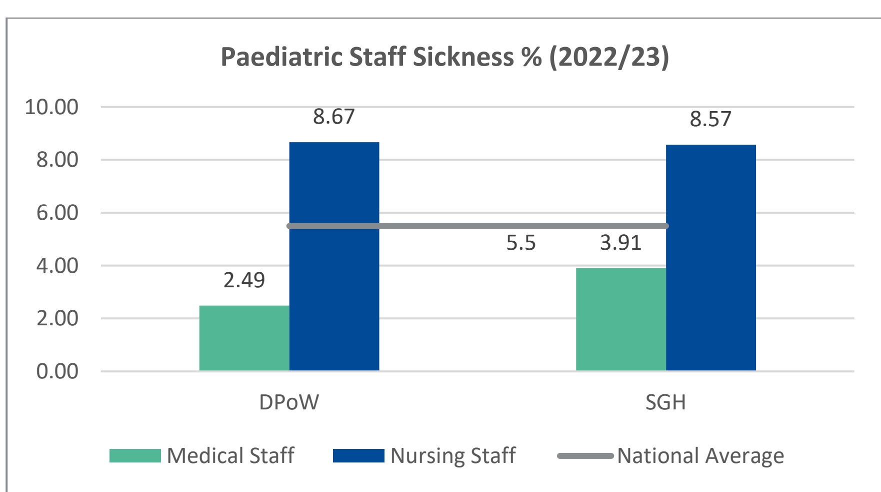


Table 2.12 Paediatric Staff Sickness - NLaG (2022/23)[101]

In addition, gaps in rotas need to be filled with temporary staffing, which puts additional cost pressures into the system. In 2021/22, temporary staffing created a cost pressure within paediatrics in NLaG of nearly £2 million, which reduced in 2022/23 as a greater proportion of the work was undertaken by bank staff rather than to external agencies, but this still amounted to nearly £1.4 million.

£000s	Spend on temporary staffing (£k) – Paediatrics	
	2021/22	2022/23
Agency Staff (Nursing and Medical)	519	365
Locum Staff (Medical)	802	95
TOTAL (Agency and Locum)	1,321	460
Bank Staff (Nursing and Medical)	642	916
TOTAL (all temporary staffing)	**1,963**	**1,376**

Table 2.13 Summary of termporary staffing spend (NLaG) 2021/22 to 2022/23[102]

The age profile of the paediatric workforce suggests there will be significant numbers of staff retiring over the next 5-10 years. At NLaG 22% of paediatric staff are aged 50 years or over and **at HUTH 30% of**

[100] *Internal trust data* (June 2023)
[101] *Internal trust data* (June 2023) and NHS Digital (2023) *NHS Sickness Absence Rates* Data Dashboard
[102] *Internal trust data* (June 2023)

paediatric staff are aged over 50 years.[103] This represents a potential loss of skills and experience to the service unless action is taken to retain these staff and ensure a strong pipeline of trainees is in place for the future.

2.4.3 Research, training and innovation

Because we spread our specialist staff thinly across small services on multiple sites, **we are not maximising opportunities for training and research.** Gaps in rotas need to be filled to keep services safe and so staff are not always able to be released to undertake additional training or research that could improve services in the long run. This impacts on trainee satisfaction, which, over time, makes recruitment harder.

The models of care have been designed with new staffing models, that will improve the training offer and help us to build a more sustainable workforce in the longer term.

Challenges covering rotas means that some staff are often on the rota more than we would like them to be. As a result, there are fewer opportunities for training and development, innovation and research. What's more, not all our hospitals currently offer the research and teaching programmes that are available at other hospitals because of their relatively small size. Operating small services – such as the 12-bed paediatric wards in Scunthorpe and Grimsby – does not provide the same exposure to complex cases that trainees in other, larger hospitals can have. Not only are staff members not getting the best opportunities to train and develop but our organisations and the population are not getting the benefit of additional training and research. Limited opportunities for training and research also make roles less attractive and compound our recruitment challenges.

The most recent trainee satisfaction survey results highlight a number of areas where trainee satisfaction is lower within NLaG than other comparable trusts and with national average scores. The main areas where concerns were highlighted related to workload pressures, facilities, supervision and quality of care. Within Paediatrics, for example, those surveyed gave a score of 59% for overall experience and 68% for quality of care, which was significantly below the national average.

		Quality of Care	Supervision	Facilities	Overall Experience
Paediatrics	NLaG	67.9%	61.1%	57.1%	59.5%
	HUTH	77.1%	61.0%	42.5%	74.0%
Emergency Medicine	NLaG	76.4%	75.0%	60.0%	72.5%
	HUTH	58.3%	48.1%	34.6%	44.2%

KEY
Within Interquartile Range
Lower Quartile But Not Outlier
Low-Scoring Outlier

Table 2.14 Summary of trainee satisfaction survey results - Nov 2022[104]

If we change what we do and how we do it, including investing in more research facilities and working with our universities, further education colleges, commercial research partners and other allied businesses, we will provide the best opportunity to be able to attract and retain more staff. Working collaboratively with universities and commercial research partners could also open up and/or create new jobs and opportunities, which in turn could help us to recruit more staff in the longer term.

[103] *Internal trust data* (March 2022)
[104] Health Education England (2022) *National Education and Training Survey (NETS)* NETS 2022 Reporting Tool

2.5 Buildings and Infrastructure Challenges

Many of our buildings and much of our equipment and digital infrastructure is out of date and not fit for the delivery of modern healthcare. We have limited access to the investment we need to improve or replace them. This impacts on the care we can provide and makes it more difficult to attract the staff we need.

The ageing condition of our estate limits the changes we can make within a capital affordability envelope.

Summary Box 2.7 – Buildings and infrastructure challenges

2.5.1 Buildings

Whilst we have some fantastic new buildings on our sites, these are the exception rather than the rule and many of our hospital buildings are not fit for purpose for the delivery of modern healthcare. As an example, 82% of Scunthorpe General Hospital's critical infrastructure is at risk of failing within five years and we have already had to close parts of that hospital to patients because the buildings were not safe, which has impacted on our capacity to treat patients.

The state of our buildings significantly impacts on our ability to provide good quality, efficient patient care. For example,

- The HRI tower block suffers with poor ventilation and cooling (particularly in summer months). Asbestos is present within the structure causing challenges for upgrading, and there are not enough lifts and storage areas.
- Many of the wards across our hospitals are smaller than current specification and do not have suitable ensuite facilities. Not only is this unpleasant and inconvenient for patients but also makes it more difficult to effectively control the spread of infection. The layout of six beds per bay does not meet modern standards.
- The obstetric units at Scunthorpe and Grimsby have only one dedicated obstetric theatre meaning that planned caesarean sections sometimes have to be cancelled or postponed when emergency c-sections need to take place.
- The CQC criticised the quality of accommodation for children within HRI, with concerns about patient privacy, as well as a lack of parental accommodation.
- Significant fire safety issues were identified in relation to evacuation of patients due to the layout of the Coronation Building at Scunthorpe General Hospital.
- Oxygen delivery systems are not up to modern standards and impact upon the ability to provide oxygen to certain parts of the hospital sites.

The buildings we operate from today have not coped well during the COVID-19 pandemic. Infection prevention and control measures have reduced the overall number of beds available and led to some patients receiving their care in pop-up facilities or having to wait longer for care. It has been challenging to adapt the current buildings to separate COVID and non-COVID patients effectively without losing significant capacity within the bed base. Within Hull Royal Infirmary's tower block, in particular, it is extremely challenging to create separate 'green' or COVID-free areas due to the layout of wards, the limited number of lifts serving the tower block and the configuration of particular wards within the tower block. As a result, elective services within HUTH were particularly badly impacted by the

restrictions brought about by COVID-19 and it was particularly challenging to maintain elective services during the pandemic.

We don't have enough operating theatres to do the number of operations we need to – which has a significant impact on waiting lists and waiting times. Across the Humber hospitals, there are relatively few dedicated day case facilities, with most sites operating mixed theatre lists and utilising shared spaces for pre-op and recovery. This increases the likelihood of patients who were listed for day case surgery being kept in hospital overnight and increases the overall length of stay.

In addition, some facilities are in such poor condition they can no longer be used. The operating theatres at Scunthorpe General Hospital (SGH) have significant issues with the estate: Theatres F and G within the coronation building have been closed due to issues relating to water supply and fire safety, which has impacted upon the types and volume of elective surgery that is able to take place on the SGH site.

2.5.1.1 Investing in our buildings

Critical infrastructure costs for both trusts significantly exceed the national median of £13.7m – within NLaG alone, there is almost £80 million of critical infrastructure risk (CIR), the most significant proportion of which sits within the Scunthorpe site. Over the next 15 years, if we did nothing to change services, significant capital expenditure (>£100 million) would be required to increase capacity in our existing hospitals in addition to the significant investment required to keep our buildings serviceable and operational. The table below sets out some of the key infrastructure risks highlighted in recent six facet surveys (2022/23) carried out in both trusts.

Description	HUTH	NLaG	Total
Physical Condition	£82,587,749	£103,135,699	**£185,723,448**
Statutory Compliance	£2,007,534	£4,611,763	**£6,619,297**
Quality	No data	£3,139,560	**£3,139,560**
Functional Suitability	No data	£883,724	**£883,724**
Environmental	No data	£5,692,500	**£5,692,500**
Space	No data	0	**0**
Total	**£84,595,283**	**£117,463,246**	**£202,058,529**

Figure 2.9 Backlog Maintenance and Investment Requirements (HUTH and NLaG)[105]

In September 2021, an Expression of Interest (EOI) was submitted to the New Hospitals Programme seeking a total of £720 million (in April 2021 prices) across the Humber to deliver a radical improvement in our local hospital infrastructure.[106] This EOI was not successful and a position on the New Hospitals Programme was not secured. Both trusts are working together to develop alternative financing options to address the significant buildings issues faced and deliver improved facilities across the region over the long term – which could deliver significant additional benefits to the local economy thanks to the partnerships we have developed to maximise the impact of investment locally. In the medium term, however, we must find a way to deliver the clinical change that is needed within the limits created by

[105] *Internal trust data* (March 2023)
[106] HUTH and NLaG Trusts – Joint submission (Sept 2021) *Expression of Interest submitted to the New Hospitals Programme* (see document library)

the existing buildings and infrastructure because of the pressing clinical need to change. The proposals within this business case would enable clinical changes to be delivered within existing financial resources.[107]

The clinical change proposals set out within this business case – and estates changes that would be required – can be delivered within existing financial resources, enabling many of the identified benefits to be realised quickly.

2.5.2 Equipment

In addition to the challenges our buildings present, the equipment available to our staff is not always the best it could be and can hinder the potential of staff to deliver the best possible care for patients. Due to limited funding available, both trusts prioritise equipment based on clinical and service risk. Equipment replacement lists are behind with prioritisation given to the top risks only. This means that we have inefficient equipment in a number of departments impacting on productivity due to slow running and/or frequent repairs being required. It also restricts innovation and the ability to make longer-term strategic investments to improve efficiency and ways of working. Within some departments staff have reported shortfalls in the provision of basic medical equipment in our clinical areas (e.g. blood pressure monitors, infusion pumps), which also impact on the timeliness and efficiency of care provision.

Furthermore, there is a lack of standardisation with different types of equipment and different systems in place not only between the two trusts but also sometimes within them. This creates an additional barrier for staff working across sites as staff have to be trained on and comfortable using more than one type of equipment or more than one approach.

Greater collaboration between HUTH and NLaG creates opportunities to improve our position on equipment, with work underway to align procurement and finance processes, under the leadership of the joint Director of Finance. Working together in this way will offer substantial opportunity for economies of scale to be realised. Standardisation of equipment across the Humber will allow staff to work on different sites more easily and will support the training and development of staff across sites and across trusts. In addition, working together across both trusts to procure, manage and maintain equipment using a standardised approach can contribute to financial efficiencies and improved use of equipment budgets.

2.5.3 Digital infrastructure

Many of our digital systems are outdated and a lack of digital maturity is a significant barrier to providing high quality, personalised care.

In designing the proposals for change, we have looked at opportunities to keep people out of hospital supported by digital and ensured plans for pathway changes are linked to planned digital investments across the system.

The main digital challenges facing hospital services across the Humber include:

[107] See section 8.2.3 for further detail.

Our systems do not talk to one another.

- Over the years many systems have been deployed by different services, resulting in a myriad of different digital systems that are not as interoperable as we require. In a world where activity is increasingly interconnected not just between hospitals but across the wider system with primary, community and social care we need our digital infrastructure to match.
- Patients need to repeat histories when they meet multiple clinicians in different organisations and clinical staff often do not have access to a comprehensive patient record. 'Work around' processes increase the likelihood of clinical risk if vital patient information is not available at the point of care.

Some of our ways of working are very inefficient.

- Staff spend a large amount of their time manually filling in forms that could be automated, freeing up more time to care for patients. The situation is not equal across both trusts, with a greater proportion of paper processing continuing to take place within NLaG.
- Patients receive communication in a disparate way – that does not support their understanding of where they are on a waiting list or assure of timely communication with other professionals. This is compounded by the use of outdated appointment systems that do not support intelligent scheduling, coordination across departments and patient choice and control over appointment times.
- We do not optimise remote monitoring in patient care particularly for those people who have multiple comorbidities, long term conditions or those in care homes. Furthermore, because of the way our systems operate, it is not always possible to identify high risk patients to ensure that they are managed appropriately and in accordance with a clinical management plan, which can result in unnecessary hospital attendances and a poor patient experience.

We are not using the data we have to its full potential.

- We have a wealth of data within and about our services, but we have to manually manipulate it to gain an understanding of performance and quality.
- Information from other partners is sometimes not available to our clinicians resulting in reduced clinical empowerment.
- We are not making use of our data to drive improved patient flow or to deliver predictive care planning and early intervention. Our data sources are plentiful but disparate and our use of advanced analytics and artificial intelligence is extremely limited.

Working collaboratively we can address these challenges and support the proposed new models of care with effective digital solutions and underpinning infrastructure. Building on planned investments as part of the wider ICS digital strategy, enabling digital solutions and new ways of working will underpin the proposed models of care. Under the leadership of the joint Chief Information Officer, Chief Medical Information Officer and Chief Nurse/Allied Health Professional Information Officer, HUTH and NLaG are working alongside partners in the wider health and care system to develop and implement the Humber and North Yorkshire (ICS) digital strategy, aligning investments to system-wide priorities.

The clinical change proposals set out within this business case have been developed alongside and aligned to the Humber and North Yorkshire digital strategy to ensure the critical digital enablers can be delivered.

2.6 Performance and Efficiency

The way in which our services are currently structured is inefficient and results in poor performance in a number of areas.

We are **duplicating 24/7 on-call teams** across sites for small volumes of patients and we are **unable to provide 7-day consultant reviews**, meaning our patients spend longer in hospital to get the same care and treatment than in many other parts of the country. The number of emergency operations undertaken overnight at Grimsby (172/year) and Scunthorpe (196/year) combined equates to around one patient per night yet both have fully-staffed 24/7 on-call rotas for overnight surgery.

Planned care services often have to compete with urgent and emergency care services for resources (workforce, theatres and recovery space) meaning that **services are impacted when there are peaks in urgent care demand**.

Staffing shortages and operating relatively small services means that **our staff and trainees do not always have enough opportunity to undertake specialist training**, as they are needed to cover rotas, and they don't have the same opportunities as those working in larger units to see a variety of cases and keep their skills up, potentially impacting on the quality and sustainability of services in the longer-term.

The Humber health and care system is operating under **extremely challenging financial pressures**, impacting on all organisations. Changes have to be made to ensure services can continue to be viable and sustainable in the longer-term.

Summary Box 2.8 – Performancy and efficiency challenges

2.6.1 Quality of Care

The Care Quality Commission (CQC) inspected both organisations in 2019/20 and again in 2022 – HUTH report March 2023,[108] NLaG report December 2022.[109] The findings from both inspections highlight a number of key areas for improvement within both trusts.

	Organisation /Site	Safe	Effective	Caring	Responsive	Well-led	Overall
Overall	HUTH	Inadequate	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement
	NLaG	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement
Urgent and Emergency Care	Hull Royal	Inadequate	Inadequate	Requires Improvement	Inadequate	Inadequate	Inadequate
	DPoW	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement
	Scunthorpe	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement

[108] Care Quality Commission (2023) *Hull University Teaching Hospitals NHS Trust – Inspection Report* CQC Report
[109] Care Quality Commission (2022) *Northern Lincolnshire and Goole NHS Foundation Trust – Inspection Report* CQC Report

Services for Children and YP	Hull Royal	Requires Improvement	Good	Good	Good	Good	Good
	DPoW	Requires Improvement	Good	Good	Good	Requires Improvement	Requires Improvement
	Scunthorpe	Requires Improvement	Good	Good	Good	Requires Improvement	Requires Improvement

Table 2.15 Summary of CQC Ratings (HUTH and NLaG)[110]

Many of the areas for improvement across services related to workforce shortages and/or skills gaps that were identified, for example:

- Services did not always have enough nursing or medical staff with the right qualifications, skills, training and experience to comply with national guidance.
- High sickness rates for qualified nurses and midwives and high use of bank staff.
- Out of hours (duty) anaesthetist cover for obstetrics was shared with the intensive care unit and the CQC were not assured the anaesthetist could be immediately available to cover emergency work on the delivery suite, without potentially placing patients at risk.
- Unfilled junior doctor posts had resulted in the inability to meet the demands of the service.

Other key areas where improvements to performance and quality need to be made are around waiting times, cancelled operations and the potential harm to patients caused by long waits.

2.6.2 Efficiency and productivity

The way in which services are currently configured is inefficient in a number of ways, resulting in high levels of cancelled or postponed procedures, long waiting lists, poor utilisation of facilities and poorer outcomes for patients.

Developing and implementing more integrated pathways within and outside of hospitals can deliver improvements in efficiency and productivity.

Until last year, all three hospitals had a higher conversion of Emergency Department attendances being admitted to a hospital as an emergency compared to the national average. This has been consistently high across all hospitals before, during and after the COVID-19 pandemic.

A number of factors contribute to this higher rate of admission, including the lack of availability of alternative service models such as frailty services in the community, workforce availability, hospital admission practices and difficulty in accessing primary care that results in deterioration of a patients' condition. Another key contributory factor is the need for **specialist input at the early stages of the patient assessment and investigations** – when this is absent, patients are admitted to inpatient wards to await review. This practice has reduced significantly within Grimsby and Scunthorpe in the past few months following the introduction of the Integrated Acute Assessment Unit (IAAU) model (see section 5.2.3). This is approach is enabling faster senior decision-making and contributing to a reduced conversion rate into emergency admissions. Implementation of this model within HUTH and a consistent approach across the Humber will support improved performance and efficiency across the region.

[110] Care Quality Commission (2020) *Hull University Teaching Hospitals NHS Trust* CQC Report and (2022) *Northern Lincolnshire and Goole NHS Foundation Trust* CQC Report

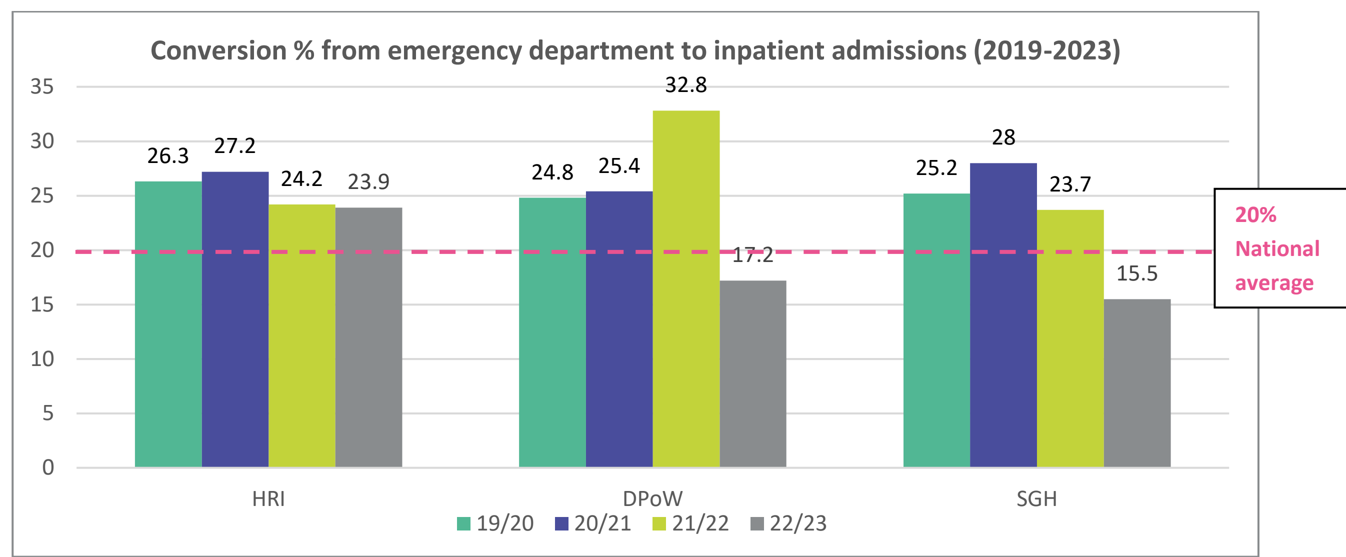


Figure 2.10 Conversion % from Emergency Department to Inpatient Admission (2019/20 to 2021/22) [111]

The interdependencies between planned and unplanned care services – whereby they often rely on the same resources (workforce, theatres and recovery space) – impacts upon performance when there are peaks in urgent care demand.[112] Even where dedicated facilities exist for elective procedures, patients often rely on the same support services such as critical care or an aesthetics and pressures within these services can lead to cancellations of planned procedures.

Before the impact of the pandemic, significantly more operations were being cancelled or postponed within HUTH than the acceptable level of 0.65%. This was exacerbated by the pandemic, particularly within HUTH, due to the constrained facilities within the Hull Royal tower block. The position within NLaG has improved in the last year, however it has continued to deteriorate within HUTH, and the level of cancelled operations is significantly above national average.

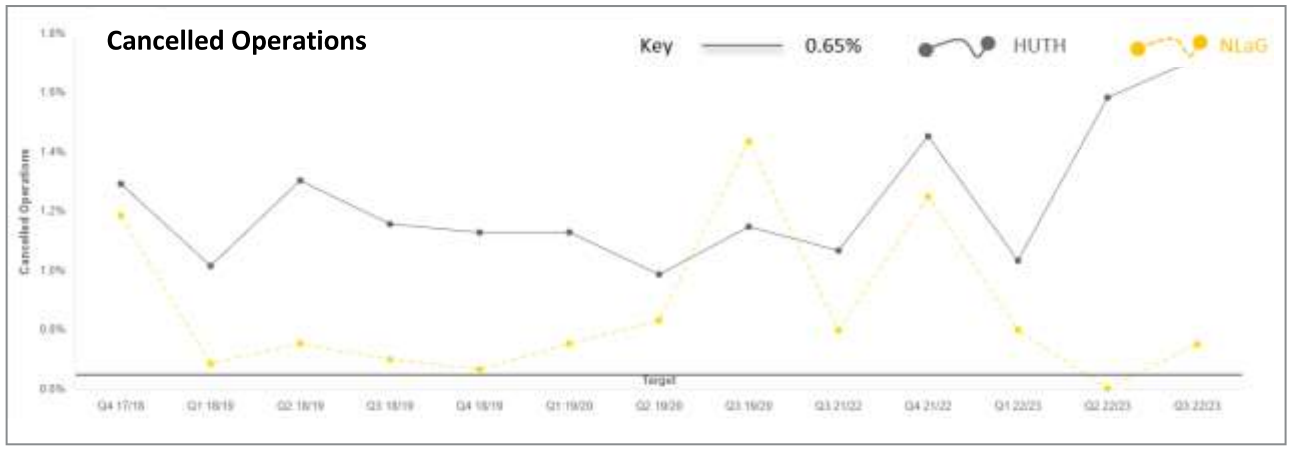


Figure 2.11 Cancelled operations (HUTH and NLaG)[113]

[111] *Internal trust data* (June 2022)
[112] There are dedicated elective facilities at Castle Hill Hospital and Goole District Hospital that deliver a mix of inpatient and day case procedures. Day surgery is also provided from a separate building on the Hull Royal Infirmary site. At Scunthorpe General Hospital (SGH) and Diana Princess of Wales Hospital, Grimsby (DPoW), elective inpatient and day case surgery is provided from within the main hospital site, utilising the same theatres and recovery space.
[113] NHS England (2022) *Cancelled Elective Operations Data* Cancelled Elective Operations

2.6.3 Disjointed care – need for better integration

Our population has poorer health outcomes and a lower-than-average healthy life expectancy due to a range of factors, including deprivation. We need to provide services that are more proactive, community-based and joined-up around the needs of children and adults, in particular those with long-term conditions and multiple co-morbidities.

New pathways and ways of working between health and care providers will enable us to provide better care for those who need it most.

A key contributory factor to many of the performance and quality challenges is the way in which our health and care services are organised, which leads to duplication, inefficiencies, poor experience and can mean people fall between the cracks. Our current way of working is based around different organisations providing primary, community and secondary care. Different providers of care are organised and funded in different ways with different strategies and targets to meet. This leads to a focus on boundaries and handovers rather than a focus on the patient and what they need. Patients tell us that they are frustrated by the lack of communication between different services and are frustrated that the current system is too complex and confusing. Services often have different eligibility criteria and different referral routes or are not available equally for all our population making it difficult to navigate for patients and staff alike. Patients can miss out on care or wait weeks and months for a hospital appointment for tests or treatment that could be completed in a primary or community care setting if the necessary skills, resources and time were available.

The way we deliver care needs to adapt to the changing needs of the local population, who are living longer and experiencing more complex or multiple health conditions. In order to deliver responsive, evidence-based and effective care, our ways of working also need to change to reflect improvements in technology. More people could manage their own conditions at home or in the community if they had access to the right support to help them live independently. Currently, however, our system is arranged in such a way that people are coming to hospital more often than they need to (particularly via our Emergency Departments), waiting longer than they should to be seen and staying in hospital longer than necessary.

Too many patients are attending hospital emergency departments or being admitted when they could benefit from supporting services outside of a hospital, at their GP surgery, at home or at a dedicated facility on their local high street. Hospital infrastructure costs are high, and travel can be cumbersome and expensive for patients. Seeing patients in their own home or in a community setting not only helps to address that, but also offers a more convenient and for many people a less stressful experience. There is more we could be doing so that far fewer people need to go to hospital for treatment (whether urgent or routine) in the future.

2.6.4 Financial Performance

Due to the way services are organised and the challenges covering rotas, our agency and locum spend is amongst the highest in the country. Last year, HUTH and NLaG together spent £55 million on agency and locum staff.

The proposed changes to pathways and models of care could help to eliminate some of the structural deficit that exists within the system and help to ensure services can be provided sustainably in the future.

The Humber Acute Services programme was clinically driven, to ensure high quality, sustainable services can be provided into the future. The programme was not initiated in order to save money, however, it is important to recognise the challenging financial context that the health and care system across the Humber and North Yorkshire is operating within and seek to support system-wide efforts to address the financial challenge.

The challenges faced are similar to those being experienced nationally and are exacerbated across the Humber, given the geography and workforce pressures. Reliance on agency and premium cost workforce, rising demand and demographic pressures driven by deprivation and health inequalities all contribute to the system financial pressure. The current configuration and duplication of services further contributes to these challenges.

Demand on services continues to rise and outstrips the available funding, putting pressure on all services, especially hospitals, GP surgeries and social care. There is insufficient funding for us to continue as we are. The reconfiguration of acute hospital services forms part of the Humber system plan to improve services for the local population. This plan includes an ambition to redefine and expand community-based services in order to bring care closer to home, providing a strong base from which sustainable and effective services can be developed.

The challenges we face are significant. The way in which our services are currently designed and delivered means that they are struggling to meet the needs of all local people now and are not equipped to do so in the future.

To address these challenges we need to substantively change how we provide care for the population of the Humber.

We must:

- Link services up better in and out of hospital so we can help more people to stay well at home and avoid coming to hospital in an emergency.
- Change the way we organise our services so that they can meet key clinical and waiting time standards and provide a high quality of care for our population.
- Address our workforce challenges by deploying the skilled workforce we have in more efficient and effective ways, creating new, more attractive roles and developing a local workforce for the future.
- Reduce the amount we are spending on expensive agency staff to plug gaps in rotas and look at other ways to make services more efficient.

The proposals outlined within the PCBC seek to address these challenges through two main areas of change:

- ✓ improved pathways
- ✓ changes to site configuration – where and how services are delivered.

Pathway changes will improve outcomes for patients through better, more joined-up care. They also create opportunities for the development of staff and new roles, working across sectors, to improve recruitment and retention.

The site configuration options enable us to make better use of our highly skilled staff, reduce double-running and provide services that meet key clinical and constitutional targets and that are clinically sustainable in the long-term.

The internal funding review has identified estate changes that are deliverable and would enable the changes to be made to address the challenges set out.

There is an opportunity through greater collaboration, by working in partnership with colleagues in and out of hospital and in partnership with individuals and communities to provide care in a better, more effective way. **This cannot be done without change.**

The next chapter sets out how we have developed the change proposals in this business case, though ongoing engagement with a wide range of stakeholders.

Summary Box 2.9

Chapter 3

Stakeholder Engagement and Assurance

3. Stakeholder Engagement and Assurance

The development of proposals for the future of hospital services across the Humber has been clinically-led, evidence-based and influenced by the involvement of a wide range of stakeholders.

Timeline

- Developing the Case for Change (2018 - Nov 19)
- Generating outline ideas (July - Nov 19)
- Developing a long list of potential models of care (Nov 19 - Jan 20)
- Reviewing the long list of potential models of care (Jan - March 20)
- Developing and refining the potential models of care (Sept 20 - Nov 21)
- Assessing and appraising the potential models of care (Oct 21 - Dec 22)
- Evaluating the impacts of the potential models of care (Oct 22 - May 23)

The design and evaluation of options was led by clinical teams from within the two acute hospital trusts, working with clinicians from primary care, community and mental health to design the proposed new pathways in and out of hospital. This has ensured that **the proposals are based upon a clear and strong clinical evidence base** and have **support from clinical commissioners** as well as clinical leads within providers.

The process undertaken to design and evaluation the proposals within this PCBC has involved **extensive public and patient engagement**, ensuring the proposals developed are **consistent with current and prospective patient choice**. Throughout the programme more than 12,000 people were involved in developing and/or evaluating the potential models of care.

The pre-Consultation engagement was independently evaluated by the Consultation Institute (tCI) who concluded "the Humber Acute Services Programme team has **delivered an effective pre-engagement exercise**".

The process undertaken has ensured the proposals for change **meet the key tests for service change** and comply with relevant guidance and statutory duties. **Ongoing oversight and assurance** were provided by partners, regulators and independent experts.

Summary Box 3.1

3.1 Overview

In line with the programme principles (see section 1.1.1), the development of this Pre-Consultation Business Case (PCBC) has been **clinically-led, evidence-based and influenced by the involvement of a wide range of stakeholders**, including: patients and service-users, clinicians, staff and partners across the health and social care sector, local authorities, voluntary and community sector organisations, the public and their representatives.

The process undertaken to design and evaluate the proposals involved extensive public and patient engagement, ensuring the proposals are consistent with current and prospective patient choice.

The design and evaluation of options was led by clinical teams from within the two acute hospital trusts, working with clinicians from primary care, community and mental health to design the proposed new pathways in and out of hospital. This has ensured that the proposals are based upon a clear and strong clinical evidence base and have support from clinical commissioners as well as clinical leads within providers.

The proposals will deliver reduced length of stay and reduced admissions to hospital through pathway changes both in and out of hospital. Joint programme management arrangements are in place to ensure necessary out of hospital enabling changes will be delivered in line with in hospital changes.

The **process has been iterative and responded to feedback, suggestions and ideas throughout**.

Summary Box 3.2

The approach to engagement and involvement has necessarily adapted in response to challenges and learning through the COVID-19 pandemic. The pandemic influenced the manner in which engagement was undertaken (in particular, having to adapt to social distancing requirements and other restrictions to face-to-face gatherings) and the views and perspectives of clinicians, staff, patients, the public and other stakeholders on what is possible for the future design of healthcare. Changing perspectives and learning from the pandemic helped to shape the potential clinical models proposed.[114]

In designing models of care for the future, we have worked with colleagues from primary and community care, mental health services, social care, local authorities and the voluntary and community sector to ensure our proposed new pathways are designed around the needs of patients and service-users, considering the whole patient journey, not just the part that takes place in a hospital. Plans for how we deliver care outside of hospital settings have been closely aligned to the development of the potential models of care for acute services (see section 7.1).

In addition, the programme undertook vanguard work to align the process of developing this Pre-Consultation Business Case (PCBC) with the process to develop a Strategic Outline Case (SOC), for the wider capital investment needed for healthcare infrastructure in the Humber area. This is a new and innovative approach and has been both beneficial and challenging to the system. Bringing the programmes together has helped to ensure alignment between the clinical case for change and plans for future buildings and infrastructure and will help to accelerate implementation following decision-making on a way forward.

[114] Yorkshire and Humber Academic Health Sciences Network (2020) *Understanding our Response to COVID-19* Humber, Coast and Vale Rapid Insights Report

This chapter provides a **high-level summary of the engagement and involvement** activities that have been undertaken to support development of the potential models of care.

The key **findings and insights gathered through the engagement** are summarised in section C of the appendices (pp.309 to 318) and set out in detail in the respective engagement reports (see p.337 for links to each report).

A more **detailed explanation of the process undertaken to develop and evaluate** the potential models of care is provided in section B of the appendices (pp.248 to 300).

Summary Box 3.3

3.1.1 Governance

The programme has been managed by robust governance, regularly reviewed and refreshed to ensure effective decision-making and that all partners were fully engaged in the programme. An Executive Oversight Group was established in March 2019 to provide oversight and leadership to the programme as a whole, replacing the previous Steering Group that led earlier phases of specialty-specific work. The Executive Oversight Group provides the leadership and direction to the programme and links to formal decision-making forums for each of the partner organisations involved in the programme.

The two acute trusts established joint decision-making processes through the creation of a Committee(s) in Common which has delegated responsibility from both Trust Boards for joint working (see section 1.2.4).

The programme governance sits within the overall structure of the Humber and North Yorkshire Health and Care Partnership, reporting through the Executive Oversight Group into the relevant boards and committees of the NHS Humber and North Yorkshire Integrated Care Board (ICB) and Humber and North Yorkshire Integrated Care Partnership (ICP).

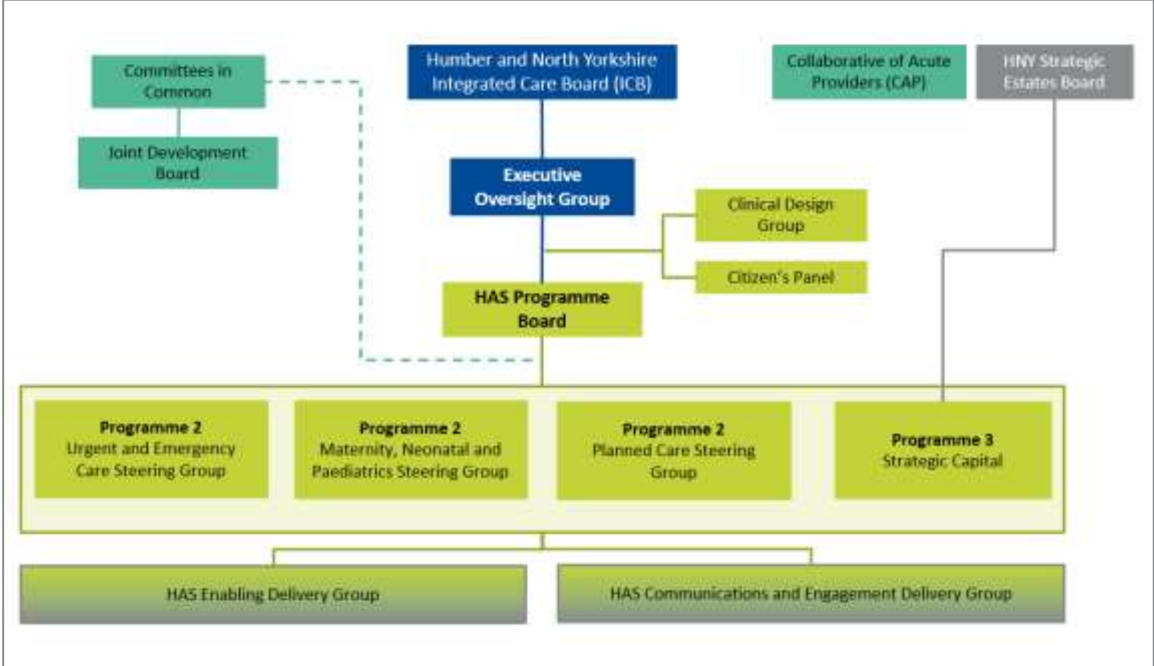


Figure 3.1 Humber Acute Services governance chart

Due to the complex nature of the programme, regular liaison meetings have also taken place with parallel programmes of work to ensure alignment of strategic objectives and approach. External

assurance and engagement with wider partners have been critically important throughout the lifetime of the programme. This has included a wide range of working groups, task and finish groups and ongoing engagement meetings – a snapshot is provided in the diagram below, however, these have changed over the course of the programme as different groups have been stood up and down to undertaken specific pieces of work (see section 3.3 for further details).

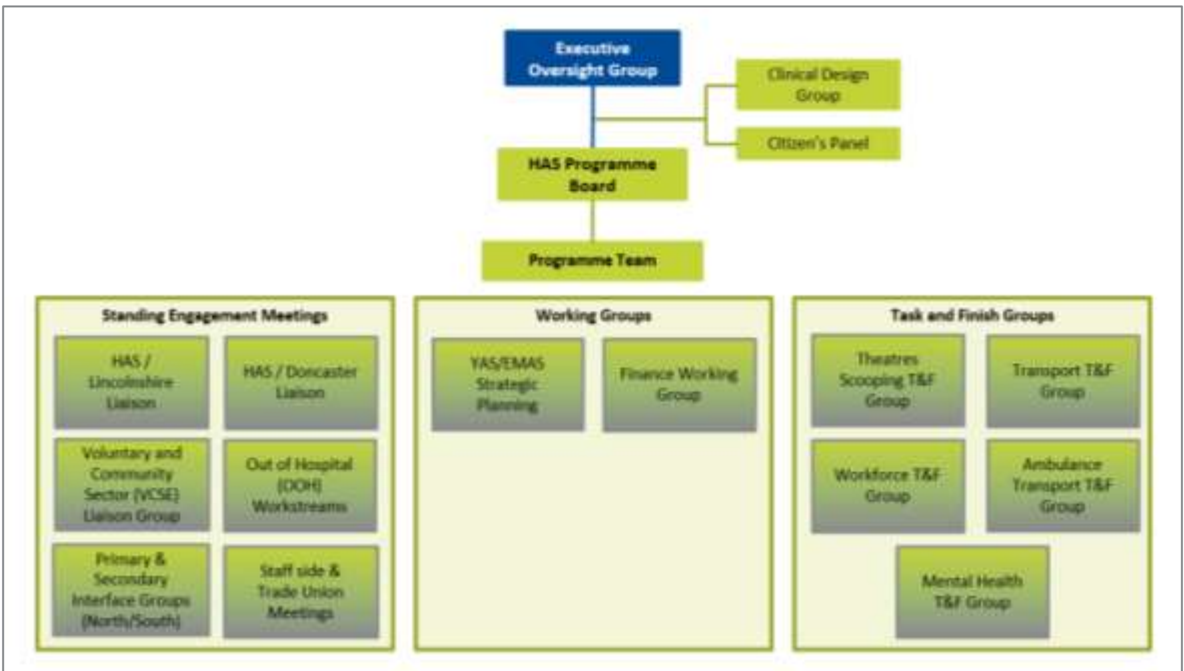


Figure 3.2 Working groups and engagement overview

3.1.2 Timeline

The Case for Change highlighted a wide range of issues and challenges facing the health and care system across the Humber.[115] In response to those challenges, a set of proposed future clinical models were developed. These potential clinical models were developed, refined and evaluated based on evidence and insight gathered through data modelling, clinical consideration and debate and ongoing stakeholder engagement.

This work was undertaken through a number of key stages:

- Developing the Case for Change (2018 - Nov 19)
- Generating outline ideas (July - Nov 19)
- Developing a long list of potential models of care (Nov 19 - Jan 20)
- Reviewing the long list of potential models of care (Jan - March 20)
- Developing and refining the potential models of care (Sept 20 - Nov 21)
- Assessing and appraising the potential models of care (Oct 21 - Dec 22)
- Evaluating the impacts of the potential models of care (Oct 22 - May 23)

[115] Humber, Coast and Vale Health and Care Partnership (November 2019) *Humber Acute Services Review Case for Change* Case for Change

Throughout each stage of the process, we have engaged with a range of stakeholders on an ongoing basis, responding to feedback and refining the models continuously.[116]

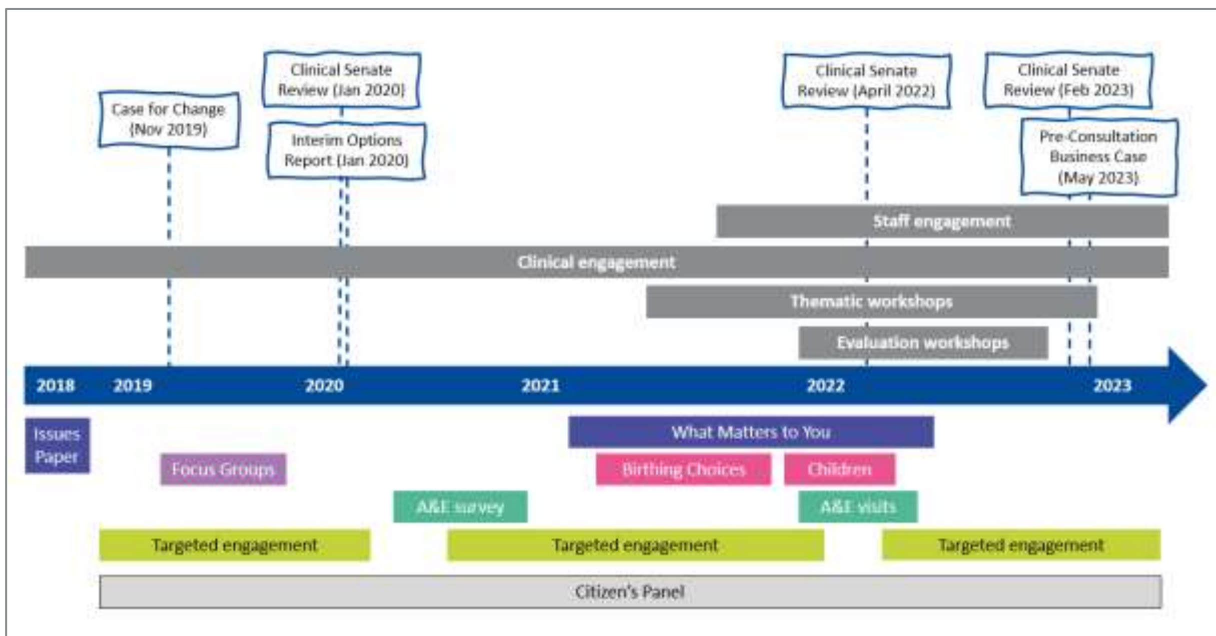


Figure 3.3 Overarching engagement timeline

3.1.3 Principles

Our approach to the development of the potential models of care has been informed by the principles agreed at the outset of the Humber Acute Services Review (see section 1.1.1). The service review was clinically-led and, as a result, included consideration of a wide range of potential models of care put forward by clinical teams. The programme looked at best practice around the UK and beyond and used evidence and data to drive the development of potential models of care. Whilst investment in our buildings is a critical enabler of change, the programme prioritised the development of effective models of care and developed estates plans around the clinical models rather than the other way around. Work was undertaken in partnership with colleagues across the health and care system to ensure we are designing solutions that support joined-up care across the system. Programme plans, setting out objectives, processes, timescales and resources, were developed and refreshed throughout the programme to ensure effective delivery and respond to changing external circumstances, in particular the COVID-19 pandemic.

A transparent, collaborative and inclusive approach was adopted throughout, ensuring engagement with key stakeholders. The approach to evaluating the potential models of care considered the levels of human, physical and financial resource expected to be available. Potential models of care were developed with a focus on the possible options for the future provision of urgent and emergency care and maternity, neonatal care and paediatrics in Hull, Grimsby and Scunthorpe along with planned care principles for delivery across the Humber region. In all service areas, the programme focused on developing models of care that deliver as much care at or close to home as possible. Throughout the programme all partners have maintained their commitment to provide acute hospital services that are patient-focussed, safe and sustainable, meeting the needs of our population both now and in the future.

[116] The Engagement Timeline in appendix 10.15 provides an overview of the extensive engagement and involvement undertaken.

3.2 Stakeholder engagement – our approach

We have undertaken extensive engagement and involvement activities to help shape and assess the different potential models of care. Over the course of the programme, **more than 12,000 people have contributed to the design and/or evaluation of the proposals set out in this PCBC**. Our pre-Consultation engagement has been independently reviewed and assured by Overview and Scrutiny Committees (OSCs) and the Consultation Institute.

The proposals help to address health inequalities by responding to some of the issues and challenges people have told us impact upon them and their ability to stay healthy.

The evaluation of the potential options prioritised what people told us was most important to them, helping to ensure services meet the needs of local people in the future and continue to provide choice for patients across the Humber.

A detailed record of the engagement undertaken is provided in the Engagement Timeline.

Summary Box 3.4

Picture 3:A Overview of engagement [117]

[117] Figures quoted in the diagram were correct as of 12th June 2023.

3.2.1 Aims and objectives

Involving and engaging stakeholders has played a crucial role in developing the potential models of care described in this Pre-Consultation Business Case. Engagement activities served to:

- **Generate ideas**
  - Engagement with clinicians, patients and other stakeholders helped us to develop ideas about what models of care might be possible in the future.
  - Clinical and wider engagement also helped us to rule out approaches that would not be considered possible or safe, for example, due to clinical interdependencies.
- **Provide critique and challenge assumptions**
  - Stakeholder engagement has been invaluable in shaping the underlying assumptions within the potential models of care and ensuring these are robust and consistently understood and applied across our health and care system.
- **Understand the impact**
  - Ongoing engagement with clinical teams, patients and the wider public has helped to build our understanding of the potential impact of each of the potential models of care.
  - In particular, this has helped us to understand how impacts might differ between different population cohorts and in turn may impact upon regional health inequalities.
- **Support evaluation**
  - Engagement and involvement activities helped us to develop a better understanding of the priorities and preferences of people in our communities and see how these differ between different population cohorts and staff groups.
  - The evaluation framework used to assess the potential models of care was co-designed through ongoing engagement with stakeholders on priorities and preferences.
  - A wide range of stakeholders were involved in evaluating the potential models of care.

3.2.2 Addressing Health Inequalities

Engagement and involvement activities were shaped by early analysis of the potential impacts of any changes and **detailed analysis of the underlying health inequalities within the region**. Population health analysis fed into the published Case for Change and was used to shape the early involvement work at the start of the programme.

Regularly updated population health and impact assessments underpinned our approach to engagement, ensuring **continued fulfilment of our Public Sector Equality Duty (PSED)**. Our engagement programme paid particular attention to ensure those with protected characteristics under the Equality Act and/or impacted by other health inequalities that exist within the population were provided with opportunities to be fully involved in the design and evaluation of potential models of care. This targeted engagement was supported by a Voluntary, Community and Social Enterprise (VCSE) sector working group, representative groups and trusted intermediaries and was assured by our Citizen's Panel.

Summary Box 3.5

In July 2018, a local voluntary sector organisation – Humber and Wolds Rural Action (HWRA) – was commissioned to undertake targeted engagement with people and groups across the region who may experience barriers to accessing services or are underrepresented in healthcare decision making. The

purpose of the engagement was to capture the views of those who face additional barriers to having their voices heard because of cultural differences, disability, gender or for any other reason. The majority of engagement was undertaken through existing meetings or group activities, utilising the network of voluntary and community sector organisations known to HWRA. Participants were drawn from a wide range of groups including people who are homeless or those at risk of homelessness, people with learning difficulties and disabilities, gypsy and traveller communities, people with physical disabilities and/or impacted by poor mental health, young people and people identifying as LGBTQ+.[118] In addition to helping to shape the potential models of care, this work also shaped our approach to engagement, highlighting steps we could take to ensure our work is as inclusive as possible.

Following completion of the Case for Change, a further, more detailed analysis of the potentially impacted population(s) was undertaken to support planning of the next phase of engagement.[119] Key target groups that were identified for engagement purposes included the following:

- People living in deprived communities and neighbourhoods (postcode level analysis undertaken)
- Younger mothers (using maternity services), particularly those living in deprived areas
- People who are homeless or in temporary or insecure accommodation
- Migrant populations, including asylum seekers and refugees
- Children and young people, their parents and carers
- People with severe and enduring mental illness
- People without access to digital technology

In planning the engagement, particular effort was made to ensure it was visible and accessible to those population cohorts facing the greatest health inequalities and undertaken using inclusive methods to address existing barriers that were identified. This was particularly challenging given the onset of the COVID-19 pandemic at this time. For example, the impact of digital exclusion was disproportionately high on those already identified as target populations for involvement either due to lack of capacity/skills to engage digitally or a lack of resources. A range of measures were put in place to mitigate against digital exclusion and, more broadly, to ensure wherever possible barriers to involvement were removed and the programme of engagement was as inclusive as possible. Even in the height of the pandemic when restrictions on face-to-face interactions were most stringent, we created opportunities for people without internet access or skills to take part in our engagement. During the latter part of the programme, when restrictions had eased, engagement activities had a strong focus on using non-digital methods to boost opportunities amongst those most likely to be impacted by digital exclusion.

Some of the measures that were adopted included:

- Working with trusted partners to gather feedback and insight on our behalf.
    - Utilising voluntary and community sector partnerships to build connections with and gather feedback from potentially excluded groups (e.g., sex workers, people who are homeless).
    - Working with Healthwatch to undertake ‘Enter and View’ visits of our Emergency Departments and engage with those using services face-to-face.

- Targeted paid-for advertising on social media.

[118] The insight gathered through these discussions is set out in full in the Engagement Report. Humber and Wolds Rural Action (2020) *Humber Acute Services Review – Targeted Engagement Report* HWRA Report
[119] See Public Health data pack within the document library

  - Utilising detailed postcode analysis to target online surveys and other engagement opportunities to those living in postcode areas with highest instances of deprivation.
  - Targeted promotion of surveys to social media users with specific characteristics in line with health inequalities analysis (e.g., younger mothers).

- Promoting and facilitating off-line methods of involvement.
  - Hosting face-to-face conversations where possible (e.g., hosting a drop-in listening session at a soft play venue for younger mums).
  - Advertising surveys, focus groups and other involvement opportunities in venues still seeing high footfall of relevant target populations (e.g., posters in children's centres in deprived areas).
  - Offering all surveys and involvement opportunities in alternative formats such as telephone calls or paper-based surveys.

- Recognising and seeking to remove barriers to involvement wherever possible.
  - Offering all surveys and involvement opportunities in different languages or alternative formats.

Throughout all our engagement, efforts were focused on ensuring those least able to participate were included wherever possible.

3.2.3 Clinical, staff and partner engagement

The design and evaluation of options was led by clinical teams from within the two acute hospital trusts, working with clinicians from primary care, community and mental health to design the proposed new pathways in and out of hospital. This has ensured that the proposals are based upon a clear and strong clinical evidence base and have support from clinical commissioners as well as clinical leads within providers.

Clinical engagement has been critical to the success of the programme.[120] For the purposes of this document, the term 'clinical engagement' is used to refer to the involvement of a wide range of health and care professionals including nurses, midwives, GPs, paramedics, junior and middle-grade doctors, consultants, social care professionals and allied health professionals (AHPs).

Clinical engagement has been carried out through a number of different forums and using a variety of approaches, guided and overseen by the programme's Clinical Design Group. Engagement with clinicians and other healthcare professionals was undertaken using a range of methods including:

- Workshops (both virtual and face-to-face) – **50 workshops** in total
- Face-to-face and virtual drop-in briefing sessions held at a range of times to enable shift workers to attend and available to watch on demand – **34 sessions** in total
- Virtual Question and Answer sessions led by the Trust Chief Executives and Medical Directors – **2 sessions**
- Online and paper-based surveys – **1,717 responses**
- Online question and answer/feedback portal open to all staff and partners – **47 questions**
- Engagement through existing meetings and forums.

[120] Full details of our clinical, staff and partner engagement are provided in appendix 10.3.

In addition to the clinical design workshops, we engaged with specific cohorts of staff (e.g., consultants' conference, nursing workshops, junior doctor's forum, liaison meetings with union representatives) and convened workshops with a range of partners to consider specific thematic areas (e.g., mental health, transport, digital) to help shape the potential models of care. Over the course of the programme these workshops reached approximately **1,350 clinicians and members of staff** from across the Humber health and care system.[121]

Regular liaison meetings took place with neighbouring health economies and representatives from their acute services review programmes including Doncaster, Lincolnshire and Scarborough/East Coast, to gather feedback on assumptions about current and future activity, to share the potential models of care as they have been developed and to understand the impact of the different potential models of care in neighbouring areas.

The clinical engagement and co-design process was supported and enabled through a comprehensive internal communications campaign across both acute trusts and also incorporating partners in primary, community and mental health care. The aims of the communications campaign were to ensure all members of staff working within both acute trusts were aware of the change programme, had access to up-to-date information about the work, could provide feedback and input into the change and knew how to ask questions if they had concerns or ideas about the programme.

- Information provided on Trust intranets.
- A regular newsletter (**31 issues** in total, from June 2021 to January 2023).
- A printed leaflet distributed across both acute trusts targeting staff who don't or can't access digital communications and poster campaign.

Over the course of the programme approximately **1,717 members of staff responded to a survey, 1,366 clinicians and members of staff participated in a workshop, 47 questions were raised through the portal and the virtual engagement sessions were attended/watched by 1,323 people.**[122]

3.2.4 Public engagement

A strong focus on public, patient and service-user engagement has underpinned the development of solutions to the challenges set out in the case for change, ensuring the proposals are consistent with current and prospective patient choice.

Public engagement has been carried out using a wide variety of methods, supported by the programme's Communications and Engagement Delivery Group and independent Citizen's Panel.[123]
In the context of the COVID-19 pandemic, the public engagement programme had to be flexible and adapt to rapidly changing circumstances. A co-production approach was adopted throughout, supporting the design and delivery of engagement activities. In addition, a wealth of other insights work, undertaken by partners across the region, was drawn upon to inform the development of potential models of care. Engagement with patients and the public was undertaken using a range of methods including:

[121] Detailed reports with outputs from key workshops are included within the Engagement timeline.
[122] Figures collated in February 2023, additional engagement has continued and may not be included in the figures.
[123] Full details of our public, patient and service-user engagement are provided in appendix 10.6.

- online and paper-based surveys – **8,402 responses.**
- workshops (both virtual and face-to-face) – **21 workshops** in total.
- focus groups (both virtual and face-to-face) – **37 sessions** in total.
- drop-in listening events – **10 sessions** in total.
- engagement via third parties such as voluntary and community sector partners and representative groups (e.g., Maternity Voices Partnerships, Healthwatch and our Citizen's Panel).

During the options development stage, public and service-user engagement focused on the following key areas to help shape the potential models of care:

- Engagement with women, birthing people and their families about their ***Birthing Choices*** to find out where they would choose to give birth and why to help shape potential models of care for maternity and neonatal services.

- Engagement with ***children and young people***, their parents, carers and families to find out what their priorities are and what changes they would like to see to help shape potential models of care for paediatric services, in particular to ensure we fully understand any impacts of changes in this area on our younger patients.

- Engagement with people who have used our Emergency Departments to find out more about their experiences and understand the barriers to accessing ***alternatives to A&E*** to help shape potential models of care for urgent and emergency care services, including getting urgent care provision outside of hospitals right.

- Engagement with recent patients and those currently awaiting treatment – directly and through our partnership with Healthwatch – to help understand peoples' views and perspectives about accessing ***planned care*** services.

- Engagement with a wide range of stakeholders – staff, clinicians, partners, patients, service-users, the public and their representatives – to understand the needs, priorities and preferences of different population cohorts. By asking ***What Matters to You?*** this engagement has shaped the potential models of care and the evaluation framework used to appraise them.

Throughout 2022 and early 2023 engagement continued with a particular focus on addressing health inequalities, taking advantage of opportunities to undertake engagement face to face and reach communities who may have struggled to engage during the height of the pandemic. This engagement supported evaluation of the potential models of care and has been used throughout to develop and refine the Integrated Impact Assessment.[124]

The public engagement and co-design process was supported by a wide-ranging communications campaign utilising a variety of channels, adapted to the relevant audience for each activity, including:

- development of a programme website.
- a monthly stakeholder newsletter.
- an online question portal.
- promotion of activities via social media across all partner organisations and channels, including the use of paid-for social media advertising.

[124] See Integrated Impact Assessment (IIA) – document library.

- partnership working with Healthwatch, Maternity Voices Partnerships and other service-user-led groups.
- establishment of a voluntary and community sector liaison group.

Over the course of the programme approximately 8,400 people responded to a survey, approximately 680 people took part in a focus group or workshop, 15 questions were raised through the portal and targeted social media campaigns reached approximately 83,670 people.[125]

Picture 3:B Key themes from engagement

Ongoing engagement with patients, service-users, staff and other stakeholders influenced both the design and the evaluation of the potential models of care. The table below summarises some of the ways in which engagement has shaped the programme.[126]

What we heard	How we responded
You said…	**We have…**
Travel and accessibility are key concerns.	**Mapped all patient journeys** by postcode to understand travel impact of any potential changes (see section 0) and established a transport action group to address key areas of concern (see section 8.4.3).
Being seen and treated quickly was your number 1 priority.	Focused on developing proposals that will **reduce waiting times** and speed up diagnosis and treatment by optimising how we deploy skilled staff and resources (see section 7.1.3).

[125] Figures collated in February 2023, additional engagement has continued and may not be included in the figures.
[126] Details of the outcomes of the engagement undertaken, including how they have influenced the potential models of care, are provided in section C of the appendices and in the respective feedback reports.

Safety is the number one priority within maternity care and paediatrics.	**Undertaken focused work with clinical teams to review the safety** aspects of different potential models of care and options for the future (see section 10.4.3.3.1).
Children and young people want to **feel safe** and their **physical surroundings** matter a lot to them.	Sought to develop models of care that will **support children and young people to stay at home** for their care wherever possible (see section **Error! Reference source not found.**).
Having the **right workforce** (and enough of them) is important to staff and patients alike.	Modelled the **workforce requirements** for potential future models as part of the evaluation process (see section 10.4.3.3.5). Worked with our teams and local education providers to explore **new roles** and ways to improve training and career development (see section 8.3.4).

Table 3.1 Summary of engagement influence

3.2.5 Wider stakeholder involvement

Ongoing engagement with key stakeholders was undertaken throughout the programme to ensure that the views, ideas and insights from a wide range of individuals and communities who might be impacted by any changes to services in the future were understood and taken into account as the potential models of care were developed.

Members of the team met regularly with elected representatives, leaders and colleagues from partner organisations and other relevant partnership bodies.[127] We also worked hard to establish links with patient and service-user groups, staff and patient forums and other relevant local groups. Extensive internal engagement was undertaken with staff from all areas within all partner organisations.

Stakeholder involvement and engagement activities that were undertaken and not covered in the sections above include:

- liaison meetings with MPs and local councillors.
- regular attendance at Local Authority Overview and Scrutiny Committee meetings (see section 3.3.3.1).
- briefing meetings with Council leaders and cabinets.
- engagement with other elected members.
- regular liaison with NHS England and Improvement (see section 3.3.1).
- regular engagement with representatives from neighbouring health economies.
- engagement with Place Boards, CCG Governing Bodies and committees of the Integrated Care Board (ICB).
- monthly meetings with voluntary, community and social enterprise (VCSE) sector leaders.
- attendance at Maternity Voices Partnerships (MVP) meetings.
- attendance at a range of patient representative forums.

Ongoing dialogue with stakeholders helped to shape the development and evaluation of the potential models of care.

[127] As far as possible, a log of meetings that took place and the feedback that was raised was maintained. The Meeting Log can be found within the document library.

3.3 Assurance

The programme has benefited from extensive involvement of external bodies to provide challenge, independent assessment and assurance that the models are effective and represent the best potential solutions to the challenges faced.

The process and the proposed models of care have been reviewed and assured by multiple external bodies including the Yorkshire and Humber Clinical Senate, the Consultation Institute, independent clinical experts and NHS England.

3.3.1 NHS England and Improvement Assurance

Assurance from NHS England and Improvement (NHSEI) was undertaken both formally and informally throughout the programme. NHSEI assurance has helped to ensure there is strategic alignment between the programme and other work across the region, that appropriate processes have been adopted throughout and that sufficient progress has been made in the context of continued operational challenges within the system. Programme team representatives met with NHSEI colleagues on a fortnightly basis to provide updates on progress of the work and assure the direction of travel and key milestones.

In addition, a number of reviews have been undertaken that have been pivotal to delivering this Pre-Consultation Business Case. Following completion of the Case for Change, a review meeting took place on 18th August 2020 with the Regional Director for NHS England and Improvement, Independent Lead for the Humber, Coast and Vale Health and Care Partnership (ICS lead) and the Executive leadership of the programme. The meeting reviewed the progress made to date and agreed next steps for the programme to get to Pre-Consultation Business Case (PCBC) stage – these included strengthening governance arrangements and developing a simple narrative to explain the aims and ambitions of the programme in the context of wider changes to health and care.[128]

Informal stocktake reviews also took place with the Regional Director and ICS leadership in March 2020, April 2021 and February 2022. These sessions considered key risks and issues and ensured the programme could take a focused approach to completing proposals for change, in particular by aligning the approach to developing service change proposals with development of the strategic outline case for capital investment.

A review meeting with the NHSEI regional team took place in December 2021, to consider and give feedback on an early draft of this Pre-Consultation Business Case. The feedback and suggestions provided by NHSEI colleagues were helpful in shaping both the process and the models that have emerged through it.

An informal review of the proposals by NHS England and the ICB took place in early June 2023. A key issue identified was that the picture and landscape in relation to maternity services, both nationally and regionally, has changed significantly and remains dynamic. As such, it was deemed necessary to decouple maternity and neonatal services from the wider programme proposals in order to undertake a more comprehensive review of the current provision and future delivery of these services across the full Humber and North Yorkshire ICB footprint. The extensive engagement that has been undertaken on

[128] NHS England (2020) *Regional review letter* – see document library

maternity and neonatal care through the Humber Acute Services programme will help to support this ongoing work across the region.

The Pre-Consultation Business Case (PCBC) was therefore split into two, to enable the proposals for changes to Urgent and Emergency Care and Paediatric Care to be taken forward for consultation whilst further work continues to be done on maternity and neonatal services.

3.3.2 External review and challenge

3.3.2.1 Yorkshire and Humber Clinical Senate

Clinical Senates are made up of independent diverse multi-professional experts from a broad range of health and care professions. They provide independent and impartial advice and guidance on any proposals for service change to assist in making the best decisions about healthcare for the populations they represent. The Yorkshire and Humber Clinical Senate has undertaken multiple reviews at key stages of the Humber Acute Services programme.

- Stage 1 review (January 2020) – initial review of the high-level options responding to the Case for Change[129]
- Stage 2 review (March 2022) – review to appraise the potential models of care and variations, including the approach to evaluation[130]
- PCBC review (February 2023) – review of the Pre-Consultation Business Case and proposed options for consultation[131]

In January 2020, the Clinical Senate undertook a review of the Case for Change and early options development (Interim Options Report). They provided a clinical assessment of the work to date, commenting on feasibility and sustainability of the high-level options and the extent to which they addressed the challenges presented in the Case for Change. The Senate provided advice on how to take forward the development of options and where to focus efforts during the next phase of work.[132] These recommendations were pivotal in shaping the next steps and development of the potential models of care.

In March 2022, the Clinical Senate undertook an assurance review of the draft Pre-Consultation Business Case, providing clinical assurance that the models are sound and evidence-based, are in the best interest of patients, and will improve the quality, safety and sustainability of care. The Senate provided feedback and clinical assurance on the models and variations taken through the evaluation process as well as commenting on the process itself.[133] The feedback was considered as part of the final evaluation of the potential models of care and helped to confirm the exclusion of certain models (variations) from the options taken forward for consultation.

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[129] Yorkshire and Humber Clinical Senate (November 2020) *Clinical Senate Review of Humber Acute Services on behalf of Humber, Coast and Vale Health and Care Partnership* Senate report

[130] Yorkshire and Humber Clinical Senate (June 2022) *Clinical Senate Review of Humber Acute Services at North Lincolnshire and Goole NHS Foundation Trust and Hull University Teaching Hospitals NHS Trust on behalf of The Clinical Commissioning Groups of: NHS Hull, NHS East Riding, NHS North Lincolnshire and NHS North East Lincolnshire* Senate report

[131] Yorkshire and Humber Clinical Senate (April 2023) *Clinical Senate Review of Humber Acute Services on behalf of Humber and North Yorkshire Integrated Care Board* Senate report

[132] The recommendations made during this review are set out in appendix 10.5.1.

[133] The feedback provided by the Senate panel is summarised in appendix 10.5.2.

The PCBC review by the Clinical Senate in February 2023, was undertaken to provide an additional level of assurance that the proposals and options being put forward for public consultation are clinically viable and will ensure services are more sustainable, support the improvement of health inequalities, and provide good quality care for the future. The Senate was asked:

1. To provide assurance, from a clinical perspective that the evaluation process has resulted in **clinically viable proposals** that ensure services are:
    - More sustainable
    - Provide good quality of care for the future
    - Support the improvement of health inequalities
2. To provide assurance that the **assumptions have been fully considered** in relation to:
    - Demand for services
    - Patient flow
    - Travel and access for patients and staff
    - Impact on neighbouring providers of secondary care
    - Impact on interdependent/related services (e.g. ambulance/community/primary care)
3. To provide assurance that the clinical models have taken account of the **relevant clinical interdependencies** and whether there is anything that has not been included in the proposed clinical models, within the current ability of the system to enact, that should be considered.

The Senate provided the highest level of assurance against all three questions posed and highlighted several areas for further consideration.[134]

The Clinical Senate concluded:

- ✓ The options for the future models of care have been designed to address the challenges.
- ✓ The proposals have been developed and refined through a robust process including in depth clinical input discussions with Clinical Design Groups, specialty project groups, a citizens panel, focus groups and workshops with elected members, representative groups and other stakeholders.
- ✓ The proposed model affords the opportunity to consolidate specialised skills and expertise on one site.
- ✓ **The proposed models of care are clinically coherent, more sustainable and would provide quality care.**

3.3.2.2 Independent Clinical Advisors

To ensure the development of models of care, service options and assumptions were viable, independent confirm and challenge was incorporated in the design process by inviting expert clinical advisors to comment on the work at key stages, within their professional remit.[135]

Independent Urgent and Emergency Care clinical leads were engaged to provide an independent assessment of the models that were in development. This included review sessions with emergency medicine consultant leads and primary care leads in June and September 2021, who provided an independent assessment of the shortlisted models, advising on any clinical risks or safety concerns. In

[134] The Senate panel feedback is summarised in appendix 10.5.3.
[135] The advice, comments and recommendations made and how they have influenced the proposals developed are detailed in appendices 10.5.5 and 10.5.5.

addition, they provided advice on future workforce models and technology advancements and assurance on the planned activity shift into community and primary care.

In July 2021, independent midwifery and obstetric reviews were undertaken in parallel to provide independent assurance and assessment of the potential models of care being developed for maternity, neonatal care and paediatrics. The reviews highlighted some of the issues in relation to current service provision and compliance with standards. They also advised on future workforce models and how the potential models of care could be delivered safely as well as suggesting potential mitigations for any scenarios that result in consolidation of obstetric services.

In addition to these reviews, we incorporated expertise, support and advice from regional Operational Delivery Networks (ODNs) for Neonatal services, Major Trauma and Critical Care. As part of the planned care elements we also engaged with 'Getting if Right First Time' (GiRFT) regional leads for planned care.

3.3.2.3 The Consultation Institute

The Consultation Institute was commissioned in November 2022 to carry out a risk review of the programme to identify issues and challenges that could compromise best practice and create grounds for challenge early enough to minimise them. A desktop review of documentation was undertaken in December 2022, which was supplemented by interviews with key stakeholders during February and March 2023.

The review was undertaken whilst work was ongoing on a number of aspects of the programme and as such recognised that some elements of risk have been addressed since the assessment was undertaken. Overall, tCI did not identify any areas of serious risk from the desk review and concluded that the Humber Acute Services Programme team has delivered an effective pre-engagement exercise.

The Consultation Institute risk review concluded:

- ✓ "The HASP team has **delivered an effective pre-consultation engagement exercise**, with significant engagement having taken place over a number of years in preparation for public consultation."
- ✓ **The pre-consultation business case (PCBC) is robust** and contains a clear summary of the work undertaken to date and there is evidence of influence within this from the public engagement undertaken.

The review work undertaken will support formal quality assurance of the consultation, which will be undertaken during the planning and delivery phases of the Consultation.

3.3.2.4 Citizen's Panel

To ensure our approach to engagement and involvement was effective and meaningful throughout, we recruited a Citizen's Panel to provide oversight and independent assurance of the programme and, in particular, its approach to engagement and involvement. The Panel is made up of citizens from across the Humber – up to five from each local authority area – who represent a wide range of stakeholders, patient and public groups, including local voluntary organisations and community groups.

When the panel was established, the four Humber Clinical Commissioning Groups (CCGs) were responsible for recruiting up to four members from their respective geographical areas to sit on the Citizen's Panel and represent the voices of their communities. Humber and Wolds Rural Action (HWRA)

was responsible for recruiting the remaining panel members with protected characteristics as part of their targeted engagement work (see section 3.2.2). This was to ensure that a broad range of views and perspectives were able to inform and influence the development of potential models of care.

Initially, this approach did not result in a full complement of panel members and the Humber Acute Services Programme team had to re-recruit a number of times. The panel was periodically refreshed with new membership over the course of the programme, to ensure new ideas and perspectives were continually being added. As of September 2022 the Citizen's Panel had the following representation:

Area / Represented Group	Number of Panel Members	Population Cohorts Represented
North Lincolnshire	3	Children with disabilities, deprived communities
North East Lincolnshire	4	People with long-term conditions
Hull	2	Deprived communities
East Riding of Yorkshire	4	People with long-term conditions, parent-carers
Protected Characteristics / Health Inclusion groups	3	Carers, migrants and people from BAME backgrounds, people with learning disabilities
CCG Lay Member	1	

Table 3.2 Citizen's Panel membership

Panel members were involved in designing engagement and communication resources – ensuring information is presented in a meaningful way, free from jargon – evaluation workshops, focus groups and other activities to test and challenge our approach. The Citizen's Panel provided invaluable insight into the needs and ambitions of our population and helped to ensure patients and service-users were at the heart of our design process.[136]

3.3.3 Statutory engagement with local authorities

Health scrutiny is a statutory function of top-tier local authorities and is usually discharged through appointed Health Overview and Scrutiny Committees (HOSCs). HOSCs form part of the overall accountability and governance arrangements of local health and care systems. The primary aim of health scrutiny is to act as a lever to improve the health of local people, ensuring their needs are considered as an integral part of the commissioning, delivery and development of health services.

Current legislation requires NHS bodies to consult with the appropriate local authorities where there are any proposed substantial developments or variations in the provisions of health services (substantial service reconfiguration) in the area(s) of a local authority under consideration. Details are set out in the Local Authority (Public health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013.[137]

The Regulations also make provision for the establishment of mandatory joint health overview and scrutiny committees (JHOSC) where NHS bodies plan to consult more than one local authority in relation to any specific proposed substantial service reconfiguration. Plans around the establishment of a formal JHOSC are being developed, in line with plans for consultation on the potential models of care (see chapter 9).

[136] A summary of the work undertaken by the Citizen's Panel, details of the outputs and the impact of their involvement in provided in appendix 10.14.
[137] HM Government (2013) *The Local Authority (Public Health, Health and Wellbeing Board and Health Scrutiny) Regulations* the Regulations

Future legislative requirements around local authority health scrutiny powers may change as part of the formalisation of Integrated Care Systems / Boards and is being kept under close review. In the development of this Pre-Consultation Business Case we have followed the existing legislation and continue to adhere to the Regulations until such time that these may be superseded. Working with our local authorities, we will respond accordingly to any changes to the legislative framework governing the Humber Acute Services Programme.

3.3.3.1 Overview and Scrutiny Committees

Regular and proactive engagement with the four constituent local authority Health Overview and Scrutiny Committees (HOSCs) has been an important aspect of our ongoing engagement in developing the potential models of care in this PCBC.[138] Updates on the progress of the Programme have been provided, with regular attendance at formal committee meetings, written briefing papers and a series of informal engagement workshops, which formed part of the *What Matters to You?* engagement programme (findings from which are included in the feedback report).[139]

During 2021 we extended our engagement to include Lincolnshire County Council's Health Overview and Scrutiny Committee – to reflect the flow of patients from parts of Lincolnshire County, particularly communities in Mablethorpe and Louth, many of whom would routinely access hospital services at Diana, Princess of Wales Hospital in Grimsby.

In November 2021, we outlined the ambition to formally consult with the public on potential clinical models in Summer 2022 (subject to the associated governance and assurance processes) and advised HOSCs that we have started to develop our plans for consultation. We also signalled our intention to seek views on draft plans for consultation from relevant HOSCs ahead of launching the consultation.

Our ongoing engagement with Local Authority health scrutiny committees highlighted a number of key areas of focus which were either added to or undertaken in greater depth as part of the programme. These key themes and how they influenced the development of proposals are summarised in appendix 10.5.6. Feedback gathered through engagement with OSCs has helped to shape the potential future models of care as well as the engagement approach undertaken through the programme.

The Overview and Scrutiny Committees of the Humber Local Authorities have:

- ✓ Been involved in developing the evaluation framework – through *What Matters to You?* workshops.
- ✓ Reviewed and provided assurance on pre-Consultation engagement activities.

In addition to engaging formally with top tier local authorities through current and proposed future scrutiny arrangements, we are continuing to develop our involvement mechanisms across the region to ensure our consultation approach will include dialogue with the relevant district councils within Lincolnshire County and, where they exist, parish councils across the Humber in recognition of the important role these local democratic bodies play in representing the people living within their local areas.

[138] Full details of meetings attended, and issues raised, are provided in appendix 10.5.6.
[139] HAS Programme (2021) *What Matters to You? Public, Staff and Stakeholder Engagement Feedback Report* WMTY Report (pp.37-43)

The Humber Acute Services Programme is a **hugely complex programme of change**, seeking to design the optimum way to organise services for the future. In order to ensure the potential models of care for the future proposed represent the best possible solutions for the local population, the process to develop them has involved a wide range of internal and external stakeholders over a number of years.

The process has been iterative and responded to feedback, suggestions and ideas throughout.

By undertaking a robust process with extensive engagement and involvement, we can demonstrate compliance with the key tests for service change and ensure the proposals will deliver improvements for patients and service-users:

Four Tests		How we are meeting them
☑	Strong public and patient engagement	• Extensive (c12,000 people) engagement of patients, the public, staff and other stakeholders in design of proposals. • Ongoing involvement of public representatives and OSCs.
☑	Consistency with current and prospective need for patient choice	• Extensive clinical and public engagement in design, reflects understanding of communities and impact of any changes on choice. • Detailed population health analysis underpins modelling and engagement.
☑	Clear, clinical evidence base	• Extensive clinical involvement in design and evaluation of proposals. • Models of care reviewed by Clinical and Professional Leaders Group, Clinical Senate, ODN and other independent clinical experts.
☑	Support for proposals from clinical commissioners	• CCG/ICB (clinical and managerial) involvement in development and evaluation of proposals

In addition, the strong collaborative working across the system will ensure necessary out of hospital enabling changes will be delivered in line with in hospital changes to deliver reduced length of stay and reduced admissions to hospital through pathway changes both in and out of hospital.

As demonstrated through the Clinical Senate review, **the proposed models of care are clinically coherent, more sustainable and would provide quality care.**

The next chapter describes the change proposals and the alternative solutions that were considered as part of the options development and evaluation process.

Summary Box 3.6

Chapter 4

Proposals for the Future

4. Proposals for the Future

To improve the quality and safety of services and make sure they are sustainable into the future, we propose that **some specialist services** at our hospitals in Northern Lincolnshire (Diana Princess of Wales Hospital, Grimsby and Scunthorpe General Hospital) **should be consolidated and in future be delivered from just one site.**

The following specialist services would be consolidated at a single hospital in Northern Lincolnshire:

- Trauma Unit
- Specialist Medical Inpatients – *gastroenterology, cardiology, respiratory* (>72 hours)
- Acute Surgery Inpatients (>24 hours or requiring overnight surgery)
- Paediatric Inpatients (>24 hours)

We propose that **other services**, including urgent and emergency care for most patients, should continue to be provided as locally as possible and **should remain at both hospitals**.

The following services would continue to be provided at both hospitals in Northern Lincolnshire and are out of scope for the proposed changes:

- Urgent and emergency care from a 24/7 Emergency Department, assessment unit and short stay (up to 72 hours)
- Day case emergency surgery
- Longer stay inpatient care for elderly and general medical patients
- Paediatric Assessment Unit (up to 24 hours)
- Maternity and neonatal care
- Planned care services, including surgery, diagnostics and outpatient services (some of which may be provided in a community location e.g. GP surgery or Community Diagnostic Centre)

Services at Hull Royal Infirmary (HRI), Castle Hill Hospital (CHH) and Goole and District Hospital (GDH) would continue as is.

The proposed changes would enable us to address critical shortages in workforce, consolidate rotas and improve patient access, waiting times and length of stay, whilst maintaining the majority of services locally.

To maximise the benefits of these proposed changes and help as many people as possible to avoid going to hospital if they don't need to, a number of supporting changes both in and outside of hospital would be put in place across the Humber.

Based upon the **detailed financial affordability analysis**, only one of the two site scenarios – where the specialist services are provided at Diana Princess of Wales Hospital, Grimsby (DPoW) – can be delivered within the capital available to the system and therefore is the recommended site option.

This chapter provides an **overview of the proposals** and outlines a number of **potential alternative solutions** that were evaluated and discounted. More detailed descriptions of the proposals for each service area – including new integrated pathways with out of hospital – are provided in chapters 5 and 6.

Summary Box 4.1

4.1 Background

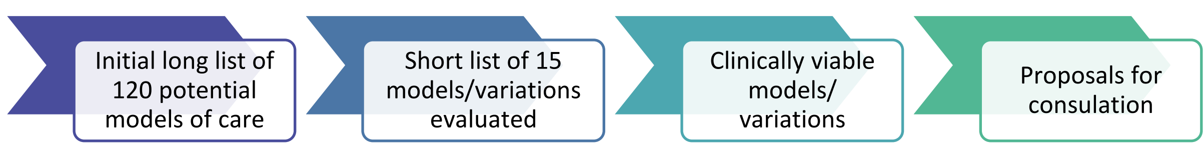
In line with the principles established at the outset of the programme, the development of solutions has been clinically-led and evidence-based. A wide range of potential solutions was considered, ranging from creating a single Urgent and Emergency Care hospital for the whole of the Humber population, splitting all hospital activity on the south bank of the Humber to provide all unplanned services (urgent and emergency care, maternity, neonatal care and paediatrics) at one hospital and all elective care (planned care) at the other, to consolidating a range of services at one hospital on the south bank but retaining the three existing Emergency Departments.

The process to develop the potential models of care took place over 18 months and involved extensive engagement with clinicians, staff, patients, the public and other stakeholders and is set out in detail in appendix B. Detailed work was undertaken in parallel to design new Humber-wide pathways of care that would reduce reliance on hospital-based care, improve responsiveness of services and meet the needs of the local population better.

Beginning with a long list of around 120 potential models of care, these were reduced through an iterative process to three potential models of care[140] and a short list of 15 potential site-specific solutions – including different combinations of service models for urgent and emergency care, paediatrics, maternity and neonatal care. The evaluation process reduced the short list further to the proposed model of care described within this business case.[141]

The proposed model of care was evaluated against both scenarios with specialist services being provided at ***either*** Diana Princess of Wales Hospital, Grimsby (DPoW) ***or*** Scunthorpe General Hospital (SGH). Financial analysis looked at the ongoing revenue impact of each model versus the cost of doing nothing (BAU) and also considered the capital investment that would be required to deliver the models in each of the potential site options.

Based upon the capital affordability analysis, only one of the two site scenarios – where the specialist services are provided at Diana Princess of Wales Hospital, Grimsby (DPoW) – is viable as it can be delivered within the capital available to the system.



This business case recommends taking these proposals for change through a formal public consultation process to gather views on the preferred way forward, to develop a better understanding of the potential impacts of the proposed changes and co-produce mitigations with those most likely to be impacted by the proposed changes. Given the significant challenges within current hospital services, it is essential that the system can move forward with changes to ensure services can remain clinically safe and sustainable in the medium and longer term.

[140] Detailed descriptions of the potential models of care are provided in appendix 10.3.6.
[141] The evaluation process undertaken is detailed in appendix 10.4.

4.1.1 Vision for the future

Working with clinicians, patients, service-users and other stakeholders, we defined an overarching vision that describes – at a very high level – how services will look in the future and what will be different as a result of any proposed changes to models of care.

- ✓ Everyone across the Humber will have access to the best possible healthcare and opportunities to help them live healthy, happy lives.
- ✓ People will only use hospitals if they really need to.
- ✓ More care and treatment people need will be offered in other places – e.g. GP surgeries, at home or on the high street.
- ✓ Care will be provided by a flexible, committed and valued workforce, who will be supported to deliver the best care.
- ✓ Local people will be able to access state of the art treatments from highly skilled, specialist staff.
- ✓ The use of technology – where appropriate – will be an increasingly important feature in the delivery of care and treatment and we will support people to make the most of the opportunities digital can bring.

Summary Box 4.2 Vision for the Future

Delivering this vision requires all parts of the health and care system to change, not just the core hospital services described in this business case.

4.2 Summary of proposals and benefits

4.2.1 Humber-wide pathway changes

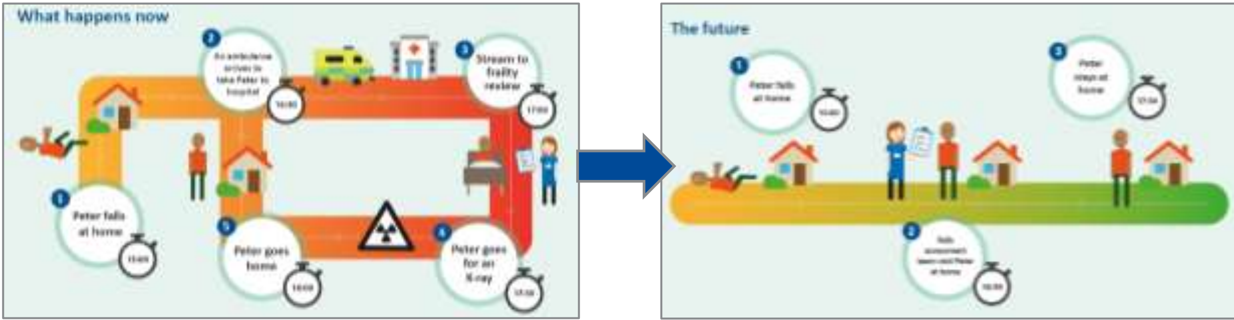
In order to improve the efficiency and effectiveness of current hospital services across the Humber, promote integration with services provided outside of hospitals and provide more streamlined care for patients, **a number of proposed pathway changes were developed**.

Proposals were designed in collaboration with partners from across the health and care system and align with other system plans.

The proposed pathway changes are set out in more detail in the following chapter, as they relate to each service area (see sections 5.2, 5.3 and 7.1.3). Broadly they include:

- **Clinical assessment closer to home** to reduce conveyance rates to hospital and help more people to access the right service, first time.
- **Co-located urgent care service (UCS)** within the Emergency Department (ED). To treat people with more minor injuries and illnesses more quickly and reduce pressure on the ED.
- **Integrated acute assessment** model (IAAU) and same day emergency care (SDEC) to improve flow within the hospital and reduce overall levels of acute inpatient admissions.
- **Integrated frailty services** across all localities in the Humber to provide more proactive support for people who are frail and help them to stay well and avoid injuries (e.g. falls).

- **Virtual wards, Hospital at Home** and other innovative approaches that will bring more care that is currently provided within our hospitals to peoples' own homes.
- **New staffing models** across a range of services, including the development of new roles to provide long-term sustainable solutions to our workforce challenges.
- **Improved use of digital** to support remote monitoring, provide more responsive services (e.g. patient initiated follow-up) and reduce the overall need for patients to travel to hospital.



Picture 4:A Example pathway change

- ✓ Patients with urgent care needs will be **seen and treated more quickly.**
- ✓ Services will be easier to navigate for the public, helping to **reduce inequalities** and barriers to access.
- ✓ Emergency services will be less pressured and able to **treat emergency patients more quickly.**
- ✓ More efficient EDs will reduce ambulance handover delays.
- ✓ Improved SDEC and Acute Assessment will support a **reduction in emergency admissions.**
- ✓ Proactive support in the community, including integrated frailty services, will **reduce emergency admissions**.
- ✓ Improved continuity of care and **patient experience.**
- ✓ Reduced length of stay in hospital.
- ✓ **Reduction in demand** for ambulance service and Emergency Department
- ✓ Patients can **get directly to the service they need** and by-pass the Emergency Department.
- ✓ Adults and children can have **shorter hospitals stays** or avoid them altogether and be investigated and treated at home instead.
- ✓ People will be able to manage their own conditions better and **go to hospital less often** for check-ups.
- ✓ **Improved outcomes** for patients (reduced Hospital Acquired Infection / deconditioning etc.).
- ✓ Better utilisation of theatres and **more efficient** workflow.
- ✓ Reduced waiting time for patients.

Figure 4.1 summary of benefits (Humber-wide pathway)[142]

[142] The benefits of proposed pathway changes are set out in more detail in sections 0, **Error! Reference source not found.** and 7.1.5.

4.2.2 Proposals for reconfiguration of services

To improve the quality and safety of services and make sure they are sustainable into the future, we propose that **some specialist services** at our hospitals in Northern Lincolnshire (Diana Princess of Wales Hospital, Grimsby and Scunthorpe General Hospital) **should be consolidated and in future be delivered from just one site.**

The following specialist services would be consolidated at a single hospital in Northern Lincolnshire:

- Trauma Unit
- Specialist Medical Inpatients – *gastroenterology, cardiology, respiratory* (>72 hours)
- Acute Surgery Inpatients (>24 hours or requiring overnight surgery)
- Paediatric Inpatients (>24 hours)

We propose that **other services**, including urgent and emergency care for most patients, should continue to be provided as locally as possible and **should remain at both hospitals**.

The following services would continue to be provided at both hospitals in Northern Lincolnshire and are out of scope for the proposed changes:

- Urgent and emergency care from a 24/7 Emergency Department, assessment unit and short stay (up to 72 hours)
- Day case emergency surgery
- Longer stay inpatient care for elderly and general medical patients
- Paediatric Assessment Unit (up to 24 hours)
- Maternity and neonatal care
- Planned care services, including surgery, diagnostics and outpatient services (some of which may be provided in a community location e.g. GP surgery or Community Diagnostic Centre)

Services at Hull Royal Infirmary (HRI), Castle Hill Hospital (CHH) and Goole and District Hospital (GDH) would continue as is.

4.2.3 Site selection

The proposed model of care was evaluated against both scenarios with specialist services being provided at ***either*** Diana Princess of Wales Hospital, Grimsby (DPoW) ***or*** Scunthorpe General Hospital (SGH). In all the options considered, services at Hull Royal Infirmary (HRI), Castle Hill Hospital (CHH) and Goole and District Hospital (GDH) would continue as is.

The detailed evaluation considered:

- The potential of different models of care to deliver national standards – with a focus on quality and safety.
- The need to maximise the skills of our existing workforce and the potential of different models of care to support plans to develop new skills and roles and build a resilient local workforce.
- The need to ensure that patients have access to local services for regular and ongoing care.
- The need to make best use of more specialist skills and maximise clinical time available to see and treat patients.

- The need to deliver longer-term more sustainable services which are an improvement on the current models of care.
- The need to deliver financial savings aligned with the need for any future model to be affordable from an internally funded capital pot.

The only option that has been identified as viable is to **consolidate these specialist services at Diana Princess of Wales Hospital, Grimsby.**

Services should be consolidated at Diana Princess of Wales Hospital, Grimsby (DPoW) because:

- **It is the only option that satisfies the NHSE financial requirement to fund capital investment internally**. [143]
- Based upon the capital affordability analysis, only one of the two site scenarios – where the specialist services are provided at Diana Princess of Wales Hospital, Grimsby (DPoW) – can be delivered within the capital available to the system. The capital cost to deliver this site option is c.£25m, whereas the cost to deliver the site options where services were consolidated at Scunthorpe would cost c.£89m, which cannot be delivered from internal capital resources.[144]

There are some additional advantages to consolidating services at DPoW rather than Scunthorpe, including:

- The travel analysis highlighted that it is closer to more patients from deprived areas, who would otherwise have to travel further, and DPoW provides services for many deprived communities living on the East Lincolnshire coast.
  - Overall, fewer people would be impacted by having to travel to a different hospital site (c.20 per day, compared to c.22 per day if services were consolidated at SGH – based on post code analysis to nearest service).
  - Overall, fewer people would be impacted by longer journeys to hospital (c.10 per day, compared to c.13 per day if services were consolidated at SGH – based on post code to nearest site).
- The ambulance travel and journey time mapping has highlighted that it has the least impact on ambulance services, requiring only ½ of a Dual Crewed Vehicle extra, which could be delivered through productivity/efficiency improvements in the emergency care pathways.

Based upon the capital affordability analysis, only one of the two site scenarios – where the specialist services are provided at Diana Princess of Wales Hospital, Grimsby (DPoW) – can be delivered within the capital available to the system and therefore is the recommended site option.

The proposed changes would bring significant benefits, delivering improvements to clinical effectiveness, workforce sustainability and quality of care across services. Making changes to services will reduce waiting times, improve access and help to tackle underlying health inequalities by improving quality and effectiveness of the care provided across our hospitals.[145]

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[143] The evaluation process and detailed outcomes are set out in detail in appendix 10.4.3.
[144] Details of the financial analysis undertaken are provided in section **Error! Reference source not found.**.
[145] The benefits of the proposed models are provided in more detail in sections **Error! Reference source not found.** and 6.4.7.

All the potential options considered would result in some patients having to travel further for care. The proposed model has the lowest travel impact of all the potential options considered. To mitigate against any adverse impacts, travel and transport plans are being developed to support the proposals and will continue to be developed and refined through consultation, decision-making and implementation.

This pre-consultation business case proposes statutory public consultation on the proposed new model of care and variations to gather information on the potential impact of the proposals to support decision-making on the best way forward for acute hospital services across the Humber. The consultation will seek views from staff, patients, the public and other stakeholders. Public consultation will enable us to develop a better understanding from those who may be impacted by the changes of what the changes would mean for them and how the impacts will differ under each of the potential options. In addition, we will also be seeking suggestions and ideas for mitigations against any potential negative impacts for our patients, service-users, staff and those who care for and support patients.

4.2.4 Summary of changes, benefits and impacts

The proposed models of care have been assessed by the Clinical Senate, who have confirmed they will **provide better, more sustainable services for our population**. The models of care have also been subject to a rigorous travel and transport mapping exercise aligned to a comprehensive Integrated Impact Assessment.[146]

Proposal	Change	Benefit
The proposed configuration for urgent and emergency care and paediatric services, would: ✓ retain 24/7 Emergency Departments in their current three locations (Hull, Grimsby and Scunthorpe). ✓ deliver a range of benefits – improving quality and sustainability of services. ✓ maximise the benefits gained from the recent £58m investment in our Emergency Departments.	**Co-located Urgent Care Services** would be developed within the Emergency Departments to enable patients with minor illnesses or injuries to be streamed away from ED and treated appropriately within and Urgent Care pathway.	Over 300 people a day who attend our Emergency Departments would be **seen and treated more quickly** within an integrated Urgent Care Service across our hospital sites.
	Trauma services for Northern Lincolnshire patients would be provided at Diana Princess of Wales Hospital, Grimsby (DPoW), with Hull Royal Infirmary (HRI) remaining as the regional Major Trauma Centre (MTC). Patients would be taken by ambulance directly to DPoW or HRI Hospital based on their clinical needs. Patients who self-present to Scunthorpe General Hospital and require trauma services would be transferred to DPoW.	The centralisation of trauma services would **provide access to more specialty skills on the Acute hospital site 24/7** and allow for more rapid patient intervention potentially reducing length of stay and improving the experience for patients. It is estimated this change may impact **up to 2 patients per day,** which could be mitigated though improved ambulance transfer protocol and advice and guidance for crews prior to conveyance.

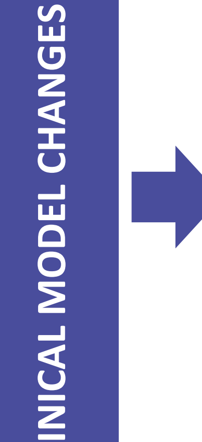
[146] Detailed outputs are provided in appendices 10.16 to **Error! Reference source not found.** and contained within the document library.

	Speciality inpatient services (*Gastroenterology, Cardiology and Respiratory*) for Northern Lincolnshire patients who require admission post-72 hours or require a higher level of specialist clinical input would be provided at Diana Princess of Wales Hospital, Grimsby (DPoW).	We would be able to provide **specialist dedicated 7-day per week care** for gastroenterology, cardiology and respiratory medicine improving the quality of patient experience, reducing our lengths of stay and supporting patients to go home more quickly. It is estimated that the number of patients requiring transfer for specialist care would be **up to 3 per day**. This could be mitigated and potentially reduced as many patients could be cared for via a General Medical Physician or Geriatrician on site with specialist in-reach.
	Emergency surgery would be provided across all sites, but on a day case basis at Scunthorpe General Hospital. Northern Lincolnshire Patients requiring out of hours surgery or an acute surgical admission for >24 hours would be treated at Diana Princess of Wales Hospital, Grimsby (DPoW).	The consolidation of emergency surgery with 24/7 teams including surgeons, theatre teams, nursing staff on the Acute site will **reduce out of hours on-call and support future sustainability of workforce**. This could impact **up to 6 patients per day**. A proportion of these patients could be seen and treated on a day case basis (e.g., fractured hip pathway) and therefore the daily impact should be less as surgical pathways and protocols change in line with the model of care.
	Paediatric inpatient care would be provided at Diana Princess of Wales Hospital, Grimsby (DPoW) for Northern Lincolnshire patients. Children and young people could continue to attend their local hospital Emergency Department as required and be treated in the Paediatric Assessment Unit. Children in Scunthorpe who require admission post-24 hours would be transferred to DPoW for ongoing	The consolidation of Paediatric inpatient services would improve training and development opportunities and **support the future sustainability of the workforce**. We estimate that this may impact on **up to 2 patients per day.** This could be reduced as the Hospital at Home model of care for paediatric cases becomes embedded. Hospital at Home has been seen in its pilot

	care supported by a dedicated team to ensure safe transfers.	form to reduce the need for admission and support earlier discharge, reducing length of stay.

Table 4.1 Summary of changes, benefits and impacts

The proposed new models of care would deliver a range of benefits.



- ✓ Ability to **deliver clinical standards** across a range of services.
- ✓ Improved ability to recruit and retain skilled workforce.
- ✓ Helps to **address workforce challenges**.
- ✓ Increased **confidence** in patients – access to specialist teams.
- ✓ **Competency** of staff in dealing with more complex cases improves.
- ✓ More **resilient services**, less likely to be impacted by key staff leaving.
- ✓ Opportunities to create more **specialist** teams.
- ✓ Improved quality of care.
- ✓ Supports continuation of specialist services (e.g. Neonatal Intensive Care Unit) in the region.
- ✓ Provide **responsive services** 24/7, with local access maintained.
- ✓ Swifter discharge of patients working with local authorities and social care.
- ✓ **Fewer cancelled operations** and reduction in waiting times for treatment.
- ✓ **Reduced waiting times** and better outcomes for patients.

Figure 4.2 summary of benefits (clinical model changes)

4.3 Discounted alternative solutions

A number of potential alternative solutions were also considered. Following extensive engagement and evaluation, a number of these were discounted because they were not considered to be viable solutions to the challenges faced across the Humber.

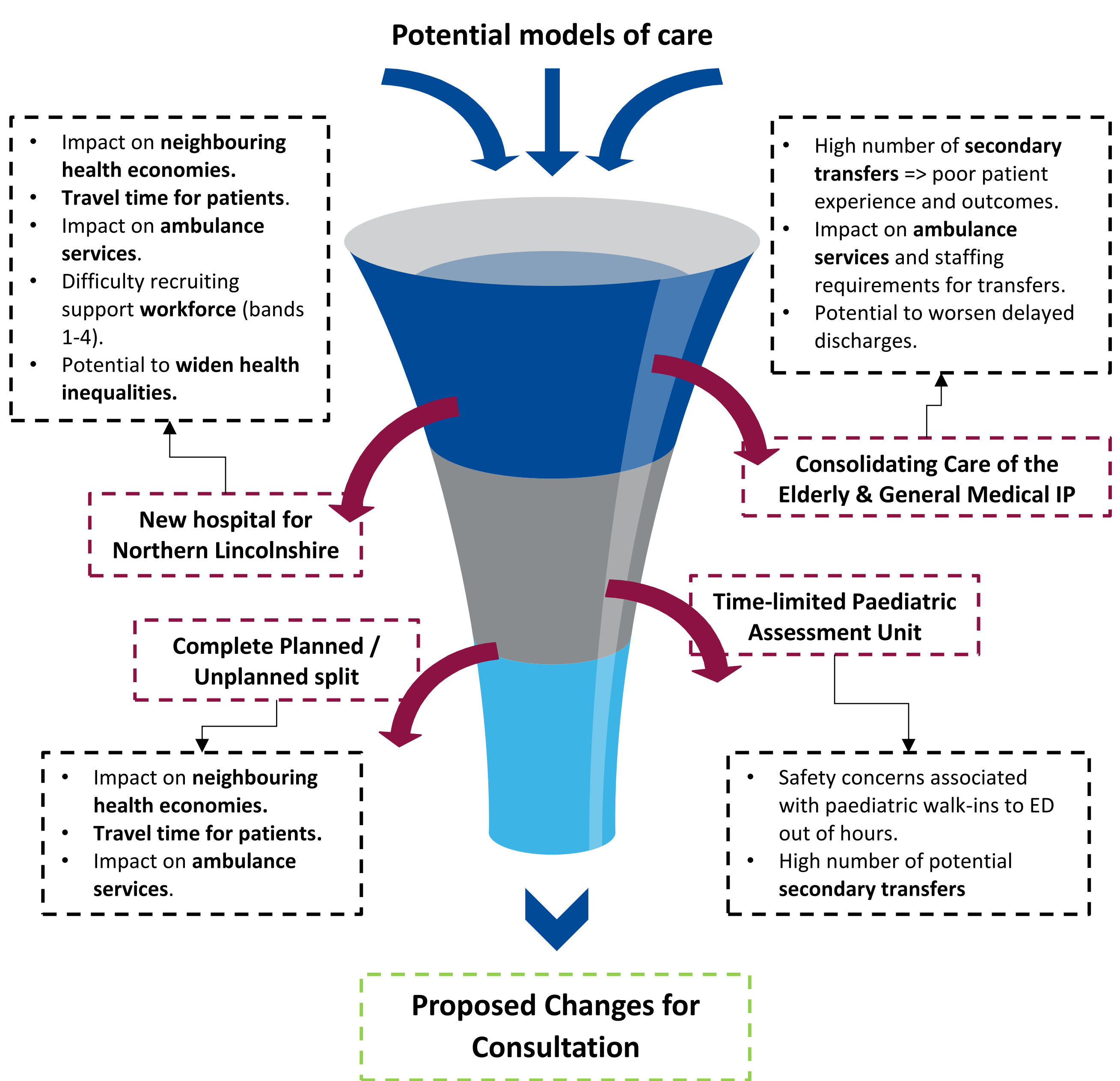


Figure 4.3 Summary of discounted alternative solutions

4.3.1 Splitting all Planned and Unplanned Care in Northern Lincolnshire

One of the possible scenarios considered was to adopt the same model on the south bank of the Humber as on the north bank by providing *all* emergency and unplanned care, maternity, neonatal and paediatric services at one Northern Lincolnshire hospital and all planned care at the other. On the north bank, Hull Royal Infirmary (HRI) provides the vast majority of urgent and emergency and acute care services with an Emergency Department and acute specialties delivered on site (with some limited exceptions, e.g. cardiology and urology) and Castle Hill Hospital (CHH) functions as a separate elective centre providing planned care on an inpatient and day case basis. Both hospitals are specialist centres and provide a range of additional specialist/tertiary services (e.g. Major Trauma Centre at HRI and the regional Cancer Centre at CHH). [147]

A similar approach – splitting all planned and unplanned care was considered with *either* Scunthorpe General Hospital *or* Diana Princess of Wales Hospital, Grimsby providing Acute (unplanned) care and the other site providing Elective (planned) care.[148]

During our engagement, this model was the preferred approach of many clinicians, in particular surgeons, due to the significant benefits it could bring in relation to delivering more effective and efficient planned care. In the April 2022 review, the Clinical Senate also identified a number of important benefits of this model.[149] The key benefits of having a separate, dedicated elective hospital included:

- Ability to deliver clinical standards and best practice through consolidated workforce.
- Ability to deliver constitutional standards, particularly for planned care and diagnostics.
- More effective deployment of workforce.
- Reduced risk of planned activity being cancelled due to demand on emergency services.
- Reduces/eliminates the need for secondary transfer of patients as all acute patients would go directly to the Acute hospital site because there would be no Emergency Department on the Elective site.

However, this model also had significant impacts on patients, staff and neighbouring providers that were considered too great for the model to present a viable solution for the region. These key negative impacts included:

- Significant displacement of activity to neighbouring health economies (particularly in the scenario where all unplanned care services were provided at DPoW) – potential to destabilise Doncaster's Emergency Department.
- Significant additional travel for a large number of patients (particularly in the scenario where all unplanned care services were provided at Scunthorpe) – long distances for population on the Lincolnshire Coast to travel to access an Emergency Department.

[147] Full details of the evaluation process that was undertaken and the outputs used to discount alternative potential models of care are provided in appendix 10.4.
[148] This model of care (described at the options development stage as the Acute/Elective model) is explained in section 10.3.6.1.2 and details of the impacts can be found in section D of the appendices.
[149] Yorkshire and Humber Clinical Senate (June 2022) *Clinical Senate Review of Humber Acute Services at North Lincolnshire and Goole NHS Foundation Trust and Hull University Teaching Hospitals NHS Trust on behalf of The Clinical Commissioning Groups of: NHS Hull, NHS East Riding, NHS North Lincolnshire and NHS North East Lincolnshire* Senate report

4.3.2 Consolidating General Medical and Care of the Elderly Inpatient Services

In addition to the services proposed to be consolidated, another variation of the model was considered during the model development and evaluation stage. In this variation *all* inpatient care, including Care of the Elderly and General Medical inpatient beds, (post-72 hours) would be consolidated at one hospital for Northern Lincolnshire. [150]

Whilst this potential solution did offer some additional benefits, for example greater potential for consolidation of workforce and delivery of key clinical standards, it was discounted for a number of reasons, most notably concerns from clinicians and patient representatives about the impact of secondary transfers on acutely ill, frail and elderly patients. These concerns were also reflected by the Clinical Senate in their review of the potential models of care.[151] The detailed modelling quantified the number of elderly and/or frail patients requiring a secondary transfer for a Care of the Elderly/General Medical bed as between 4,581 and 5,223, which equates to around **12-14 additional transfers per day** on average (depending on where the service was located).

In addition to the potential negative impact of the journey itself on the patients, the large number of transfers required would have a significant impact on ambulance services (see 0 for details) and staffing required to support transfers. In addition, consolidating inpatient services for frail and elderly patients would have a number of negative knock-on effects, which were highlighted through our ongoing engagement and dialogue. This includes, making it harder and more costly for family members to visit and support relatives as well as making it more difficult to coordinate with social care services across multiple local authorities to put in place packages of care and support swift discharge from hospital.

4.3.3 Operating a Time-Limited Paediatric Assessment Unit (PAU)

A further variation that was considered and modelled within the paediatrics workstream was the potential scenario to operate the Paediatric Assessment Unit on a time-limited basis only, closing overnight when attendances were likely to be lowest. This variation was considered during the first step evaluation process and not carried forward for further evaluation through step two.

This model was considered because it could potentially reduce the staffing requirements within the paediatric service, by only requiring paediatric cover for 14 hours a day rather than 24/7. This would represent a further improvement to the workforce situation within paediatrics. Nevertheless, it was noted by clinicians involved in the evaluation that paediatricians would still be required on-site to support with neonatal care and so the gains would not be realisable if maternity and neonatal care continued to be provided.

A further consideration was that a significant proportion of paediatric patients attending the PAU are seen, treated and discharged within 24 hours. If the PAU was only operating with limited hours, a significant number of children would need to transfer to the other hospital for care lasting <24hours, causing significant additional stress to the children and their families for relatively little gain. With the introduction of virtual wards and hospital at home the number of children who can be discharged within 24 hours of admission could potentially be increased further still.[152] Some clinicians also raised concerns

[150] The evaluation process and outputs are covered in more detail in appendix 10.4
[151] Yorkshire and Humber Clinical Senate (June 2022) *Clinical Senate Review of Humber Acute Services at North Lincolnshire and Goole NHS Foundation Trust and Hull University Teaching Hospitals NHS Trust on behalf of The Clinical Commissioning Groups of: NHS Hull, NHS East Riding, NHS North Lincolnshire and NHS North East Lincolnshire* Senate report
[152] see section **Error! Reference source not found.** for further details of the Hospital at Home model.

that the model could pose safety implications for children or young people presenting to the Emergency Department out of hours when the PAU is closed and not having access to paediatric trained staff.

4.3.4 A new hospital for Northern Lincolnshire

Another potential idea that was raised through our ongoing engagement was to build a new hospital for Northern Lincolnshire in a location half-way between the existing hospitals in Grimsby and Scunthorpe and consolidate most or all of existing hospital services onto that site. Different variations of this idea have been proposed in previous programmes to look at hospital services across the Humber and throughout our engagement this was a very popular idea amongst clinicians as well as patient and public representatives.

The key benefits and reasons why this model was particularly popular include:

- Ability to deliver clinical standards and best practice through consolidated workforce.
- Ability to deliver constitutional standards, particularly for planned care and diagnostics.
- More effective deployment of clinical workforce.
- Easier for the public to understand (everything is in one place).
- Reduces/eliminates the need for secondary transfer of patients as all acute patients would go directly to the new hospital – there would be no Emergency Department at either of the existing hospital sites.
- A new, purpose-built facility could bring additional benefits:
    - More efficient services (digitally enabled 'Smart' hospital).
    - More attractive to staff.
    - More pleasant surroundings for patients.

However, this potential solution also had significant impacts on patients, staff, neighbouring providers and the local economy that were considered too great for the model to present a viable solution for the region. These key impacts included:

- Significant displacement of activity to neighbouring health economies – potential to destabilise Doncaster's Emergency Department.
- Significant additional travel for a large number of patients.
- Difficulty recruiting sufficient support workforce (including estates and facilities staff and other ancillary services, who mostly live within 2 miles of existing sites).
- Potential to widen health inequalities – those from most deprived communities and other health inclusion groups would face the biggest barriers accessing an 'out of town' site.
- Negative impact on local economy in Grimsby and Scunthorpe by taking a large number of jobs out of the towns.

Additionally, the level of capital funding required for this scale of clinical change and redevelopment is not available within the required timescales to address the pressing issues and urgent challenges within services today, meaning this is not a viable option to take forward for public consultation.

The proposed changes would enable us to address critical shortages in workforce, consolidate rotas and improve patient access, waiting times and length of stay, whilst maintaining the majority of services locally.

The proposals outlined in this business case address the key challenges set out within the case for change:

- Changing population needs.
- Poor performance and not delivering clinical or waiting time standards.
- Workforce shortages and skills gaps.
- Inadequate buildings, equipment and digital infrastructure.
- Inefficient or unsustainable models of care.

The proposed changes would deliver more effective services that are better able to meet the changing health needs of our population. They make better use of the workforce we have and enable us to develop more effective staffing models in the future and create attractive career prospects for our current and future workforce. The proposed changes have been designed to support delivery of clinical standards in areas where services are currently falling short, improve clinical outcomes for patients and help to reduce inequalities of access and outcomes.

To maximise the benefits of these proposed changes and help as many people as possible to avoid going to hospital if they don't need to, a number of supporting changes both in and outside of hospital would be put in place across the Humber.

More detailed descriptions of the proposals, benefits and impacts for each service area – including new integrated pathways in and out of hospital – are provided in chapters 5 and 6.

Summary Box 4.3

Chapter 5

Humber-wide Pathway Changes

Detailed proposals, benefits and impacts

5. Humber-wide Pathway Changes

To maximise the benefits of the proposed changes and help as many people as possible to avoid going to hospital if they don't need to, we have worked with colleagues across the health and care system to design a number of supporting changes that would be put in place across the Humber.

- **Clinical assessment closer to home** to reduce conveyance rates to hospital and help more people to access the right service, first time.
- **Co-located urgent care service (UCS)** within the Emergency Department (ED). To treat people with more minor injuries and illnesses more quickly and reduce pressure on the ED.
- **Integrated acute assessment** model (IAAU) and same day emergency care (SDEC) to improve flow within the hospital and reduce overall levels of acute inpatient admissions.
- **Integrated frailty services** across all localities in the Humber to provide more proactive support for people who are frail and help them to stay well and avoid injuries (e.g. falls).
- **Virtual wards**, **Hospital at Home** and other innovative approaches that will bring more care that is currently provided within our hospitals to peoples' own homes.
- **New staffing models** across a range of services, including the development of new roles to provide long-term sustainable solutions to our workforce challenges.
- **Improved use of digital** to support remote monitoring, provide more responsive services (e.g. patient initiated follow-up) and reduce the overall need for patients to travel to hospital.

We recognise that we can only deliver the models of care successfully if there are changes in how we provide care outside of hospitals too. We have worked with Place and ICB teams to map the programmes that are underway and identify those which we need to support implementation of the proposed model of care. We are working together on five priority projects, which will help to ensure the proposed new models of care are successful.

The key benefits of improved pathways of care in and out of hospital include:

- ✓ Simpler access for public – ensuring more people get the right care, first time.
- ✓ Faster assessment, treatment and discharge and reduced ambulance handover delays.
- ✓ Make the best use of skilled workforce – reduced duplication.
- ✓ Ensure patients with most complex needs can access specialist care.
- ✓ Support more people to stay well, be seen and treated at or close to home.

Summary Box 5.1

5.1 Vision for the future

The Humber and North Yorkshire Health and Care Partnership integrated health and care strategy sets out the Partnership's overarching ambition, vision and strategy for health, care and wellbeing in the region.

Our ambition is:

for everyone in our population to live longer, healthier lives by narrowing the gap in healthy life expectancy between the highest and lowest levels in our communities by 2030 and increasing healthy life expectancy by five years by 2035.

To reach the ambition, the Partnership's **vision** is to ensure that all our people ***start well, live well, age well and die well.*** These strategic aims and ambitions have shaped the pathways and proposals within this business case.

5.1.1 Our vision – right care, right time, right place

Urgent and emergency care and paediatric services in hospital are closely intertwined and reliant on community, primary, social and mental health care services provided outside of hospital settings. This is particularly important for preventing unnecessary urgent and emergency care episodes and supporting patients to recover following an urgent or emergency care episode to avoid readmission or a return attendance at the Emergency Department. Better early identification and proactive care can prevent someone's condition deteriorating and support faster recovery. Early intervention and prevention is also vitally important to improve the mental and physical wellbeing of our population, in particular our children and young people.

Our proposals for improving hospital services across the Humber have therefore been developed in close collaboration with partners from across the system and seek to enhance the integration of hospital, community, primary, mental health, social care and voluntary sector support.

Working together more closely will ensure we can provide seamless care and deliver the Partnership's ambition to "**ensure every one of our citizens can get the best start in life**", backed by a commitment to support every child and young person to thrive.[153] To achieve this we have worked with partners across primary, community, mental health, social care and the voluntary sector to develop plans for paediatric services that will better support children and young people, maximise the provision available outside of hospital settings and provide the most responsive service possible for children in our communities who experience injury or ill-health and need care and support.

The proposed changes will help us to deliver the vision of the Humber and North Yorkshire Urgent and Emergency Care Network:

[153] Humber, Coast and Vale Health and Care Partnership (2020) *The Humber, Coast and Vale Health and Care Partnership Long Term Plan* HCV Partnership Long Term Plan
Humber and North Yorkshire Health and Care Partnership (2023) *Integrated Health and Care Strategy* (publication pending)

Our vision is ***to provide outstanding urgent and emergency care services at the right time, in the right place, delivered by the right skilled healthcare professionals.***

We want to provide a responsive service for patients with life threatening and non-life-threatening injuries and illnesses both within our hospitals and in other community settings. ***We want to provide as much care as possible in the community or in people's own homes to avoid admissions to hospital where appropriate.***

When someone does need to be admitted to hospital, we want our emergency inpatient services to be sustainable and efficient, delivering consultant-led seven-day care to best practice standards. We also want to ensure services are in place to ensure quick and efficient discharge home, supported by appropriate community, primary and social care. Our vision for the future is that admissions to hospital will be for those who require specialist care and ***time spent in hospital will be minimal****.*

We want to ensure we are designing services which are attractive to staff, that facilitate great training, provide development opportunities and lead to high levels of staff satisfaction.

Summary Box 5.2 Urgent and Emergency Care Network vision

This overarching vision, informed by our ongoing engagement with patients, service-users, the public, clinicians, staff and other stakeholders, is what we are aiming to deliver through the new pathways and proposed model of care.

5.2 Urgent and emergency care pathways

Our population is ageing but many people are living for longer with one or more long-term condition and healthy life expectancy is lower in our region than elsewhere in the country.

Our service models need to adapt so that they can provide better, more responsive care and support more people to manage their own health and avoid the need for emergency hospital admissions.

We worked with clinical teams and partners to review and re-design the pathways of care for urgent and emergency care services across the Humber to help to address the challenges facing our current services and provide more joined up care and support for people across the region.

We propose to implement these pathway changes across the Humber region, supported by the required out of hospital provision, new workforce models and enabled by improved digital connectivity and infrastructure.

We have worked with clinical teams and partners to re-design the pathway for urgent and emergency care across the Humber. We propose to implement these pathway changes in all three Emergency Departments, supported by the required out of hospital provision across the region, a new workforce model and enabled by improved digital connectivity and infrastructure.

Our core aims for urgent and emergency care across the Humber are to:

- Integrate urgent and emergency care services across all health and social care partners (including mental health) to work as one system.
- Have sufficient skilled workforce to meet the demand, working in a multi-disciplinary team approach.
- Provide better support for people and their families to avoid crisis situations through self-care and prevention.
- Support high intensity users of the Emergency Departments through multidisciplinary support.
- Support people who need urgent care to be able to access advice and services in the right place, at any time which includes providing responsive services for minor injuries, illnesses and mental health support seven days a week.
- Provide quick responsive services for more serious or life-threatening emergencies in the right place with the right skilled staff and facilities.
- Put in place virtual wards to achieve a sustainable shift from hospital to home-based care when it is safe to do so (children and adults).
- Work in a joined-up way with Ambulance services to ensure patients who need hospital care are directed to a specified area in the most appropriate local, acute or specialist hospital and/or supported by 'hear and treat' / 'see and treat' – ensuring as far as possible patients get to the right place for their care needs first time.
- Make use of improved facilities and environments that exceed minimum standards and are supported by digital and technology solutions.
- Be built on a digitally delivered support infrastructure, providing remote assessments, monitoring, shared care planning and diagnostics access.

The proposed future pathway of care for patients across the Humber is set out below, summarising how each element will help to address one or more of the challenges facing our current services.

Responsibility for the delivery of many of the pathway elements outlined below sits with the Out of Hospital programme.[154]

5.2.1 Clinical assessment closer to home

One of the barriers to using Urgent Treatment Centres (UTCs) or other primary care-led services rather than an Emergency Department identified through our engagement is the lack of clarity or understanding of whether they could provide the level of care required and meet the person's need at that time. Most people were willing to use alternative provision, where they have confidence that it will meet their needs, however, they default to the Emergency Department because they know it will always be open and have confidence it will meet their needs. Urgent care services must be as easy to access as Emergency Departments if they are to be successful.

A key focus of our efforts to join-up health and care services will be ensuring that citizens across the Humber are able to access advice, care and support in an urgent or emergency situation. Our aim is that, when needed, everyone will have access to services whether through information, advice or direct care that will meet their needs in hospital or in the community 24 hours a day, seven days a week. Access will be straight-forward and easy for our public to understand. The overall model focuses on clinical assessment closer to home and to the first contact of the patient, whilst reducing the need for patients ending up in an Emergency Department. The model ensures that people are cared for by the most appropriate person to meet their urgent or emergency need by initially accessing:

- **111 via phone or online** who provide a clinical assessment service, usually provided by senior nurses and senior paramedics.
  OR
- **999** for life threatening situations.

Where clinically appropriate, patients will be directed to a service other than the Emergency Department in the first instance, including:

- **Primary care services** – includes general practice, community pharmacy, optometry and dentistry, all should have an on the day facility for urgent care needs as GP surgeries are often the first port of call for all urgent health care needs by the public.
- **Community services** – a range of services provided closer to the patient's home, this could include, for example, a rapid response falls service, community care practitioners, social care.
- **Urgent Care Service** – a facility for patients with urgent care needs that allows 111 calls to be booked into an appointment slot or where individuals can walk in and be seen and treated. This maybe co-located at the hospital front door or may be provided through a standalone Urgent Treatment Centre (existing or new).
- **Same day emergency care** – services provided within the hospital on the day for people that have an acute care need (enables them to be seen and treated in the same day without the need for a hospital admission).

There are opportunities already within the system to direct people to alternative services if these are available. Most of those surveyed sought advice before turning up at the Emergency Department, most commonly through NHS 111. We intend to build on this opportunity to work with partners to develop

[154] Section 7.2.1 describes the integrated approach being taken to align this programme with the Out of Hospital programme and ensure the enabling changes out of hospital are in place to support the service reconfiguration proposals set out within this business case.

the NHS 111 service. This will include working as a system to review the potential options for developing Clinical Advisory Services (CAS) at a Humber and North Yorkshire level to help more people to access the right care, first time.

Our model works towards a future scenario where NHS 111 will provide the primary route of access for most people with urgent care needs. The development of an 'any-to-any' booking system will enable more patients to bypass the Emergency Department through provision of direct access to the services people need.

Challenge	Solution	Benefit / Impact
Excessive (and increasing) Emergency Department demand Lack of clarity for patients on where to go for help – leading to a default to A&E	NHS111 triage and divert (developing Clinical Assessment Services) Direct booking into Urgent Care Service (UCS), Same Day Emergency Care (SDEC), Acute Assessment Unit (AAU) and other diversionary pathways	Reduction in ED attendances Better experience for patients (easier to navigate) Better outcomes – patients get to the right place, first time

Table 5.1 Clinical assessment closer to home - summary benefits

5.2.2 Co-located Urgent Care Service (UCS)

For the Humber's three Emergency Departments, demand is increasing resulting in a higher number of attendances compared to the national average. If current patterns of ED use continue with no change, there could be approximately 55 additional patients per day in both EDs at DPoW and SGH and 100 additional patients per day in Hull's ED within the next 5 years.

Analysis of activity in the baseline year across the three Emergency Departments demonstrated that a high proportion of attendances could be seen in an Urgent Care Service (UCS) and did not require the specialist provision within an ED. Detailed modelling carried out through the programme suggests that in the region of 35,000 to 46,000 annual attendances per hospital could access an Urgent Care Service (UCS) rather than the ED. In the baseline year, between 35% and 48% of total Emergency Department attendances across the three Humber hospitals could potentially be seen and treated in an UCS, 28% of these are accessing the Emergency Department out of hours when the existing Urgent Care Services in DPoW and SGH are not currently in operation.

A key element of the proposed new Humber-wide pathway is the expansion of co-located Urgent Care Services (UCS) so that they are available 24 hours a day, seven days a week at all three hospital Emergency Departments, in addition to other urgent care services, such as Urgent Treatment Centres (UTCs), provided in other locations across the region. This will enable people in need of urgent care to be seen and treated in a timely manner and for those who are severely ill or have life threatening conditions to be seen and treated quickly by dedicated emergency care staff.

Within Diana Princess of Wales Hospital, Grimsby (DPoW) and Scunthorpe General Hospital (SGH), an Urgent Care Service was introduced in April 2022 in front of the ED to support the streaming of patients to the right place, to reduce demand on the departments. The proposed future model of care would extend the operating time of the existing services in DPoW and SGH and introduce a co-located Urgent Care Service (UCS) within Hull Royal Infirmary (HRI), building on existing streaming and redirection pathways in place for patients attending the ED with urgent care needs.

The proposed UCS pathway in Hull could be delivered in a range of different ways – at the front of ED to support streaming and gatekeeping to the Emergency Department or as an alongside, but separate, service. If operating as an alongside service, it could also be expanded and developed as a Primary Care Access Centre or into a full Urgent Treatment Centre. Some of the benefits of co-location (e.g. enabling teams to work flexibly across UCS and ED) would be reduced if not located in the same place, however, from an estate's perspective a separate, alongside service would be easier to implement in the short term. A local, place-based review of options with all providers is currently being undertaken to assess the different potential delivery models for the proposed UCS in Hull. The specifics of the delivery model for each UCS will be described in detail in a Decision-making Business Case (DMBC) subject to approval of the proposals within this PCBC.

5.2.2.1 Staffing Model – Urgent Care Service (UCS)

The specific delivery model for each UCS will be set out at DMBC stage. The outline workforce model that has been developed, however, is GP or practitioner led and seeks to maximise the benefits of co-location to enhance skills and training for practitioners and ensure clinical decision-making is swift and effective. The UCS staffing model will be developed, working with clinical teams, to comprise:

- Nurse staffing – co-located Urgent Care Services enables the nursing leadership and nursing workforce to be shared across UCS and the Emergency Department to build networks, workforce resilience and maintain skills.
- Advanced Clinical Practitioners (Physiotherapists, Paramedics and Registered Nurses) with the ability to prescribe will provide high level clinical input to support patients attending the Urgent Care Service with minor illness or injury introducing the role of Urgent Care Practitioners.
- Advanced Clinical Practitioners and Nursing establishments can be complemented by Physician Associates to deliver non-complex clinical interventions.
- First Contact Practitioners would rotate between the Urgent Care Service and GP practice where they can directly support patients with urgent care needs, thereby avoiding unnecessary referrals into urgent and emergency services. First Contact Practitioners would provide immediate urgent care for minor MSK injury:
    - Paramedic First Contact Practitioners would rotate between GP/UEC services and their respective Ambulance Trust. Work is already underway within EMAS to develop new paramedic roles that can support the new urgent and emergency care pathways.
    - Physiotherapist First Contact Practitioners would rotate between GP/UEC and their respective clinical service.

Developing co-located Urgent Care Services, rather than standalone centres in other locations, enables us to develop a staffing model that facilitates staff in a wide variety of roles to work in multi-disciplinary teams across urgent and emergency care pathways and develop their skills and expertise in urgent care and emergency medicine.

Challenge	Solution	Benefit / Impact
Excessive (and increasing) Emergency Department demand	Co-located Urgent Care Service (UCS)	35-48% reduction in demand for ED services by treating patients differently through the UCS (on site).

Table 5.2 Urgent Care Service - summary benefits

5.2.3 Integrated Acute Assessment and improved flow

In addition to co-located Urgent Care Services (UCS), the Humber-wide urgent and emergency care pathway proposed also seeks to standardise the approach to assessment across the Humber's hospitals to improve flow through our Emergency Departments (EDs) and support the proposed model of care and configuration set out below (see section **Error! Reference source not found.**).

The model is based on providing a multi-disciplinary acute care service which can assess and treat patients without necessarily being admitted under a speciality, with the exception of a small number of specialties (paediatrics, acute cardiac, trauma, stroke patients and obstetrics). The model also promotes speciality input at the front door for those more acute patients that need it.

Operating an integrated acute assessment service (AAU), providing frailty, ambulatory care, assessment, Same Day Emergency Care (SCED) and short stay (<72 hours), supports specialist teams to work in a joined up multidisciplinary manner. This way of working reduces handoffs between departments, reducing risk to patients and speeding up assessment and treatment pathways and supports the delivery of the Local Emergency Hospital model described below.

When a patient needs a short stay in hospital of less than 72 hours, they would be admitted to the short stay ward, rather than a hospital specialty base ward. Patients identified as requiring specialty care or requiring hospital stays of more than 72 hours (short stay) at assessment would be promptly transferred to the relevant specialty ward. There would be in-reach into the AAU by specialties for those patients who can go home within 3 days but need specialty input.

In the proposed model, Ambulance Services, GPs, primary care practitioners and consultants would be able to send patients directly through to AAU referring via a single point of access or following clinical advice and guidance. All three hospitals have seen a spike in ambulance handover delays in the past year (see Figure 2.4). By enabling ambulance crews to have direct access to AAU, where appropriate, we can reduce the delay to handovers and improve flow within the Emergency Department.

The new Emergency Department buildings at Diana Princess of Wales Hospital (DPoW) and Scunthorpe General hospital (SGH) will create the additional space required to enable full implementation of the Integrated Acute Assessment Model described above. They will facilitate appropriate streaming of patients to UCS, ED, Acute Assessment and Same Day Emergency Care, improve flow throughout the hospital and reduce ambulance handover delays. The new assessment area buildings are due for completion in 2023.

Hull Royal Infirmary (HRI) already has Same Day emergency assessment services in place for surgical, medical and paediatric acute assessment located in various parts of the hospital site (in individual specialty areas). The proposed Humber-wide pathway for urgent and emergency care proposes that medical and surgical assessment units are brought together into an integrated assessment unit to enable joint assessment, reduce handovers and support a continued reduction in length of stay. These changes would require significant changes to the current estate within HRI and would need to be considered alongside broader ambitions for the re-provision of the upper floors of the tower block. Implementation of this proposed pathway within HRI is not essential for the delivery of the reconfiguration proposals set out in section **Error! Reference source not found.** and therefore it is proposed that the estates solutions be considered as part of the Trust's long-term estates planning over a phased period.

Challenge	Solution	Benefit / Impact
Excessive (and increasing) Emergency Department demand Ambulance handover delays	Integrated Acute Assessment model to improve flow through the hospital	Reduced length of stay Better experience for patients (quicker diagnosis and treatment and fewer handoffs) Reduction in ambulance handover delays

Table 5.3 Integrated Acute Assessment - summary benefits

5.2.4 Integrated Frailty services

Currently across the Humber region there are variations of access to services for the frail and elderly population with exemplar integrated community services provided in the Hull area but not within the other Humber localities. Services such as these provide care in a proactive way to avoid the need for patients to attend a hospital and ultimately avoid an emergency situation. Given the projected rise in age and frailty, these services will be essential to enable equity of access and reduce demand on urgent and emergency care services across the Humber.

Under the proposed pathway changes, out of hospital provision would be scaled up to shift significant activity from hospitals to the local community system where safe and appropriate to do so. For urgent and emergency care this means a focus on frailty conditions and long-term conditions as part of the **integrated frailty** programme. The integrated frailty programme, working across the Humber, has identified three elements within their Ageing Well workstream, which will support the transition of care away from hospital services:

- **Urgent community response** (UCR) – integrated models in each locality (at 'place') to support those who are frail with urgent care needs or in crisis to stay at home or in the community when it is best to do so (includes NHS 111 First, Frailty Clinical Assessment Service with a specific focus on falls)
- **Enhanced Health in care homes** – enhanced support and better co-ordinated care, reablement and rehabilitation. Rolling out Enhanced Health in Care homes Models across the Humber.
- **Anticipatory management** – helping people with complex needs stay healthy and functionally able. This involves the use of risk stratification to shift the focus of delivery towards models of early intervention, planning future care and prevention.

In order to achieve these changes, clinical assessment will be delivered close to first contact wherever a person enters the urgent and emergency care pathway to ensure they are on the right pathway to meet their needs and not ending up in an Emergency Department or being admitted to hospital when they don't need to be there.

5.2.4.1 Urgent Community Response

In line with national policy, a range of urgent response services have been developed across Humber and North Yorkshire to support people in our communities who are frail, particularly those who recently returned home from hospital, who are at a much higher risk of attending a hospital Emergency Department and being admitted into hospital in an emergency situation.

The 2-hour Urgent Community Response Service (2UCR) supports adults who, if not seen within 2 hours, are likely to need to attend an Emergency Department and potentially an unplanned admission to

hospital. To date over 90% of calls to the service are made by paramedics on site within patients' homes (including care homes). Feedback from paramedics has been positive and conveyance rates from ambulance dispatches to patients in crisis are consistently low.

The service is structured slightly differently in each locality to best meet local needs. Across Hull and the East Riding of Yorkshire, for example, the 2UCR service is offered, from 8am to 8pm 7 days per week. The service is led by three community-based Consultant Geriatricians, supported by GPs with Enhanced Roles (GPwER) and a full multidisciplinary professional team.

Urgent Community Response Services have been in place since October 2021 and are supporting clinicians to deliver urgent clinical care in the patient's preferred place of care, helping to reduce conveyances to hospital and unnecessary admissions. The vast majority of patients who access 2UCR are frail and there are clear links to social deprivation and recent hospital admissions. Data around the service is recorded so that demand, activity, reasons for referral and treatment can accurately be analysed to improve the pathways further in the future.

5.2.4.2 Anticipatory Care

Within the Humber, we are already delivering a nationally recognised best-practice approach to Anticipatory Care at the Jean Bishop Integrated Care Centre (ICC) in Hull. The approach was designed by local community geriatricians and GPs working in partnership with patients and a range of partners. GPs in Hull use the Electronic Frailty Index (eFI) tool to identify patients at risk of moderate to severe frailty and invite them to a half-day appointment at the ICC where they receive a number of multi-disciplinary reviews of their care. The team providing care and services at the centre includes GPs with extended roles, community geriatricians, pharmacists, advanced practitioners, social workers, carer support and therapists who link up with other speciality teams within the community, including the Fire Service operating a falls intervention and support service.

The ICC aims to take a proactive approach (identifying people at risk of frailty using a risk stratification tool) rather than a reactive approach (responding when people go into crisis or require help for a medical condition). By working with elderly and frail residents to ensure they have the support they need to stay well, rather than waiting until they have an issue that needs to be addressed, the ICC has contributed to significant reductions in ED attendances, emergency admissions and re-admissions for Hull's frail population.

- Compared with the 12 months prior to review at the ICC, those who have been seen at the ICC have had (on average) a 13% reduction of Emergency Department attendances and a 24% reduction of unplanned hospital admissions.
- Those who had attended ED more than 5 times in the preceding year had the greatest benefit with a 34% reduction in ED attends and 100% reduction in admissions.

With a focus on quality improvement and data, the ICC team have now expanded to include those who are moderately frail plus other conditions. The team are also working together with partners across the Humber to learn from and expand the approach across other parts of the region. This includes a virtual model of delivery which is now in place within East Riding (Holderness area) with plans to expand further across the region.

Challenge	Solution	Benefit / Impact
Excessive (and increasing) Emergency Department demand Unnecessary admissions of frail elderly patients	Integrated frailty services • rapid response/UCR • anticipatory care • enhanced care • front door assessment	Improved outcomes and faster recovery for frail patients Reduction in emergency admissions

Table 5.4 Integrated Frailty - summary benefits

5.2.5 Virtual wards

Taken together, our hospitals have long lengths of stay for emergency admissions of up to one day higher than national average. This has improved significantly in DPoW and SGH in 2021/22 as the new models of care for assessment and same day emergency care described above are being implemented, however, the position in Hull has deteriorated in recent years. Inpatient admissions where there is an increased length of stay (LoS) can impact on quality of care. They also have a considerable financial impact and reduce capacity for patients requiring acute admission and care.

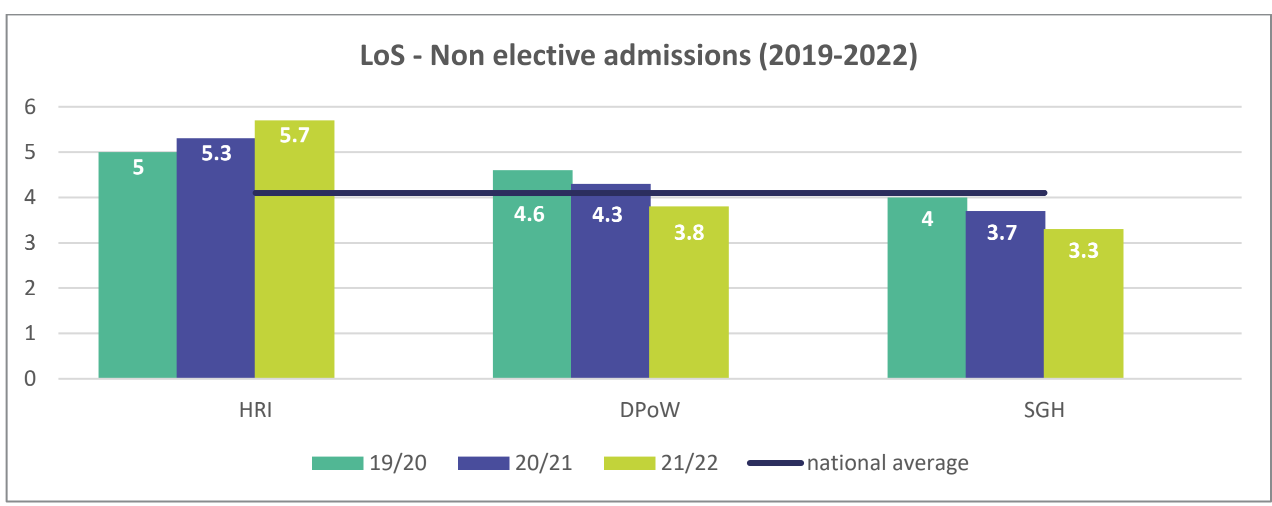


Figure 5.1 Length of Stay for emergency admissions in days (2019/20 to 2021/22) [155]

Our acute hospital services can work more effectively with partners in primary and community care to avoid the need to attend hospital, through the use of virtual wards. Virtual wards allow patients to get the care they need at home safely and conveniently, rather than being in hospital. Virtual wards are in place already in many parts of the country, with the approach being developed during the COVID-19 pandemic to provide care for COVID positive patients within their own homes through the use of remote pulse oximetry and other interventions that could be provided remotely. People with other conditions can also be treated in a virtual ward, for example people living with frailty and people with acute respiratory infection including children.

Across the Humber, we are seeking to introduce virtual wards to support more people at home (including within care homes). The approach will be underpinned by improvements to digital technology as a critical enabler and will ensure many more patients, particularly those who are frail who require an intervention that does not need to be in a hospital setting, will be able to stay at home to receive their care. Primary care, community services, hospital wards, the Emergency Department, the Ambulance Service and NHS 111 will all have the ability to refer a patient to be triaged and referred to

[155] *Internal trust data* (June 2022)

the virtual ward if they meet the eligibility criteria. When required the community response team can be dispatched for a face-to-face clinical assessment after which the patient will either be admitted to the virtual ward, taken to hospital or referred to an alternative service that better suits their needs.

Initially the key focus will be on integration and interoperability of existing services and workforce for high volume pathways within respiratory and frailty, evolving at pace to include other areas e.g. heart failure.

The benefits of this approach include an improved experience for the patient who is able to get well more comfortably in their own environment where it is easier for loved ones to visit and support and where they are less likely to deteriorate. There are also benefits in terms of increased capacity and improved flow in hospitals and benefits to Primary Care and other partners by reducing the 'bounce back' rates for these patients by providing a better, more responsive service the first time around.

Challenge	Solution	Benefit / Impact
Delayed discharge, long stays in hospital (contributing to ambulance handover delays and long ED waits)	Virtual wards – people can get home more quickly or avoid an admission in the first place	Reduction of adult inpatients through reduced length of stay

Table 5.5 Virtual wards - summary benefits

5.2.6 Discharge from hospital

Ensuring patients can leave hospital as soon as they are medically fit to do so is critically important to enabling flow through the hospital and tackling the challenges of ambulance handover delays and long waits within the Emergency Department. If the back door of the hospital is functioning well, this has a significant positive impact on performance at the front door.

Whilst it was a major area of focus prior to the COVID-19 pandemic, the mandate and resources provided during the early phase of the pandemic to rapidly improve discharge from hospitals was an important catalyst to improving the approach to hospital discharge across the region. NHS and Local Authority partners were able to work closely on developing more streamlined processes to manage the discharge to assess scheme. Within NLaG a successful way of working had already been introduced in North East Lincolnshire, with social services, mental health and NHS staff working together in a base to attend front door and also discharge assessments. In North Lincolnshire, the teams adopted a prevention and early discharge approach, utilising virtual wards.

Within NLaG the discharge HUB, staffed by a multi-disciplinary team, ensures all patients requiring support on discharge are discharged within 24 hours of the request on the relevant pathway. The trust length of stay during implementation of this new approach improved significantly.

Making further improvements to streamline the discharge processes across all hospital sites in the Humber is an important enabler of pathway improvements that are proposed through this business case. A crucial blockage that remains, however, is the lack of staff and high levels of vacancies within the care sector, including domiciliary care and nursing/care homes. This leads to increasing strain and frustration across all sectors. The workforce and OD plans developed through the programme aim to support improvement in this vitally important area.[156] The development of new roles and the creation

[156] See section 8.3 for further details of our workforce plans.

of rotational posts working across different organisations and different sectors presents an opportunity to develop the social care workforce and offer development opportunities to staff by enabling them to work across the NHS and social care. This approach to developing a one Humber workforce will support the staff across all sectors to consistently access training and development opportunities, improve staff's understanding of the processes and ways of working in other sectors and could also help to improve consistency in staff pay and conditions across sectors (including domiciliary care staff).

Challenge	Solution	Benefit / Impact
Delayed discharge, long stays in hospital (contributing to ambulance handover delays and long ED waits)	Improving discharge processes and investing in social care workforce	Reduction in length of stay, particularly for frail or elderly patients.

Table 5.6 Discharge Improvements - summary benefits

5.2.7 Mental Health – increased integration

People with prolonged severe mental illness (SMI) are particularly vulnerable to poor physical health. Patients diagnosed with SMI have almost seven times more emergency inpatient admissions and half of these admissions unrelated to their mental health but driven by an urgent physical healthcare need.[157] Regionally 14% of people aged 16 -24 have mental health disorders and this is expected to rise along with recent national increases.[158] In addition, our region has higher than average rates of suicide and self-harming behaviour.[159]

For many people experiencing mental health crisis, sanctuaries, safe havens and crisis cafes provide a more suitable alternative to an Emergency Department (ED). However, it was clear from our engagement with patients, the public and staff that it can be very difficult to know where to go and the Emergency Department often becomes the default position. It was also identified that although attempts had been made to integrate mental health and secondary care hospital teams, there have been varying levels of success in each locality. Mental health teams are supporting police and ambulance call centres, but there remains some confusion amongst partners as to where else patients can be diverted and often the Emergency Department becomes the default.

The table below details how many people present at our Emergency Departments with a recorded mental health condition – this may or may not be the reason they are attending the ED. This data demonstrates the importance for ED teams to have a good understanding and competency in managing patients with mental health conditions.

	Mental Health Attendances at ED					
	2019/2020			2021/2022		
	DPoW	SGH	HRI	DPoW	SGH	HRI
Paediatrics	87	88	302	81	99	267
17 to 25	276	423	1,057	230	333	1,168

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[157] Nuffield Trust (2015) *Focus on: People with mental ill health and hospital use* Focus on report
[158] NHS Digital (2020) *Mental Health of Children and Young People in England, 2020: Wave 1 follow up to the 2017 survey* Follow up survey
[159] Humber, Coast and Vale Health and Care Partnership (2018) *Suicide prevention strategy – 2018-2023* (document library).

25+	960	1,350	2,862	908	1,199	3,147
Total	1,323	1,861	4,221	1219	1631	4,582

Table 5.7 Mental Health Attendances at ED[160]

We are working in collaboration with our Mental Health care providers to ensure patients receive the best possible care and immediate response in the right place and at the right time. The overall model is to ensure equity of access in a safe place with the right skilled teams to support crisis situations where urgent and emergency services are required. The aim is to develop future opportunities to improve Mental Health services across the Humber and address areas such as:

- Staff training to support understanding and holistic management of the whole person
- Partnership working across all health sectors and collaboration across Mental Health providers
- 24/7 support to those who need to access it (i.e. in a crisis, enhanced liaison)
- Improved communication and information sharing

5.2.7.1 Training and improved collaboration

An important enabler for this proposed approach will be changes to culture and ways of working for our teams. Our clinicians and professionals need to work more closely together with a multi-disciplinary team approach to support skill set training and the ability to be flexible to manage workforce challenges and vacancies. Training all staff on how to spot mental health needs and ensuring a clear directory for support and signposting is in place, will be essential to prevent unnecessary attendances at ED and ensure patients receive the best care at the right time by the right skilled services.

As pressure on acute pathways continues to build – the time and space to ensure staff are trained in holistic assessment will always be a challenge until we can do something to address this. The proposals set out within this business case (PCBC) offer alternative models of care that can alleviate that pressure and allow the acute hospital the space and time to address this important training need.

5.2.7.2 Mental Health Liaison staffing model

Mental Health Liaison is a nationally recognised service that should be available in every acute trust. In each of our Emergency Departments (HRI, SGH and DPoW) core 24 mental health liaison services are in place. Across Hull and East Riding, the Mental Health Liaison service is provided by Humber Teaching NHS Foundation Trust. The service provides a dedicated team who offer a service to patients presenting at Hull Royal Infirmary or Castle Hill Hospital with self-harm behaviour, acute mental illness or emotional distress, which also offers support and advice to urgent care services in the area. Work is ongoing to extend mental health response services into Goole District Hospital, working in partnership with Humber FT. Within DPoW and SGH, the mental health liaison service delivers the specification required to support patients presenting to either Emergency Department or acute care with mental health needs, where there is sufficient demand across the 24-hour period to merit a full service.

In order to ensure our renewed pathways and models of care for urgent and emergency care meet the needs of all patients and service-users, acute services will continue to work alongside mental health care provider partners to develop workforce skills and roles. In particular, improving understanding of urgent and emergency care teams that mental health problems can be integral to a patient's physical disorder and vice versa meaning that neither can be treated in isolation.

[160] *Internal trust data* (June 2022)

We will continue to work to ensure liaison mental health is integrated with our other hospital services and pathways, working collaboratively with our mental health partners to develop a culture of partnership working, effective risk assessments across settings and integrated policies and guidelines.

More integrated pathways for urgent and emergency care both in and out of hospital will improve the experience for patients and improve performance on key waiting time targets.

The key benefits of these improved pathways include:

- ✓ Reduction in ED attendances
- ✓ Better experience for patients (easier to navigate)
- ✓ Better outcomes – patients get to the right place, first time
- ✓ 35-48% reduction in demand for ED services by treating patients differently through the consolidated Urgent Care Service (on site).
- ✓ Reduced length of stay
- ✓ Better experience for patients (quicker diagnosis and treatment and fewer handoffs)
- ✓ Reduction in ambulance handover delays
- ✓ Improved outcomes and faster recovery for frail patients
- ✓ Reduction in emergency admissions

A shift of resources from the acute hospital sector into primary, community and other out of hospital provision has been assumed within the financial modelling to support these improved pathways and deliver the benefits highlighted.

5.3 Paediatric pathways

The needs of children have changed, and it is important that our service models adapt to reflect these changes and meet the needs of children, young people and their families better.

We worked with clinical teams and partners to review and re-design the pathways of care for paediatrics across the Humber to help to address the challenges facing our current services and provide more joined up care and support for children and young people across the region.

We propose to implement these pathway changes across the Humber region, supported by the required out of hospital provision, new workforce models and enabled by improved digital connectivity and infrastructure.

The population of the Humber area faces a number of health challenges.[161] A quarter of children in North East Lincolnshire and nearly a third in Hull live in poverty. Levels of childhood obesity are high. The proportion of 10–11-year-olds who are obese ranges from 18% in East Riding to 23% across Northern Lincolnshire and Hull.[162] These underlying socio-economic factors mean that a growing number of children and young people are affected by complex long-term conditions including both physical and mental health conditions.

Managing these long-term conditions in children and young people requires a joined-up multidisciplinary approach in order to get the best results and support children and families to live happy, healthy lives. Research shows that new approaches need to be collaborative service-models – not “drag-and-drop” replicas of hospital clinics in the community.[163] We have therefore developed our new approaches to paediatric services based on collaborative working between different professions, learning through the pandemic of what works and what does not and supporting all new initiatives with good quality digital infrastructure. Digital technology offers multiple new opportunities. It enables the hospital to come to a patient’s home, it supports professionals from different organisations to share information and make collective decisions with patients and their families and it also provides engaging opportunities for children and young people to get more involved in managing their own health and wellbeing.

Through the community paediatrics (ill child) programme, several key projects are contributing to reducing the need for children to come to or stay in hospital.

5.3.1 Paediatric advice and guidance

Too many children and young people attend our Emergency Departments (ED) in the absence of appropriate alternatives. Across the Humber region it is recognised that many paediatric attendances to our Emergency Departments are inappropriate, but parents/carers of children, and young people themselves, attend due to a lack of information, advice and guidance or services within primary care and the community. On average, 31% of paediatric ED attendances receive advice and guidance only. We are developing improved advice and guidance so that hospital-based, specialist teams can support

[161] See section 1.4.1 for further details.
[162] OHID (2022) *Child and Maternal Health profile* Obesity profile
[163] Singh, Ritvij, Edward Maile, Dougal Hargreaves, Mitch Blair and Georgia Black (2022) *Back to the future? What we can learn from the history of integrated paediatric care in England* Nuffield Trust Blog

parents, carers, GPs and community staff, to aid prevention and self-management and reduce the need for children to attend hospital unnecessarily.

Challenge	Solution	Benefit / Impact
High levels of paediatric Emergency Department attendances.	Improved advice and guidance.	Reduction in paediatric ED attendances.

Table 5.8 Advice and Guidance - summary benefits

5.3.2 Hospital at Home

In addition, we will continue to develop the 'Hospital at Home' service, harnessing digital technology to provide diagnostic tools and paediatric consultations remotely to prevent unnecessary attendances to the Emergency Department or admissions to hospital. The provision of 'hospital at home' care to children means that children who would normally have to attend hospital either through an Emergency Department or being admitted to the paediatric ward can instead receive multidisciplinary team support in their own homes and avoid travelling to hospital for their care. It also supports paediatric teams to discharge patients sooner, reducing length of stay and improving the outcomes for patients. Avoiding a hospital admission is not only more convenient for the child and their family but it provides additional benefits, such as enabling families to stay together, reducing disruption and impact on siblings and other family members and it can lead to better clinical outcomes for children who are able to recover in comfortable and familiar surroundings. This model of care supports us to deliver what children and young people have told us matters most to them – being in a physical environment where they feel safe and well looked after.[164]

The Hospital at Home model began as a pilot in North East Lincolnshire in November 2021 and is looking after an average of around 17 children each week, many of whom would otherwise have ended up in the hospital Emergency Department and/or being admitted onto the paediatric ward. Referrals were higher during the winter months and the service supported a large number of infants with respiratory conditions, forming a key element of the system response to winter pressures. Feedback from clinicians during the pilot was extremely positive, confirming that the service gives them increased confidence in sending children home and/or treating children at home who would previously have been admitted for observation.[165] Rolling this approach out across the Humber will support delivery of the proposed model of care for paediatrics and help ensure more children can be seen and treated in their own home instead of attending an Emergency Department or being admitted to hospital.

Challenge	Solution	Benefit / Impact
Long stays in hospital for some children and young people	Hospital at Home – children can get home more quickly or avoid an admission to hospital in the first place	Improved experience and outcomes for patients and their families Reduction in paediatric Emergency Department

[164] See section 10.8 for further details of what we heard from children and young people.
[165] NLaG (2022) *Review of Hospital at Home Pilot* - see document library

		attendances and unplanned admissions[166]

Table 5.9 Hospital at Home - summary benefits

5.3.3 Children and Young People's Mental Health

Significant challenges exist within children and adolescent mental health services (CAMHS) both locally and nationally and, as a result, many children and young people experience long waits for mental health support. CAMHS services are outside of the scope of the Humber Acute Services programme, however, we have worked with mental health partners to design the pathways of care for acute and community paediatrics to maximise the opportunities for joint working and ensure we support children and young people to access care and support as quickly as possible.

The Hospital at Home model supports a reduction in admissions to hospital and improved mental and emotional wellbeing for children and their families. Similarly, our aims to improve remote or virtual access to paediatric outpatient appointments can support more children and young people to access the expert advice and treatment they need in their own environment where they can be more comfortable and at ease. Developing local community hubs will support better integration across community, mental health and acute services working together to improve mental health and wellbeing in our children and young people.

5.3.4 Staffing Model – Paediatric Community Hubs

The concept of developing Paediatric Community Hubs emerged through the workforce planning to support development of the Pre-Consultation Business Case. Under this approach a blended workforce model would be developed, comprising of unregistered and registered professionals from GP practices, acute children's services, social care and public health, providing an integrated location for community-based paediatric outpatient appointments and children's diagnostics as well as:

- Public health information to positively impact on reducing health inequalities.
- Specialist health advice and guidance for children and families.
- Social care advice and support for families, especially within deprived areas.

This proposal has also embraced the concept of joint appointments where retiring staff from paediatrics and children's services could return to provide education support, advice and guidance within community and Women and Children's Integrated Care hubs.

[166] The impact of Hospital @ Home on paediatric ED attendances and admissions was not included in the activity modelling due to the pilot being in a very early stage when this work was undertaken. Further modelling will be undertaken as part of the development of the Decision-Making Business Case (DMBC) to quantify the impact of H@H on paediatric activity in ED, PAU and inpatients.

Deprivation in the Humber has a disproportionate impact on children and young people, with as many as 1 in 3 living in poverty in parts of our region. This has an impact on their health and wellbeing and can put increased demand on healthcare services.

More integrated pathways for children and young people both in and out of hospital help to ensure paediatric services are sustainable in the long-term and can meet the needs of children and young people, delivering more care and support at or close to home and ensuring children only go to hospital and spend time there when it is absolutely necessary.

The key benefits of these improved pathways include:

- ✓ Reduction in paediatric ED attendances
- ✓ Reduction in paediatric admissions
- ✓ Improved experience and outcomes for patients and their families

A shift of resources from the acute hospital sector into primary, community and other out of hospital provision has been assumed within the financial modelling to support these improved pathways and deliver the benefits highlighted.

5.4 Benefits of pathway changes

More integrated pathways both in and out of hospital will improve the experience for patients, reduce the need for people to go to hospital for care and treatment and improve performance on key waiting time targets.

The Humber-wide re-design of urgent and emergency care and paediatric pathways will enable more people to have their needs met within or closer to their own homes and reduce the overall demand and pressure on Emergency Departments (ED) and inpatient care. The volumes accessing our urgent and emergency care services in the baseline year (2019/20) are outlined in diagram below:

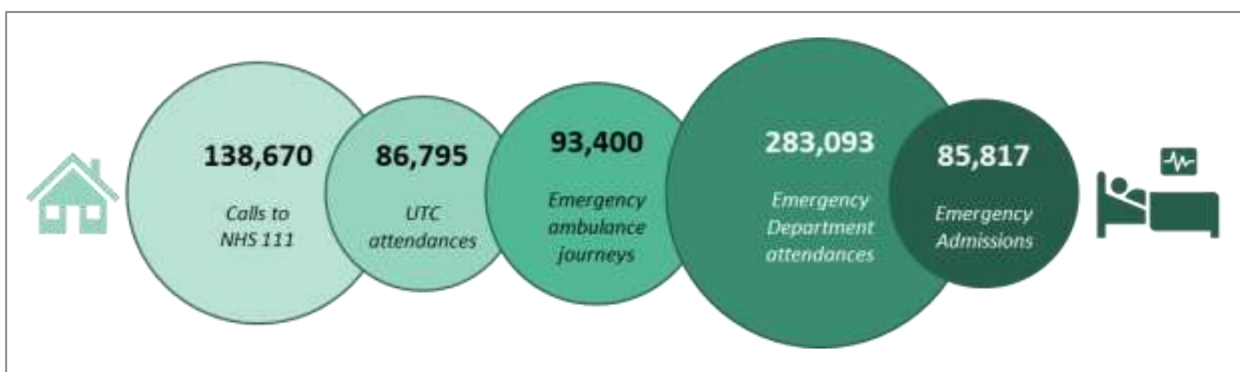


Figure 5.2 Current volumes of activity - UEC Humber[167]

In 2019/20, out of the above totals:

- 55% of emergency ambulance journeys were seen and discharged from ED on the same day
- 35-48% of total attendances at ED could have been seen in an Urgent Care Service (e.g. UTC)
- 6-8% of emergency admissions could have been managed by an Integrated Frailty service in the community and avoided the hospital Emergency Department

By re-designing the overall pathway of care, we will seek to support more people in community and other settings outside of hospital, to reduce overall demand on Emergency Departments across the Humber. This work has been undertaken in collaboration with the out of hospital programme, which is delivering a number of projects that will support this overall vision (as detailed above).

As services are re-designed, more care will be provided closer to home by multi-disciplinary teams across all domains of urgent and emergency care as illustrated in the diagram below. As usage of Urgent Treatment Centres and Urgent Care Services increases, this will reduce the overall demand on Emergency Departments across the Humber, supporting all EDs to run more effectively, avoid delays in ambulance handovers and enable rapid assessment of patients to take place. NHS 111, supported by an effective 'any-to-any' booking system (currently under development), will play a pivotal role in delivering this better, more joined up approach and help to ensure every patient gets to the right place, first time, enabling assessment by the right person.

[167] *Internal trust data* (June 2021)

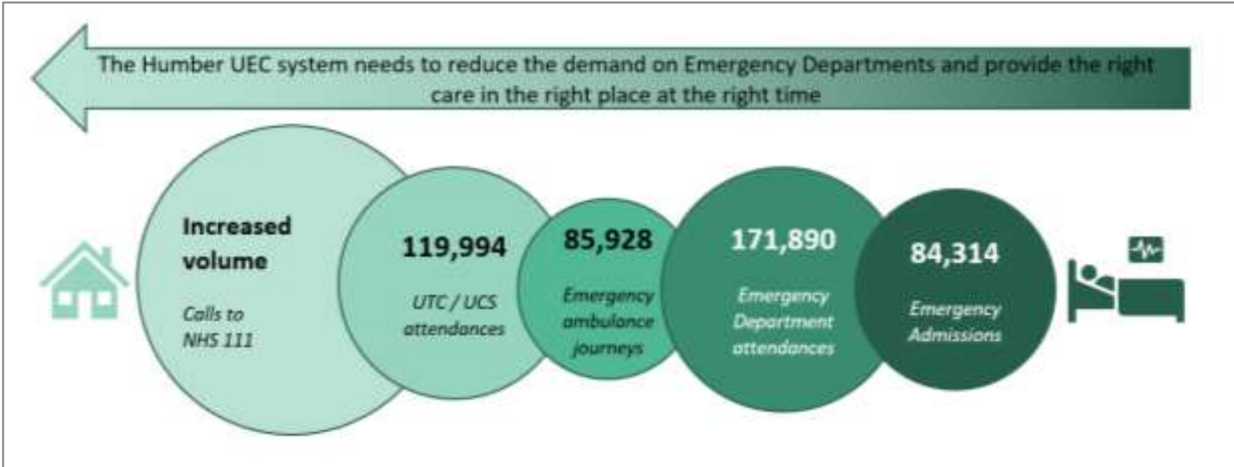


Figure 5.3 Future vision for UEC activity – Humber[168]

The proposed new pathway for urgent and emergency care across the Humber is expected to deliver the following key benefits:

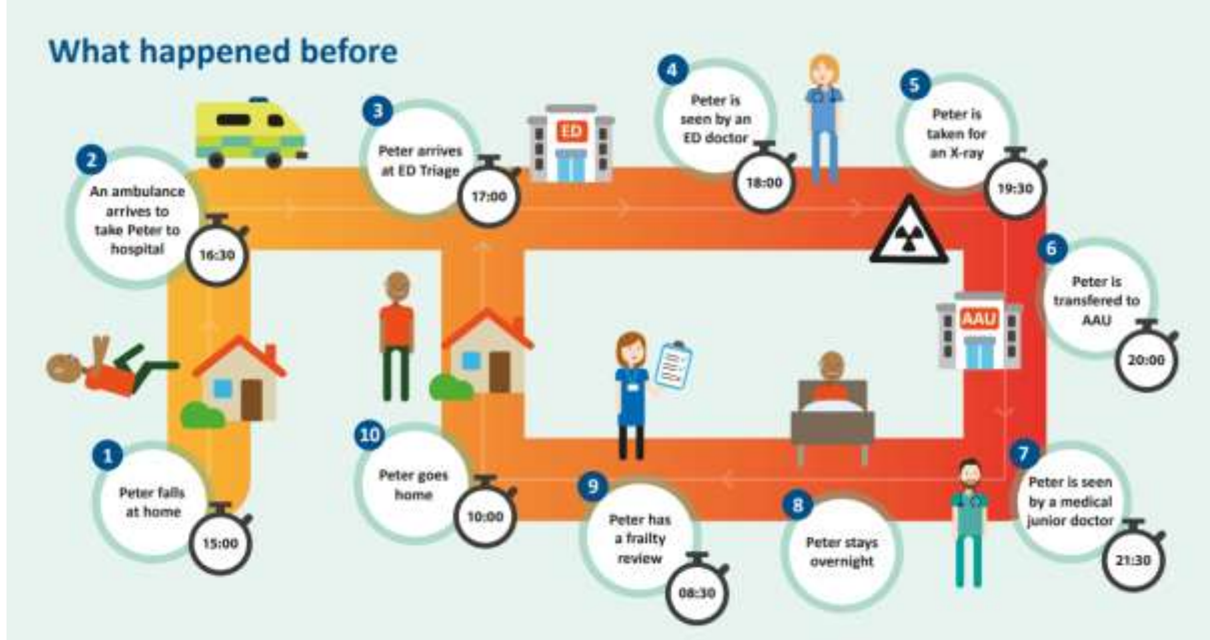
- 35-48% of total ED attendances seen in an Urgent Care Service (co-located within the hospital ED) or Urgent Treatment Centre.
- 4% of emergency admissions avoided and seen in a community service e.g. Integrated Frailty service.[169]
- Reduction of adult inpatient stays, through extended use of virtual wards.
- Reduction in those people who attend an Emergency Department 5 times or more per year.

5.4.1.1 Patient perspective – urgent and emergency care

From the perspective of patients using our services, the changes will mean fewer people needing to travel to hospital to have their urgent care needs met due to having more responsive services outside of hospital where these are clinically appropriate.

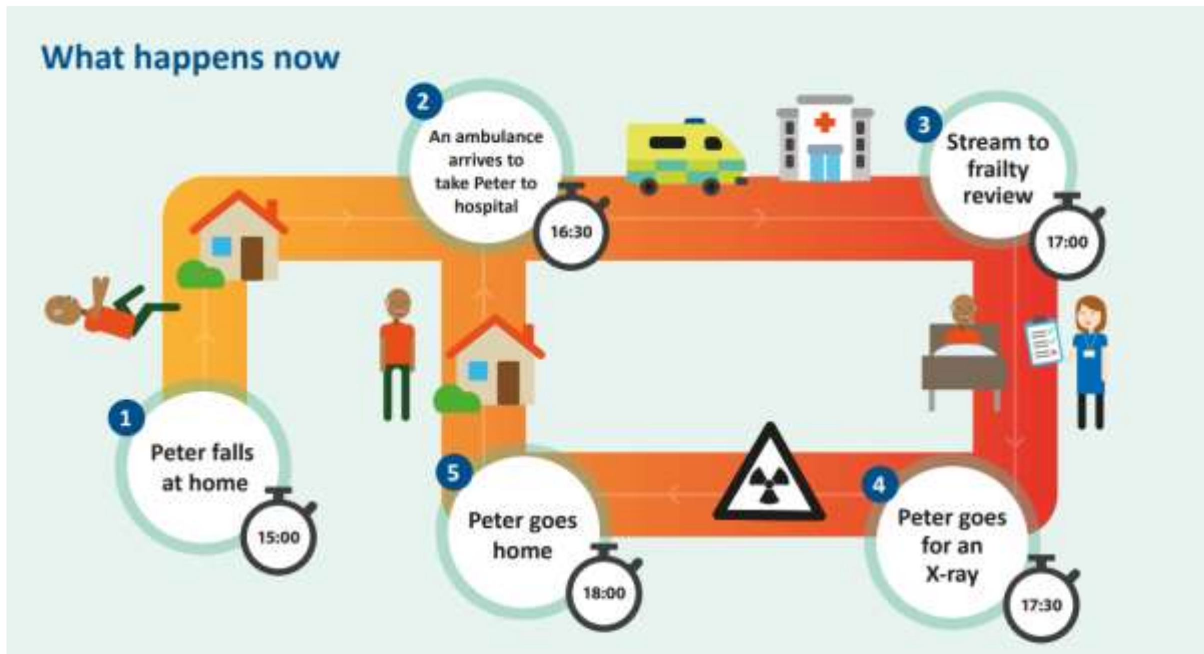
These changes would mean fewer trips to hospital for a typical patient like Peter, who is 80 years old, is frail and has a fall at home. Typically, someone like Peter would be taken to hospital by ambulance. With the current pressures within the system, he may have to wait several hours for the ambulance to arrive and potentially be cared for by paramedics in the ambulance for several hours before being able to access the Emergency Department. Historically Peter would been admitted to hospital overnight to await a clinical review by the specialist frailty team, with a strong likelihood of his overall health deteriorating during that time.

[168] *Modelling outputs* (refreshed January 2023) – see appendix D
[169] An additional 4% reduction is assumed in BAU as a result of out of hospital programmes that are already in place and delivering changes.



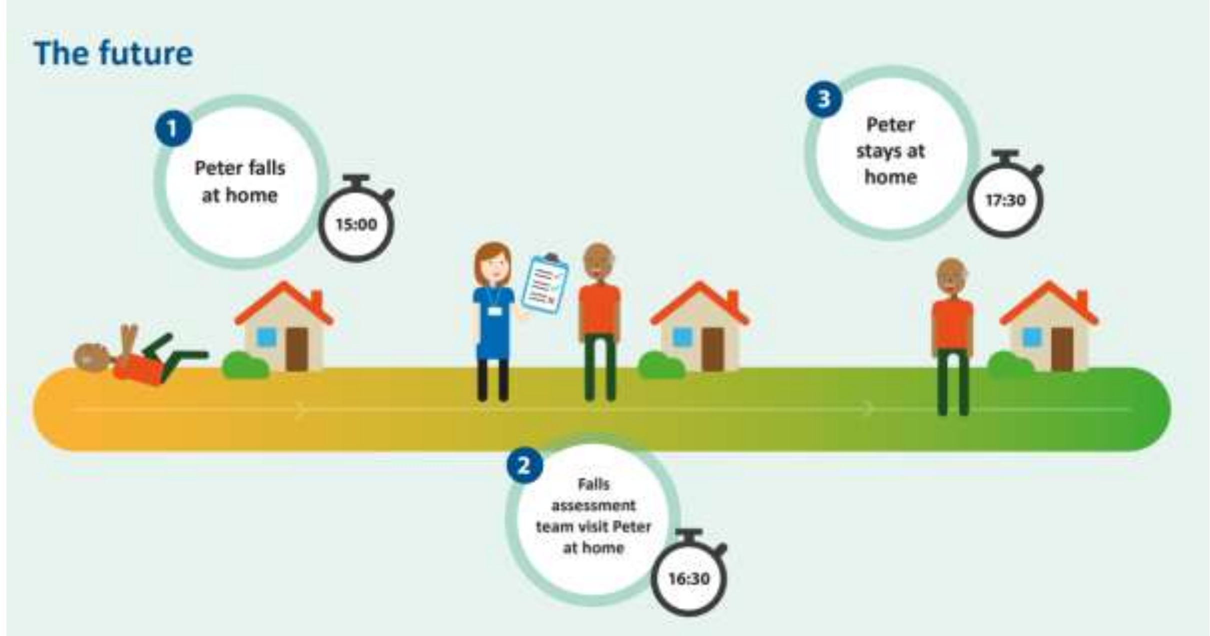
Picture 5:A Traditional pathway for frail patient with a fall

The introduction of the Integrated Acute Assessment Model and same day emergency care services is improving the pathway of care for patients like Peter in some of our hospitals (see section 5.2.3). The Acute Assessment Model reduces the number of clinical contacts and is helping to reduce the need for a patient like Peter to be admitted overnight to await clinical review. This model is now in place within the Emergency Departments in Scunthorpe General Hospital (SGH) and Diana Princess of Wales Hospital (DPoW) and is being developed within Hull Royal Infirmary (HRI). The new Emergency Department and assessment buildings at SGH and DPoW – due for completion in 2023 – will enable this model to be delivered more effectively.



Picture 5:B Integrated Acute Assessment pathway for frail patient with a fall

The further pathway changes described above would mean that Peter could be assessed by an urgent response team at home and avoid coming to hospital at all.



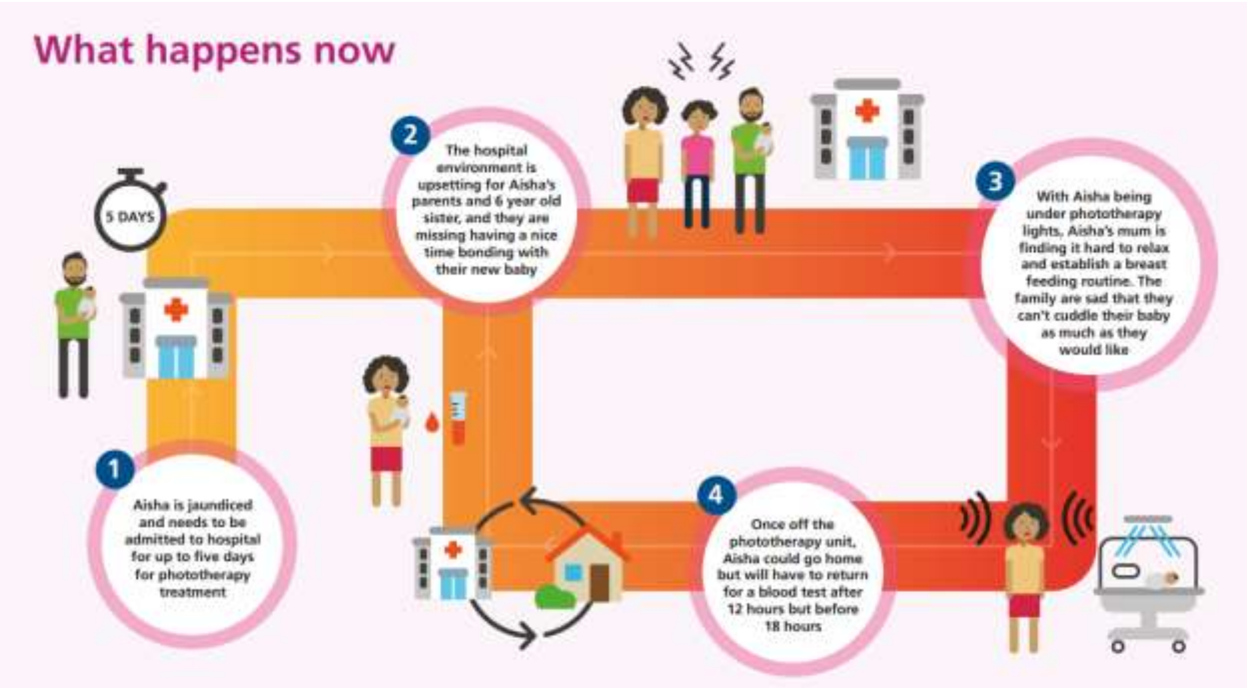
Picture 5:C Future pathway for frail patient with a fall

5.4.1.2 Patient perspective – paediatrics

From the perspective of patients using our services, many of the changes described will mean fewer children and families needing to travel to hospital to have their urgent care needs met due to having more responsive services outside of hospital, where these are clinically appropriate.

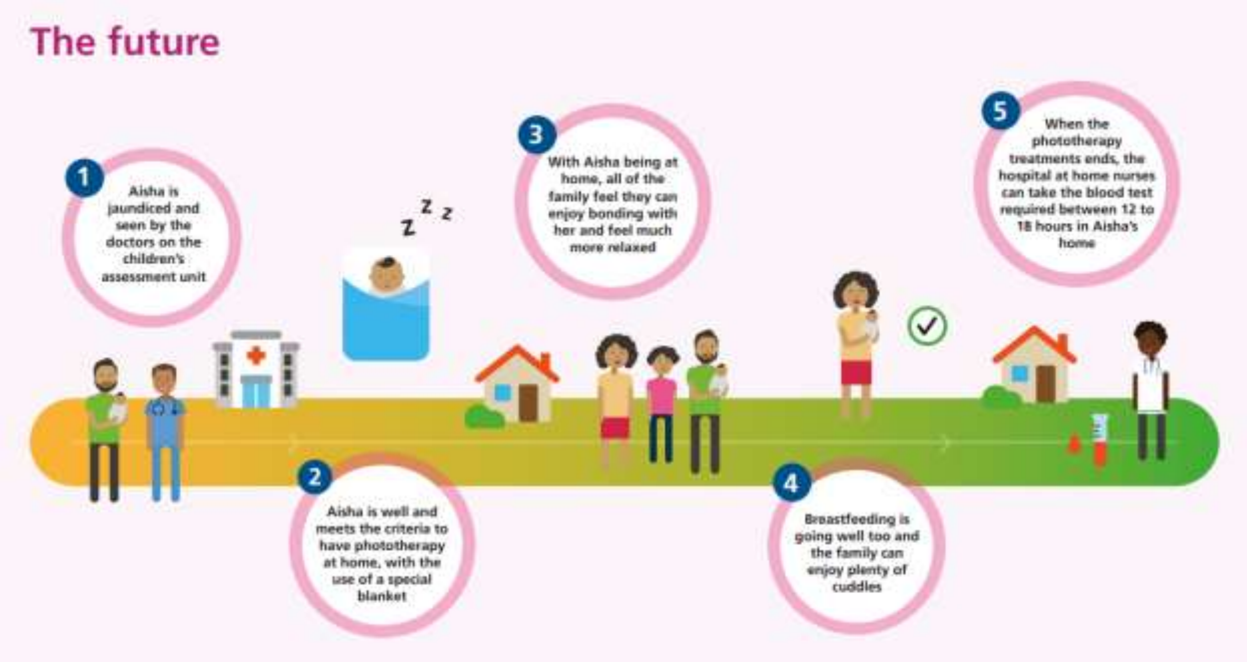
These changes would mean fewer trips to hospital for a typical patient like Aisha, who is new born baby with the condition neonatal jaundice, which is caused by the build-up of bilirubin in the blood. Treatment for neonatal jaundice is not usually needed because the symptoms normally pass within 10 to 14 days, however, in some cases, like Aisha's, the condition is serious enough that she needs to have a treatment called phototherapy.

Typically, a baby like Aisha would be admitted to hospital for up to five days to undergo phototherapy treatment. Then, when the treatment is finished, her family would have to bring her back to the hospital for a simple blood test, more than 12 hours but less than 18 hours later. This approach to treatment is highly disruptive for a family such as Aisha's, particularly if, like many families in the Humber, they do not have access to a car.



Picture 5:D Current pathway for patient with neonatal jaundice

With the introduction of Hospital at Home and related pathway changes, Aisha could receive her treatment at home, under supervision from the hospital team, leading to a significantly better experience for Aisha's family in her first few days. How this would work in practice is set out in the picture below.



Picture 5:E Future pathway for patient with neonatal jaundice

This is just one example of the more integrated pathways that will support the proposed new models of care across the Humber and enable us to deliver our ambition of reducing the overall need for patients to travel to hospital for their care.

5.4.1.3 Humber pathway redesign impact

Overall volumes of Emergency Department (ED) attendances can be reduced by ensuring urgent care services are available and easily accessible by the Humber population. The potential models of care – in all scenarios – include a 24/7 Urgent Care Service (UCS) co-located with the EDs across the Humber. The table below shows the forecast reduction in total ED attendances and the diversion to on-site urgent care services, enabling ED teams to focus on life-threatening injuries and illnesses and dedicated multi-skilled teams to provide round the clock urgent care for those conditions which are not life threatening. Focusing on integrated community pathways will enable patients to be supported and seen closer to home and avoid the need for a hospital attendance or admission where appropriate with the integration of frailty models, virtual wards and support for high intensity users. Continued collaborative working with partners across the Humber will support development and delivery of these pathway changes.

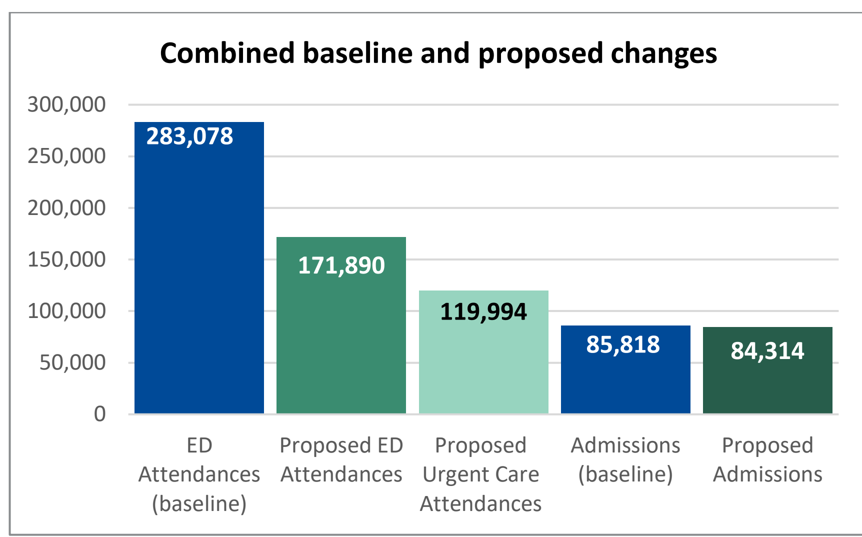


Figure 5.4 Pathway change impact - ED Attendances and Admissions (Humber)[170]

Combined impact
(HRI/SGH/DPoW)

Pathway changes => reduction in **ED attendances** of **35-48%** attending urgent care services instead (co-located with ED or at a local UTC).

Pathway changes => reduction in **emergency admissions** of medical patients by **4%** receiving care in the community or same day emergency care (SDEC) instead.

By working in these new ways, we can significantly reduce the overall levels of demand faced by all our Emergency Departments. Applying 5 years of expected growth to the baseline shows the continued rise in demand in ED and admissions, which would put additional pressure on services already struggling to cope with the current levels of demand. The Business As Usual (BAU) model shown in the chart below includes a 4% reduction in admissions in line with the integrated Acute Assessment Unit pathway changes described above (see section 5.2.3), which have already begun to be implemented within Grimsby and Scunthorpe. Full implementation of this pathway change, plus other pathway changes described, would lead to a further 4% reduction in emergency admissions and significant reduction in ED attendances over the period.

[170] *Modelling outputs* (refreshed January 2023) – see appendix D

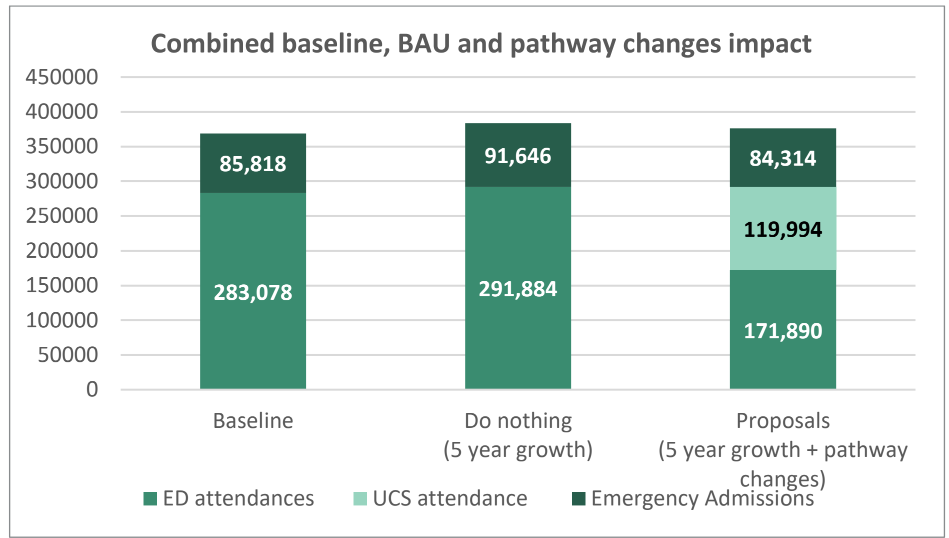


Figure 5.5 UEC baseline activity, growth assumptions and impact of pathway redesign[171]

More integrated pathways for urgent and emergency care both in and out of hospital will improve the experience for patients and improve performance on key waiting time targets.

The key benefits of these improved pathways include:

- ✓ Reduction in ED attendances (adults and children)
- ✓ Better experience for patients, carers and families (easier to navigate)
- ✓ Better outcomes – patients get to the right place, first time
- ✓ 35-48% reduction in demand for ED services by treating patients differently through the collocated Urgent Care Service (on site).
- ✓ Reduced length of stay
- ✓ Better experience for patients (quicker diagnosis and treatment and fewer handoffs)
- ✓ Reduction in ambulance handover delays
- ✓ Improved outcomes and faster recovery for frail patients
- ✓ Reduction in emergency admissions (adults and children)

The impact of the changes on activity levels includes:

- ✓ **reduction in ED attendances of 35-48%** attending urgent care services instead (co-located with ED or at a local UTC).
- ✓ **reduction in emergency admissions of medical patients by 4%** receiving care in the community or same day emergency care (SDEC) instead.

A shift of resources from the acute hospital sector into primary, community and other out of hospital provision will enable these improved pathways and deliver the benefits highlighted.

[171] *Modelling outputs* (refreshed January 2023) – see appendix D

Chapter 6

Proposed Models of Care

Detailed proposals, benefits and impacts

6. Detailed Proposals, Benefits and Impacts

To improve the quality and safety of services and make sure they are sustainable into the future, this PCBC recommends that **some specialist services** at our hospitals in Northern Lincolnshire (Diana Princess of Wales Hospital, Grimsby and Scunthorpe General Hospital) **should be consolidated and in future be delivered from just one site.**

Other services, including urgent and emergency care for most patients, should continue to be provided as locally as possible and **should remain at both hospitals**.

- **Trauma services** should be consolidated to provide access to more specialty skills 24/7 and allow for more rapid patient intervention potentially reducing length of stay and improving the experience for patients.
- **Emergency Surgery and Acute Surgical Inpatient Care** should be consolidated – with 24/7 teams including surgeons, theatre teams, nursing staff on one site to make reduce out of hours on-call and support future sustainability of workforce.
- **Specialty Medical Inpatient Care** for Cardiology, Gastroenterology and Respiratory services (>72 hours) should be consolidated to enable services to deliver clinical standards, in particular, 7-day consultant-led care, improving the quality of patient experience, reducing our lengths of stay and supporting patients to go home more quickly.
- **Paediatric Inpatient Care** (>24 hours) should be consolidated to enable services to improve training and development opportunities and support the future sustainability of the workforce.

The proposed changes would enable us to address critical shortages in workforce, consolidate rotas and improve patient access, waiting times and length of stay, whilst maintaining the majority of services locally.

The key benefits of the proposed model of care include:

- ✓ Make the best use of skilled workforce – reduce duplication.
- ✓ Ensure patients with most complex needs can access specialist care from well-supported teams of highly skilled professionals.
- ✓ Improve training and development opportunities for staff.
- ✓ Develop Centres of Excellence for specific services, building confidence in patients and staff.
- ✓ Support more people to stay well, be seen and treated at or close to home.

We recognise that any changes we make will have an impact on patients, carers and staff and for some people will mean longer journey times to access particular hospital services. Detailed impact analyses have been undertaken to quantify the likely impact and develop mitigations.

Summary Box 6.1

6.1 Current service configuration

We want to continue to provide the best care for those living in our region and invest in the many specialist services our hospitals provide. As a collective of hospitals working better, together, we can provide improved services and care for all. But to do so, **things need to change.**

The proposals have been designed to ensure that high quality hospital care can continue to be provided across the Humber now and in the future.

Our population have told us they find services confusing, disjointed and difficult to navigate. They want to be seen and treated quickly and are willing to use alternative services (to the hospital Emergency Department) if they are confident that they will meet their needs.

Patients of all ages have increasingly complex needs, which require staff with specialist skills, knowledge and experience. Our current services in North and North East Lincolnshire are small in comparison to others in the country and this makes it more challenging to achieve the required national standards, such as ensuring we have the right mix of skilled professionals dedicated to specific elements of the service and we are not relying on staff to cover multiple roles at the same time. With the teams of nurses, doctors and other professionals that are available to us, meeting every standard all of the time is extremely difficult.

6.1.1 Current service configuration

Across the Humber the NHS provides a wide range of urgent and emergency care services and paediatric services, which play a role in supporting patients when they need medical help quickly.

- **Urgent care** is medical care provided for illness and injuries which require prompt attention but are typically not of such seriousness to require the services of an Emergency Department.
- **Emergency care** is required when a person has a life-threatening accident, injury or illness and has to be immediately assessed and treated in a hospital Emergency Department.

Emergency care is currently provided 24/7 across three hospital sites in the Humber – Hull Royal Infirmary (HRI), Diana Princess of Wales Hospital, Grimsby (DPoW) and Scunthorpe General Hospital (SGH). These hospitals operate an Emergency Department, acute assessment service with same day emergency care (SDEC) and emergency admissions for most specialities, supported by 999 and emergency ambulance services, mainly provided by Yorkshire Ambulance Service NHS Trust (YAS) on the north bank of the Humber and East Midlands Ambulance Service NHS Trust (EMAS) on the south bank.

Hull Royal Infirmary provides the adult Major Trauma Centre (MTC) for the region. Major Trauma provision for children is delivered from regional centres in Sheffield and Leeds. A Major Trauma Centre (MTC) is a specialist centre with equipment and skilled staff who are trained in dealing with the most serious and life-threatening injuries. An MTC operates as part of a major trauma network, supported by Trauma Units where patients can be stabilised and transferred as appropriate. In addition, Hull provides tertiary services for neurosurgery, vascular, specialist cardiology and cancer services. Most of these services are provided from Hull Royal Infirmary, but emergency care is also provided from Castle Hill Hospital, Cottingham for cardiology, cardio-thoracic and urology acute and specialist services.

Both **Scunthorpe General Hospital (SGH) and Diana Princess of Wales Hospital, Grimsby (DPoW)** operate 24/7 Emergency Departments and have designated Trauma Unit status. This means that they

can see and treat all urgent and emergency patients who attend themselves or in an ambulance (except major trauma) and have the capability to do emergency surgery 24/7. Both hospitals have wards for medical patients and surgical patients, however, some acute services are consolidated on one or other site (e.g. Hyper Acute Stroke Unit, urology and ENT).

A range of other urgent care services are provided across the Humber, including Urgent Treatment Centres (UTCs) in Goole, Beverley, Bridlington and Bransholme in Hull. There is a GP walk in service provided at Storey Street in Hull and planned care centres that provide treatment for minor injuries (accessed via NHS 111) in Driffield and Withernsea.[172] In addition, an Urgent Care Service (UCS) has recently been introduced within the hospitals at DPoW and SGH at the hospital front door for managing patients with urgent care needs, in line with the latest national guidance.[173]

For **children and young people**, Paediatric Assessment Units are provided within the three hospitals – HRI, DPoW and SGH – available 24/7. Acute paediatric inpatient services are also provided at all three sites. In addition, Hull Royal Infirmary is a tertiary centre and provides surgical paediatric care, as well as specialist services. Paediatric intensive care is accessed in Leeds or Sheffield for patients living within the Humber region. Whilst some tertiary referrals are made to HRI, much of the specialist paediatric patient activity from NLaG flows out of the Humber area to Sheffield Children's Hospital. Specialist outpatient paediatric clinics are delivered in partnership with Sheffield and Leeds at both Scunthorpe and Grimsby through a hub and spoke model.

6.1.2 Current activity

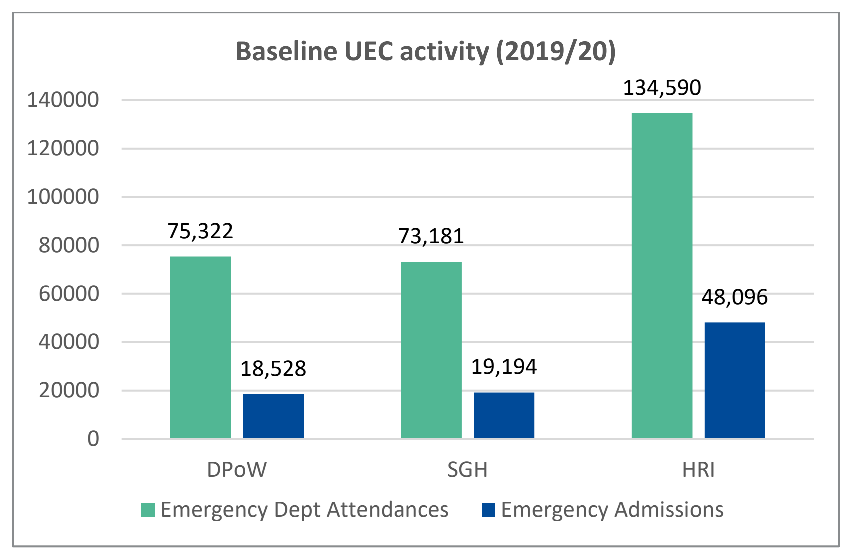
Each year there are around 283,000 attendances at our Emergency Departments (EDs), which is roughly one attendance for every 3 people living in the Humber. Emergency Department Demand was impacted during the initial onset of the pandemic, but attendances have since returned to pre-pandemic levels.[174] Each year there are around 85,818 emergency admissions, which equates to around one admission every 7 minutes.

Of the approximately **775 people** who attend one of the three **Emergency Departments** (EDs) in the Humber each day, on average only **471** of them (~60%) will be seen and treated within the expected four hours,[175] falling far short of the 95% target. Based on recent performance data, as many as **25 people** a day could be **waiting for more than 12 hours**.[176] In addition, up to **150 people** each day wait longer than they should (15 minutes) in the ambulance they arrived in because there are not enough staff or beds in the department for the ambulance crews to safely hand patients over.

Around 20% of people attending our Emergency Departments are children (16 years and under), many of whom have minor injuries or illnesses that can be quickly treated. In addition, our Paediatric Assessment Units (PAUs) see approximately 15,588 children every year and around 4,193 are admitted to hospital for an overnight stay. These numbers are not consistent throughout the year, however, and there are significant seasonal variations with increased demand in winter and, for Grimsby in particular, summer.

[172] Potential delivery models for urgent care services for the population of the west of Hull are currently subject to a place-based review of options with all providers, which could result in additional UTC provision and/or changes to the services provided at Storey Street (see also section 5.2.2).
[173] A more detailed explanation of the current configuration of services is provided in appendix 10.2.
[174] See section 2.2.1.1 for activity over time.
[175] See Figure 2.2 – %age of patients seen and treated in ED within 4-hours, 2021/22
[176] See Figure 2.3 – Ambulance handovers within 15 minutes, 2019 - 2022

The number of children admitted for an overnight stay in our hospitals is relatively small, particularly in the children's wards in Scunthorpe and Grimsby (around **2-3 per day** at each unit). New clinical standards combined with national and regional shortages of specialist paediatric staff mean that it is becoming increasingly difficult to provide the level of cover required in our paediatric services at all times and ensure our teams and new trainees have sufficient exposure to more complex cases in order to maintain the high level of skills and expertise our current teams have.



The total annual **ED attendances** in 2019/20:

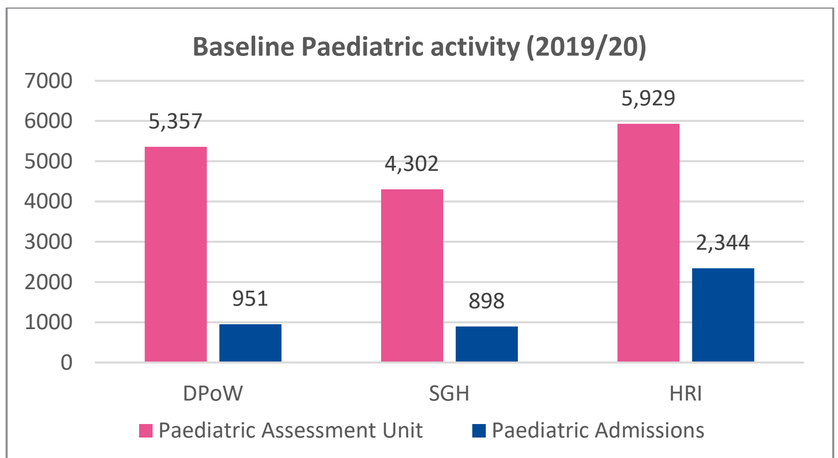
- HRI = 134,590
- DPoW = 75,322
- SGH = 73,181

These include walk-ins and patients brought in by ambulance.

The annual **emergency admissions** in 2019/20 were:

- HRI = 48,096
- DPoW = 18,528
- SGH = 19,194

Figure 6.1 Baseline ED attendances and admissions (2019/20) [177]



The total annual **PAU attendances** in 2019/20:

- HRI = 5,929
- DPoW = 5,357
- SGH = 4,302

The annual **emergency paediatric admissions** in 2019/20 were:

- HRI = 2,344
- DPoW = 951
- SGH = 898

Figure 6.2 Baseline PAU attendances and admissions (2019/20)[178]

The way in which services are currently designed, is not meeting the required standards in a system that is experiencing unprecedented challenges and ever-increasing demand.

Urgent and emergency care and paediatric services need to change to ensure we can continue to meet the needs of our population now and into the future.

[177] *Internal trust data* (June 2021). NOTE: 2019/20 was used as the baseline line against which the different potential changes were modelled due to the pandemic impact on 2020/21 data, which was the most recent data available when the options development work was undertaken. Details on all modelling assumptions used and work undertaken to review and confirm the activity modelling outputs are provided in appendix 10.16 and the document library.
[178] *Internal trust data* (June 2021). NOTE: paediatric ED attendances are within the ED numbers in figure 5.1.

6.2 Views and priorities of our population

Over the course of the programme we engaged with over **9,000** patients and service-users and involved more than **3,000** clinicians and members of staff in our clinical design process, through workshops, focus groups and surveys.[179]

This engagement has been critical in helping to shape and to evaluate the proposals within this business case, ensuring they reflect the priorities and preferences expressed by our local population.

Some key highlights were:

- **Being seen and treated quickly** was the most important thing to most people when it comes to hospital care.
    - Overall, respondents to the *What Matters to You* survey said that being seen and treated quickly was most important.
    - Many of the people we engaged with had a good understanding of the challenges within the NHS both locally and nationally and were willing to accept changes (e.g. by using online services or going to a different location for care) if it could help them to be seen more quickly.
    - Poor communication and a lack of transparency around waiting times and alternative options were raised as areas for improvement.

- **Safety was comparatively more important to parents, carers and guardians than the public as a whole.**
    - In our *Children and Young People, Parent, Carer and Guardian* and *Your Birthing Choices* surveys, "being kept safe and well looked after" ranked the number one priority overall.
    - This was in contrast to wider public responses, which ranked it either second or third, after "being seen and treated as quickly as possible".
    - Parents and prospective parents were consistent in prioritising safety above other factors.

- **Accessibility and experience** were also very important for parents and guardians.
    - Parents and guardians provided feedback on how hospital visits can be stressful and made suggestions on how they could be improved.
    - Parents highlighted the need for more experienced and well-trained paediatric staff working in Emergency Departments (ED), wards and clinics.

- **Having the right workforce – and enough of them – is important to staff and patients alike.**
    - Compassionate and caring staff were the most common reason for a positive experience of care. The public recognise the pressures on hospital staff and want to see things change and for staff to have time to care.
    - A healthy work/life balance and making a difference to patients are the things that matter most to our staff. Staff we engaged with want to ensure any future models of care will be adequately staffed.
    - Our workforce wants to work differently and try new approaches.

[179] Further details of the methods and findings is provided in appendices 10.7 to 10.15.

- **Most people attend an Emergency Department because someone advised them to go there.**
  - The vast majority of people we heard from told us that they went to an Emergency Department because they were advised to go by a medical professional – most commonly a GP or NHS 111.
- **People are willing to use alternative urgent care provision *if they are confident* that it is appropriate for their needs.**
  - Knowledge of alternatives to the Emergency Department was mixed across the region.
  - Many people knew about other services but were not confident they would meet their needs.
  - For some communities the hospital is easier to get to than alternatives.
- **Models of care for the future need to be simple and easy to understand.**
  - Urgent and emergency care provision is currently too disjointed and confusing.
  - People told us they want to 'do the right thing' and use the most appropriate service but they find the NHS confusing and don't always know where they should go for help, particularly in an urgent or emergency situation.
  - If people do not know where to go or have difficulty accessing other services, they default to the Emergency Department because they know it is 'always open' and they will be able to get help there.
- There is an opportunity to tackle some of the challenges faced by **providing direct access to the services people need** (bypassing the Emergency Department) if services are better coordinated 'behind the scenes'.
  - Many people in our communities already use NHS 111 (or NEL Single Point of Access) and would welcome improvements to the treatment options available via 111.
- **People face a lot of existing barriers that make accessing care difficult.** These sometimes include travel and transport challenges but can be impacted by a much wider range of factors.
  - Throughout our engagement people told us that travel and accessibility issues are not all about distance. Simple changes like better signage, improved communication and more accessible parking spaces could significantly improve their experience of coming to hospital.

The proposals have been designed to improve performance on waiting times and help to ensure more people are seen and treated more quickly. They have been designed to address key workforce concerns – raised by patients and staff – that staff do not have as much time as they would like to spend with patients as they are spread very thinly across multiple services. The proposed pathway changes (see sections 5.2 and 5.3) have been designed to make services more accessible, less disjointed and ultimately easier to navigate so people get the right care, first time, every time.

> The engagement work undertaken has shaped the overall vision for urgent and emergency care services, paediatric services and the proposed models of care for the future.
>
> **Our proposals have been designed and evaluated based upon what patients, staff, carers, families and other stakeholders have told us is most important to them.**

6.3 The proposed model of care

To improve the quality and safety of services and make sure they are sustainable into the future, we propose that **some specialist services** at our hospitals in Northern Lincolnshire (Diana Princess of Wales Hospital, Grimsby, DPoW and Scunthorpe General Hospital, SGH) **should be consolidated and in future be delivered from just one site** in Northern Lincolnshire.

The following specialist services would be consolidated at a single hospital in Northern Lincolnshire:

- Trauma Unit
- Specialist Medical Inpatients – *gastroenterology, cardiology, respiratory* (>72 hours)
- Acute Surgery Inpatients (>24 hours or requiring overnight surgery)
- Paediatric Inpatients (>24 hours)

We propose that **other services**, including urgent and emergency care for most patients, should continue to be provided as locally as possible and **should remain at both Northern Lincolnshire hospitals.**

The following services would continue to be provided at both hospitals in Northern Lincolnshire and are out of scope for the proposed changes:

- Urgent and emergency care from a 24/7 Emergency Department, assessment unit and short stay (up to 72 hours)
- Day case emergency surgery
- Longer stay inpatient care for elderly and general medical patients
- Paediatric Assessment Unit (up to 24 hours)
- Maternity and neonatal care
- Planned care services, including surgery, diagnostics and outpatient services (some of which may be provided in a community location e.g. GP surgery or Community Diagnostic Centre)

Services at Hull Royal Infirmary (HRI), Castle Hill Hospital (CHH) and Goole and District Hospital (GDH) would continue as is.

The proposed changes would enable us to address critical shortages in workforce, consolidate rotas and improve patient access, waiting times and length of stay, whilst maintaining the majority of services locally.

6.3.1.1 Proposed changes – urgent care and specialty medicine

Our services are seeing **increasing demand** for A&E, ambulances and urgent treatment services and continuing to manage the elective backlog created by the COVID-19 pandemic. **Our services do not deliver the NHS Constitutional Standards or performance standards**, particularly in relation to waiting times and patient access. Too many patients are waiting too long to be seen and treated for both urgent and emergency care needs and for planned care and treatment.

Last month (May 2023), **only two thirds of patients were seen and treated within 4 hours** in our Emergency Departments (68.3% in NLaG, 62.2% in HUTH) and more than **40 people a day waited for over 12 hours** (854 in NLaG and 386 in HUTH).

The proposed changes will help to ensure more people are seen and treated quickly and improve performance against waiting time, access and clinical standards. The proposed changes are summarised in the table below.

Service	Current situation	Proposed change	What would be different
Urgent Care	High volumes of patients attending Emergency Departments for **urgent care** needs. **Poor performance** on A&E waiting times (~43-56%, target = 95%)	**Co-located Urgent Care Service** in all three Emergency Departments (Hull, Grimsby and Scunthorpe) to see and treat non-life-threatening illnesses and injuries	Up to **120,000 patients** (c.329 per day) that attend our Emergency Departments every year can be seen and treated more quickly in an Urgent Care Service (co-located within the Emergency Department).
Specialty Medicine	**Speciality inpatient services** currently provided from both Grimsby and Scunthorpe Hospitals. Current services provide senior review for patients approx. 3 to 4 days a week only, leading to delays and longer length of stay. Current services **do not meet clinical standards**.	**Speciality inpatient services** (*Gastroenterology, Cardiology and Respiratory*) would be provided at Diana Princess of Wales Hospital, Grimsby (DPoW) for patients who require admission after 72 hours or require a higher level of specialist clinical input. Care would be provided at Scunthorpe with specialist in-reach into the assessment, short stay wards and general medical/care of the elderly inpatient admissions.	Consolidation of specialty inpatient services would enable specialist 7-day service to be provided, improve quality of care through reduced length of stay with combined specialist workforce and Consultant of the Week. This would enable daily senior review and support future sustainability of workforce. Patients who require admission post-72 hours would transfer from SGH to DPoW, supported by timely inter-hospital transfer solutions. This would impact approximately **3 patients** per day (based on current activity numbers).

Table 6.1 Summary of proposed changes (medicine)

What this would mean for patients across the Humber is:

- Patients with minor injuries or illnesses could be seen and treated more quickly in a co-located Urgent Care Service (UCS) at their local hospital.
- Patients who can be assessed, treated and discharged within 72 hours would continue to go to their nearest hospital and receive treatment for their condition.

- Patients who are acutely ill and/or require additional clinical input from specialist teams would be treated at Diana Princess of Wales Hospital, Grimsby (DPoW). Where patients are brought by ambulance, they will be taken directly to DPoW (or Hull Royal) if it is identified they will require ongoing specialist care. Patients who arrive themselves or whose condition worsens would be transferred to DPoW.

Case Study – Cardiology (angiography)

Patients who require angiography following a heart attack (NSTEMI) or because they are at increased risk should be treated within 72 hours, according to national guidance.

Currently such patients are admitted and monitored (often for several days), because 7-day consultant cover is not available on either site. This means that patients are waiting longer to be seen and treated than in other parts of the country and can lead to poorer outcomes and negative experience for our patients.

Under the proposed model, 7-day services would be provided, and patients could be treated within the 72-hour window and return home.

6.3.1.2 Proposed changes – emergency surgery and trauma

Our staff are spread too thinly across hospital sites, with relatively small services provided from a number of different hospitals; this means that we are **not always able to meet clinical standards** set nationally and that jobs for our staff are tougher than in other parts of the country. We are **duplicating 24/7 on-call teams** across sites for small volumes of patients and we are unable to provide 7-day consultant reviews, meaning our patients spend longer in hospital to get the same care and treatment than in many other parts of the country.

The number of emergency operations undertaken overnight at Grimsby (172/year) and Scunthorpe (196/year) combined equates to around **one patient per night** yet both have fully-staffed 24/7 on-call rotas for overnight surgery.

The proposed changes will make better use of our skilled workforce, enable us to deliver on key clinical standards and help to improve staff recruitment and retention by offering more attractive jobs and innovative ways of working. The proposed changes are summarised in the table below.

Service	Current situation	Proposed change	What would be different
Trauma	Major Trauma Centre (adult) in Hull and Trauma Units located in both Grimsby and Scunthorpe Hospitals.	Single Trauma Unit for the south bank at Grimsby Hospital (DPoW). Major Trauma Centre (adult) continue to be provided at Hull Royal Infirmary for the region.	Working closely with Ambulance services, patients requiring trauma services would be conveyed directly to HRI or DPoW where specialist teams and skills will be dedicated to deal with trauma emergencies. This would affect a maximum of **2 patients** per day that previously

			attended the Scunthorpe Trauma Unit (based on current activity numbers).
Surgery	Emergency Surgery is currently provided from both Grimsby and Scunthorpe Hospitals (and Hull Royal). Workforce challenges impact on surgical teams across the Humber.	Emergency Surgery for patients requiring an admission would be consolidated to Grimsby Hospital. Emergency surgery that is appropriate to be dealt with as a day case would also be provided at Scunthorpe Hospital.	Consolidation of emergency surgery 24/7 teams including surgeons, theatre teams, nursing staff would reduce out of hours on-call and support future sustainability of workforce. This could impact up to 7 patients per day that currently are admitted to Scunthorpe Hospital for surgical inpatient care – a proportion of these patients could be continue to be seen and treated in Scunthorpe Hospital where emergency day surgery would continue to provided, thereby reducing the impact through different clinical pathways.

Table 6.2 Summary of proposed change (surgery and trauma)

What this would mean for patients who experience trauma or require emergency surgery across the Humber:

- Trauma services would continue to be provided across the Humber and North Yorkshire through a Major Trauma Network with Hull Royal Infirmary as the Major Trauma Centre, proving care for those with severe injuries (sustained anywhere across the region).
- In addition, there would continue to be a Trauma Unit provided at Diana Princess of Wales Hospital, Grimsby (DPoW), caring for less serious injuries and stabilising any seriously injured patients before transferring them to the Major Trauma Centre (MTC).
- Ambulances would take patients requiring care from a trauma service directly to the Trauma Unit or MTC depending on level of severity of injury, location of accident and clinical need with clear pathway direction.
- Patients who arrive at Scunthorpe General Hospital (SGH) themselves (walk-ins) who require the services provided within a Trauma Unit would be transferred to DPoW.
- Patients requiring surgery in an emergency would continue to be treated at any of the three hospital sites and patients would go to their nearest hospital.
- Out of hours surgery would be provided at DPoW and HRI only, meaning patients who need surgery out of hours or need to be looked after overnight on a surgical ward would transfer from SGH to DPoW.

Case Study – Fractured Hip (emergency day surgery)

Patients who have fractured their hip (fractured neck of femur) should be operated on within 36 hours. This target is not consistently met in all our hospitals and as a result some older, frail residents are waiting longer than they should to have their operation.

Under the proposed model of care, patients with a fractured hip (and no other trauma) could still be cared for at their local hospital. Patients in Scunthorpe would have their operation performed by a surgeon and be looked after by ortho-geriatricians with support by therapy for enhanced post operative care and swift discharge.

6.3.1.3 Proposed changes – paediatrics

The needs of our population are changing, and our models of care are outdated. High levels of deprivation and an ageing population mean that more people are living with one or more long-term condition, contributing to an increase in demand care that needs to be met in a different way. Our current models of care focus on hospital first. We can provide much better care if we change how we work and support more people to stay well at home and access the care and treatment they need at home or in their local community.

The number of children living in poverty is significantly higher in the Humber than in England as a whole. 1 in 3 children in Hull (30.7%), 1 in 4 children in North East Lincolnshire (24.8%) and 1 in 5 children in North Lincolnshire (20.8%) live in poverty. This impacts on children's health and wellbeing and their future health and life chances.

The proposed changes will enable us to deliver more responsive care in the community, make better use of our skilled workforce and improve the training offer for current and potential future staff. The proposed changes are summarised in the table below.

Service	Current situation	Proposed change	What would be different
Paediatrics	Paediatric inpatient services currently provided at both Grimsby and Scunthorpe Hospitals.	Paediatric Assessment Units would continue to be provided at both DPoW and Scunthorpe, providing 24/7 assessment and care for up to 24 hours. Those requiring a longer stay admission or more specialist care would be admitted to the paediatric ward at DPoW.	Consolidation of paediatric inpatient services would support future sustainability of workforce. It would help support the delivery of hospital at home services in the community. Children who require admission post-24 hours would transfer from Scunthorpe to Grimsby supported by a dedicated team to ensure safe transfers. This would impact up to 3 patients per day.

Table 6.3 Summary of proposed change (paediatrics)

What this would mean for children and young people across the Humber region:

- Children and young people with urgent or emergency care needs would continue to be seen and treated at the Urgent Care Service, Emergency Department and/or Paediatric Assessment Unit at any of the three hospital sites.
    - Development of Urgent Care Services within the Emergency Departments (ED) and improved assessment pathways will support more children and young people to be seen and treated more quickly.
- Children and young people who can be assessed, treated and discharged within 24 hours would be treated in the Paediatric Assessment Unit (PAU) at their nearest hospital.
- Children and young people at Scunthorpe Hospital who are acutely ill and/or require additional clinical input from specialist teams would be transferred and admitted for treatment at DPoW.

Case Study – Hospital @ Home

Hospital at Home provides nurse-led acute care within the patient's own home enabling quicker discharge from hospital and/or avoidance of a hospital visit. This would enable more children to have a short stay in the PAU and be transferred home with support from H@H team rather than having to be transferred to DPoW.

6.4 Benefits and impacts

The proposed changes would enable us to address critical shortages in workforce, consolidate rotas and improve patient access, waiting times and length of stay, whilst maintaining the majority of services locally.

Some patients and some staff would be impacted by longer travel times. The travel impacts have all been mapped and a transport action plan is in development to mitigate against these impacts.

6.4.1 Overview

The proposed model of care focuses on providing specialist services from dedicated skilled workforce operating from fully equipped facilities on one hospital site for Northern Lincolnshire, reducing duplication and helping to address the significant workforce and performance challenges described within the case for change.[180]

The consolidation of specialty inpatient beds ensures patients with more complex needs can access the specialist care they need from teams of highly skilled professionals who are well-supported and have increased opportunities to develop their skills and competencies. Within the proposed model of care, this is supported by an in-reach model covering Scunthorpe Hospital 7 days a week for emergency speciality needs.

The consolidation of paediatric inpatient beds will ensure children and young people can access the specialist care they need from teams of highly skilled professionals who are well-supported and have increased opportunities to develop their skills and competencies. The proposed model of care will support delivery of improved training and development and open up wider opportunities for our teams to develop their skills and expertise in treating patients with more complex needs.

Effective assessment and same day emergency care services (for both adults and children) will continue to be developed and improved to ensure as many patients as possible can be assessed, treated and discharged locally, within 72 hours of arrival at hospital (24 hours for children). In addition, General Medical and Care of the Elderly inpatient services would continue to be delivered in Scunthorpe Hospital (as well as DPoW and HRI). This reduces the need to transfer patients from SGH to DPoW, particularly those who are frail or elderly.

The Hospital at Home service will continue to be developed to minimise the need to admit paediatric patients after the initial assessment period, enabling more children to be cared for at home in their own beds with support from specialist teams.

Working closely with the ambulance services, severely ill or injured patients would be directed at source to HRI or DPoW depending on clinical need and distance, ensuring patients are seen in the right place at the right time, reducing the need for secondary transfers from Scunthorpe.

[180] See section 2.4 for further details.

6.4.2 Staffing Models

In developing the proposals, engagement with staff and clinical teams has ensured there are robust workforce and staffing assumptions behind each of the models of care and proposed changes.

The proposed models of care seek to make best use of existing skilled staff and maximise the opportunities for and benefits of new roles and ways of working. This will help to ensure services are sustainable in the long run.

6.4.2.1 Urgent and Emergency Care

A correctly configured and resourced workforce is critical to pathway redesign and delivering the proposed model of care. We need to take a number of actions to stabilise services and deliver high quality care in the future. This includes developing the staff, including considering General Medical Council (GMC) Certificate or Eligibility for Specialist Registration (CESR) pathways, supporting unregistered staff into registered roles and looking beyond the acute workforce to find solutions.

To do this we aim to create a future urgent and emergency care workforce model which:

- is 'Senior Decisionmaker-led, Team delivered'
- delivers timely and safe urgent and emergency care through the introduction of new roles, developed system partnerships and shared resources
- strengthens the training and educational offer to all of our clinical workforce
- embraces new talent pipelines, new roles and ways of working to improve staff recruitment and retention

To deliver the future workforce we require, a comprehensive workforce plan has been developed as part of the programme to underpin the proposed new models of care.[181] There are a number of potential new roles that can support the delivery of these models of care, which are summarised in the diagram and set out in more detail below.

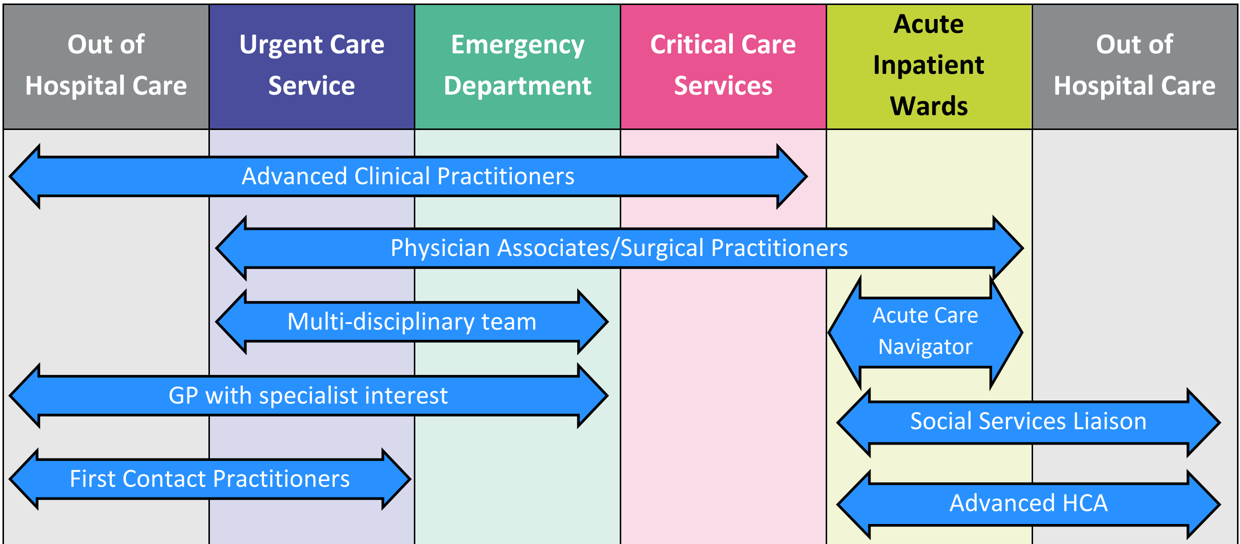


Figure 6.3 Overview of new roles (UEC)

[181] See section 8.3.4 for further details.

6.4.2.1.1 Emergency Department and Assessment staffing model

The proposed Emergency Department service on all three sites will operate in line with all the Royal College standards, delivered by a Multi-disciplinary Team (MDT) led by Senior decision makers.

- **Advanced Clinical Practitioners** (ACP) and **First Contact Practitioners** (e.g. extended scope physiotherapists) based at the front door to immediately treat appropriate patients referred via triage. In turn this enables the more appropriate use of medical workforce for more acutely unwell patients.
- **Speciality medical staff** working alongside doctors in training, provide medical expertise within the Emergency Department.
- **Advanced Clinical Practitioners** (ACP) with 'injury competence' and the ability to prescribe to support specialty doctor rotas, helping to address shortages and build resilience within teams. These could be rotational post operating between the Urgent Care Service and Emergency Department to build competence.
- **Advanced Clinical Practitioners** (with 'acute medical competence') within the Same Day Emergency Care service would rotate into community frailty teams. Cumulatively these rotations will build networked teams, aid staff resilience and business continuity through flexible teams.
- **Rotational Paramedics** working across the Urgent Care Service, Emergency Department and ambulance services. These rotational posts develop competencies and support with the delivery of see and hear and treat, reducing the overall conveyance rates to hospital.
- **Physician Associates** (PA) support Doctors in training rotas to release time for Foundation Year 1 and Year 2 doctors to receive an improved training experience, aiding future recruitment and retention of emergency medicine trained medical staff and, in their role, provide continuity of care for inpatients.

The remaining Multi-disciplinary Team (MDT) would comprise of a complement of reporting **Radiographer** (Diagnostic), **Sonographer**, **Operating Departmental Practitioners** (within resuscitation services) and **multi-skilled clinical support workers** trained in unregistered competencies such a phlebotomy. Additional digital, Artificial Intelligence (AI) and administration support will be considered for the department to relieve medical staff and ACPs from the need to divert time away from direct clinical activity.

The Emergency Department staffing model has also been designed with flexibility to enable partnerships with GP practices and primary care networks to be developed over time, leading to additional roles and benefits such as:

- **GPs with Enhanced Role (GPWER)** to work across primary care and acute care settings – the specialist knowledge they would develop would be used within their practice and primary care networks to avoid unnecessary urgent and emergency care referrals and helps staffing Urgent and Emergency Care roles in hospitals.
- Seek support from the Yorkshire and Humber Deanery to increase GP Vocational Training Scheme numbers within the North and North East Lincolnshire, Hull and East Riding urgent, emergency care and frailty services (both in hospital and in the community).
- GPs, who wish to take flexible retirement and continue to practice post-retirement could be offered opportunities within our Urgent Care Service.

6.4.2.1.2 Acute Inpatient Wards staffing model

Acute inpatient wards will continue to observe Royal College guidance on Safe Medical Staffing[182] and the National Institute for Health and Care Excellence (NICE) staffing for Adult Inpatient Ward standards.[183] Acute inpatient wards would be supported by the full range of medical staff, registered and unregistered nurses in line with Safer Nursing Care Tool (SNCT) guidance.[184] Additionally Allied Health Professional, Physicians Associates, Advanced Care Practitioners, and Therapists will continue to advise on rehabilitation plans to support the safe and timely discharge of patients.

In the model, discharges would be supported by:

- **Physician Associates** for continuity of care
- **Acute Care Navigator** and **Social Services Liaison** posts; liaison between these posts would be critical in ensuring the timely and coordinated discharge of patients.
- **Community and Social Care Nursing** roles operating within acute care alongside Acute Care Navigators and the discharge teams to ensure community nursing and social care support packages are proactively in place to support the safe and timely discharge of patients to aid patient flow and reduce unnecessary long stays in hospitals for patients.
- **Voluntary Sector partnerships** to aid patient transport solutions and provide patients with wraparound support, such as the provision of food shopping, prescription collection and the support of other domestic requirements.

Most medical teams would be based at the DPoW site, providing in-reach into Scunthorpe Hospital with the option of rotational posts covering both sites. This approach will facilitate daily senior decision making, continuity of care for patients and provide continuation of training places across both hospitals, fostering a 'one-team' culture. Nursing teams will largely be site-based but with career development opportunities available across the system.

Further detailed work will be undertaken at the decision-making business case stage to firm up the specific workforce models and rota plans for each element of the proposed pathway changes and reconfiguration proposals.

6.4.2.2 Staffing Models – Paediatrics

The staffing model for the proposed model of care for Paediatric services has been developed considering the requirements set out in the *National Quality Board guidance on Safe Staffing*[185] and Facing the Future[186] standards to deliver their services. 24/7 consultant cover will continue to be required at both Northern Lincolnshire hospitals to provide leadership to the Paediatric Assessment Unit team and support maternity and neonatal services, as required. Consolidation of paediatric inpatient services to Diana Princess of Wales Hospital, Grimsby (DPoW) helps to support improved development and training for the specialist paediatric workforce and improve the long-term sustainability of paediatric services. Developing the Hospital at Home services creates opportunities for specialist

[182] The Royal College of Physicians (RCP) (July 2018) *Guidance on safe medical staffing* RCP Guidance
[183] National Institute for Health and Care Excellence (NICE) (2014) *Safe staffing for nursing in adult inpatient wards in acute hospitals* NICE Guidance
[184] The Shelford Group (2023) *Safer Nursing Care Tool* SNCT Guidance
[185] NHS England (2016) *National Quality Board guidance on Safe Staffing* Safe Staffing Guidance
[186] Royal College of Paediatrics and Child Health (2015) *Facing the Future: Standards for Acute General Paediatric Services* Facing the Future

paediatric nurses and other highly-skilled professionals to work more flexibly supporting the PAU and Hospital at Home elements of the pathway in all localities.

A range of potential new roles and new ways of working for the paediatric workforce are being developed through ongoing engagement to support the implementation of the proposed new models of care. These include, but are not limited to, the following:

- **Rotational induction programme** for all new starters, which enables staff to rotate through all service locations and teams. This would help the workforce to develop end-to-end awareness of the services activities as well as develop effective staff networks.
- **A dedicated apprenticeship programme** across all current unregistered nursing and maternity roles (e.g. Paediatric Healthcare Support Workers) to allow those with capability and motivation to progress from unregistered to registered roles.
- Supernumerary **'retire and return' mentorship/educational supervisor** posts to support newly appointed staff, staff undertaking apprenticeships and university students across paediatric services. Joint appointments where retiring staff could return to provide education support, advice and guidance.
- **Young Person's Nurse specialist role** – dedicated to providing clinical care, advice and support to young people to support the transition from paediatric to adult services (c.16-25 years). This role would be especially effective in supporting young people with complex long-term conditions or other underlying reasons for health inequalities (e.g. looked after children) as trust in relationships can be key to young people engaging in the care plan.

New ways of working and innovative new roles working across sectors and disciplines will continue to be developed following decision-making regarding the future model of care to ensure services make best use of the skills within the current workforce and continue to develop a diverse and multiskilled workforce for the future.

6.4.2.3 Workforce Impact

Extensive workforce modelling was undertaken to determine the impact of each of the potential models of care on the workforce challenges faced and was a key part of the evaluation process.[187] Workforce modelling has incorporated the benefits of new roles and ways of working that have been developed and has also ensured compliance with key clinical standards, many of which are not currently being met.

The workforce modelling shows that there is a net reduction against baseline budget and against the 'do nothing' position in the Whole Time Equivalent (WTE) workforce that would be required to implement the proposed models of care.

	WTE staffing requirement		
	WTE required *(in hospital)*	Difference vs current	Difference vs BAU
Proposed model of care	2,634.76	↓195.33	↓90.52
BAU (do nothing)	2,725.28	↓104.80	0
Current budgeted workforce (Jan 2023)	2,830.09	0	-

Table 6.4 Summary of workforce modelling

[187] See appendices 10.16 to 10.19 for detailed outputs.

Implementing the proposed model of care represents a reduction in required workforce over the current budgeted baseline of nearly 200 WTE posts and a reduction against the 'do nothing' (BAU) position of nearly 100 WTE posts *within the hospitals*. This would help to address the significant vacancies across the system and also support reduction in agency and locum spend.[188]

The proposed model of care will **improve the quality of specialist care** and ensure everyone across the Humber can access the most highly skilled professionals when they need them. By concentrating the workforce in fewer locations for the most specialist care, those delivering specialist services will have more opportunities to develop their skills, treating a higher number of complex cases and a wider variety of experiences. They will be able to work in larger teams, which improves resilience and enables us to design rotas to cover services that will be more attractive to current and future workforce. This will create more sustainable services in the longer term.

Consolidating longer-stay medical specialty inpatient beds, trauma and acute surgery inpatients at one hospital for Northern Lincolnshire will **enable nursing teams to develop a higher level of expertise** in particular specialties, building confidence and skills in teams who are working in a more specialist way. Developing centres of excellence for acute medical specialties will also **build confidence in patients**, many of whom have told us through our engagement that they would prefer to be treated where the specialists are and have full specialist team wrapped around them.

The proposed model of care would require the equivalent of around 200 (WTE) fewer members of staff than our current position, helping to significantly address the vacancy challenges across our hospitals and make better use of the valuable and highly skilled workforce we do have.

The proposed new model of care would also enable us to provide better training and development opportunities and make future roles more attractive helping to **secure the workforce we need for the future**.

6.4.3 Digital requirements

Integration of systems and improvements to our digital infrastructure are critical enablers of change and will form part of any/all future models of care. Digital enablers will be aligned across all the future models of care to ensure investment in new digital solutions is focused on the top system priorities to maximise the benefit to patients, staff and partners.

The key digital developments that will support the proposed model of care are highlighted in the table below. Working with digital leads across the Humber and North Yorkshire, the digital enabling projects have been mapped to the existing ICS digital portfolio, which has been prioritised and categorised according to the level of confidence that funding is available or will be available to implement.

Digital Enabler	Intended Output	Status
Yorkshire and Humber Care Record	To provide access to records for all urgent and emergency care disposition points to all clinical contacts along the pathway who require the information – at the point of care.	High priority programme High degree of cost confidence

[188] *Workforce modelling outputs* (May 2023) – see appendix D
NOTE: this is an aggregate number which includes significant investment in some cohorts of staff (e.g. ACPs and maternity theatre staff) and reductions in other areas (e.g. vacant consultant and junior doctor posts).

Any to Any booking	To allow patients to be referred into the relevant service regardless of their entry point, therefore reducing demand on the care system and ensuring consistent access to the right service to appropriately manage the clinical needs of patients.	High priority programme Medium cost confidence
Remote monitoring	Establishing technology-enabled remote monitoring at a regional level across the care sector, mental health, long term conditions management and virtual wards.	High priority programme Medium cost confidence
Virtual wards	Develop and implement of a standardised Virtual Wards solution with integration to the data warehouse and reporting through development of a reporting dashboard.	High priority programme Medium cost confidence
Clinical messaging	To simplify teamwork for care workers, connecting them with relevant colleagues and patient information required to make decisions, at the point of care. Electronic message from streaming source (Ambulance/primary care/UTC) => reduction in ED attendances.	High priority programme Medium cost confidence
Digital Red Book	The digital red book programme is focused on transferring the current physical maternity red book to digital platform, accessed virtually by care providers and citizens. It will cross boundaries between maternity care and into Health Visiting, Safeguarding Children and other children's social care services.	Low priority Medium cost confidence

Table 6.5 Summary of digital enablers[189]

Further detailed work will be undertaken at the decision-making business case stage to firm up the specific deliverables for each element of the proposed pathway changes and reconfiguration proposals.

The proposed model of care will be supported by enabling digital developments, aligned to the wider system strategy for digital transformation.

6.4.4 Estates and capital investment

The new-build Emergency Departments at Scunthorpe General Hospital (SGH) and DPoW will deliver improved ED facilities and fully functional integrated acute assessment areas in 2023. This will provide a significant increase in capacity and enable the integration of assessment services supporting increased same day emergency care and delivery of the new pathways described. The new builds also include capacity for a co-located urgent care service to deliver improvements in waiting times and outcomes for patients. The new builds will be fit for purpose to support the proposed model of care, including the collocation of trauma services at DPoW.

[189] Humber and North Yorkshire (2022) *Digital Transformation Investment Plan (DTIP) Portfolio Overview* (see document library).

To deliver the other proposed service changes, investment would be required to either refurbish, relocate or expand clinical areas at Diana Princess of Wales Hospital, Grimsby (DPoW) to accommodate additional patients for the consolidated services.

Additional investment would be required to deliver:

- an increase in non-elective inpatient beds
- an increase in critical care capacity and development of purpose-build facilities
- an increase in the capacity of the paediatric inpatient ward and expanded family accommodation.

Critical Care at DPoW is currently running from a temporary location with a reduced number of beds. Investing in additional critical care capacity at DPoW would provide the opportunity to create a co-located critical care service which will be fit for purpose and meet the required standards. The additional investments would also support delivery of better clinical adjacencies by relocating adult short stay and paediatric assessment areas, creating space for the consolidated specialist inpatient services.

The anticipated capital investment required to deliver the proposed changes is summarised below.

Summary of capital investment requirements				
Est. cost (£m) for implementation (exc. BAU)	Approx. total (m^2) required	Approx. total m^2 cost (£000) variance	*HAS model BLM impact (£m)*	*HAS model % of total site BLM*
25.5	5,257	1,500 - 4,770	3.0	11.0%

Table 6.6 Summary of capital investment requirements [190]

NHS England require any service change to be financially affordable from within existing financial resource. Initial work demonstrated that this level of investment is affordable from within existing capital resource. The proposed investments could be accommodated within the Trust's internal capital programme over a period of three years.[191]

> The prosed changes – and estates changes that would be required – can be delivered within existing financial resources, enabling many of the identified benefits to be realised quickly.

6.4.5 Financial analysis

The Humber Acute Services programme was clinically driven, to ensure high quality, sustainable services can be provided into the future. The programme was not initiated in order to save money, however, it is important to recognise the challenging financial context that the health and care system across the Humber and North Yorkshire is operating within and seek to support system-wide efforts to address the financial challenge.

Financial modelling was undertaken to determine the revenue impact of the potential models of care. This was undertaken as the final stage of the evaluation process.[192] The financial modelling undertaken

[190] *Financial modelling outputs* (June 2023) – see appendix D.
[191] See section 10.4.3.4 for further details.
[192] See section 10.19 for detailed outputs

to support the PCBC focussed on staffing requirements for each of the models, linked to activity and growth assumptions since pay is generally 70% of the cost base.

Running duplicate services across multiple sites presents significant workforce challenges and can result in a poor employee experience for some of the Trust's medical and non-medical teams. This compounds an already challenging recruitment environment and leads to difficulty in recruiting the right substantive workforce to provide high quality safe care.

The current service configuration and the requirement for consultants and other specialist staff to cover all hospital sites can, at times, limit their ability to provide senior patient reviews. In addition, services are unable to achieve Royal College guidance standards in many areas. Challenges are similar for the non-medical workforce, with senior expertise split across a number of sites. In addition, the learning environment and provision of workforce development is challenging. The current configuration continues to create cost pressures for premium rate working, poor economies of scale and duplication of rotas as well as exacerbating the Trust's ability to resource 'hard to fill' posts.

The activity and growth assumptions, along with the changes proposed to pathways and configuration of services, drive the capacity requirements for the proposed future model of care. A significant element of a hospital's workforce is related to the bed base and ward establishments. There is a net reduction in bed requirements associated with the proposed model of care, which drives a reduction in the required workforce.

The proposed new model of care would result in a reduced staffing requirement of c.195 WTE against the baseline position and around 90.5 WTE compared with the BAU scenario.

Furthermore, the workforce models and transformation of acute services have been designed to foster a more attractive work environment, with reduced reliance on agency and premium staffing. The current level of agency spend at NLaG is over £30m and the financial models assume a reduction in the agency reliance by 50% by year 5, resulting in a net £4.6m saving in the premium element of pay as the substantive vacancies are reduced. In order to reduce the pay bill, the key drivers are:

- Activity and pathway driven changes in workforce e.g. improved pathways of care leading to faster diagnosis and treatment and reduced length of stay, bed reduction, improved rota management and removal of duplication, reducing reliance on high-cost temporary staffing.
- Productivity driven reductions in workforce, leading to fewer WTE to deliver a given quantity of activity e.g. use of technology and improved processes.
- Reduction in the cost per WTE of the future establishment e.g. ensuring that staff spend a greater proportion of their time conducting tasks appropriate to their grade through role re-design and the introduction of more advanced practitioner roles.
- More attractive place to work, innovative and therefore improving recruitment and retention, reducing agency use.

The gross impact on the revenue position of the proposed model of care is summarised below:

Models	Revenue cost est. (£m)	Saving from BAU (£m)
Business as Usual (do nothing)	258.3	-
Proposed model of care	249.5	↓**8.8**

Table 6.7 Summary of revenue impact

The cost of the 'do nothing' (BAU) position is approximately £258 million. The proposed model of care could be delivered at a cost of around £249.5 million. This represents a **gross** saving of £8.8 million.

We recognise that in moving services and implementing the enabling pathway changes there may need to be a transfer of revenue savings to community and/or primary care services and therefore the net saving to the system may be reduced. Detailed and costed plans for any potential re-investment of resources into out of hospital services will be developed as part of planning for implementation and will form part of the Decision-Making Business Case (DMBC).

As detailed above, the capital cost to deliver the changes is approximately £25 million, which is affordable and deliverable from within internal resources.

The proposed model of care would reduce the ongoing revenue cost of providing hospital services across Northern Lincolnshire by making better use of skilled staff and organising services in a more effective and efficient way.

The proposed changes to pathways and models of care could help to eliminate some of the structural deficit that exists within the system and help to ensure services can be provided sustainably in the future.

6.4.6 Travel and displacement impact

The proposed model of care seeks to address the key challenges identified in the case for change, improve outcomes for patients whilst **minimising the impact on the local population** across North and North East Lincolnshire. A number of alternative models of care and variations were considered and rejected due to the larger impact on the number of patients who would have to travel further or safety implications for the model of delivery.

The changes proposed would result in some patients, service-users and staff, as well as visitors, carers and loved ones, having to travel to a different hospital that the one they currently use, which in many cases would result in an **increased travel time**.

The table below shows the number of patients who would go to a different hospital to where they go currently to access care. These impacts have been modelled using postcode level data for all patients in the baseline year (based on distance to nearest site, not patient choice) and do not account for all the potential impacts of improved pathways (e.g. Hospital at Home) and changes to behaviour. These activity estimates are therefore considered the maximum potential impact, likely transfer numbers are expected to be lower in the longer term. Under the proposed model of care, these patients would be transferred by trained teams with the required skills and expertise to undertake inter-hospital transfers.

Summary of displacement impact *Number of patients transferred from Scunthorpe to Grimsby in the proposed model*	**Average per day**	**Yearly total**
Acute surgical inpatients requiring an overnight stay (>24 hrs) or emergency surgery overnight	8.3	3,028
Specialist medical inpatients requiring >72-hour stay	3.7	1,352
Acute medical inpatients *(patients subject to identified transfer conditions)*	3.5	1,265
Paediatric inpatients requiring >24 hrs stay	2.5	935

TOTAL IMPACT	**18.0**	**6,580**
Number of patients transferred from Scunthorpe or Grimsby to Hull in the proposed model	1.2	423
TOTAL IMPACT	**19.2**	**7,003**

***Table 6.8 Patient displacement impact*[193]**

The changes to patient travel times are summarised in the tables below.

Summary Travel Time Impacts					
Impact	**Description**	**ED Attends**	**UEC Admissions**	**Paediatric inpatients**	**TOTAL**
Positive impact	*Reduction in journey time by more 10 minutes*	3	354	17	374
Neutral impact	*Reduction in journey time by less than 10 minutes and/or increase in journey time by less than 10 minutes*	52	451	75	578
Negative impact (moderate)	*Increase in journey time by 10 to 30 minutes*	333	2,244	260	2837
Negative impact (significant)	*Increase in journey time by more than 30 minutes*	575	2,589	550	3714
Total Activity Impacted		**963**	**5,638**	**902**	**7,503**

Activity Not impacted or unrouteable	147,594	79,990	3,291	230,875
Total Activity	148,557	85,628	4,193	238,378

***Table 6.9 Travel impact summary*[194]**

The changes also have a (minimal) **impact on ambulance service providers**.[195] The ambulance modelling shows that approximately 88 additional hours per week would be required to maintain performance of the ambulance service with the proposed model of care. This equates to approximately **half a dual-crewed emergency ambulance**.[196]

	Summary of impacts of proposed changes		
	Average per day	Total per year	%age of total activity[197]
Displacement *(patients treated at a different hospital)*	19	7,003	2.2%
Travel impact *(patients with increased travel time of >30mins)*	10	3,714	1.6%
Health inequalities *(increased travel time of >30mins from most deprived decile)*	2	825	-
Inter-hospital transfers *(non-emergency transfers required)*	18	6,551	2.0%

Table 6.10 Summary of impacts

[193] Activity modelling outputs (refreshed Feb 2023) see section 10.16 for detailed outputs
[194] Travel modelling outputs (October 2022) see section 0 for detailed outputs
[195] Full details of modelling outputs are provided in appendix section D
[196] 168 hours = 1 additional ambulance 24/7
[197] Expressed as a percentage of total urgent and emergency care, maternity, neonatal and paediatric activity across the Humber (denominator = 320,323).

6.4.7 Conclusion

The proposed model of care **retains local services** at each of the three existing sites and enables the NHS across the Humber to continue to operate three Emergency Departments with specialist Paediatric Assessment Units (PAU) operating 24/7 in the three main localities: Hull, Grimsby and Scunthorpe, with access to urgent care services across the region. This will help to ensure **sustainable services** are in place across the Humber now and into the future.

Consolidation of emergency surgery, specialist medical and paediatric inpatient services will help to improve the quality and ensure long-term safety and sustainability of inpatient care ensuring everyone across the Humber can access the most highly skilled professionals when they need them. By concentrating the workforce in fewer locations for the most specialist care, those delivering specialist services will have more opportunities to develop their skills, treating a higher number of complex cases and a wider variety of experiences. They will be able to work in larger teams, which improves resilience and enables us to design rotas to cover services that will be more attractive to current and future workforce. This will create more sustainable services in the longer term. Providing general medical and care of the elderly inpatient care at both Northern Lincolnshire hospitals will minimise the requirement for secondary transfers.

Consolidating specialist services will enable nursing teams to develop a higher level of expertise and gain more experience in supporting patients with complex needs, building confidence and skills in teams who are working in a more specialist way. It will also help us to develop research, training and development opportunities for staff working there. Specialist nurses will be able to work across community and acute settings, building skills, confidence and expertise.

Developing centres of excellence will also build confidence in patients, many of whom have told us through our engagement that they would prefer to be treated where the specialists are and have full specialist team wrapped around them.

The proposed new pathways of care will **improve performance on waiting time standards** by reducing the number of handovers within and between services, helping to improve the flow of patients through the hospital, reducing ambulance handover delays and ensuring that patients do not stay in hospital any longer than they have to.

By maximising opportunities for collaboration with partners across the Humber and focusing on how we can provide more care at home or in other out of hospital settings we will support the overall ambition to bring care closer to home for as many people as possible.

Consolidation of specialist services will help to improve the quality and ensure long-term safety and sustainability of inpatient care ensuring everyone across the Humber can access the most highly skilled professionals when they need them.

The key benefits of the proposed model of care include:

- ✓ Make the best use of skilled workforce – reduce duplication.
- ✓ Ensure patients with most complex needs can access specialist care from well-supported teams of highly skilled professionals.
- ✓ Improve training and development opportunities for staff.
- ✓ Develop Centres of Excellence for specific services, building confidence in patients and staff.
- ✓ Support more people to stay well, be seen and treated at or close to home.

The proposed changes would enable us to address critical shortages in workforce, consolidate rotas and improve patient access, waiting times and length of stay, whilst maintaining the majority of services locally.

We recognise that any changes we make will have an impact on patients, carers and staff and for some people will mean longer journey times to access particular hospital services. Detailed impact analyses have been undertaken to quantify the likely impact and develop mitigations.

The impact of the changes includes:

- ✓ A maximum of 18 patients per day would require transfer between hospital sites.
- ✓ Transfer solutions are in development to support timely and safe transfers.

Chapter 7

Dependencies

Planned Care and Out of Hospital Integration

7. Dependencies

The proposals in this business case have been designed to address challenges within acute hospital services. The solutions to those challenges, however, require the whole health and care system to work together differently. To ensure the proposed changes within urgent and emergency care and paediatrics can be delivered effectively, they were designed alongside plans for interdependent services and out of hospital enabling changes.

The proposals were developed alongside a **high-level strategy for the future of planned care** across the Humber, due to the strong interdependencies between planned and unplanned care. The planned care principles seek to improve efficiency, productivity and performance, particularly in relation to waiting time standards and elective recovery, by protecting planned care better from demand pressures within urgent and emergency care services.

Planned Care Principles

PLACE-based care wherever possible	ensuring equity of access
Taking outpatient care out of the hospital	delivering local care
Faster diagnosis, closer to home	maximising community diagnostics
Dedicated facilities and resources	protecting elective activity
Day case and elective hubs	increasing productivity
Complex surgery at main site(s)	reducing duplication

The potential models of care were designed in collaboration with colleagues from across all sectors and are aligned to wider out of hospital and mental health strategies. Joint PMO arrangements are in place to ensure critical out of hospital enabling projects are in place to support implementation of the proposals for service change set out in this business case.

Priority Projects	Link to PCBC proposals
Frailty **Falls prevention** **Enhanced health in care homes**	Supports proposals for **integrated urgent and emergency care** – key enablers to reduce ED attendances and hospital admissions.
Community ill child programme	Supports proposals for **paediatrics** – key enabler to reduce ED attendances and hospital admissions and reduce impact of consolidation of inpatient paediatrics.
Community diagnostic centres	Supports proposals by bringing **planned care** closer to home – key enabler to reduce outpatient attendances at hospital sites.

Summary Box 7.1

7.1 Planned Care

The configuration changes proposed for public consultation encompass urgent and emergency care (and associated acute services) and paediatrics. In addition, our hospitals provide a wide range of services on a planned basis (pre-booked appointments) and maternity and neonatal services for women and birthing people (which are out of scope of these proposals). The way in which planned care services are currently delivered means that they are sometimes impacted by surges in demand for unplanned services, for example, relying on the same medical workforce and sharing facilities such as operating theatres, recovery areas and support services such as anaesthetics and critical care can lead to delays or cancellations for elective patients.

The proposals for change in this business case have been developed alongside a high-level strategy for the future of planned care across the Humber, which seeks to improve efficiency, productivity and performance, particularly in relation to waiting time standards and elective recovery by protecting planned care from demand pressures within urgent and emergency care services better. The planned care principles developed seek to deliver more integrated care with hospital and out of hospital services working together to support the needs of the patient and deliver a radical reduction in the need for people to travel to hospital sites for tests, advice and procedures.

Summary Box 7.2 Planned Care

7.1.1 Background and context

Across the Humber the NHS provides a wide range of planned (or elective) care services. Planned care incorporates a wide range of services and modes of delivery, from initial outpatient appointments to diagnostic tests and procedures to surgeries or other treatments. These services can be split into outpatient appointments, outpatient procedures, day case procedures and inpatient care. Elements of planned care services are delivered at all five of the Humber's hospital sites, however, the specific configuration differs on a service-by-service basis.[198] The vast majority of planned patient attendances to hospital are for outpatient care. **About 90% of all patient trips to hospital are for outpatient appointments** with smaller levels of activity for day case operations. The proportion of planned activity that requires an overnight stay is even smaller still (less than 2% of all planned care activity).

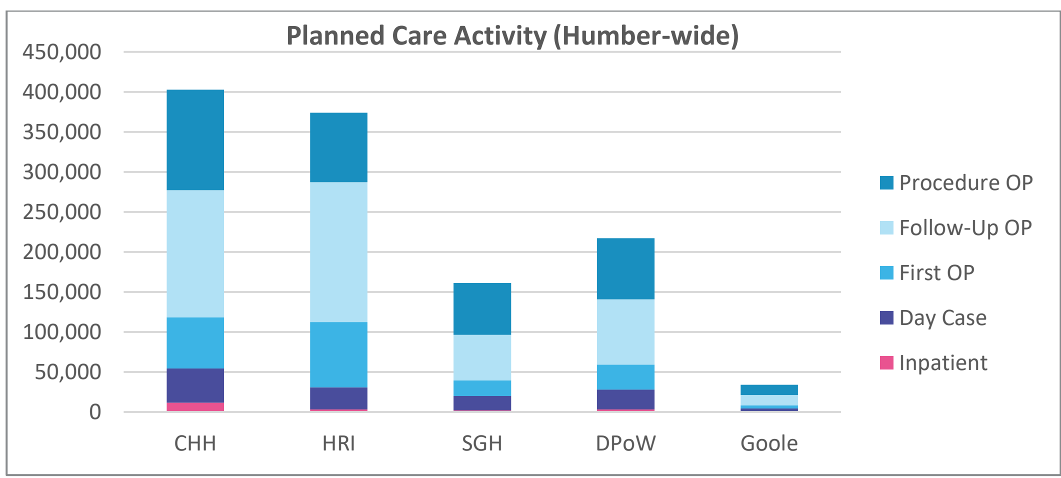


Figure 7.1 Activity numbers by Inpatient, Daycase and Outpatients (all specialties - baseline)[199]

[198] A service schedule is provided in section 10.2, which sets out which services are provided at which hospital site.
[199] *Internal trust data* (June 2021).

Heading into the COVID-19 pandemic, many patients in the Humber area were already waiting longer than they should be for planned care, including outpatient appointments, tests, surgery or other treatments. The impact of responding to urgent and emergency care needs throughout the pandemic and since has worsened this position further still.

The way in which services are currently designed, is not meeting the required standards in a system that is experiencing unprecedented challenges and ever-increasing demand. Waiting lists are growing, and people are not being seen as quickly as they would be if services were organised differently. Operating theatres and other facilities sometimes get taken up with emergency cases, which means some people who had a planned operation booked have it cancelled and have to wait even longer. The COVID-19 pandemic had a significant impact on planned care as appointments and operations were postponed. Across the Humber over 10,000 patients have been waiting more than a year for treatment, compared with only 9 prior to the pandemic.

We need to make changes to our urgent and emergency care services and provide planned care differently in the future so that it will not be impacted by fluctuations in urgent and emergency care needs and ensure a long-term sustainable model of care is in place to meet the needs of our population.

7.1.2 Planned care principles

Initially the potential models of care were designed for the six specialties identified within the Case for Change as being particularly challenged. However, the significant impact of the COVID-19 pandemic on elective care required us, as a programme, to look more broadly at all planned care activity and develop a strategy that could help put services on a sustainable footing for the long term.[200] The work to develop and implement this planned care strategy is being undertaken by the Humber and North Yorkshire Collaborative of Acute Providers (CAP), building on the work undertaken through the Humber Acute Services programme.

The reconfiguration proposals described in this business case – for urgent and emergency care and paediatrics – were designed alongside a set of core principles for how planned care would be delivered in the future. These core concepts will underpin the system-wide planned care strategy and were designed in line with national strategies to deliver improvements against the current challenges.

The process of ongoing engagement with clinicians, partners, service-users and the public helped to develop and define a collective vision for the future of planned care and planned diagnostic services across the Humber. This includes addressing inequalities in health by putting the patient at the heart of decision-making, redesigning and integrating pathways of care and delivering improved outcomes and experiences for patients.

Our vision is…

*to deliver **more responsive, easier to access planned care and diagnostics – closer to home** for people living across the Humber region.*

Summary Box 7.3 Planned Care Vision

[200] An early evaluation of different potential models of care was undertaken and the outcomes are detailed in appendix 10.4, which sets out the alternative proposals that were also considered and explains the approach taken to planned care within this business case.

This means that:

- People will only come to hospital if they absolutely need to and will not stay any longer than is absolutely necessary.
- People will be supported to make the most of the opportunities digital can bring as it becomes an increasingly important feature in the delivery of care and treatment.

A key focus of the programme has been to re-design current patient pathways to make them more responsive to the needs of patients and more efficient so that they can provide care safely and in a timely manner. Building on the feedback gathered through our engagement, we have re-designed pathways of care by focusing on how to:

- Make best use of the workforce we have to ensure staff **have time to care.**
- Fully **integrate services** across primary, secondary and community care.
- Provide **accessible** services for patients across the Humber.

Wherever possible, planned care pathways have been designed to enable the provision of outpatient and routine care outside of hospital environments often with different staff groups working collaboratively to deliver the care. Future pathways will be supported by:

- Multidisciplinary workforce models of care (working across sectors in new ways)
- Harnessing technology (e.g. remote monitoring, smart scheduling)
- Integration of information systems (improved data sharing enabling seamless care)
- Integration of care, treatment and diagnosis within a community setting
- Resources provided within a community setting – workforce, estates and digital technology.

The proposed Planned Care concepts are summarised in the diagram below.

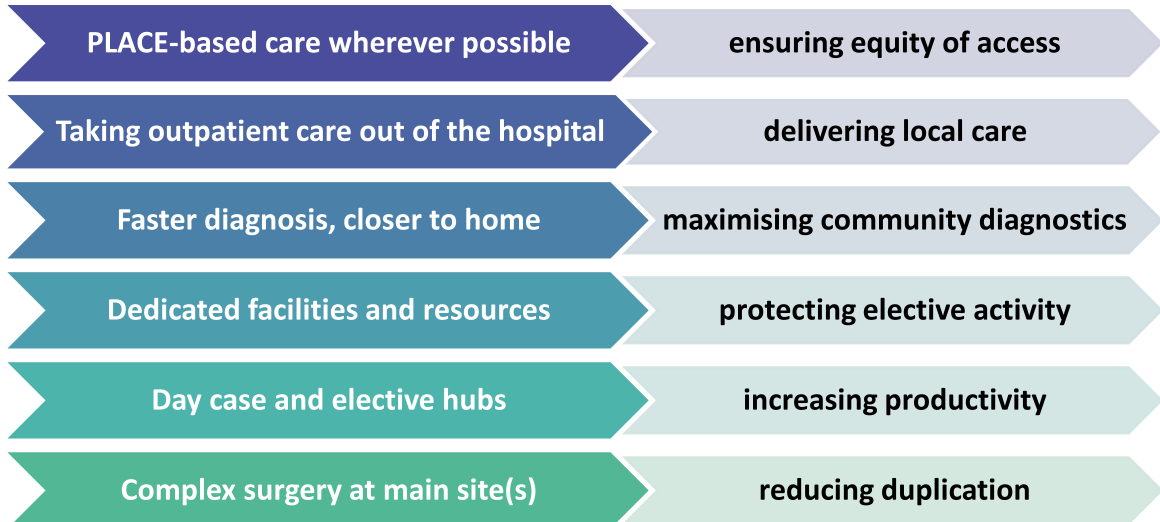


Figure 7.2 Planned Care Concepts

These proposals have been developed collaboratively with the out of hospital programme to ensure close alignment across system plans.

7.1.3 Future models of care

Developing the future shape of planned care according to these core principles will support our ambition to **reduce the overall level of activity taking place in hospitals** and help to deliver more responsive, easier to access care and diagnostics, closer to home, whilst also providing the highest quality specialist care for those who need complex or more specialist interventions. The types of changes and what they might mean for patients are summarised below.

Outpatient Services

- Working with GP practices, more patients could have their initial appointments in their local practice and not be required to go to hospital.
- More people will be able to talk to their clinician over the phone or via video call when they are not required to attend face to face.
- More people with long-term conditions can request a follow-up appointment when needed rather than waiting for a set period of time between reviews.
- Wherever possible, outpatient appointments will continue to be provided at local hospital sites for those patients who cannot be managed remotely or seen in their GP practice or other community clinic.

Routine Diagnostics

- More patients will be able to go straight to test before being referred to a hospital service, meaning they can get a result more quickly and avoid unnecessary delays in their care.
- Increasingly, diagnostic testing will take place away from the hospital sites at Community Diagnostic Centres or at a mobile clinic serving more rural communities.

Day Case Surgery/Procedures

- Where possible, pre- and post-operative care (e.g. pre-op questionnaire, post-op wound check etc.) will be offered remotely or at a local centre – not necessarily the hospital where the operation is taking place.
- A greater proportion of surgeries will be completed on a day case basis, enabling more people to be seen locally and recover at home.
- Day case hubs will be developed, to increase efficiency and treat more people more quickly. Wherever possible, day case facilities will have their own theatres, recovery areas and nursing staff to ensure care can continue unaffected by winter pressures or pandemics and maximise the efficiency of those services.
- Facilities for day case procedures will be provided locally. This does not mean that every day case procedure will be offered on every site, this will be dependent on plans within individual specialties to determine the most efficient way of organising care within that specialty.

Inpatient Care

- Inpatient elective care will become an increasingly small proportion of planned care. In order to ensure patient safety and deliver efficient and sustainable services, inpatient care may be consolidated onto fewer sites, particularly in smaller specialities.
- Complicated procedures that are done infrequently may be concentrated in one centre to ensure the teams delivering those procedures can maintain their high level of skills and offer the best possible care to our populations. Different specialisms may be concentrated at different hospitals across the Humber.

Figure 7.3 Summary of pathway changes (Planned Care)

7.1.3.1 Transforming outpatient services

Too often people are travelling for hours to a hospital appointment that lasts a few minutes. We know from our engagement with patients, carers and other stakeholders that this can be frustrating, incur a great deal of expense and inconvenience. If the service was provided in a different way, we could save patients time, cost and stress. We have an ambition to deliver more care closer to or at home, but this will not work if we try to lift and shift our existing models of care into community or primary care buildings or expect primary care to absorb more work without the additional workforce to support it. Instead, we will work together to develop new pathways for patients that make the best use of the workforce and assets we have – in our hospital teams, primary care networks, community and mental health teams, local authorities, social care and across the voluntary and community sector. We have an opportunity to do things differently and better.

7.1.3.1.1 Connected Health Network approach

The Connected Health Network model provides a blueprint for how hospital-based outpatient services can be turned on their head and operate in a more joined up, patient-focused way and demonstrates how this can be done without putting undue pressure on already stretched primary care services. The Connected Health Network (CHN) model began as a pilot between cardiology and a Primary Care Network in North East Lincolnshire. The cardiology pilot saw the creation of a new model of care where primary and secondary care (GPs and hospitals) work together as one clinical network, putting the patient at the heart of how we provide their care, reducing multiple appointments at the hospital. This model of care dispenses with the need for the GP to make a referral to a hospital, instead they work directly with the hospital specialist to agree what treatment can be safely delivered in primary care. This means that access to specialist advice is always available in providing ongoing care, and if specialist diagnostics are required, or the patient needs to see a specialist, it is arranged quickly and efficiently.

By working in this way, waiting times for patients drastically reduced (typical wait time for CHN referral = 1 week compared with 16 weeks wait time for new outpatient appointment), the backlog of follow-up appointments for Meridian PCN cardiology patients was cleared within 4 months. Only 30% of patients required a hospital-based intervention and 'in person' clinical attendances were significantly reduced through supporting patients to make use of digital communication. Important to its success, a digital maturity assessment is carried out with all patients at the outset to ensure those who need it are given support to use digital communications methods or provided with non-digital alternatives.

Picture 7:A Summary of benefits of Connected Health Network model

The CHN model is currently being rolled out in cardiology across additional Primary Care Networks and is being considered within other specialties across the Humber.

Challenge	Solution	Benefit / Impact
Long waits for first outpatient appointment following GP referral. This could potentially lead to delays in starting treatment and added anxiety for patients whilst they are waiting.	Connected Health Network model of care. Patients are managed by primary and secondary care working together as part of one team.	Reduction in journeys to hospital for outpatient appointments (75% of OP work can be delivered away from hospitals) Specialist input available to GPs at the click of a button. Reduced waiting time and better experience for patients.

Table 7.1 Summary benefits - Connect Health Network

7.1.3.1.2 Outpatient clinics – workforce models

The traditional model for planned care being delivered in the community consists of a consultant-run outreach clinic based in a community hospital or GP practice. This approach, however, will not alleviate the workforce challenges we face across our services and can lead to increases in overall cost and inefficiencies if services are spread even more thinly trying to cover multiple geographical areas. Recognising these challenges, we are looking at the problem in a different way and seeking to build a sustainable workforce for the future that can deliver traditional hospital-based services in communities in a different way.

Collaboration and support across primary/community and secondary care will enable care to be delivered jointly by the GP and secondary care clinician, putting education at the core of our approach, redesigning the patient pathway and the roles of the professionals. This can be achieved in a number of ways by enhancing the skills of GPs and other health care professionals in both diagnosis and treatment through:

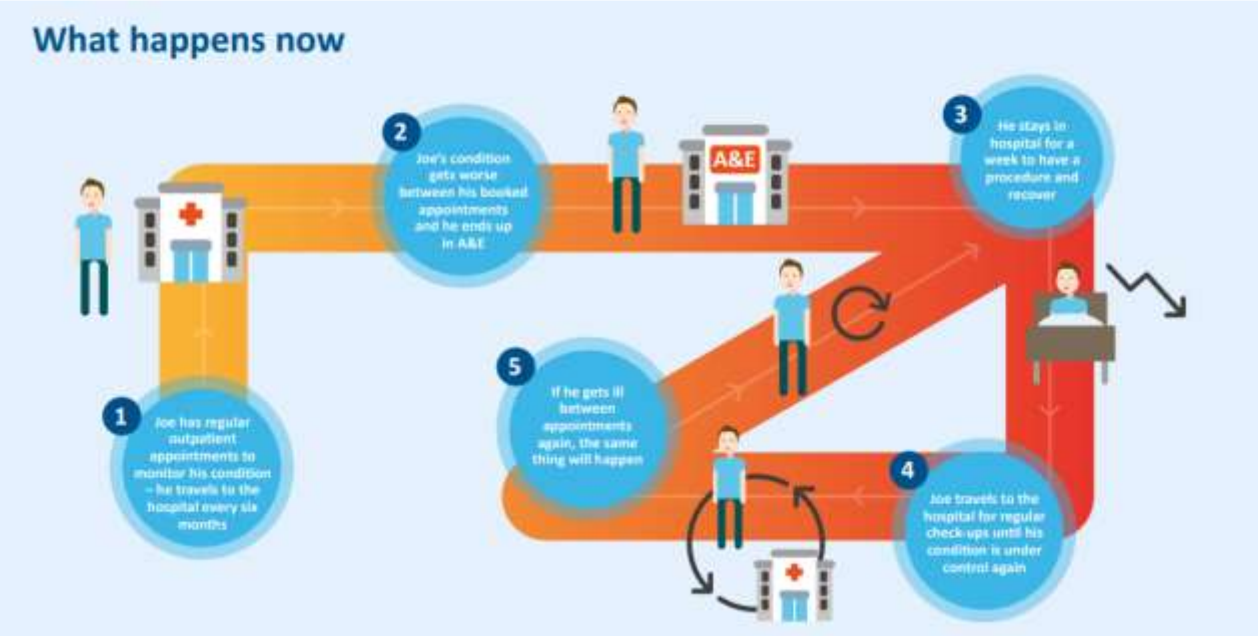
- Outreach clinics jointly staffed by hospital consultants and other health care professionals (such as Advanced Care Practitioners and GPs). In this approach, benefits accrue beyond the patients seen in clinic, as GPs and other healthcare professionals gain confidence and experience to manage similar cases themselves in primary care.
- Consultant-run email and telephone helplines that provide advice for GPs, nurses and other health care professionals to enable them to better diagnose and treat patients in primary care or make more appropriate referrals.
- Consultant participation in multidisciplinary team (MDT) meetings, which brings specialist input into the management of patients in the community and facilitates joint learning.
- Consultant-run education sessions; for instance, one-to-one sessions for GP practices on topics of their choice, education sessions at MDT meetings and education sessions for GPs and other health care professionals across an area.
- Consultants supporting staff to work in extended roles. In consultant-led intermediate care services, consultants can support nurses and other healthcare professionals to run clinics that would traditionally be staffed by doctors.
- Rotation of GPs, nursing and AHP staff in and out hospital (including through the use of virtual technology) to understand services available, challenges, and opportunities provide a range of perspectives.

Challenge	Solution	Benefit / Impact
Lack of capacity within primary care to undertake additional work. Insufficient workforce within acute teams to run outreach clinics in every locality.	New roles, rotational posts and development of joint teams across primary and secondary care.	Increased skills and knowledge for GPs, ACPs and other primary care staff. Better experience for patients as care professionals work together as part of one team.

Table 7.2 Summary benefits - new workforce models

7.1.3.1.3 Patient-Initiated Follow-Up (PIFU)

A large proportion of outpatient appointments are taken up providing routine follow-up for patients with long-term conditions. Under the current, traditional model of care, the patient experiences multiple follow-up appointments, which are often overdue and/or not at a point where the patient's condition required the review. The patient's condition can deteriorate in the interval between appointments, and this can lead to emergency appointments and complex interventions being required that could have been avoided with more proactive support.



Picture 7:B Current pathway - Planned Care

Under an integrated pathway, with Patient-Initiated Follow-Up available, the patient would have far greater control over their own condition and be able to access care, support and advice when they need it, rather than having to wait for a specified period of time. Under this type of approach there would be minimal secondary care input, instead medical applications would support the patient to stay well with health tips and advice and direct access to specialist advice when needed. Deteriorations in the condition spotted at a very early stage where minimal interventions (e.g. dietary advice) or minor interventions (e.g. medication changes) may be all that is required to help the patient stay well. When there is requirement for clinical involvement, they have access to data about how the patient's condition has changed over time to support the appropriate and timely intervention. This model is associated with improved outcomes for the patient and a reduction in impact on urgent and emergency care.

Picture 7:C Future pathway - Planned Care

Challenge	Solution	Benefit / Impact
Pressure on GP services, Emergency Department and hospital services treating patients whose long-term condition has deteriorated. This could potentially have been avoided if the condition was managed more proactively.	Integrated community pathways for management of chronic conditions. Patient Initiated Follow-Up (PIFU), supported by remote monitoring and other digital tools.	Support patients to have better control over their own condition. Reduce likelihood of unmanaged deterioration. Better outcomes for the patient and a reduction in attendances in ED and primary care.

Table 7.3 Summary of benefits - integrated pathways for long-term condition management

7.1.3.2 Community Diagnostic Centres

A key enabler for improving performance within planned care and ensuring patients are seen and treated as quickly as possible is the development of local Community Diagnostic Centres. CDCs will enable patients to undergo examinations to help inform the management plans prior to being referred into secondary care, reducing referrals that do not need to be seen in an acute setting and allowing an earlier decision for the patient on the most appropriate management plan.

In October 2020, NHS England published a report entitled 'Diagnostics: Recovery and Renewal', which concluded that the configuration, delivery and capacity of diagnostic services would need to be significantly enhanced to meet future needs and to support post-COVID recovery across the NHS.[201] The report set out a number of recommendations, including the provision of new and improved facilities and equipment, expansion and development of the workforce and a shift of planned diagnostic services into community-based facilities, **away from busy acute hospital sites**.

[201] NHS England (2020) *Diagnostics: Recovery and Renewal – Report of the Independent Review of Diagnostic Services for NHS England* Diagnostics Review

Our proposals for change are supported and enabled by the development of Community Diagnostic Centres within the Humber, which seek to:

- Increase the range of diagnostic service provision in a locality setting.
- Develop primary health care services.
- Support workforce expansion through increased training and clinical placement opportunities.
- Drive improvement in diagnostic pathways.
- Improve service access and reduce health inequalities.
- Promote clinical collaboration.
- Develop Community Diagnostic Centres to be anchor institutions for communities.
- Deliver a better diagnostic experience for patients.

Plans are in an advanced stage for new Community Diagnostic Centres in Scunthorpe and Scarborough with further plans being developed for improved community diagnostic provision across the region. Business cases have also been developed to support the expansion of diagnostic service provision in a number of existing community-based facilities, including community hospitals, and for further mobile facilities that can be used flexibly to provide easier access for people living in the rural and coastal communities across Humber and North Yorkshire. A workforce approach is being explored that combines rotational opportunities, with sub contracts that mitigate the potential loss of staff from the acute sector and provides opportunities for development at the same time.

Challenge	Solution	Benefit / Impact
Long waits for first outpatient appointments and diagnostics. Unnecessary or inappropriate referrals into secondary care. Patients required to travel to hospital for planned diagnostic tests.	Community Diagnostic Centres and improved straight to test pathways.	Reduced demand for diagnostics within secondary care settings. Improved experience and faster diagnosis for patients. *Potential disbenefit – impact on planned care waiting lists due to increased demand for services.*

Table 7.4 Summary benefits - Community Diagnostic Centres

7.1.3.3 Elective Care Hubs

Our planned care services within the hospitals often have to compete with urgent and emergency care services for resources (workforce, theatres and recovery space) meaning that performance is impacted when there are peaks in urgent care demand.

One of the key principles set out in the national plan for elective recovery,[202] and prior to that within the NHS Long Term Plan,[203] is the importance of separating elective care facilities from those for urgent and emergency care, to reduce disruptions to care and build resilience in services. The pandemic reinforced issues and challenges that were already well understood within the health service in relation to the fragility of some of our service models and susceptibility of planned care to disruption caused by peaks in demand for urgent and emergency care services.

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[202] NHS England (2022) *Delivery plan for tackling the COVID-19 backlog of elective care* Delivering Elective Recovery
[203] NHS England and Improvement (2019) *The NHS Long Term Plan* The NHS Long Term Plan

The way in which services are currently configured across the Humber is mixed, with some dedicated facilities and some that are integrated with facilities for unplanned care.[204] Even where dedicated facilities exist for elective procedures, patients often rely on the same support services such as critical care or anaesthetics and pressures within these services can lead to cancellations of planned procedures if the staff or beds are not available when required.

To support the effective delivery of planned care services for the future, we propose developing the concept of elective care hubs across the Humber's hospital sites to ensure elective care can continue to be delivered unaffected by surges in demand for urgent and emergency care. The exact configuration of individual specialties will be determined by the work undertaken to support elective recovery and develop the system-wide planned care strategy, however, they will be developed on the basis of **facilitating the separation of emergency and planned care** wherever possible.

Whilst a complete split of planned and unplanned care across the two Northern Lincolnshire sites was not considered a viable option for consultation,[205] the key benefits of the model have been replicated within the proposals wherever possible. Specialty-specific plans (developed as part of planning for implementation) will seek to deliver the maximum separation of acute and elective care provision across the Humber hospitals.

It is proposed that existing elective facilities in Castle Hill Hospital (CHH) and Goole and District Hospital (GDH) will continue to be developed to enable them to deliver the most efficient services possible through their theatres and other infrastructure. This would include the continued development of day case facilities for high volume and low complexity procedures. **In line with the proposals outlined for Diana Princess of Wales Hospital, Grimsby (DPoW) and Scunthorpe General hospital (SGH) for urgent and emergency care and paediatrics provision, both hospitals would continue to provide facilities for planned care on site.**

Specialty-specific plans will be developed following consultation and focus on developing the most efficient configuration of day case and inpatient care to align with the configuration for urgent care that is determined following the consultation process. It is anticipated for most specialties this will include consolidation of complex, low volume and/or all inpatient work onto a reduced number of sites across the Humber to make the most efficient use of highly skilled clinical teams and other resources to provide the best and quickest care for patients, in line with what we have heard through our ongoing engagement.

Challenge	Solution	Benefit / Impact
Cancelled operations and long waiting times for elective procedures.	Separation of elective and urgent care services (facilities and staffing) and development of Elective Care Hubs.	Patients are seen and treated more quickly.

Table 7.5 Summary benefits - Elective Care Hubs

[204] There are dedicated elective facilities at Castle Hill Hospital and Goole District Hospital that deliver a mix of inpatient and day case procedures. Day surgery is provided from a separate building at Hull Royal Infirmary. At Scunthorpe General Hospital and Diana Princess of Wales Hospital, Grimsby, elective inpatient and day case surgery is provided from within the main hospital site, utilising the same theatres and recovery space.
[205] See section 10.4 for an overview of the evaluation process.

7.1.3.3.1 Elective hubs – workforce models

Developing elective hubs also offers potentially attractive new roles supporting with recruitment and retention across the region. Operating efficient elective hubs, at maximum productivity, requires teams of highly skilled staff to be available from early morning to late evening, however, there are multiple ways teams can be organised to deliver this that can offer a range of benefits to staff within those teams, including:

- Predictable working hours
- Career advancement opportunities and new roles
- Improved staff wellbeing and morale
- Recruitment and retention improvements

A theatres working group has been developed to work up the detailed staffing model for all theatre staff to ensure we can operate high productivity elective hubs. Future staffing models for will seek to maximise opportunities for career development and progression amongst theatre and support staff. Working with partners across the Integrated Care Partnership, we will develop an integrated career pathway for theatre staff (bands 2 to 7) to improve recruitment and retention for the longer term. In addition, we are exploring training for various Allied Health Professionals in critical care, enabling them to provide additional support to existing medical rotas.

7.1.3.4 Day Surgery

When considering how to maximise the separation of planned and unplanned care, a key area where all specialties are continuing to develop is in increasing the proportion of activity undertaken on a day case basis. Not only does day case surgery provide a better experience for the patient, who is able to recuperate in their own bed, it also enables services to be provided more efficiently and supports the overall system ambitions to cut waiting times for planned care. Day surgery is highly cost effective, improves efficiency, staff morale and increases capacity for elective care and frees up inpatient beds.[206] It allows for "a quicker recovery, less disruption to you and your home life and also cuts the risk of hospital acquired infections."[207] Day surgery is particularly beneficial for elderly patients, patients who are obese and those with underlying conditions such as diabetes. Day surgery helps to prevent deterioration in a patients' overall health that can arise from an extended stay in hospital.

Guidance from GiRFT is that day surgery should be delivered from a dedicated unit, ideally situated away from other parts of the hospital.[208] Admissions, pre-op areas, secondary recovery and discharge lounge, should not include facilities that support an overnight stay (e.g. showers) and should be located in areas geographically separated from inpatient wards. This is because combined units often send mixed messages to patients and nursing staff – admission into an inpatient bed may be seen as an easier option than discharge home and day surgery patients cared for post-operatively alongside inpatients can get mixed messages.

Currently, such facilities are only available at Hull Royal Infirmary (HRI), which has a small day surgery unit providing a limited range of services and at Castle Hill Hospital (CHH). In December 2021, through the Targeted Investment Fund, HUTH secured £10million investment to develop day surgery facilities at Castle Hill Hospital. The new Day Surgery Unit will include four additional dedicated day case theatres,

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[206] GiRFT (2020) *National Day Surgery Delivery Pack* GiRFT Report
[207] Academy of Royal Colleges (2019) *Royal College of Anaesthetists and Royal College of Surgeons England* Choosing Wisely
[208] GiRFT (2020) *National Day Surgery Delivery Pack* GiRFT Report

which will improve efficiency of day surgery provided at CHH. At Diana Princess of Wales Hospital, Grimsby (DPoW) and Scunthorpe General Hospital (SGH), there is a day surgery ward but no dedicated theatres, instead day surgery is done at beginning and end of a list. At Goole and District Hospital (GDH) the majority of activity is day surgery, however, some inpatient operations are also listed within the same lists, using the same theatres and staff teams. Within the Humber's hospitals, day surgery rates have increased marginally over recent years, however, they continue to sit at or below national average in NLaG and are significantly lower than national average in HUTH. For example, Day surgery rates at NLaG for general surgery are below 75% and within HUTH do not reach 70% in comparison to a national average of 90%.[209]

The Department of Health and Social Care states that "day surgery performed using inpatient wards and inpatients operating theatres is less successful and cannot be recommended. The stay-in rate (unsuccessful discharge of patients home on day of surgery) rises from 2.4% in a freestanding unit to 14% in an inpatient ward."[210]

The proposed model of care set out in this business case includes provision on all five existing hospital sites for some planned care activity (subject to speciality-specific business cases to define configuration of each service, to be developed as part of the system planned care strategy). To enable services to operate efficiently and effectively across those sites, we will seek to develop day case hubs. Within the constraints of the existing buildings and infrastructure, we will seek to implement day case hubs through operating arrangements to ensure the most efficient and effective use of facilities to deliver more activity and treat more patients quickly and effectively. The development of physical hubs will continue to form part of future ambitions, subject to securing the additional capital investment required.

7.1.4 Humber Pathway Redesign Impact

The development of integrated pathways for planned care will result in a **significant reduction in overall travel to hospital sites** and support delivery of the proposed changes by:

- Reducing unnecessary outpatient appointments.
- Moving a substantial proportion of outpatient care to community settings and virtual appointments.
- Shifting a greater proportion of existing day case procedures to outpatient procedures that can be carried out in a community setting.

In addition, shifting a further proportion of care from inpatient to day case will enable more people to stay closer to home. Around 1.1 million outpatient appointments took place during 2019/20 across the Humber, meaning millions of journeys to our hospital sites. In the future we expect that to change significantly with more of these appointments taking place virtually or within primary care and other community settings.

Importantly, the resources to deliver these new approaches would follow the activity to ensure they can be delivered effectively given the current pressures on out of hospital and primary care providers. This means investing in additional staffing, equipment and buildings in community settings to deliver planned care in a different way, working across the traditional primary and secondary care divide. We are working with partners across the health and care system to design future models of care that are

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[209] *Internal trust data* (June 2022)
[210] GiRFT (2020) *National Day Surgery Delivery Pack* GiRFT Report, p.12

fully integrated from the perspective of the patient and exploring innovative workforce models – such as rotational posts and staff passports – to ensure we can deliver these models effectively.

The table below sets out the anticipated impact of implementation of new integrated pathways of care in conjunction with work being undertaken through the outpatient transformation program to reduce unnecessary travel to hospital for outpatient appointments. Assumptions are applied on top of growth (from 19/20 baseline) to give a 5-year projection with the efficiency impacts.

Measure	Impact	Actions/contributory factors
Outpatient attendance reduction	8%	Outpatient Transformation Patient-initiated Follow Up (PIFU) Patient Knows Best (PKB) Pathway redesign
Outpatient shift off-site	15% *(face-to-face only)*	Outpatient activity undertaken within a community setting
Outpatient shift from face-to-face to virtual	50% for non-procedures *(applied after attendance reduction and shift off-site)*	Digitally enabled changes
Elective to day case shift	100% of 0 day LoS 6% of 1-2 day LoS	Day case hubs
Day case to outpatient procedure	10%	Day case hubs and outpatient transformation
Elective inpatient admission avoidance (adults only)	8%	Multi-disciplinary place-based teams, consultant connect, greater primary and community care input

Table 7.6 Efficiency assumptions (year 0-5 only) [211]

Based on these assumptions, the following activity figures have been calculated for all planned care activity at baseline and baseline plus five years.

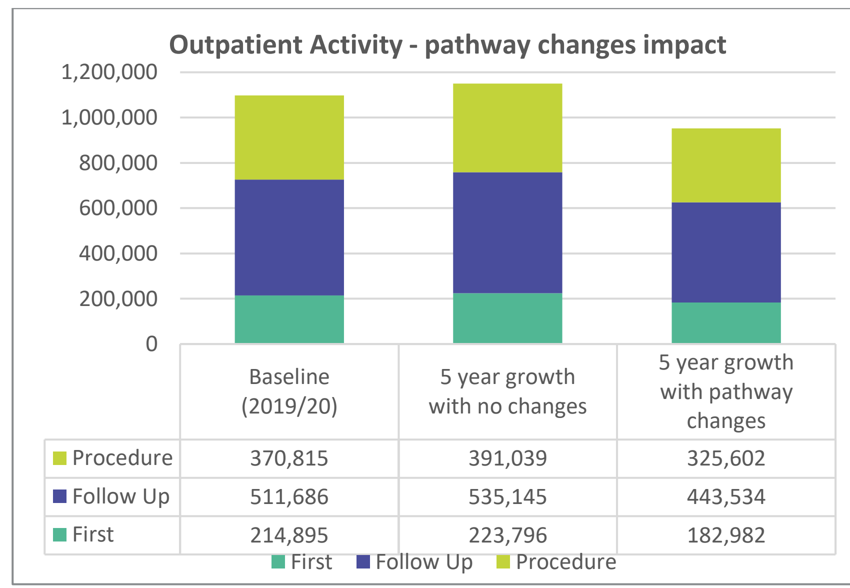


Figure 7.4 Humber Pathway redesign impact – outpatient care [212]

Outpatient impacts

Without pathway changes, F2F activity is expected to increase by:

- First Appointments: ↑4.1%
- Follow Up: ↑4.6%
- Procedures: ↑5.5%

With pathway changes, F2F activity in hospital would decrease by:

- First Appointments: ↓14.9%
- Follow Up: ↓13.3%
- Procedures: ↓12.2%

[211] Modelling assumptions – see document library
[212] *Modelling outputs* (refreshed January 2023) – see appendix D

Without the integration and transformation of outpatient services, the level of outpatient activity within the acute trusts would increase by an average of 5% in five years. Given current challenges facing both trusts in relation to delivering care for the current demand, this would lead to a further deterioration of the planned care position across the Humber. With the integration and transformation of outpatient services, demand for outpatient services would be reduced thereby creating capacity for patients who are required to attend a hospital for treatment.

In addition, shifting activity from inpatient to day case and from day case to outpatient, will support the overall reduction of activity that needs to be undertaken in a hospital setting.

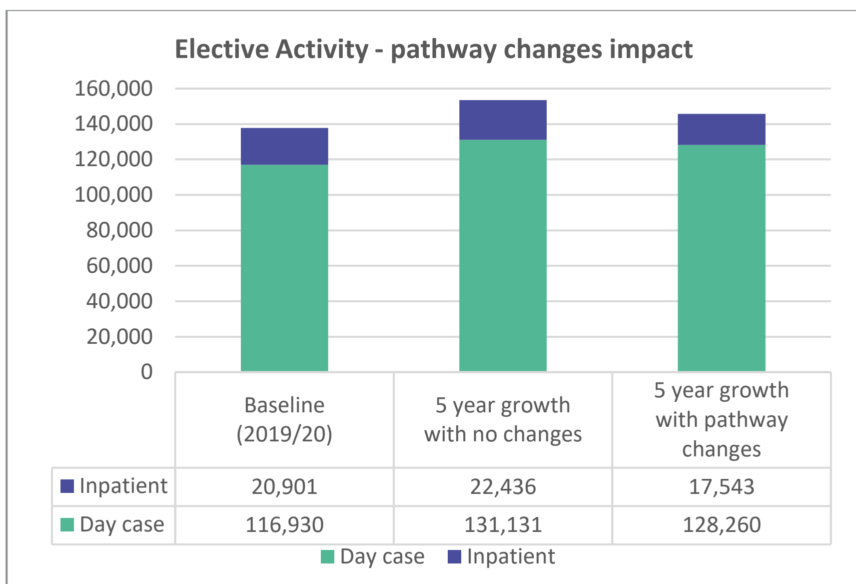


Figure 7.5 Humber Pathway redesign impact – inpatients and day case[213]

Elective activity (*day case and inpatient*) **impacts**

Without pathway changes, activity is expected to *increase* by:

- Day Case: ↑12%
- Inpatient: ↑7%

With pathway changes

- Inpatient activity would *decrease* by ↓16%
- Day case activity would *increase* by ↑9.7% as inpatient activity becomes day case.

7.1.5 Key benefits

Making changes to the pathways for planned care to increase integration between primary, community and secondary care will enable us to provide **better quality services**, an **improved experience for patients and their families** and ensure people are **kept safe** now and into the future.

Putting in place workforce models that support the separation of planned and unplanned care will **improve performance on waiting time standards** by maximising productivity and throughput for elective procedures, protecting staff and facilities from the impact of surges in urgent and emergency care demand and increasing opportunities for collaboration across the region.

Developing dedicated day case facilities and **centres of excellence** for particular specialties and/or procedures will also build confidence in patients, many of whom have told us through our engagement that they would prefer to be treated where the specialists are and have full specialist team wrapped around them. By concentrating the workforce in fewer locations for the most specialist care, those delivering specialist services will have more opportunities to develop their skills, treating a higher number of complex cases and a wider variety of experiences. They will be able to work in larger teams, which improves resilience and enables us to design rotas to cover services that will be more attractive to current and future workforce. This will **create more sustainable services** in the longer term.

[213] *Modelling outputs* (refreshed January 2023) – see appendix D

7.2 Out of Hospital Care

We can only deliver the proposed models of care successfully if there are changes in how we provide care outside of hospitals too.

There are strong linkages and interdependencies between hospital services and other health and care services and support provided in our communities through primary care, community services, mental health providers, residential and domiciliary care, voluntary and community sector agencies, carers, family members and friends. Making changes to the acute hospital elements of health care provision is only part of the story and will only be successful if aligned to changes within the other parts of the health and care system.

In developing the proposed new models of care, we have adopted a patient-centred system approach. This means looking how best to ensure an individual's needs are met and working back from there to design models of care for the future. To do this we have engaged with and involved partners across the health and care system to ensure our potential models of care have been designed in a way that takes account of dependencies and wider system impacts.

The potential future models of care have been designed to reduce the overall need for patients to travel to hospital sites by meeting their needs closer to home, ensuring a better overall experience for our patients and staff. They make use of alternative staffing models – blurring the boundaries between primary, secondary, community and mental health care.

We have worked with local teams to map the out of hospital programmes that are underway and identify those which we need to support implementation of the proposed model of care. **We are working together on five priority projects, which will help to ensure the proposed new models of care are successful.**

Summary Box 7.4 Out of Hospital Care

7.2.1 Adopting a collaborative approach

Across the Humber there is a wide network of organisations responsible for planning and delivering health and care services outside of hospital, including NHS organisations, Local Authorities, social enterprises, community and voluntary sector organisations, other public sector and private sector providers (see appendix 10.1 for a list of key partners).

Place-based partnerships are the key mechanism for these organisations to collaborate and to oversee transformation of out of hospital care. Place boards and place-based partnerships have been actively engaged in the development of this Pre-Consultation Business Case (PCBC). The Place partnerships are:

- North East Lincolnshire Place
- North Lincolnshire Place
- Hull Place
- East Riding of Yorkshire Place

In designing approaches to care for the future, we have worked to break down the barriers between different parts of the health and care system to ensure our services in the future will be designed around the needs of patients not organisations, building on strong collaborative relationships between health and care organisations in our region.

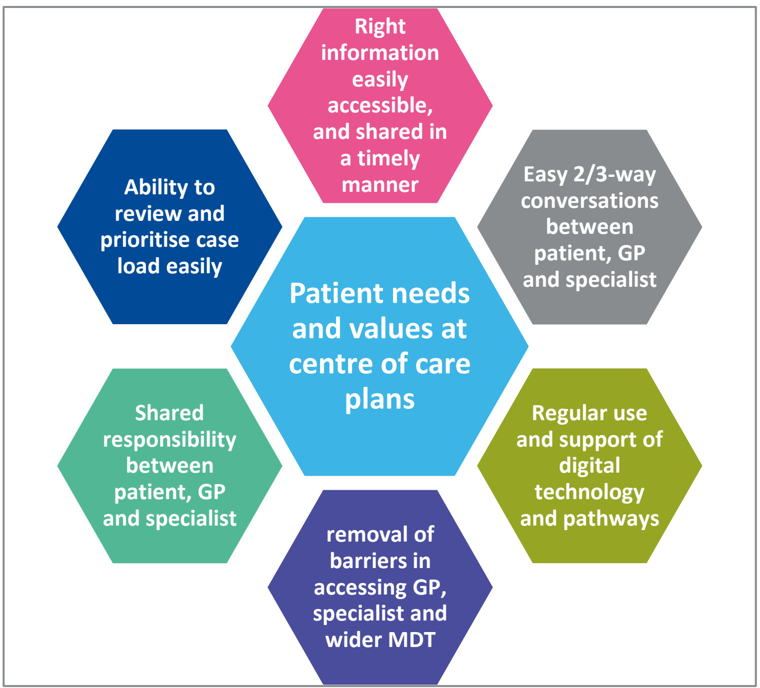
7.2.2 Principles and ways of working

In primary and community care the aim is to care for people rather than specific diseases. This covers a broad range of physical, psychological and social problems rather than specialists in a particular disease area. Traditionally, a secondary (hospital) care opinion is then sought from consultants and their teams in a secondary care hospital setting if required.

During the COVID-19 pandemic there have been great strides in working together collaboratively across the sectors of primary, community and secondary care – offering advice and guidance, and reviewing patients virtually to support decision making as to whether a referral is required and whether further prevention and management can occur to prevent it requiring acute intervention. As a system we have built on this learning as we designed the future shape of services.

Working in this more joined up way represents an important shift whereby consultants begin to look beyond the patients in their clinic to consider the needs of their patient population at each stage of their care pathway from home to hospital and back home. This changes the consultant role from an individual acting alone to a member of a multidisciplinary team working across all health care sectors to deliver a package of services for their local community. In order to do this, partners across the Humber have already started to strengthen their clinical leadership and create a culture receptive to change with Humber-wide clinical leads working together with Primary Care Network (PCN) leads in developing new ways of working. The form and function of this collaboration was established through the Humber Acute Services Programme and is now being operationalised through the collaborative arrangements in place between the two acute trusts.[214]

We have worked with partners from across the health and care system, in particular with colleagues leading the Out of Hospital Programme in the Humber, to develop a set of shared principles and strategic goals that underpin the proposals for pathway changes set out in this business case.



Picture 7:D Principles – Out of Hospital and Humber Acute Services

[214] Collaborative arrangements are described in more detail in section 1.2.4.

7.2.3 Future models of care

We have an ambition to deliver more care at, or closer to, home, but this will not work if we try to lift and shift our existing models of hospital care into community or primary care buildings or if we expect primary care services to absorb more work without the additional workforce to support it. Instead, we will work together to develop new pathways for patients that make the best use of the workforce and assets we do have – in our hospital teams, primary care networks, community and mental health teams, local authorities, social care and across the voluntary and community sector. We have an opportunity to do things differently and better.

In each of the core service areas, a future vision for service provision has been developed in partnership with out of hospital colleagues to ensure alignment of plans across the system. The potential future models of care consider all aspects of a patient's journey, not just the part that is the traditional reserve of the acute hospital.

7.2.3.1 Priorities for action

The key areas of focus, enablers and dependencies between the programmes of work are summarised in the table below, which describes the specific actions and impacts that support the delivery of the Humber-wide pathway changes and potential future models of care proposed in this business case.

Area	Key Enablers	Impact	Dependency
Urgent and Emergency Care (UEC)	• Urgent Care Services (co-located in Emergency Departments) • Urgent care hubs (primary) • 2-hr crisis community response • Education/behavioural change in accessing UEC services • Self-care and prevention • Integrated frailty and long-term conditions support in the community • Mental health services/ improved access	• Reduced attendance in Emergency Departments and waiting times • Improved access to urgent care 24/7 • Reduced emergency admissions • Improved patient flow to right place, right time • Reduced waiting time for mental health support • Compliance with clinical and constitutional standards	• Hospital/Primary/ Community/Mental Health/ MDT working • Workforce education and training – new skills/roles • Facilities/equipment • Digital enablers
Paediatrics	• Community Paediatrics (advice and guidance, prevention and self-management, hospital at home, high intensity users) • Mental health services • Education, self-care and prevention	• Reduced attendance in Emergency Departments • Reduced emergency admissions • Increased support closer to home • Improved patient flow to right place, right time • Compliance with Facing the Future Standards, including increased support to primary care	• Hospital/Primary/ Community/Mental Health/MDT working • Workforce education and development – new skills/roles • Facilities/equipment • Digital enablers

		• Reduced waiting times for mental health service input to ED and inpatient wards • Improved access • Reduced waiting times for outpatient appointments (paediatrics) • Making every contact count	
Planned Care and Diagnostics	• Integrated patient pathways in a community setting • Community Diagnostic Centres • Day case to outpatients in the community • Optometrists' pathways for imaging and treatment following Advice and Guidance	• Care closer to home • Improved access • Improved outcomes • Improved satisfaction • Patients supported to stay well • Reduced waiting times for diagnosis and treatment • Reduced referrals and secondary care waiting lists	• Hospital/Primary/ Community/ MDT working • Facilities in the community - Estates and equipment • Skills, Roles, Recruitment • Digital enablers

Table 7.7 Out of hospital priorities for action

The approach described for out of hospital services does not pass the capacity pressures to another area of the system without supporting it with redesigned pathways and resources (workforce, buildings, equipment and technology). The new ways of working described – incorporating revised roles, increased education, digital advancements and collaborative working to redesign pathways – will support the changes required in the acute hospital setting set out within this business case.

7.2.4 Delivering the change

The Humber out of hospital programme is extensive and made up of many different and distinct projects, which are all in varying stages of maturity. Some projects are in pilot stage in one place, for example, the Hospital at Home project, which is supporting children in North East Lincolnshire to avoid a hospital admission and/or have a reduced length of stay in hospital and be cared for at home instead.[215] Some services are well established and making a difference for a population in one place, for example, the Jean Bishop Integrated Care Centre, which is reducing the likelihood of for people living with frailty in Hull needing to be admitted to hospital for care in an emergency by looking after their needs proactively.[216]

The aim of the out of hospital programme, working closely with the Humber Acute Services programme, is to develop and scale-up successful pilot projects, implementing changes across the Humber to ensure the benefits are delivered across the whole region.

We have worked collaboratively with colleagues working on out of hospital projects, holding monthly meetings to map interdependencies, identify any gaps or areas of duplication and ensure alignment of plans and proposals. The following diagram outlines the key programmes of work, what stage of development they are at and where increased joint working between hospital services and out of hospital services is required to support new ways of working, shifting the focus of care away from hospital buildings and into services that are more responsive to the needs of patients where they are.

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[215] See section **Error! Reference source not found.** for further details.
[216] See section 5.2.4.2 for further details.

Hospital

Emergency Department
Acute Assessment Unit
Paediatric Assessment Unit
Maternity and Obstetrics
Neonatal
Medical Specialities
Surgical Specialties

Joint Working

Frailty
End of Life
Urgent Treatment Centre/Urgent Care Service
Urgent Community Response (2hrs)
Hear and treat/see and treat
Long Covid
Virtual Wards
Long term conditions
Community Diagnostic Hubs
Connected Health Network (CHN) (including PIFU)*
*Rheumatology, Cardiology, Diabetes, ENT, Urology
Orthopaedics, Respiratory, Skin, Gastroenterology, Dementia, MSK, Pain, Gynae

Children's
Integrated Health and Care Community Hub
Community Care (The Ill Child)
Palliative and End of Life Care
Neurodiversity Service

Clinical enablers
Intelligent booking scheduler
Clinical messaging tool
Any-to-any booking

'Out of Hospital'

Enhanced health in care homes
Anticipatory Care
Social Prescribing
Smoking cessation
Weight Management
Falls Prevention
Clinical Assessment Service
7 day crisis response
Mental Health

Picture 7:E Out of Hospital Dependencies

Key

- Already in place or can be undertaken now
- In development but not yet active
- Opportunities for working together in the future

PIFU = Patient Initiated Follow Up (see section 7.1.3.1.3)

Many of the projects highlighted in the diagram above are enablers for implementing changes to acute services and/or as integral aspects of proposed new pathways. The table below provides links to where these projects are described within this business case.

Urgent and Emergency Care	Paediatrics	Planned Care and Diagnostics
Frailty (Integrated Frailty Service)	Integrated Health and Care Community Hub	Long term conditions
Urgent Treatment Centre/ Urgent Care Service	Community Care (the Ill Child)	Community Diagnostic Centres
Urgent Community Response (2hrs)		Connected Health Network (CHN)
Virtual Wards		
Anticipatory Care		
Clinical Assessment Service		
Mental Health		
Any-to-any booking		

Table 7.8 Out of Hospital enabling projects

In order to ensure the proposals for hospital services can be successfully delivered, we developed an integrated programme management office (PMO) to maintain oversight and ensure delivery of the key out of hospital enabling projects. The integrated PMO is initially focusing on five priority projects, adding new projects on a rolling basis to ensure the necessary out of hospital developments will be in place within the required timeframe to support proposed changes in acute services.

The role of the integrated PMO is to coordinate the projects within the out of hospital programme and provide assurance that they will deliver the outcomes required to facilitate the changes in acute hospital services described in this business case. The integrated PMO will support by ensuring a consistent approach to data analysis is utilised and that there is alignment across all workstreams.

The first five projects are:

- Frailty
- Enhanced health in care homes
- Falls prevention
- Community Diagnostic Centres
- The community ill child programme (Hospital at Home)

These initial five projects were selected because they are priority areas where change is needed to enable the proposed changes to acute hospital services to take place. Frailty, enhanced health in care homes and falls admission prevention all contribute to improved pathways for Urgent and Emergency Care across the Humber by reducing the need to convey patients to hospital, particularly those who are frail and/or elderly. The community ill child programme is an important enabler for changes to paediatric services within the hospital. In particular, it can support us to minimise the impact on families of making changes to hospital-based services by supporting more children and young people in their own homes and improving experiences for children and young people who need care and support. Community Diagnostics Centres (CDCs) will play an important role in the future shape of planned care services. It is important the pathway of care and routes to access CDC services are fully integrated with the new models of care both in and out of hospital to ensure maximum benefit for the population and the system.

Priority Projects	Link to PCBC proposals
Frailty	Supports proposals for **integrated urgent and emergency care** – key enablers to reduce ED attendances and hospital admissions.
Falls prevention	
Enhanced health in care homes	
Community ill child programme	Supports proposals for **paediatrics** – key enabler to reduce ED attendances and hospital admissions and reduce impact of consolidation of inpatient paediatrics.
Community diagnostic centres	Supports proposals by bringing **planned care** closer to home – key enabler to reduce outpatient attendances at hospital sites.

Table 7.9 Out of hospital priority projects and linkages to PCBC proposals

Building on strong collaborative relationships between health and care organisations in our region will ensure we provide the best possible access to care and services for conditions and treatments that do not need to be provided within a hospital and enable the proposed models of care for hospital services to work effectively.

Summary Box 7.5

Chapter 8

Enablers

Digital, estates, workforce and transport

8. Enablers

There are a number of areas where changes need to be made in order to enable the proposals to be implemented successfully and bring about the benefits described. **These key enablers have been considered and action plans have been developed to support the proposed models of care.**

The proposed new models of care have been developed alongside to the Partnership digital strategy and investment portfolio to ensure we can maximise the benefit of current and planned future digital investments. The proposals have also been designed to take account of the Partnership's digital inclusion principles to ensure everyone can benefit from digitally-enabled changes.

Digital Action Plan

- Digital solutions that "just work" – getting the basics right.
- Digital first, digital for all – developing systems that work for everyone.
- Addressing Digital Exclusion – breaking down barriers, offering alternatives.

Detailed capital planning work has been undertaken to demonstrate that **the proposals within this business case – and the estates changes needed to implement them – can be delivered within existing financial resources** are not dependent on securing external capital investment.

Estates and Infrastructure Ambitions

- Better buildings for improved clinical outcomes – spaces that work and enhance care.
- Stronger, Greener Buildings – supporting carbon reduction goals.
- Levelling Up Humber – leveraging investment to boost the local economy.

The proposals for change are supported by innovative workforce models, new roles and new ways of working that will **make better use of the workforce we have today and help us to attract and retain the workforce we need for tomorrow**.

Workforce Action Plan

- New roles and ways of working – one Humber team, centred on the needs of the patient.
- Flexible and rewarding careers – supporting retention and attracting new workforce.
- Levelling Up Humber – maximising our impact as anchor institutions.

Recognising that it is not possible to make changes without some impact, we have mapped travel times to limit the impact on those facing barriers to access and worked with partners to **develop potential transport solutions for patients, visitors and staff**. The proposed new models of care and pathway changes will support efforts to design out unnecessary travel and ensure people only go to hospital when it is absolutely necessary.

Transport Action Plan

- Understand holistic needs – responsive services that flex about the patients' needs.
- Design out unnecessary travel – reduce overall need to travel for care.
- Make transport easier – simplify the transport offer.

Across all of these areas, system partners are working together to ensure we can deliver change in a way that meets the needs of our population best.

Summary Box 8.1

8.1 Digital

Despite investment over recent years, the digital infrastructure within our hospitals continues to pose significant challenges. In particular, the lack of integration between different systems poses a barrier to implementing the proposed new models of care and maximising the benefits for staff and patients.

Digital exclusion is also an issue for many people in the Humber region, particularly those in the most deprived areas. Many people lack the skills, knowledge or equipment to make use of the new opportunities that digital can bring.

The proposed new models of care have been developed alongside to the Partnership digital strategy and investment portfolio to ensure we can maximise the benefit of current and planned future digital investments. The proposals have also been designed to take account of the Partnership's digital inclusion principles to ensure everyone can benefit from digitally-enabled changes.

Summary Box 8.2 Digital

Health and social care organisations across Humber and North Yorkshire have invested in technology and digital solutions over the past ten years to varying degrees. But our hospitals are not maximising the potential of digital technology for the delivery of modern healthcare services (see section 2.5.3).

Within the Humber's acute hospital settings, the two trusts have historically worked independently on developing their digital strategies in isolation. Investment made to date has varied in terms of scale and areas of focus between the two organisations, which has led to different starting points for the two organisations. Nevertheless, strategic alignment of approach and solutions is underway and significant progress has been made in recent years to build the infrastructure that is needed to support collaborative working between the acute providers and with the wider health and care sector in the Humber.

8.1.1 Current Position

Over recent years, investments have been made in key areas such as:

- Underpinning infrastructure and equipment – improved cybersecurity, more resilient networks and upgraded devices and equipment.
- Communication systems – e.g. Patient Portal (Patient Knows Best – PKB), E-correspondence to Primary Care, video consultations.
- Systems to improve efficiency – such as E-prescribing, E-observations, live tracking of assets, consumables and patients.

To support joint working across the organisations and across sites, digital teams created a link between the two trust's Electronic Patient Record (EPR) systems to share patient information for patients being seen within both organisations. To facilitate collaborative working more effectively in the long-term, the trusts are working together to implement a joint Patient Administration System (PAS) and align Electronic Patient Record (EPR) systems, data warehousing solutions and other areas where opportunities to work jointly arise.

The progress made in recent years to align and integrate digital systems lays an important foundation for greater collaborative working to support the potential models of care described in this business case.

8.1.2 Our Vision – digital first, digital for all

Digital technology is an enabler of new and better ways of working rather than an end in itself. In all aspects of our day to day lives digital is already transforming how we work, shop, play and live. It also has the potential to transform how we deliver care so that it is more efficient, more joined-up and more responsive to the needs of our communities.

From our ongoing engagement with stakeholders, we know that there is a strong willingness to engage in using new technology, but patients and service-users want us to do our bit and "get with the times" too.[217] For both patients and staff, shared care records, with consistent and accurate information across all care settings are a must and are required to underpin our efforts to develop more integrated service models. Virtual appointments and different ways of interacting with clinicians are broadly welcomed by our population, but views vary between different cohorts of service-users.

> *Our vision is for* ***digitally enabled care that is joined up around the needs of the patient (or service-user) where things "just work" like they should.***
>
> *We want to deliver improvements to the experiences of those using hospital services and those working within them, with digital inclusion at the heart of our approach.*

Summary Box 8.3 Vision for Digital

In developing the potential models of care for the future, digital technology will underpin and support all of the models in a number of important ways:

Patient experience

- Self-booking and smart scheduling
- Remote monitoring
- Patient alerts – health condition monitoring/appointments
- Patient record access
- Remote appointments – where appropriate

Data and analytics

- Improved data sharing through interoperable systems
- Use of artificial intelligence and predictive analytics to model patient flow and demand and resource allocation

Clinician and staff experience

- Shared care record
- Faster access to accurate information
- Automated completion of forms
- Easy and instant referral processes
- Patient recorded information available as standard
- Appropriate equipment
- A holistic understanding of other agencies involved

[217] See appendix 10.10.2 for a fuller description of what we have heard about digital through our engagement.

Infrastructure

- Design and build of 'smart buildings' promoting increased environmental sustainability and efficiency
- Interoperable systems reducing data transfer risk
- Increased use of robotics in both buildings and service management and point of care delivery
- Systems accessible, transparently from any location
- Maximising the use of innovative digital technologies could overtime change the building and infrastructure needs with the potential to reduce the overall estate footprint
- Radio frequency identification (RFID) where people and equipment can be tracked without human intervention
- A more integrated Care Coordination Centre not only across acute care, but with the capability to expand across a region would link up the care pathway across multiple providers and inputs enabling the best use of resources across all those linked to the provision of care. This requires robust digital foundations with interoperable data flows.

Digital can also help to predict workflow whether that be through attendances predicted for ED or monitoring footfall to identify the areas that need more domestic staff, to automatically ordering equipment as soon as an operation is booked. Advanced technologies such as Robotic surgery can also be used to great effect in surgery.

By prioritising the right investments and working in a joined-up way across Humber and North Yorkshire, we can radically improve the digital infrastructure upon which services are built. The changes and improvements described in this document cannot be delivered without the underpinning digital infrastructure. Putting those building blocks in place, brings a multitude of benefits to staff, patients and the system as a whole. We can free up staff time from doing manual administrative tasks, ensure staff have time to care, which is what both patients and staff have told us is most important to them. Digital technology also underpins greater collaboration between clinical teams and is a vital enabler to allow our clinical teams to work seamlessly across primary, community and secondary care. It also empowers patients to take control of their own health.

8.1.2.1 Addressing Digital Exclusion

Digital Inclusion is an important strategic priority of the Humber and North Yorkshire Health and Care Partnership. The Partnership's Digital Inclusion Group created a set of Digital Inclusion Core Principles, which guide the work of all organisations with the Partnership and underpin the approach to digital technology used within this programme.[218] The principles provide a simple checklist for organisations to help determine appropriate actions when implementing digital service transformation projects.

The Digital Inclusion principles are:

- Put people at the heart of everything you do
- Empower and enable people to be digitally included
- Remove digital inequalities
- Always work collaboratively
- Do the hard work to make it simple
- There's always got to be another way

[218] Humber and North Yorkshire Health and Care Partnership (2021) *Digital Inclusion Core Principles* (see document library)

- Adopt 'Digital Future Proofing'

In designing and implementing our technology solutions we will adopt an approach that actively promotes digital inclusion. We will look for creative and innovative ways to promote greater digital inclusion and help people who may struggle with the tools and learning to be able to access services and improve their health and wellbeing. We will consider people's experience from beginning to end including infrastructure and any processes involved so that our solutions are easy to use for staff and patients alike. We will be innovative and willing to think outside the box. We will undertake digital maturity assessments of our patients and staff before implementing new approaches or offering new ways of access and only make use of technology in care delivery where it is safe and appropriate to.

8.1.3 Our Digital Action Plan

The proposals for change are underpinned by a high-level digital action plan, which was developed in collaboration with partners across Humber and North Yorkshire and is aligned to wider system strategies.

Digital inclusion – for staff, patients and communities – is at the heart of our digital action plan.

8.1.3.1 A Collaborative Approach

As with other aspects of the programme, we have adopted a collaborative approach to co-produce the digital action plan to support this business case. Over recent years, digital leads from across all parts of the health and care sector in Humber and North Yorkshire have been working together collaboratively and established a strong set of governance and collaborative arrangements. These structures have supported the development of joint strategies and plans that will underpin much of the work required to deliver the future models of care described in this business case.

To support in the development of an action plan specific to this programme, we also held a bespoke workshop to generate further ideas and refine the next steps for partners. The workshop included input from a range of tech sector organisations, including Microsoft, Wincanton and Argent, as well as local sector leaders from clinical and technology backgrounds. The workshop provided an opportunity for networking, collaboration and innovative thinking and produced an action plan with priorities and next steps.

8.1.3.2 Priorities and Actions

The high-level ambitions for the system across the Humber, which will also support and enable the change proposals described within this business case, are set out in the table below.

I year	5 years	10 years
− Paperless working across both acute trusts. − Improved data sharing – consistent data capture. − Removal of unnecessary Information Governance barriers.	− Shared system across all providers and/or alignment of systems to enable more agile working between and across organisations.	− Use of advanced robotics. − Smart buildings. − Data driven assessment. − Face to face clinical review by exception.

− Removal of unnecessary Information Governance barriers. − Voice driven digital dictation. − First Version of Shared Care Record live with sharing of secondary and Primary Care information as standard. − A Plan in Place to ensure compliance with national *What Good Looks Like* (WGLL) requirements. − Understanding the full potential of current solutions.	− Shared care record covering all care providers, feeding real time population health management (PHM) solutions. − Improved access for patients in a community setting.	− Single Electronic Patient Record (EPR) across the whole Partnership (ICS).

Table 8.1 Digital priorities[219]

There are significant requirements to invest in digital infrastructure across both acute trusts and the wider health and care sector and a number of existing programmes and/or planned investments across the system. Recognising this complex picture, the programme team worked with digital leads to map planned digital investments across the Humber to the priorities and key deliverables within the Humber Acute Services programme. This has identified the key investment requirements and areas where plans are already in place to deliver the digital enablers that are required.

The table below highlights the most important digital enablers that will be required to support delivery of the proposals within this business case. These are all existing priority programmes within the Integrated Care System and are considered high priority schemes.

Enabling scheme	Specialty area	Priority for ICS	Funding Confidence
Yorkshire and Humber Care Record	All areas	High	High
Shared Patient Administration System (PAS) and alignment of Electronic Patient Record (EPR)	All areas	High	High
Any to Any booking	UEC	High	Medium
Virtual ward (digital support)	UEC and paediatrics	High	Medium

Table 8.2 Summary of digital enabling schemes

Details of the digital enabling programmes set out in section 6.4.3. Further information on timescales and current funding status of each programme is set out in the Humber and North Yorkshire Digital Transformation Investment Plan.[220]

[219] Initial action list developed through digital workshops – see the Engagement Timeline for further details of the workshops and outputs.
[220] Humber and North Yorkshire (2022) *Digital Transformation Investment Plan (DTIP) Portfolio Overview* – see document library.

8.2 Estates and Infrastructure

Many of our hospital buildings across the Humber are outdated, inefficient and do not make it easy for our teams to provide the best possible care to patients. We have limited access to the investment we need to improve or replace them. This impacts on the care we can provide and makes it more difficult to attract the staff we need.

If we did nothing to change our clinical models, the additional estate that would be required across all sites would be significant and require substantial investment (c.£100 million) just to manage growth in demand – this is in addition to the investment required to keep the buildings in good working order.

The ageing condition of our estate limits the changes we can make within a capital affordability envelope.

Nevertheless, **the clinical change proposals set out within this business case – and estates changes that would be required – can be delivered within existing financial resources, enabling many of the identified benefits to be realised quickly.**

Summary Box 8.4 Estates and Infrastructure

8.2.1 Current position

The current position of both trusts in terms of servicing their hospital estate is significantly challenged. Critical infrastructure costs for both trusts significantly exceed the national median of £13.7m – within NLaG alone, there is almost £80 million of critical infrastructure risk (CIR). Over the next 15 years, if we did nothing to change services, significant capital expenditure (>£100 million) would be required to increase capacity in our existing hospitals to meet predicted increases in demand for services. In addition, significant further investment would be required to keep our buildings serviceable and operational. Addressing all known Backlog Maintenance issues (including CIR), would require an overall investment of at least £190m.

- Our ageing estate is not fit for purpose and impacts upon our ability to deliver effective care to meet the demands we face.
- Our existing buildings in most areas are unable to meet infection control standards.
- We have significant issues of backlog maintenance and critical infrastructure failure risk.
- Equipment investment has been limited and is not standardised for ease of use across sites.
- Our buildings are not flexible and cannot easily be adapted to delivery current models of care.
- The environments for our staff are often cramped, with lack of facilities to take breaks and change.

These challenges significantly impact on our ability to provide good quality, efficient patient care and limit the potential options for change within the envelope of capital affordability.

8.2.2 Our Vision – future-proofed buildings, anchors for the community

Whilst buildings and infrastructure were not the top concern for most people when they were forced to rank preferences, we heard through our feedback about the significant impact that good quality, well designed buildings can have on patients and staff. Making our buildings easier to navigate, creating ways

to connect with nature and improving access, facilities and privacy were all important to patients and staff. We want to be able to provide services from buildings that are fit for purpose and provide pleasant environments for staff to work in. We have many problems with our existing infrastructure: we want to take a strategic approach to addressing them, ensuring that we are investing in the right buildings for the right services. We also recognise the potential to bring additional benefits to our communities through the investments we do make in our infrastructure and have designed our capital investment programme with this aim in mind (see section 1.2.2.1 for details on our anchor network ambition).

In parallel to developing the potential models of care described in this Pre-Consultation Business Case, we have also developed comprehensive capital investment plans to support the delivery of new models of care and address the estates and infrastructure challenges we face. In September 2021, the Partnership submitted an Expression of Interest to become part of the next phase of the New Hospitals Programme, seeking £720 million (in April 2021 prices) of capital investment across the Humber. The EOI sought substantial investment in new buildings to enable a radical improvement in local hospital infrastructure and support the creation of new, high-quality jobs in fields such as research, innovation, construction, engineering and much more, helping to grow the local economy.

In putting together the bid for funding, we developed an innovative approach to estates and infrastructure investment built on strong partnerships with local authorities, education providers and the private sector to maximise our impact as an anchor network. By working in this way we will be able to leverage any infrastructure investments to maximise the opportunities for local people to gain good employment opportunities and maximise the benefit to the local economy through supply chain and related opportunities.[221]

We have adopted a unique approach to our capital investment programme to ensure that it serves as a catalyst for economic and social revitalisation on a much grander scale, transforming the lives and welfare of people and communities across the Humber region.

8.2.3 Delivering proposals for clinical change

Additional work was undertaken during 2022 to determine what would be required from an estates and capital investment perspective to deliver the proposed clinical changes set out in this business case, given the high degree of uncertainty around the timescale and process for progressing additional schemes through the New Hospitals Programme at that time. It was subsequently confirmed that the Expression of Interest to the New Hospitals Programme was not successful and therefore the capital investment required to implement the clinical change proposals would need to be delivered from within existing financial resources.

Service provision requires capital investment to ensure any change in configuration of the hospital services are:

- Fit for purpose.
- Right-sized to ensure capacity meets the change in demand.
- Reconfigured to meet the required building and quality standards (HBN/HTM).

[221] Humber, Coast and Vale Health and Care Partnership (2021) *Building Better Places: Our ambition to build a healthier future for the Humber* (see document library)

Assumptions were taken into consideration based on existing service provision, forecast change in the near future (e.g. Emergency Department builds in DPoW and SGH that are nearing completion) and the space requirements and clinical adjacencies to achieve the future potential of the models of care. Each of the potential models was reviewed against current service provision and whether investment would be required for new builds or refurbishment to ensure successful delivery of the services in the future. In undertaking this work, the following assumptions and considerations were made:

- The space requirements are based on the 'original Models 5yr growth' forecasted models.
- The existing bed space numbers/quantities for the UEC areas are based on the completion of both new Emergency Department projects at SGH and DPoW.
- There is a working assumption that the proposed capital solutions are operationally and technically deliverable, further feasibility work is required to provide a detailed technical solution.
- The calculations are based on retaining exiting bed/space/place/theatre quantities without undertaking further upgrades to achieve full HTM/HNB Compliance.
- There is a working assumption that the existing/generated spare capacity can be re-utilised to address shortfalls under each of the models.
- Goole and Castle Hill Hospital have not been modelled due to little/no change to the configuration of the services currently delivered from the sites.

The totals for bed requirements and outline costs are net of any investment that would be required to respond to growth in demand (not associated with the proposed service changes) or comply with legal or regulatory requirements.

To deliver the proposed service changes, investment would be required to either refurbish, relocate or expand clinical areas at Diana Princess of Wales Hospital, Grimsby (DPoW) to accommodate additional patients for the consolidated services.

The key areas where additional investment would be required are:

- an increase in non-elective inpatient beds
- an increase in critical care capacity and development of purpose-build facilities
- an increase in the capacity of the paediatric inpatient ward and expanded family accommodation.

Critical Care at DPoW is currently running from a temporary location with a reduced number of beds. Investing in additional critical care capacity at DPoW would support the opportunity to create a co-located critical care service which will be fit for purpose and meet the required standards. The additional investments would also support delivery of better clinical adjacencies by relocating adult short stay and paediatric assessment areas, creating space for consolidated specialist services.

The new-build Emergency Departments at Scunthorpe General Hospital (SGH) and DPoW will deliver improved ED facilities and fully functional integrated acute assessment areas in 2023. This will provide a significant increase in capacity and enable the integration of assessment services supporting increased same day emergency care and delivery of the new pathways described. The new builds also include the ability for a co-located urgent care service. The new builds will be fit for purpose to support the proposed model of care, including the collocation of trauma services at DPoW.

The capital cost estimates were undertaken by Cost Advisors and estimates follow best practice and the guidance within the NHS Capital Investment Manual. The anticipated capital investment required to deliver the proposed changes is summarised below.

Summary of capital investment requirements				
Est. cost (£m) for implementation (exc. BAU)	Approx. total (m^2) required	Approx. total m^2 cost (£000) variance	*HAS model BLM impact (£m)*	*HAS model % of total site BLM*
25.5	5,257	1,500 - 4,770	3.0	11.0%

Table 8.3 Summary of capital investment requirements [222]

In terms of capital affordability, the proposed investments could be accommodated within the Trust's internal capital programme over a period of three years. The alternative site option that was considered – where specialist services were consolidated at Scunthorpe General Hospital – was not deliverable due to the significant capital that would be required over and above the internal capital investment that is available to the Trusts.

The proposals within this business case – and the estates changes needed to implement them – can be delivered within existing financial resources are not dependent on securing external capital investment.

[222] *Financial modelling outputs* (May 2023) – see appendix D.

8.3 Workforce

Our workforce is our biggest asset, yet we are struggling to recruit and retain the expert clinical staff we need to continue to deliver safe, high-quality services.

Our current staff are under pressure due to vacancies and (national and international) skills shortages. They are often stretched too thinly trying to cover services across multiple sites and are not always being deployed in the most effective ways. They do not always get the time and opportunities to train and develop their skills.

There is an appetite – and a necessity – to work differently.

The proposals for change are supported by innovative workforce models, new roles and new ways of working that will make better use of the workforce we have today and help us to attract and retain the workforce we need for tomorrow.

Summary Box 8.5 Workforce

8.3.1 Current position

HUTH and NLaG together employ more than 14,000 people (WTE) across the two acute hospital trusts. There are a further 6,800 (WTE) roles in primary, community and mental health providers and approximately 21,700 (WTE) within social care across the Humber. We know from our engagement with staff that making a difference to patients is really important to them and the main reason that many feel proud to work within health and care. We also heard from staff that many feel under pressure due to the impact of vacancies or staff shortages within their department or teams. A healthy work/life balance was the top priority for staff surveyed and they told us the one thing we have to get right through this programme of work is workforce, specifically staffing levels and ensuring staff are involved and feel valued.

The current workforce position across both trusts is detailed in section 2.4. Both HUTH and NLaG face challenges recruiting to clinical roles, doctors, nurses, midwives and allied health professionals (AHPs). Despite active recruitment campaigns, there are still significant vacancies across all hospitals (especially in specialist positions) and key roles that cannot currently be filled. Most of the resulting gaps in rotas are being filled through a mixture of agency and locum staff and our existing staff undertaking additional overtime. This in turn increases pressure on remaining staff within our organisations.

Within the next decade we can expect well above 30% of our staff, including those in hard-to-fill posts, to retire. Our Primary Care Networks are also experiencing an increase in GPs retiring with lower number of GPs in training to replace them. Social care partners experience difficulty recruiting and extremely high staff turnover rates – up to 30% in some localities. Upwards of 40% of registered clinical staff and professional corporate staff who leave, relocate away from the Humber to pursue career development opportunities that they cannot find locally.

This situation is not sustainable in the long term, and it is important that we offer our staff rewarding careers that do not stretch them too thinly.

8.3.2 A collaborative approach

To support the proposals for clinical change within this pre-consultation business case, a robust approach to workforce considerations was required. This involved comprehensive workforce planning to model future workforce requirements for each of the potential models of care (detailed in section 10.19). It also involved looking at the wider strategic ambitions for our workforce across the Humber health and care system and considering new and innovative approaches to tackling our workforce challenges.

During 2021/22 in depth evaluation of the Humber health and care workforce was undertaken. This included a review of:

- The size, skills, demographics, vacancy and staff turnover over rates as well as key equality profiling analysis of HUTH and NLaG staff.
- The number of staff, by staff group, of the other Humber primary care, community and mental health providers workforce.
- A Staff 'What Matters to You' survey, to understand staff needs and wants from the Humber Acute Services change programme.
- Existing workforce feedback and data from other sources, such as the NHS national staff survey, Workforce Race Equality Survey, Workforce Disability Equality Survey and Gender Pay Gap data.

Using the intelligence and ongoing engagement with staff, HR directors, clinical teams and staff-side representatives, the Humber Acute Services People Proposal was developed. Representatives from Hull University and Lincoln University have been involved in the development and evaluation of the potential clinical models and proposals within this business case. This is important because universities require sufficient notice to make changes to their syllabus and be clear on placements for students applying for their courses. It has also been extremely beneficial to have our local universities involved from the outset because they offer a different perspective on what could be done differently in the future. University teams have met with the programme team and wider clinical stakeholders to discuss how further opportunities can be developed, identifying a number of areas for action.

8.3.3 Our Vision – One Humber workforce

We worked with staff across health and care in the Humber and with partners in education to develop a workforce vision and strategy, to support the proposals within this business case. The vision goes beyond staffing the clinical models within this PCBC and will support the broader development of the health and care workforce across the Humber.

The Humber Acute Services workforce vision is closely aligned to the Humber and North Yorkshire People Strategy.[223] The vision and wider strategy have been informed by ongoing staff engagement, which has highlighted the core elements that will enable staff to thrive and deliver the various new models of care.

The concept of having a 'One Humber' workforce in the future, was a vital part of the vision developed. This concept is about making it easier for staff to work across different parts of the health and care system, to gain wider experience and open up more opportunities for staff to develop their knowledge and skills within our region. A more collaborative approach will also prevent organisations competing for

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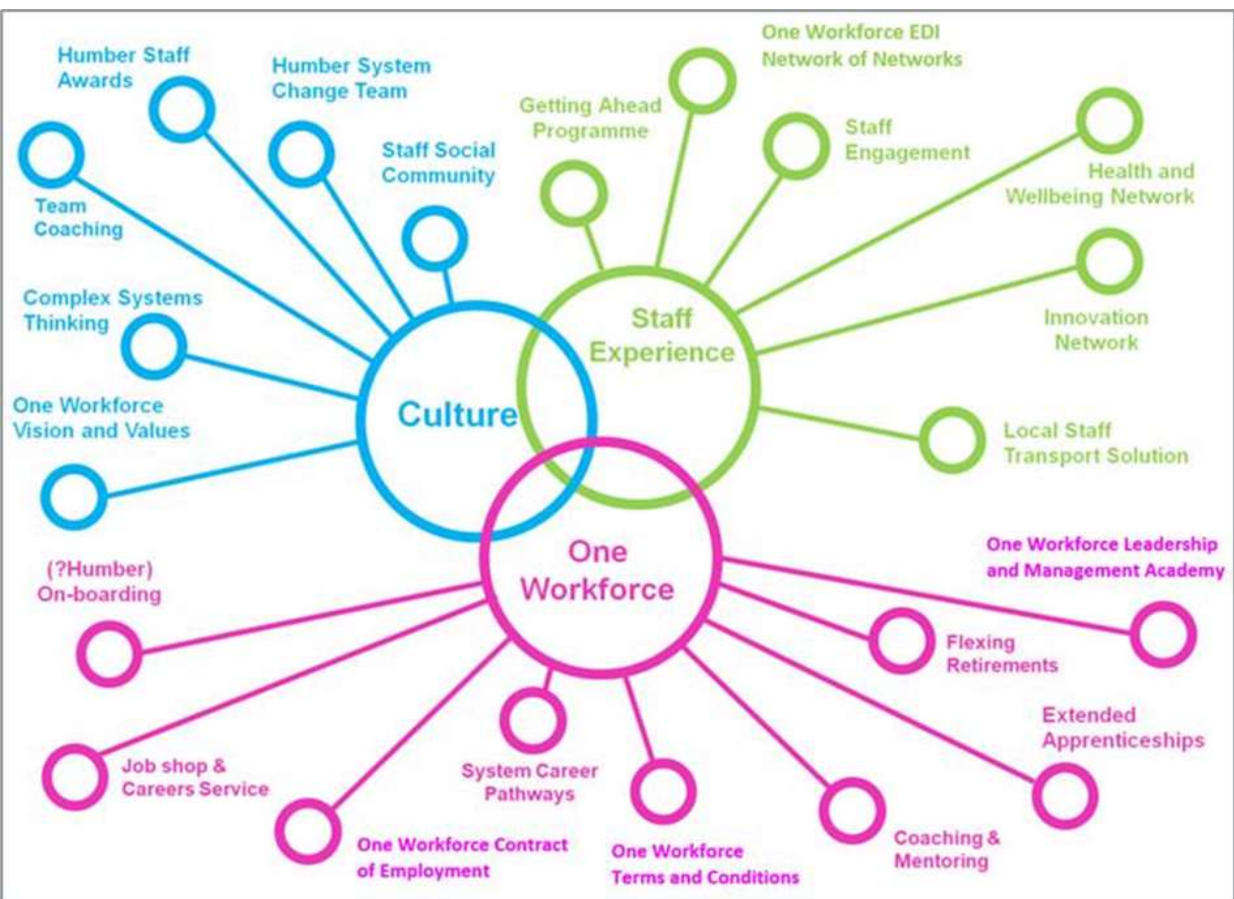
[223] Humber and North Yorkshire Health and Care Partnership (2022) *People Strategy and Function (April 2022 – March 2027)* – see document library

the same pool of talented individuals and fixing a problem in one area by creating a new one elsewhere in the system. Improving staff experience and developing a more collaborative and supportive culture underpins the delivery of this vision.



Picture 8:A Humber workforce strategy

8.3.4 Our Workforce Action Plan

From this vision, we developed a workforce action plan, that will support delivery of the proposals for change to pathways and models of care detailed in this business case. The workforce action plan incorporates a range of actions, grouped under three key themes.

- **New roles and ways of working** – one Humber team, centred on the needs of the patient.
- **Flexible and rewarding careers** – supporting retention and attracting new workforce.
- **Levelling Up Humber** – maximising our impact as anchor institutions.

Summary Box 8.6 Workforce action plan

8.3.4.1 New roles and ways of working – One Humber team

Our staff are spread too thinly across hospital sites, with relatively small services provided from a number of different hospitals; this means that we are not always able to meet clinical standards set nationally and that **jobs for our staff are tougher than in other parts of the country**.

The proposed models of care are made possible with **blended staffing models** where some roles become multi-locational to provide timely care to patients and to improve patient flow. They maximise the opportunities for staff to work differently and gain experience across the whole pathway of care, **improving the experience for patients and creating opportunities for exciting careers in our region**.

The proposed new ways of working include opportunities for staff from different organisations to form a blended team, working shoulder to shoulder in GP practices, other primary care locations, and within new town centre locations nearer to the patient to improve access. We have begun the journey of developing more cross-organisational opportunities and supporting new ways of working but there is much still to do. Across the two acute hospital trusts – HUTH and NLaG – we have developed a number of joint clinical roles and a mechanism for supporting collaborative working across both trusts. We will build on the successes of this approach, working with a wider range of partners across the health and care system to develop more flexible ways of working and opportunities for our staff to develop their skills and work ways that follow the patient and their needs, rather than being constrained by organisational boundaries.

To support these new ways of working we will:

- **Co-design new training models** with our university and further education providers. Our HE partners have embraced this and have confirmed their ability to assume multi-site and multi-team working practices into their training, including lone working competencies, within their under-graduate and post-graduate courses.
- **Introduce digital workforce solutions** that support these new ways of working and link not just clinical systems but people for enhanced communication. Our digital partners are fully engaged in this aspiration.
- Work with providers across health and care to **create new career pathways that operate across organisational boundaries** and span the length and breadth of patient pathways. This will create the means for staff to move to roles within the pathways they have trained in without feeling that they need to relocate out of the Humber to gain new opportunities.
- Invest in **multi-provider site orientation inductions** to provide all staff across all locations with the induction programme they need to establish themselves in these new roles. Agile working and agile leadership models will be explored. Supervision and accessible, timely clinical support and supervision would be provided through digital solutions.
- Consider how we can **support staff mobility**, particularly considering the locations where many of our current staff live and limited availability to transport options. Our approach to staff transport will be addressed through the transport action plan.
- **Seek to align pay and non-pay benefits across organisations** through the creation of a local Humber Terms and Conditions agreement. The Humber Terms and Conditions will seek to harmonise, wherever possible, all local pay reward in addition to providing a robust portfolio of non-pay staff benefits to all staff across the health and care sector and reduce instability and turnover with staff moving between organisations within the same care pathway.

- Look to **reduce organisational and system barriers** that stifle movement of staff between roles and providers so staff can find the roles, the career opportunities and the terms and conditions that provide what they are seeking.

The proposed pathway changes and potential clinical models all identify the importance of developing alternative roles, such as Physician Associates, Advanced Care Practitioners, Nursing Associates and a wide range of Allied Health Professional roles. We are working with our Higher Education partners to ensure the relevant training opportunities and placement environments will be available to maximise the uptake of training for current and prospective future staff into these diverse roles. This will be critical to enabling us to deliver the new models of care described.

The specific ways in which new workforce models could be deployed and descriptions of the types of new roles being developed to support the models of care and proposals for change are set out in detail as part of the description of the proposals (see section 6.4.2).

8.3.4.1.1 Pathway Career Plans

To create a system workforce, we need to embrace system working across all aspects of the workforce. We will therefore create career pathways aligned to patient pathways and transcending organisational boundaries.

Both trusts have developed ongoing staff retention plans to reduce the number of avoidable leavers, for example the NLaG Nursing Retention Plan, supported by the ICS Workforce Consortium, which focuses on areas such as individual career development, flexible working practices and ensuring nurses are able to work in environments and cultures that meet their expectations. We are exploring the creation of 'pathway career plans' which will allow staff to take their previous training and experiences and develop these across the entirety of the patient pathway. In turn this means we must create the opportunities for staff from multiple providers to come together and train and from this reduce the burden of bureaucracy within recruitment practices to allow the ease of movement of staff between providers (without reducing the rigour or safety of the recruitment process).

Supporting pathway career plans, also increases the scope for career progression and range of roles available within the Humber. Examples of new roles and how they can support career progression through pathway career plans include the following:

- Midwifery Healthcare Support Roles (Band 4 – a stepping stone for those wishing to progress to train as a Registered Midwife through an Apprenticeship or Higher Education route)
- Advanced Clinical Practitioners (Band 7/8a – for those wishing to develop higher level clinical skills to complement Junior Doctor positions or higher-level nursing/midwife/AHP roles)
- Paramedic Consultants (Band 7/8a – to support Primary Care and/or diversionary schemes to reduce unnecessary Emergency Department attendances)
- Physician Associates (Band 7/8a – to complement Junior Doctor positions within Primary Care, some acute specialities and Emergency Departments)

We will aim to provide newly appointed staff rotational induction periods where they can work along the length and breadth of the pathway, rotating through employers so they understand each aspect and role and how it fits within the system. This could include working across health, social care and even voluntary and community sector organisations as we seek to integrate our ways of working further across all parts of the system. Within the pathways new and extended roles will be championed to support career development for those seeking it, to ensure we can retain skills within the Humber area wherever possible.

Pathway Career Plans will:

- Signpost Step On/Step Off points so staff can see what is required to progress through the career plan.
- Show clear linkages between different career plans with transfer points i.e. the skills and competence needed to move between patient pathways and different career paths/roles.
- Support multi-provider and multi-staff group joint training opportunities (to develop pathway networks and learning from others different perspectives and experiences).

The ability for our staff to move between roles and organisations, developing their skills, competencies and relationships will become increasingly important to enable the pathways changes and models of care proposed within this business case.

8.3.4.2 Flexible and rewarding careers

Staff told us that having a good work/life balance was important to them. A significant number of staff also told us that good career development opportunities and feeling valued for what they do was most important to them.

In order to improve the sustainability of our services and implement more robust models of care, it will be important to ensure the career opportunities we offer are rewarding so that we can retain existing skills within the system and attract new entrants into the sector.

8.3.4.2.1 Research, training and development opportunities

Recruitment to small specialty teams can be a problem, particularly for medical staff. Consultants often prefer to work within larger teams, offering them opportunities to experience the wide-ranging aspects of their chosen clinical discipline, and participate in research activity and educational roles. These are important aspects of a consultant's on-going development and a key consideration for candidates looking to apply for consultant roles. Small departments can also be less attractive to new consultants due to the increased demands to provide out of hours on-call services. The ability to have a work-life balance is a key consideration of future employees across all areas of the workforce when choosing where they wish to work.

For our nursing, midwifery and AHP workforce, working within small teams can similarly limit the training and development opportunities that our trusts can offer. Ensuring staff have time to take up training opportunities can be more challenging in smaller teams where the impact of vacancies or absence is greater. Moreover, staff working in services with lower activity numbers can have fewer opportunities to treat patients with rare or more complex conditions.

A key consideration in developing the proposals for change has been ensuring our workforce can have rewarding careers, working more flexibly and having ample opportunities to develop their skills and expertise in their chosen field. Working in larger teams across the organisations, with the ability to rotate between sites and sectors (as appropriate), will enable us to provide more opportunities for staff to undertake research – working with our academic partners in both Hull and Lincoln – training, and professional development, offering a wide range of attractive careers in the Humber area.

8.3.4.2.2 Our workforce of the future

Whilst a large proportion of our current workforce is due to retire within the next ten years, population growth statistics show a significant net increase in students from 10 years of age over the same period

of time. It is more important than ever that we can successfully engage with children and young people in our region to encourage them to consider a career within the health and care sector.

There are many good examples in our region of partnerships between healthcare providers and educational establishment, such as the St Marys College in Hull which has become a Medical, Health and Social Care Academy. However, there is much more that could be done to embed good practice within schools across the Humber and offer more children and young people the opportunity to develop their careers within our sector. We aim to address this through the programme by forming greater partnership working with schools, colleges and other education partners, sharing best practice and investing in the work undertaken through the Humber and North Yorkshire Workforce Consortium.

Feedback from local school academies and Further Education (FE) colleges is that not all students want to or are able to go to university. Many students aspire to join the health and social care workforce but are seeking direct entry and opportunities to train 'on the job'. We will partner with apprenticeship providers to offer extended apprenticeships which:

- Support direct entry in the health and care workforce.
- Provide apprenticeships of longer durations to support those with lower academic ability.
- Partner with private sector employer to provide rotations so trainees can experience different working locations and practices.

In partnership with the Humber and North Yorkshire Workforce Consortium, we aim to provide a job shop/career service to everyone in our communities to raise the profile of health and social care careers. In particular, we will work with our education partners to deliver career interventions in school, support with the provision of information and advice and deliver a work experience programme for those considering careers within the sector.

A solid and sustained investment in local students will support the retention of local talent and help to build a more resilient workforce for the future. It also supports economic regeneration, putting money into our local educational establishments and retaining more spending within the local economy. Working proactively with students from our deprived communities to offer genuinely attractive career prospects can improve educational attainment levels and support the narrowing of health inequalities.

8.3.4.3 Levelling up Humber

Some of the most deprived wards in the country can be found within the Humber region and there are **wide disparities in income, employment, education and training and levels of crime**. Many individuals and communities across the Humber are disproportionately affected by ill-health and premature death.

Working with partners to improve access to skills, training and employment will **help to address some of the underlying issues that lead to poorer health outcomes** in our population and support improved health through good quality jobs and career opportunities.

Across the Humber, 'Human health and social work activities' is the third largest industry by numbers employed (after manufacturing and wholesale trade), except in East Riding of Yorkshire where it is the second largest.[224] Many of the staff working within our sector live in deprived communities and face a

[224] Nomis (2022) official census and labour market statistics – jobs by industry Labour Market Profiles

wide range of health inequalities. The Humber population has lower educational attainment level and higher unemployment rates than the England average.

Location	No Quals	Other Quals	NVQ1 or above	NVQ2 or above	NVQ3 or above	NVQ4 or above
East Riding	4.6%	3.7%	91.7%	81.2%	61.3%	41.8%
Hull	**11.3%**	6.8%	81.9%	65.9%	44.6%	23.4%
North Lincolnshire	7.5%	8.1%	84.4%	72.6%	52.8%	32.4%
North East Lincs.	**12.1%**	8.5%	79.4%	68.2%	43.2%	25.2%
Yorkshire & Humber	*7.0%*	*6.2%*	*86.9%*	*75.9%*	*57.7%*	*37.3%*
England	*6.2%*	*5.7%*	*88.2%*	*78.2%*	*61.3%*	*42.8%*

Table 8.4 Population Educational Attainment Levels by Local Authority[225]

As anchor institutions we are working with partners to do more to support local people to access training opportunities to gain the skills and qualifications to gain direct entry into paid employment in the health and care sector.

8.3.4.3.1 Expanding apprenticeships

Apprenticeships can expand the scope of career progression within the workforce for those not able to pursue university or Higher Education degree routes, which is particularly important for staff with family commitments when considering career progression. In addition, they can support new workforce to enter the sector from within our local communities. Apprenticeships are a key part of the pathway career model described above. Targeted investment within deprived communities, with support through accessible career pathways and supported apprenticeships, will help to increase the skills base and employment levels within those communities and make a significant impact on underlying health inequalities.

Presently HUTH and NLaG offer over 48 different apprenticeships, delivered by 30 training providers, ranging from Business Administration (Level 2/3) through to Senior Leadership (Masters Level 7). Apprenticeships for clinical registered roles, such as Physiotherapy (Level 6), Operating Departmental Practitioner (Level 6) and Occupational Therapist (Level 6) are beginning to be offered too at HUTH.

	Clinical apprenticeship programmes offered:	Non-Clinical apprenticeship programmes offered:	TOTAL
HUTH	20	21	**41**
NLaG	11	23	**33**
TOTAL	**31**	**44**	

Table 8.5 Current apprenticeship programmes (NLaG and HUTH)[226]

The majority of apprenticeships are offered to current staff. As part of our commitment through the anchor network we are seeking to expand the offer of direct entry to students from local school academies and colleges of further education who meet the apprenticeship specification and display the values and behaviours sought within the NHS workforce. In designing new apprenticeship programmes we will seek to provide placements across a range of service locations and providers to develop pathway workforce teams and develop the 'One Humber workforce'. The system-wide apprenticeship approach

[225] Nomis (2022) official census and labour market statistics – qualifications Labour Market Profiles
[226] Internal trust data (June 2022)

to career pathways will open up opportunities for unpaid carers, volunteers and social care staff to move into NHS roles as part of flexible career development routes.

We will continue to work with partners across the health and care sector and in the wider economy to develop new and exciting career opportunities for local people. Opportunities that we are currently exploring with local businesses include:

- NHS electrician and engineering apprentices holding rotational placements in the offshore wind and renewable energy industry.
- Accountants holding rotational placements in local auditors and accountancy firms.
- Healthcare Support Workers spending time in the independent social care sector.

This reciprocal approach would increase the health and social care talent pools and provide our communities with occupational training leading to sustainable employment with health and social care organisations.

This approach, combined with expanding the range of apprenticeships offered, would begin to address the forecast workforce shortfalls HUTH and NLaG will experience within the coming 5 to 10 years. This is particularly acute within Allied Health Professional occupations.

HUTH AHP workforce age profile	NLaG AHP workforce age profile
• 26.1% of Radiology (Diagnostic) are 50yrs+ • 21% of ODPs are 50yrs+ • 18.3% of Orthotics/Optic staff are 50yrs+ • 17.1% of Dieticians are 50yrs+ • 12.7% of OT staff are 50yrs+ • 11.5% of Physiotherapy are 50yrs+ • 10.9% of SALT AHPs are 50yrs+ • 5.6% Radiology (Therapeutic) are 50yrs+	• 58% of Dieticians are 50yrs+ • 36.5% of OT staff are 50Yyrs+ • 23.1% of Radiology (Diagnostic) are 50yrs+ • 22.2% of Chiropodists are 50yrs+ • 20% of SALT AHPs are 50yrs+ • 15% of Physiotherapy are 50yrs+ • 12.5% of Orthotics/Optic staff are 50yrs+

Table 8.6 AHP workforce age profile[227]

8.3.4.3.2 Developing volunteering and working with the voluntary sector

A wide range of volunteering opportunities exist already within our acute trusts. These include roles for former patients supporting others through rehabilitation, volunteer fundraisers, befrienders, gardeners and more.

In addition, the voluntary and community sector plays an increasingly important role in delivering the new pathways described in this business case, both through volunteers and paid staff, who are a vital part of the health and care workforce. Voluntary, community and social enterprise sector partners can support delivery of the new models of care in a number of ways, including:

- Delivering transport solutions enabling timely discharges and improving patient flow.
- Supporting patients to get online and access digital systems.
- Providing support with food, shopping and company for patients going home from hospital or support at home to prevent the need for an admission to hospital in the first place.
- Providing a range of social and emotional support for people waiting for treatment or living with particular conditions.

[227] Internal trust data (March 2022)

Many of our current volunteers in acute hospitals and voluntary sector providers are older people who are retired. They are an incredibly important part of the unpaid workforce and we must continue to support them. Nevertheless, there is an opportunity to diversify our volunteer base and link volunteering opportunities to defined career pathways. The work we will undertake to develop pathway careers will support us to link volunteering and work experience opportunities to apprenticeships, training courses and jobs within the sector. With support of the Humber and North Yorkshire Voluntary, Community and Social Enterprise (VCSE) Sector Collaborative, we are actively exploring how we can increase opportunities for volunteering for younger people and those who are unemployed or economically inactive in our region to open up career development opportunities, grow our own local workforce and help to tackle the underlying health inequalities our communities face.

8.3.4.3.3 *Support to get to work*

The cost and availability of transport to get to work can be a problem for many, especially those living within our most deprived communities. Car ownership rates are low with 35% of household in Hull and 27% in North East Lincolnshire having no access to a car. Public transport links between our hospitals and major population centres are in place for the most part, however, links between hospital sites and between hospitals and other healthcare facilities (e.g. primary care centres) are poor or non-existent.

Travel bursaries are available for students to access placements, however, many are not eligible for the support because they already travel a significant distance to access their University course. Working with our Higher Education and Further Education partners we are exploring how these barriers can be addressed via virtual learning or local campuses.

At least a fifth of the current Humber workforce use public transport or other means, such as walking or cycling, to commute to work, therefore we are actively considering how we support staff to work and/or training across multiple locations. Following feedback from current staff, we are also considering how support for staff with childcare and other caring responsibilities could be improved. This includes considering on-site provision and working with local businesses and our Local Authorities to address supply-side issues as well as looking at shift patterns and rota planning to provide greater flexibility to staff with caring responsibilities. This will not only help existing staff but also increase uptake of employment opportunities amongst those in our local communities.

The proposals for change are supported by innovative workforce models, new roles and new ways of working that will make better use of the workforce we have today and help us to attract and retain the workforce we need for tomorrow.

Maximising opportunities for staff to work differently and gain experience across the whole pathway of care, will improve the experience for patients and create opportunities for exciting careers in our region.

Working with partners to improve access to skills, training and employment will **help to address some of the underlying issues that lead to poorer health outcomes** in our population and support improved health through good quality jobs and career opportunities.

8.4 Travel and Transport

Many groups, families and individuals within our population face barriers to accessing health and care provision, which can exacerbate existing inequalities in health outcomes. **Our rural and coastal geography, combined with high levels of deprivation, can make it difficult for people to get around to access healthcare, visit loved ones in hospital and access employment opportunities.**

Recognising that it is not possible to make changes without some impact, we have mapped travel times to limit the impact on those facing barriers to access and worked with partners in local authorities, the private sector and across the voluntary and community (VCSE) sector to **develop potential transport solutions for patients, visitors and staff**.

Summary Box 8.7

8.4.1 Current position

Each year more than 280,000 people arrived at our Emergency Departments, around 1.2 million outpatient appointments take place, there are around 148,000 surgeries and inpatient stays in our hospitals and nearly 9000 babies are born at one of our sites. Around 14,500 members of staff work in our hospitals, typically coming into work between 3 and 6 days per week. When added together that is a lot of journeys (around 25,000 every day) as people travel across the region to access care and employment.

Many of our patients and their loved ones find it difficult to get to our hospitals. Those who access our services more often (people in the most deprived areas, older residents, those with mental health issues etc.) are also those least likely to have access to reliable and affordable transport. The range of transport options available and the criteria for accessing them is complex, confusing and inconsistent. This makes it difficult for patients, carers, visitors and staff to navigate. Transport for patients is currently commissioned separately in each locality, with different arrangements in place between health organisations and local authorities.

In many of our neighbourhoods, particularly the more rural areas, public transport provision is limited, which can mean a journey of several hours (each way) for an appointment, that lasts 20 minutes. Due to problems with accessing timely and affordable transport some patients are struggling to attend appointments. When being discharged from hospital, some patients have to wait for transport to become available, which at times means they are waiting on wards and impacting on their patient experience and also on the numbers of beds available for incoming patients. Staff also find it difficult to get to work, and parking is often challenging, resulting in unnecessary stress at the start of a shift.

The impact on travel times for each of the proposals have been modelled and were considered through the evaluation process to determine which models of care were viable to be taken forward for public consultation (see section 10.4.3.3.5). Whilst the pathway changes proposed will reduce the overall need for patients to travel to hospital sites, there would be a travel time impact on remaining patients. In addition, the new ways of working proposed, whilst beneficial to staff development could also mean a greater need for staff to travel to provide care in different localities as they work in more integrated teams across primary, community, social care and hospital services. There is a continued need to focus on improving transport solutions so that staff and patients can get to the places where they need to be.

8.4.2 A Collaborative Approach

Recognising the vital importance of travel and transport issues to the success of any change programme, we adopted a co-production approach to developing travel and transport solutions. In developing this pre-Consultation Business Case (PCBC) we have taken a proactive approach to engaging with key stakeholders. We developed a transport working group to bring together the key stakeholders who can help put in place the transport solutions we require to make the models of care work and address existing and potential future barriers to access.

Our transport working group includes representation from a wide range of stakeholders with a role to play in transport issues, including:

- Local Authority transport planners
- Public transport providers
- Community transport providers
- Patient transport providers
- Ambulance services
- Voluntary and community sector organisations
- Citizen representatives
- Healthwatch

Through the transport working group, we co-produced a high-level transport action plan, which identifies key themes and areas for action, building on existing Local Authority strategic transport plans and other intelligence gathered through our ongoing engagement with patients, staff and the public. The transport action plan will continue to be developed through and beyond public consultation as the requirements and needs of patients, staff, carers and visitors become clearer through the consultation.

8.4.3 Our Transport Action Plan

Co-produced through the Transport Working Group, we developed a transport action plan with three key strategic aims.

- **Understand holistic needs** – responsive services that flex about the patients' needs.
- **Design out unnecessary travel** – reduce overall need to travel for care.
- **Make transport easier** – simplify the transport offer.

Summary Box 8.8 Transport action plan

The transport action plan will continue to be developed throughout the next stages of the programme. The actions required will be influenced by what we hear through public consultation.

8.4.3.1.1 Understanding holistic needs

As we have developed the proposed pathway changes and potential models of care, we have sought to refocus care around the needs of the patient. This approach is required also when it comes to transport solutions. In our engagement with service-users, staff and the public it was clear that a transport need does not always require a transport solution to address it. Sometimes, the solution can be changing the way care is provided or supporting a patients' needs in a different way.

We will continue to work with our Local Authority and VCSE sector partners to improve the digital literacy of our population, enabling them to access services that are increasingly available digitally. This not only improves their access to healthcare but can also support with improving overall wellbeing by increasing connection with friends, family and wider society. In addition, Local Authority partners will lead on addressing poor Wi-Fi / connectivity in villages and areas without connection, supporting this system ambition.

We will work with our transport providers across public, private and voluntary sector to develop transport solutions around the opening times of services, including “out of hours”, making it easier for both patients and staff to access them. This will become increasingly important as more planned care services open longer hours, to maximise efficiency and productivity.

As funding becomes available, we seek to implement intelligent scheduling to enable people to book appointments at times that suit them and for services to meet the broader needs of the patient. Intelligent scheduling means taking into account if someone requires patient transport, and if so, put them later in the clinic to allow time for pick up, or understanding if someone requires disabled parking and the optimum time of the day to book the appointment.

8.4.3.1.2 Design out unnecessary travel

The way in which our hospital services are currently configured, generates a lot of unnecessary journeys. This occurs for a number of reasons, for example:

- We schedule appointments around the needs of the service not the needs of the patient meaning the same person often has to make multiple journeys when they could have had all their tests and appointments on the same day.
- We bring a lot of people to hospital regularly for check-up or follow-up appointments that may not be needed (but then when they actually do need help, they have to wait a long time until the next scheduled follow-up or end up being admitted as an emergency).
- We often require an initial outpatient appointment before ordering diagnostic test which rules out the need for them to be under hospital consultant care, rather than enabling GPs or other healthcare professional to direct them straight to the test.

The pathway changes proposed in this business case for urgent and emergency care and for planned care in particular, will support us to tackle these inefficient and ineffective ways of working to better meet the needs of our patients.

Increased access to outpatient appointments and diagnostics in GP and community settings, more virtual clinics and services such as Hospital at Home and virtual wards will all contribute to reducing the need for patients and their loved ones to travel to and from hospital sites.

> The proposed new models of care and pathway changes will support efforts to design out unnecessary travel and **ensure people only go to hospital when it is absolutely necessary**.

8.4.3.1.3 Simplify transport options

The transport working group recognised the situation described by patients, carers and staff that the current transport offer is incredibly disjointed and difficult to navigate. The working group brings together the key planners, funders and providers of transport across the region and therefore will be an

important mechanism for delivering the ambitions in the action plan to reduce the complexity and make it easier for our population to get from A to B.

A range of actions will be taken forward by the group, including looking at how we can improve the information provided by hospitals and other healthcare providers at the point of referral. Simple changes such as making clear to people where on the site they need to be, which car park is best to park in and how long they can expect it to take to get to the building can make a big difference to patients and their loved ones. In response to feedback from patients, staff and other stakeholders we will also consider our approach to car parking and public transport provision to ensure we are putting in place sustainable options for the future, considering the environmental impact of travel between sites.

We will look to simplify information to patients about their transport options, ensuring patients who do not meet criteria for patient transport are signposted to alternatives such as community transport.

We will work with our local authority partners to review and redesign bus routes, exploring the possibility for direct transport between the hospital sites for patients, visitors and staff. We will also work with community transport providers and voluntary car drivers to explore how we could build resilience in the services and offer greater consistency across the region.

8.4.3.1.4 Supporting inter-hospital transfers

Timely and safe transfers of care between hospital sites is a fundamental element to ensuring the proposed model of care operates effectively. The number and type of transfers likely to be required was modelled in detail as part of developing the different potential models of care and was a factor considered through the evaluation of the different options.[228] The workforce required to support timely and safe transfers, particularly of paediatric patients, has been identified and included within the workforce modelling.

We will continue to work with partners, including local authorities, ambulance providers and other public, private and third sector bodies to design the required transport solutions as part of planning for implementation.

8.4.3.2 Priorities and Actions

The action plan covers three key areas and has identified a number of key actions under each theme:

Theme	1 year	5 years	10 years
Understanding holistic needs *Provide more responsive services that flex around patient needs (including transport and accessibility constraints)*	• Improve information provided in appointment letters based on patient feedback	• Intelligent appointment booking system – recognises individual needs (e.g. caring responsibilities/ access needs) • MDTs across departments/ sectors	• More accessible buildings • Design-in accessibility, drop-off areas etc.

[228] See section 10.4.3.3.3 and 10.4.3.3.5 for further details.

Design out unnecessary travel *Reduce the need for patients to travel to hospital, bringing more care closer to home*	• Hospital at Home and virtual wards • Transformation of outpatient services	• Hospital at Home and virtual wards • Community Diagnostics Centres • Intelligent appointment booking system – prevents duplication and long waits	• Continued expansion of telehealth solutions
Make transport easier *Simply the transport offer to make it easier for people to get the help they need*	• Single directory of services (linking all transport available and how to apply all in one place)	• Explore potential expansion of staff shuttle bus to patients/visitors • Work with local authorities to review public transport routes and explore park and ride opportunities • Explore potential reductions and/or fee-free crossings for staff and patients with the Humber Bridge Board	

Table 8.7 Summary of transport action plan priorities

The Transport Action Plan will continue to be developed over the coming months and following consultation – taking into account the feedback provided by patients, their loved ones, carers, staff and other key stakeholders – to ensure suitable transport options are in place that enable patients and staff to access the services they need.

Addressing the challenges within our hospital services requires a system response and changes across the whole health and care system. Where specific pathways or projects need to be in place to enable the proposed clinical model to work, joint management arrangements are in place the ensure these deliver within the relevant timescales.

System-wide collaborative arrangements are in place to design and deliver the critical enabling projects that will be required to make the proposals work – this includes developing the workforce, transport, digital and estates solutions that will be required.

The next chapter describes how we intend to approach public consultation on the proposals within the business case and what will happen next.

Summary Box 8.9

Chapter 9

Approach to Consultation and Next Steps

9. Approach to Consultation and Next Steps

The purpose of this Pre-Consultation Business Case (PCBC) is to demonstrate the need for significant changes to be made to the way in which hospital services are organised and delivered across the Humber region and present potential options for the future that represent the best solutions to the challenges faced. **The proposals set out within this PCBC seek to deliver high quality, safe and sustainable health services for the people of the Humber.**

it is vitally important that decision-makers have a full understanding of the potential impact of these changes to enable them to make informed decisions about the best way forward. Undertaking formal public consultation will provide a richer understanding of the views, priorities and concerns of those who might be impacted by the proposals to support the decision-making process.

Our Consultation approach will ensure the NHS Humber and North Yorkshire Integrated Care Board (ICB) meets all of its statutory duties and legal requirements in relation to service change being mindful of:

- NHS Integrated Care Board legal duties
- Local authority scrutiny functions
- The Gunning Principles

Our Consultation approach will be shaped by guidance, best practice standards and learning from others to ensure it is undertaken in an open and inclusive way. Underpinned by key principles to be open, inclusive and accessible, we will:

- Identify the appropriate target audiences and adapt methods of engagement to meet their needs and expectations.
- Be innovative and creative, going beyond the traditional 'town hall' approach and getting out into communities.
- Rely on independent expertise to ensure a robust approach to collection and analysis of data.

Our aim is to design and deliver a consultation that will seek out the views of those most likely to be impacted by change and will ensure that everyone who wants to take part and share their views is given sufficient opportunities, sufficient information and sufficient time to do so.

Summary Box 9.1

9.1 Background

This Pre-Consultation Business Case (PCBC) demonstrates the need for significant changes to be made to the way in which hospital services are organised and delivered across the Humber region. It proposes a new model of care for urgent and emergency care and paediatrics across Northern Lincolnshire, supported by Humber-wide pathway changes and improved integration with out of hospital services.

The proposals within this document have been designed in partnership with clinicians, staff, patients, carers, the public and their representatives over a period of several years. The benefits and impacts of the proposals and alternative solutions that were considered are set out in chapter 4 (see also appendix 10.4). This information will be included in the information provided to the public and stakeholders through consultation.

Building on the extensive engagement undertaken to support the development of the options, statutory public consultation will provide a fuller understanding of the views, priorities and concerns of those who might be impacted – positively or negatively – by the proposals and options for change to inform the Humber and North Yorkshire Integrated Care Board's (HNY ICB) decision on the future shape of hospital services for the Humber.

A high-level outline of the approach that will be adopted for the consultation is set out below. We intend to co-design the consultation approach with partners and interested stakeholders to ensure the methods used are the best ones to reach the relevant target populations and therefore the final programme of activities undertaken is likely to differ from the approach described.

9.1.1 Legal Duties

Subject to approval of this Pre-Consultation Business Case (PCBC), we are committed to undertaking a full public consultation to test the ideas and proposed options for the future of acute hospital services described in the document. Public involvement is vital, not just because of the legal requirements to do so. Services work better when they are designed in partnership with those who use them and those who provide them.

Under the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012 and the Health and Care Act 2022), NHS Integrated Care Boards (ICBs) and NHS England have duties to involve the public in commissioning of healthcare services. Integrated Care Boards assumed the responsibilities previously carried out by Clinical Commissioning Groups from 1st July 2022. These duties are set out under sections 14Z2 and 13Q, respectively.

The Integrated Care Board must make arrangements to secure that individuals to whom the services are being or may be provided are involved (whether by being consulted or provided with information or in other ways):

(a) in the planning of the commissioning arrangements by the group
(b) in the development and consideration of proposals by the group for changes in the commissioning arrangements where the implementation of the proposals would have an impact on the manner in which the services are delivered to the individuals or the range of health services available to them and

(c) in decisions of the group affecting the operation of the commissioning arrangements where the implementation of the decisions would (if made) have such an impact.[229]

Under section 242(1) of the NHS Act 2006, NHS Commissioners and providers (e.g. Acute Hospital trusts) are subject to similar legal duties and are required to ensure that patients and / or the public are involved in:

- The planning and provision of services.
- The development and consideration of proposals for change in the way services are provided.
- Decisions to be made by NHS organisations that affect the operation of services.

In addition, Section 244 of the NHS Act 2006 requires NHS organisations to consult with relevant Health Overview and Scrutiny Committees (HOSCs) on any proposals for a substantial development or variation of the health service the area of the Local Authority, where patients are impacted.

9.1.2 Local authority health scrutiny functions

Local authority health scrutiny functions are usually discharged through appointed Health Overview and Scrutiny Committees (HOSCs), which form part of the overall accountability and governance arrangements of local health and care systems. Through HOSCs, local authorities may review and scrutinise any matter relating to the planning, provision and operation of health services within the boundaries of the local authority. HOSCs act as a lever to improve the health of local people and serve to ensure people's needs are considered as an integral part of the commissioning, delivery and development of local health services.

Under current legislation[230], NHS bodies must consult with the appropriate local authorities where there are any proposed substantial developments or variations in the provisions of health services (substantial service reconfiguration) in the area(s) of a local authority where those services are located, or whose residents routinely access those services.

The duty to formally consult local authorities on proposed substantial service reconfigurations should also be seen within the context of, and complementary to, the overall duties for NHS bodies to involve and consult the public (see section 9.1.1 above).[231] Details of what constitutes a substantial service reconfiguration is not defined in legislation but is generally considered to involve changing how and where patients might access large scale services, alongside when services are delivered.

The approach to working with and engaging local authority HOSCs that has been adopted throughout this programme, and by the Partnership as a whole, is summarised in the table below. This framework has been used to assess and make recommendations on the appropriate level of HOSC involvement in relation to service changes in the Humber and North Yorkshire ICB area and determine the requirement for formal public consultation on the change proposals set out within this business case.

[229] Health and Social Care Act 2012, section 14z2 (Health and Social Care Act 2012)
[230] Local Authority (Public health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013
[231] More details are available in the Department of Health '*Local Authority Health Scrutiny*' guidance document: Department of Health (2014) '*Local Authority Health Scrutiny*' Local Authority Health Scrutiny

Degree of proposed service change / variation	Level of involvement
Category 4 – Substantial or Major variation or development Introduction of a new service, proposed service reconfiguration – changing how/where and when large scale services are delivered.	**Consult**
Category 3 – Significant variation or development Change in demand for specific services or modernisation of services, changing provider of existing service, pathway redesign impacting on a wide range of people	**Engage**
Category 2 – minor change Proposals made based on routine patient/service-user feedback or activity, proposal to extend or reduce opening hours	**Advise**
Category 1 – ongoing operational change Identified need for modernisation with no / minimal impact on how, where and when patients access services. Changes to support / administration services and other non-patient facing parts of a pathway.	**Inform**

Table 9.1 Levels of Local Authority involvement in development of health services

If proposing formal consultation on specific proposals, when providing formal notification of the intention to formally consult local authorities, NHS bodies must provide the:

a) Proposed date by which a decision as to whether or not to proceed with the proposal is intended to be taken; and,
b) Date by which the local authorities must provide any comments on the proposals.

Subsequently, NHS bodies must also inform local authorities of any changes to the proposed date of decision and/or the date by which the local authorities must provide any comments on the proposals. NHS bodies must also publish details of the proposed dates and any subsequent changes to those dates.

Engagement with local authority scrutiny committees has been ongoing throughout the programme (see section 3.3.3) to ensure members are regularly updated on progress and the development of the potential future models of care. Formal notification has not yet been provided to Local Authorities setting out the date for a decision to be taken, however, when this is confirmed (following approval of this business case) this action will be taken right away to ensure all legal duties are met.

9.1.2.1 Mandatory Joint Health Overview and Scrutiny Committees

Where NHS bodies plan to consult more than one local authority in relation to any specific proposed substantial service reconfiguration, the Regulations[1] also make provision for the establishment of mandatory joint health overview and scrutiny committees (JHOSC).

Where the need for a mandatory JHOSC has been identified, the identified local authorities must appoint a JHOSC for the purposes of that consultation and it is only the established JHOSC that may:

a) Make formal comments on the proposal(s) under consideration – i.e. submit a formal consultation response.
b) Require the provision of information about the proposal(s) under consideration; or
c) Require a member or employee of the relevant NHS body to attend before it to answer questions in connection with the consultation and the proposal(s) under consideration.

The programme team wrote to local authority chief executives in May 2022[232] to inform that work was underway to complete a pre-Consultation Business Case for the Humber Acute Services Programme and that it was likely that we would bring forward consultation on options for substantial service change across the Humber. It is anticipated that potential changes could impact on the services and populations within the boundaries of the following top-tier local authority areas:

- East Riding of Yorkshire Council
- Hull City Council
- Lincolnshire County Council
- North East Lincolnshire Council
- North Lincolnshire Council

The five local authorities involved have now put in place the required mechanisms to enable the Joint HOSC to be formed, either by making the necessary arrangements through Council or via existing delegated authority. A draft Terms of Reference has been developed and will be ratified at the first meeting of the committee.

9.1.2.2 Future legislative framework

The legislative framework that supports local authority health scrutiny outlined above are correct at the time of writing, however, future legislative requirements and the associated local authority health scrutiny powers may change as a result of secondary legislation and/or further guidance being issued following the passage of the Health and Care Act 2022. The role of local Health Overview and Scrutiny Committees (HOSCs) and the requirement to involve them in reconfigurations will remain part of the future legislative framework.

The Act includes new powers for the Secretary of State to intervene in local service reconfigurations. Late changes were included in the Act to limit these powers to complex and substantial changes to services and include provisions to ensure that NHS organisations and local authorities affected are consulted and place a six-month time limit by which time the Secretary of State must make a decision. There will be a phased approach to the implementation of the new health and care legislation. The proposed new Secretary of State intervention power did not commence at the same time as statutory Integrated Care Systems came into being (1st July 2022).

Further guidance is anticipated within the coming months, which is expected to include:

- New Regulations, replacing the existing health scrutiny Regulations from 2014.
- New statutory guidance directed at the Secretary of State setting out the powers to intervene, and how those powers will need to be used.
- New statutory guidance setting out more detail on health scrutiny and its powers.

Changes to the service reconfiguration process and the implementation of the new Secretary of State powers to intervene will be subject to its own separate statutory guidance / secondary legislation, with any changes unlikely to take effect until April 2023. As a programme we will keep these changes under review and response accordingly when further guidance is issued.

[232] The letter is included in the document library.

9.1.3 The Gunning Principles

Acting fairly is an important duty which applies to all public bodies. The courts have established guiding principles for what constitutes a fair consultation exercise – usually referred to as the 'Gunning' principles.

- **Consultation must take place when the proposal is still at a formative stage.**
  Meaningful consultation cannot take place on a decision that has already been made. Decision makers can consult on a single proposal or 'preferred option' (of which those being consulted should be informed) so long as they are genuinely open to influence. There is no requirement, and it would be misleading, to consult on adopting options which are not genuinely under consideration or are unrealistic or unviable – but it may be necessary to provide some information about arguable alternatives (and explain why they have been ruled out).
- **Sufficient information and reasons must be put forward for the proposal to allow for intelligent consideration and response**.
  Those being consulted should be provided with sufficient information to enable them to understand what the proposal is, the reasons for it and why it is being considered. They should be made aware of the basis on which a proposal for consultation has been considered and will be considered thereafter, including any criteria to be applied or factors to be considered. This may involve providing information about (or at least making reference to) arguable alternatives and the reasons why they are not also being considered. The level of detail provided will depend on the circumstances.
- **Adequate time must be given for consideration and response**.
  People must have enough time to properly consider and respond to the consultation. There is no automatically required timeframe within which the consultation must take place.
- **The product of consultation must be conscientiously taken into account**.
  Decision makers must properly consider what they have heard during the consultation when the ultimate decision is taken.

Through consultation, we will aim to gather a broad range of views from our local communities, service users, and partners on our proposals whilst they are still at a formative stage, to hear if they can be improved and whether people have better ideas that we might have missed. We will listen carefully to the views of our communities and local stakeholders who have an interest in health.

The decision about what changes to make to services will be made after the full public consultation has taken place and all of the information, including the feedback from the consultation has been considered by the NHS Humber and North Yorkshire Integrated Care Board in line with Gunning principle 4 *"that the product of consultation is conscientiously taken into account when finalising the decision."* [233]

[233] The Local Government Association (2019) *LGA guide to engagement* The Gunning Principles

9.2 Designing the Consultation

9.2.1 Commitment to best practice

We aim to deliver a best practice consultation, which will be founded on the commitment to inform and listen. It will be anchored against the following key sets of guidance:

- The Gunning Principles[234]
- The Consultation Institute – Consultation Charter[235]
- NHS England – Planning, assuring and delivering service change for patients[236]
- NHS England – Planning for participation.[237]

The consultation will also be assured against the government's four tests of service change:

- Strong public and patient engagement
- Consistency with current and prospective need for patient choice
- Clear, clinical evidence base
- Support for proposals from clinical commissioners

And the additional test introduced by NHS England from April 2017, requiring any proposal including plans to significantly reduce hospital bed numbers. This requires commissioners to evidence they can meet one of the following three conditions:

i. Demonstrate that sufficient alternative provision, such as increased GP or community services, is being put in place alongside or ahead of bed closures, and that the new workforce will be there to deliver it; and/or
ii. Show that specific new treatments or therapies, such as new anti-coagulation drugs used to treat strokes, will reduce specific categories of admissions; or
iii. Where a hospital has been using beds less efficiently than the national average, that it has a credible plan to improve performance without affecting patient care (for example in line with the Getting it Right First Time programme).

The Consultation will be assured by the Consultation Institute (tCI) through their comprehensive six-step Quality Assurance process to ensure it meets all required guidance and best practice.

9.2.2 Aims and objectives

The aim of the public consultation is to seek views and explore options in developing proposals for the future shape of services. The purpose of the consultation exercise will be to gather evidence of the impact of each of the potential options on individuals, groups and relevant populations, identify ideas for potential mitigations and to ensure that decision-makers are well-informed when making decisions about the future shape of services for the region.

In order to successfully deliver those core aims, the consultation will:

- Be open and accessible to all who may be impacted by the potential changes.

[234] The Local Government Association (2019) *LGA guide to engagement* The Gunning Principles
[235] The Consultation Institute (2017) 'The Consultation Charter - The 7 Best Practice Principles' tCI Charter
[236] NHS England (2018) *Planning, assuring and delivering service change for patients* NHS England Guidance
[237] NHS England (2015) *Planning for Participation* NHS England Guidance

- Be as simple as possible to complete.
- Make additional efforts to reach out to those who might be most impacted by the potential changes.
- Make additional efforts to reach out to those who might find it most difficult to engage / respond to the consultation.
- Proactively seek views from relevant statutory bodies and external experts.
- Be innovative and flexible in approach, particularly in relation to the use of alternative engagement methods (including digital and social media).
- Use evidence-based approaches to data collection, analysis and reporting.
- Meet all relevant statutory requirements.

9.2.3 Principles for communications and engagement

Our engagement to date has been underpinned by the following guiding principles for communication, engagement and consultation, established in 2018. Our commitment to these principles will continue as we enter public consultation:

- **Open –** Decision makers are accessible and ready to engage in dialogue. When information cannot be given, the reasons are explained.
- **Corporate –** The messages communicated are consistent with the aims, values and objectives of the NHS Humber and North Yorkshire Integrated Care Board and wider Partnership vision.
- **Two-way –** There are opportunities for open and honest feedback, and people have the right to contribute their ideas and opinions about issues and decisions.
- **Timely –** Information arrives at a time when it is needed, is relevant to the people receiving it, and is able to be interpreted in the correct context.
- **Clear –** Communication should be in plain English, jargon free, easy to understand and not open to interpretation.
- **Targeted –** The right messages reach the right audiences using the most appropriate methods available at the right time.
- **Credible –** Messages have real meaning; recipients can trust their content and expect to be advised of any change in circumstances which impacts on those messages.
- **Planned –** Communications are planned rather than ad-hoc and are regularly reviewed and contributed to by senior managers, and staff, as appropriate.
- **Consistent –** There are no contradictions in messages given to different groups or individuals.
- **Efficient –** Communications and the way they are delivered are fit for purpose, cost effective, within budget and delivered on time.
- **Integrated –** Internal and external communications are consistent and mutually supportive.

As public consultation progresses, we will regularly review our communications to ensure they meet the principles outlined above.

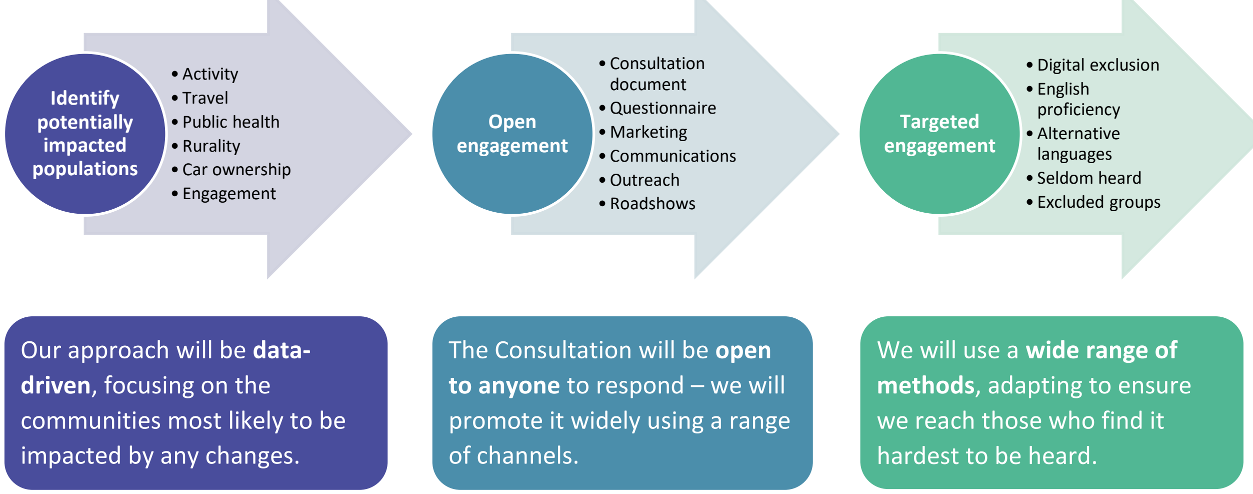
9.2.4 Co-designing our consultation plan

Our consultation plan will outline how we intend to listen to and gather insight from our local communities and partners. We will continue to use local public health data, census and other demographic information and insights gathered through pre-Consultation engagement to help us understand our population and their needs. This insight will help to ensure our consultation plan is targeted and inclusive, providing opportunities for all communities and groups who may be positively or

negatively impacted by any potential changes to how services are delivered in the Humber to get involved and provide feedback.

Our consultation plan will be co-produced with the Executive Oversight Group, Clinical leads, Citizen's Panel and Health Overview and Scrutiny Committee members (through the required Joint scrutiny arrangements), Communications and Engagement Delivery Group and VCSE Liaison Group. In particular, we will work closely with groups and trusted representatives we have built relationships with over the course of the programme and through other local partnerships with local engagement teams in place and through our Local Authority partners. This includes groups such as the Maternity Voices Partnerships who co-designed the pre-consultation engagement exercise with women and families that helped to shape the potential models of care (see sections 10.3.5.2.2 and 10.13).

The approach we will take to consultation design is outlined in the diagram below.



Our approach will be **data-driven**, focusing on the communities most likely to be impacted by any changes.

The Consultation will be **open to anyone** to respond – we will promote it widely using a range of channels.

We will use a **wide range of methods**, adapting to ensure we reach those who find it hardest to be heard.

Figure 9.1 Approach to consultation design

We will continue to test and refine the approach in ongoing engagement with stakeholders, partners and regulators.

The Consultation Institute (tCI) are undertaking a quality assurance role, reviewing and providing feedback on our plans for consultation. We will continue to develop our consultation plan by working closely with tCI, our Citizen's Panel and partners to ensure that all our statutory duties are met.

9.3 Delivering the Consultation

We are committed to ensuring information pertinent to the consultation is available, accessible, and easily interpretable for consultees to enable them to provide an informed response. We will use a range of materials and methods, both digital and non-digital, to enable local people to take part in the consultation and talk to us about our proposals.

We have learnt a lot from our early engagement and pre-consultation engagement and will ensure this learning informs our approach to consultation.

We will specifically target communities and groups of people we know to already be experiencing greater health inequalities, we will go to where people are and not expect them to come to us, and we will adapt our methods and approach to ensure everyone has an opportunity to get involved and have their say.

9.3.1 Audiences

9.3.1.1 Identifying potentially impacted populations

We will use population health data, activity data and travel impact analysis data to identify individuals, communities and groups who may be negatively or positively impacted by the proposals and different potential options for change. The detailed activity, displacement and travel impact modelling that was undertaken through the options development and evaluation (see appendix 0 and 0), combined with public health data and local areas needs assessments (see section 1.4) provide the insight needed to map different population cohorts by the extent to which they might be impacted by change against their ability to engage in the consultation.

We will undertake detailed analysis of the activity data and carry out population segmentation to identify target cohorts based on age, gender, locality, deprivation and other relevant socio-economic factors. This will shape decisions about the methods used to engage.

The approach taken to consultation will be a targeted one, reaching out to identified communities and populations through a wide variety of methods and not expecting people to come to us. This will involve working closely with and drawing upon the strong partnerships we have developed with voluntary and community sector partners to co-create opportunities for involvement within our more deprived communities. It will require us to build upon local relationships and use trusted intermediaries to reach communities who face barriers to accessing care and where mistrust or scepticism hinders our ability to reach out. We will build on our experience of working with local trusted partners (as described in section 3.2.2) and our strong links with the voluntary, community and social enterprise (VCSE) sector.

In addition, we will comprehensively map all relevant stakeholder organisations to ensure they are aware of and, where relevant, invited to respond to the consultation. This will include statutory consultees (e.g. local authorities), local organisations who may be impacted by the proposals (e.g. neighbouring trusts and Integrated Care Boards), local and national expert bodies (such as Royal Colleges and independent reviewers), key staff groups and staff-side representatives, local community groups and key public representatives.

9.3.1.2 Target audiences and key stakeholders

At a high-level, the consultation aims to engage as effectively as possible with the following groups across North Lincolnshire, North East Lincolnshire, Hull, East Riding of Yorkshire and surrounding areas –

in particular areas of East Lindsey and West Lindsey whose populations access health services within the Humber. We will determine who the relevant stakeholders are with reference to the likelihood that any changes to services will have an impact (either positive or negative) upon them.

- **Patients and service-users**
    - **Urgent and Emergency Care** – patients who have recently received emergency care, people who are likely to need emergency care in the future, the wider public and other stakeholders.
    - **Paediatrics** – children and young people, their parents, carers and guardians who are either currently receiving paediatric care, have recently received paediatric care or who are more likely to need paediatric care in the future.
- **Carers** – Paid and unpaid, including young carers.
- **Under-represented or seldom heard groups** – people living in areas of deprivation, people living with long-term conditions, people with protected characteristics, people with learning disabilities and other health inclusion groups.
- **Voluntary and community sector** – Healthwatch, local charities and patient support/representative groups.
- **Clinicians and staff** – Clinical and non-clinical staff working in primary care, secondary care, social care, mental health, commissioning, this will also include their trade unions.
- **Partners and providers** – local partners and providers of services such as ambulance trusts, community services providers and mental health providers.
- **Political stakeholders** – Joint Health Overview and Scrutiny Committee, individual Health Overview and Scrutiny Committees, Health and Wellbeing Boards, Members of Parliament and Local Councillors.
- **Media** – Local, regional and national media outlets including radio, online and newspapers, social media commentators including bloggers and vloggers.
- **Local and national government and regulators** – Yorkshire and Humber Clinical Senate, NHS England, NHS Improvement, Secretary of State.

Information will also be shared with neighbouring NHS organisations, healthcare providers, key stakeholders and interest groups in neighbouring geographical areas.

This list of stakeholders is not exhaustive, and we will continuously review the evidence we receive during the consultation to ensure we are constantly updating our stakeholder list and adapting our approach as required to allow us to target stakeholder groups effectively.

9.3.2 Consultation materials and methods

9.3.2.1 Consultation materials

Engagement materials will be accessible, informative and tailored to their intended audience to ensure consultees have 'sufficient information to give intelligent consideration'.

A detailed list of materials and timeline for production will be worked out iteratively as we co-produce the engagement plan, however, we anticipate producing the following as a minimum:

- **Consultation document** – available in online and offline versions. The document will clearly explain why we are consulting, providing enough information to enable people to fully consider the proposed options and make an informed response. Information about how to access alternative formats and additional support will also be contained within the document.
- **Consultation questionnaire** – available in online and offline versions. A structured questionnaire will be attached to the printed consultation document with a Freepost return address and also be available online.
- **Website** – we will create a microsite for the consultation, containing all the necessary information to enable people to take part in the consultation. The microsite will meet required accessibility standards and support our digital marketing strategy.
- **Infographics and/or videos** – we will use a series of creative assets to provide accessible information to the public and other stakeholders to enable them to take part in the consultation. This could include animations, explainer videos, posters and/or graphics for social media posts.

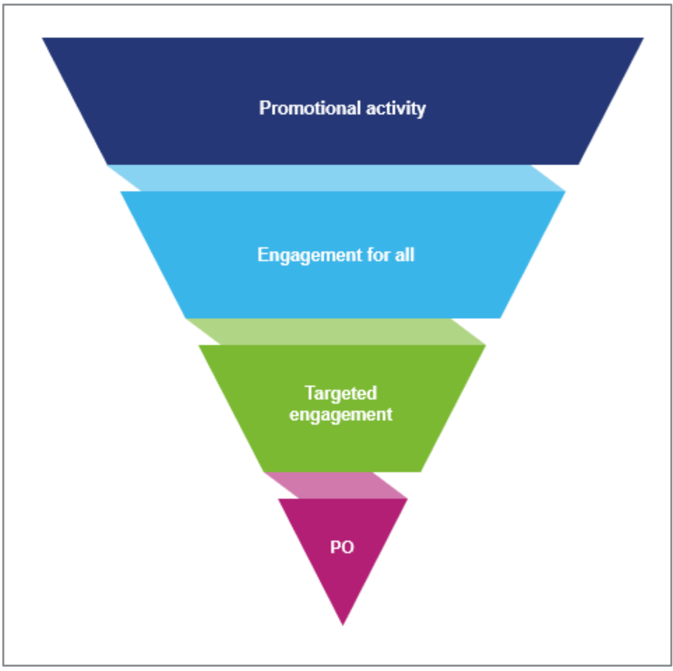
A wide range of communication channels will be supported in the lead up to and during consultation, to ensure anyone who requires support or further information can access it. This will include, as a minimum, a dedicated email address and/or web contact form, a dedicated response and enquiry telephone line (monitored during office hours) and a Freepost address.

We will use our website as an online hub and encourage people to use this as their first port of call. At the same time, we will actively seek to address digital exclusion and provide hard copies and offline materials wherever necessary. We will begin by using data to pinpoint the communities with the highest level of digital exclusion and map this against those most likely to be impacted by changes to services. Where these two populations align, we will take a targeted approach to engagement using suitable offline methods.

9.3.2.2 Engagement approach

The methods and engagement approaches used during consultation will be determined with reference to our detailed stakeholder mapping and impact assessment to ensure the methods use reach the people they need to reach.

We will adopt a tiered approach, to ensure effective targeting of priority stakeholder groups (as set out in the diagram opposite).



Picture 9:A Summary engagement approach

A detailed list of engagements and timeline for events will be worked out iteratively as we co-produce the engagement plan, however, we anticipate undertaking the following as a minimum:

- **Drop-in information sessions** – we expect to hold a number of open access drop-in events, with at least one in each major population centre/locality (Grimsby, Scunthorpe, Goole and East Lindsey). We will take advice from Healthwatch and our Citizen's Panel into account when considering venues and times to ensure we are making the sessions available for as many people as possible and not excluding them if they are all held during working hours or across school drop off times.
- **Roadshow events** – we will consider how to combine these drop-in public events with roadshow events in rural communities, partnering with GP practices, local authorities and other organisations to offer opportunities to get involved to those in rural or isolated communities. This engagement will help us to talk to people who may not have ordinarily engaged with the consultation or be aware of it at all, actively encourage them to respond to the consultation, raise awareness and continue to develop our stakeholder database.
- **Targeted listening sessions** – we anticipate holding a minimum of 10 targeted focus groups or listening events to reach specifically targeted population cohorts who we may not otherwise hear from. These sessions will be targeted at the groups most likely to be impacted by changes but where barriers exist that make it more difficult to secure their participation in the consultation through open access methods (e.g. children and young people, particular religious or ethnic minorities, people for whom English is not their first language). Where relevant, we will work with trusted partners from the voluntary and community sector, providing small grants or other support as required, to facilitate engagement with seldom heard groups. The approach taken to these groups, including the number of sessions and people involved, will be dictated by the population analysis and segmentation.
- **Staff engagement** – we will continue to engage with our workforce and providers across secondary care, primary care, social care, mental health and commissioning. We will build on the established channels developed during our pre-consultation engagement and utilise existing forums, team meetings and communication channels as well as hosting drop-in events for staff at existing hospital sites.

In addition, we will seek views on our engagement and consultation plans from the Joint Health Overview and Scrutiny Committee.

9.3.2.3 Social media approach

To support our consultation plan we will co-develop a social media strategy, which will set out our approach and commitment to communicating key messages with the public, staff and partners online. It will also set out how we will continually monitor the reach of our social media posts, record interactions and gather soft intelligence from conversations taking place online. This will allow us to adapt and target our social media presence to ensure the right people, groups and communities have access to timely, accurate information.

9.3.3 Integrated Impact Assessment

In parallel to the consultation process there are a set of detailed analyses that need to be carried out on the proposals for consultation. The Integrated Impact Assessment (IIA) provides a robust mechanism to consider and document how different changes could impact different people and different groups of

people, both positively and negatively. The IIA tool provides an assessment of impact against six different areas:

- Patient experience
- Patient safety
- Effectiveness
- Equality
- Workforce
- Sustainability

Bringing all the evidence together in this way will support decision-makers to see how different options could affect different groups. The Equalities Impact Assessment (EqIA) element considers how changes could impact on people with protected characteristics under the Equality Act 2010 – age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation. To ensure decision-makers comply with their duties under the Equality Act, the Impact Assessment (IIA) will provide a robust analysis to identify any areas where changes could have a disproportionate impact on any groups or individuals based upon one or more protected characteristic. The Integrated Impact Assessment will also look more broadly at people who face additional barriers to accessing healthcare for other reasons, such as poverty or rural isolation, to enable the ICB to show due consideration to their responsibility to reduce health inequalities. [238]

The information gathered during consultation will be used to update and refine the Integrated Impact Assessment. The outputs will be provided to JHOSC prior to finalisation of their responses to the consultation.

[238] A detailed Integrated Impact Assessment (IIA) of the proposals has been completed. See document library

9.4 Reporting and decision-making

To support the NHS Humber and North Yorkshire Integrated Care Board (ICB) to meet their responsibility to conscientiously take into account the product of consultation, a robust approach to collation, analysis and reporting will be adopted. Opinion Research Services (ORS) has been commissioned to deliver consultation design, analysis and reporting on behalf of the programme. ORS is an experienced full-service consultation design, delivery and reporting service provider with experience working on similar complex and large-scale change programmes.

ORS will be responsible for:

- Developing and delivering a suitable online and printed consultation questionnaire.
- Processing all responses, coding free-text comments to identify key themes and concerns.
- Analysing and reporting on questionnaire findings and feedback received separately to the questionnaire.
- Incorporating feedback gained from all engagement activities, e.g., focus groups, in-depth interviews, meetings, and workshops.
- Providing robust mid-point, interim (‘emerging findings’) and final reports, accessible summaries and presentations.
- Presenting overall findings to decision-makers.

Working with external, independent experts to develop and design our consultation document and questionnaire and undertake the analysis and reporting on feedback captured during the consultation will ensure a high degree of transparency and objectivity.

The consultation findings report will be presented to the Joint Health Overview and Scrutiny Committee (JHOSC) and the NHS Humber and North Yorkshire Integrated Care Board (ICB).

Following consultation, further work will be done to refine proposals covering:

- Additional analysis based on questions raised during consultation.
- Further detail on options still under consideration.
- Any additional Integrated Impact Analysis.

This analysis will be brought together in a Decision-Making Business Case (DMBC), which will be submitted to the Integrated Care Board (ICB) to enable it to make a decision on the proposals and determine a way forward for service reconfiguration for the Humber.

9.5 Plan to implement

9.5.1 Our approach to implementation planning

Detailed implementation planning cannot be undertaken until the outcome of the consultation is known and a decision is taken on which proposals, if any, should be taken forward. This section provides an overview of the proposed approach to implementing change that is anticipated; an implementation plan will be developed in full following consultation and formal decision-making.

Implementation is a key element of any programme. If implementation is not carried out correctly, not only is there a risk that the programme will not work the way it was intended, but there could be other unintended consequences, such as decreased staff morale, lack of participation or increased costs. To ensure success, implementation will be clinically led and will involve a wide range of clinical professionals from different backgrounds and organisations. Patients, carers and members of the public will also be invited to participate in the transition and implementation planning.

The first stage of planning will involve agreeing the following:

- The workstreams for this phase.
- Responsibility for undertaking the work.
- Key milestones for the planning phase.
- How the plans will be challenged and signed off.
- Evaluation review schedule.

A critical success factor for implementation will be the clear allocation of accountability and clear governance structures. Accountability for delivery will sit with the Acute Trusts (NLaG and HUTH), overseen by the Integrated Care Board (ICB) during this phase. Governance structures and decision-making arrangements will be set out in a Programme Implementation Plan. It is proposed that the governance structures established to support the development of the Pre-Consultation Business Case (see section 3.1.1) continue in place to support implementation, but that reporting is more closely aligned to the joint decision-making structures of the two Acute Trusts (as detailed in section 1.2.4).

9.5.2 Programme management arrangements

A core programme management (PMO) team will be created that will co-ordinate and oversee timelines and direction of travel. A link into each division/health group within the trusts will support the teams to lead the operationalisation themselves, ensuring good governance is adhered to. The core team will consist of an implementation SRO and Programme Director, an HR lead, a communications lead, a senior programme manager, an estates lead, a digital lead, a finance lead and an information lead. Project Managers will also be required to support implementation reaching into the clinical teams.

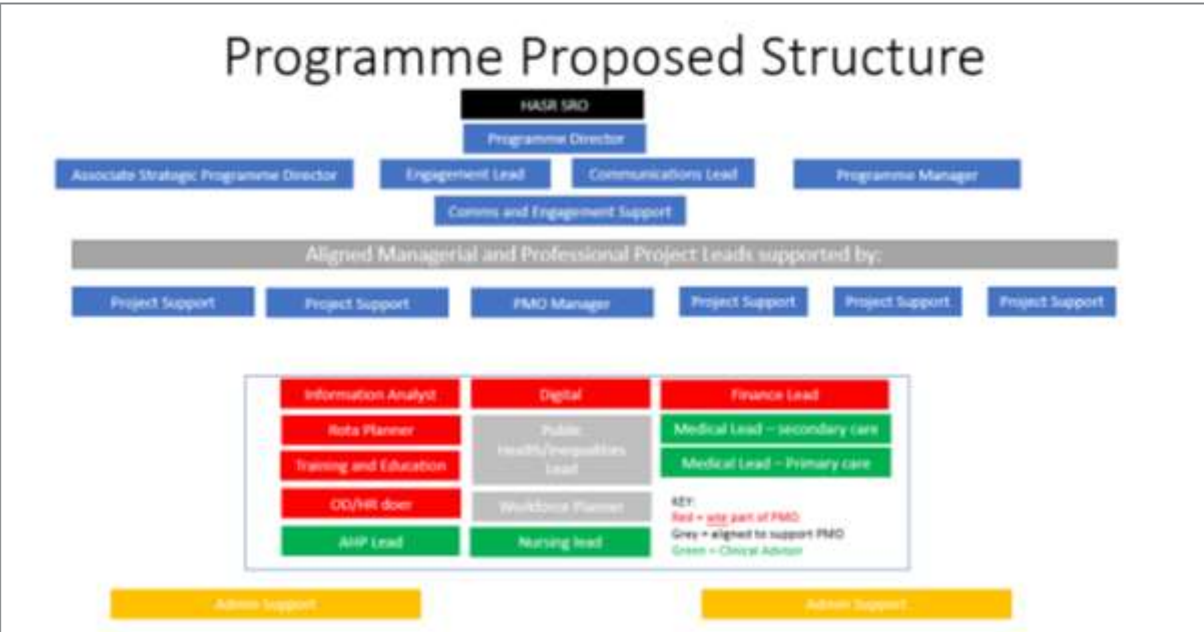


Figure 9.2 Proposed implementation team structure

The PMO will track and develop performance metrics and targets to track and manage progress against key milestones or enablers of change (e.g., reductions to acute average length of stay, increasing urgent care service throughput for displaced minors' activity from the Emergency Department, shifts in care to community settings). The implementation of changes will draw on lessons learnt from other health service changes elsewhere. Regular update reports, milestone reports and programme reports will be made available during implementation alongside financial reviews and risks/mitigation reports.

9.5.2.1 Managing risk

They will ensure a consistent approach to risk management is used across the programme. This ensures outline principles of measuring, managing and reporting risk are maintained. It provides a framework for the management of risk through rigorous governance arrangements and regular review by the Programme Board.

Key risks will be reviewed and mitigation developed in areas such as:

- Delays in implementing workforce transformation, including staff training / migration from acute to community in addition to development of new roles.
- Delays to the capital procurement process and/or lack of availability of capital to create the required changes to physical capacity across the Humber.
- Removal of training accreditation / temporary service closure due to safety concerns, impacting on the planned sequencing of service transfer.
- Risk that acute hospital services fail in advance of reconfiguration.
- Risk to recruitment and retention through ongoing poor media coverage and damage to reputation of organisations.
- Risk that changes to care outside of hospital and other critical enabling works do not deliver within the required timeframe to support implementation of acute pathway changes.

9.5.3 Workstreams

In order to develop and deliver the implementation plan a number of workstreams will need to be established. Each workstream will be responsible for planning the service transformation and

reconfiguration programme, with governance assurance under the Executive Oversight Group reporting through to the ICB, escalating any risks, issues and dependencies they are unable to resolve internally.

The workstreams currently identified as being required for the implementation planning phase include

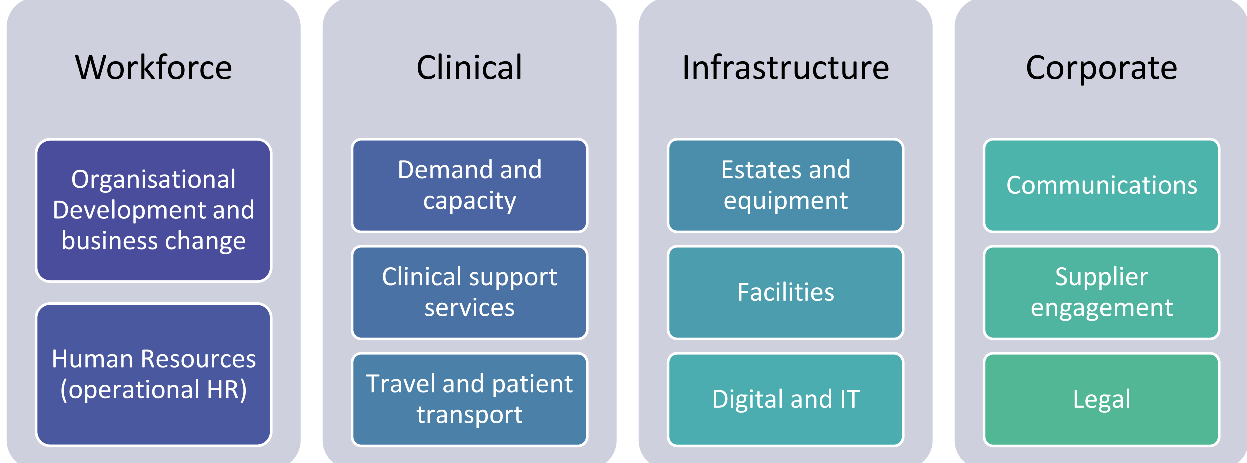


Figure 9.3 Overview of implementation workstreams

9.5.3.1 Workforce strategy

We will need to outline the approach to how staff changes during implementation will be managed. The impact on staffing numbers and structures is potentially one of the most complex areas for transition and one likely to create significant concern amongst our current workforce. Policies for staff transition will be developed and communicated effectively and regular briefings developed and communicated to all staff in those providers likely to be affected by the proposed reconfiguration.

The proposals contained within this business case involve changes to settings of care, consolidation of resources in different areas and changes to the way in which we provide services. Changes in service delivery models may mean that staff require additional training or further development of existing skills. Changes of this nature would have an impact on the workforce in the Humber, including:

- A requirement for training / recruitment to develop new skills within the local health economy.
- A requirement for staff to move to work on different sites and potentially for different employers.
- Changes in the overall mix of skills / grades required across different settings of care.
- Improved integrated working across organisational boundaries, including closer working between health and social care.
- New roles development, such as care coordinators, urgent care practitioners, specialist community nursing, intermediate care clinicians and senior clinical leaders for community care.
- Greater number of roles requiring rotation between acute and community settings.

To support implementation, therefore, a number of key workstreams would be required to support these transitions and the new workforce models proposed in this business case.

The Organisational Development (OD) and business change workstream will be critical in supporting the clinical workstreams to make the necessary workforce transformation. We will need to continue to actively engage staff as stakeholders during implementation. To build awareness of the reconfiguration proposals and to consider and promote their central role in making these changes happen.

The Implementation Plan will also need to detail the approach to how staff changes during Implementation will be managed. A robust approach to HR change will be required and supported by sufficiently resourced operational HR team. Preparatory activities will include collecting complete data about existing staff in the areas likely to be affected, including their current terms and conditions, lengths of service. This information will be needed for any staff that may be transferred under the TUPE process to other organisations if a service is to be transferred, or for staff asking to retire early as part of the process. Policies for staff transition will need to be developed and communicated effectively.

9.5.3.2 Clinical workstreams

Clinicians will need to be actively involved in the planning and implementation of service change to ensure patient safety is not compromised as changes are made. There will be a range of **clinical workstreams** to focus on the service changes needed. These will be agreed when the implementation plan is being prepared, and are currently identified as Urgent and Emergency Care, Paediatrics and Planned Care. In order to plan effectively these groups will need to be broken down into specialties to understand the granular detail of proposed changes to services (a full list of specialty working groups will be developed at the implementation planning phase).

Further work will be required to review, test and assure assumptions around **demand and capacity**. Detailed confirmation and assurance on the forecasted demand will be undertaken for the service option selected following consultation to ensure capacity (in terms of workforce, beds, chairs, etc.) will meet future demand.

Changes in service configuration will have implications for the provision of **clinical support services** including diagnostics, theatres, clinical administration and similar. A dedicated workstream will be established to ensure these important interdependencies are considered.

Depending on the option selected and feedback gathered through consultation, there be additional action needed to change or enhance **transport options**, including public transport, patient transport and blue light services. This will require coordination with key stakeholders including Local Authorities, patient transport providers, the voluntary sector, and ambulance services.

9.5.3.3 Infrastructure

Ensuring the required infrastructure and resources are in place to implement the chosen service model and clinical changes will be an extremely important aspect of implementation.

Estates planning will be undertaken in detail prior to the implementation phase so that lead-in times for changes to configurations are properly understood and the full scope of activities are built into the implementation plan (design, planning, defining and awarding contracts, oversight of delivery, commissioning the new/ refurbished buildings, completion and snagging). There will also be elements of the estate that may become redundant and need to be closed down and disposed of. The planning for this workstream will include planning for the management of transition (when facilities may be temporarily re-used) as well as investment/divestment of existing premises to reach the desired end state.

Alongside future estates planning, **facilities management planning** will be undertaken to ensure implications of any changes to configuration for the facilities needed in the hospitals – such as cleaning, catering, ICT – are fully understood and planned for.

Detailed planning will also be undertaken with **digital and informatics** teams to ensure all the enabling works identified within this business case can be delivered to enable the clinical changes to be put in

place. This will include reviewing the enabling works following decision-making to confirm the digital requirements to support the new models of care. Physical transfer and implementation of supporting IT infrastructure will also form a key part of the implementation plan.

9.5.3.4 Corporate support

A range of other supporting workstreams will also be required to ensure the implementation plan considers all potential areas of risk and can deliver change successfully within the required timeframe.

Communications and media handling activities will be critical during implementation. It will be key to ensuring that communications are continued during the planning phase – to maintain engagement, particularly with clinicians, and ensuring that there is a coherent communications plan in place to underpin implementation.

There will also need to be a workstream that focuses on engagement with existing **external suppliers**. This will need to include collecting information on relationships and contracts with external suppliers so that services are not compromised during the transition. The relationships will consequently need to be managed to ensure that contracts can be extended if required to maintain safe delivery of services during transition and to keep suppliers informed of future opportunities.

Legal work will contribute across the workstreams, but is identified as a separate workstream, as the programme will need to call on legal resources throughout the process.

Workstreams will report through the PMO and programme governance arrangements and reviewed regularly to ensure the infrastructure is in place to deliver the changes that are agreed upon following consultation.

9.5.4 Timeline and next steps

A detailed timeline for implementation will be produced as part of the Decision-Making Business Case (DMBC), when it is clearer what specific changes will be implemented and what the required enabling projects will be. At this stage, an indicative timeline has been developed, that will be subject to review at DMBC stage.

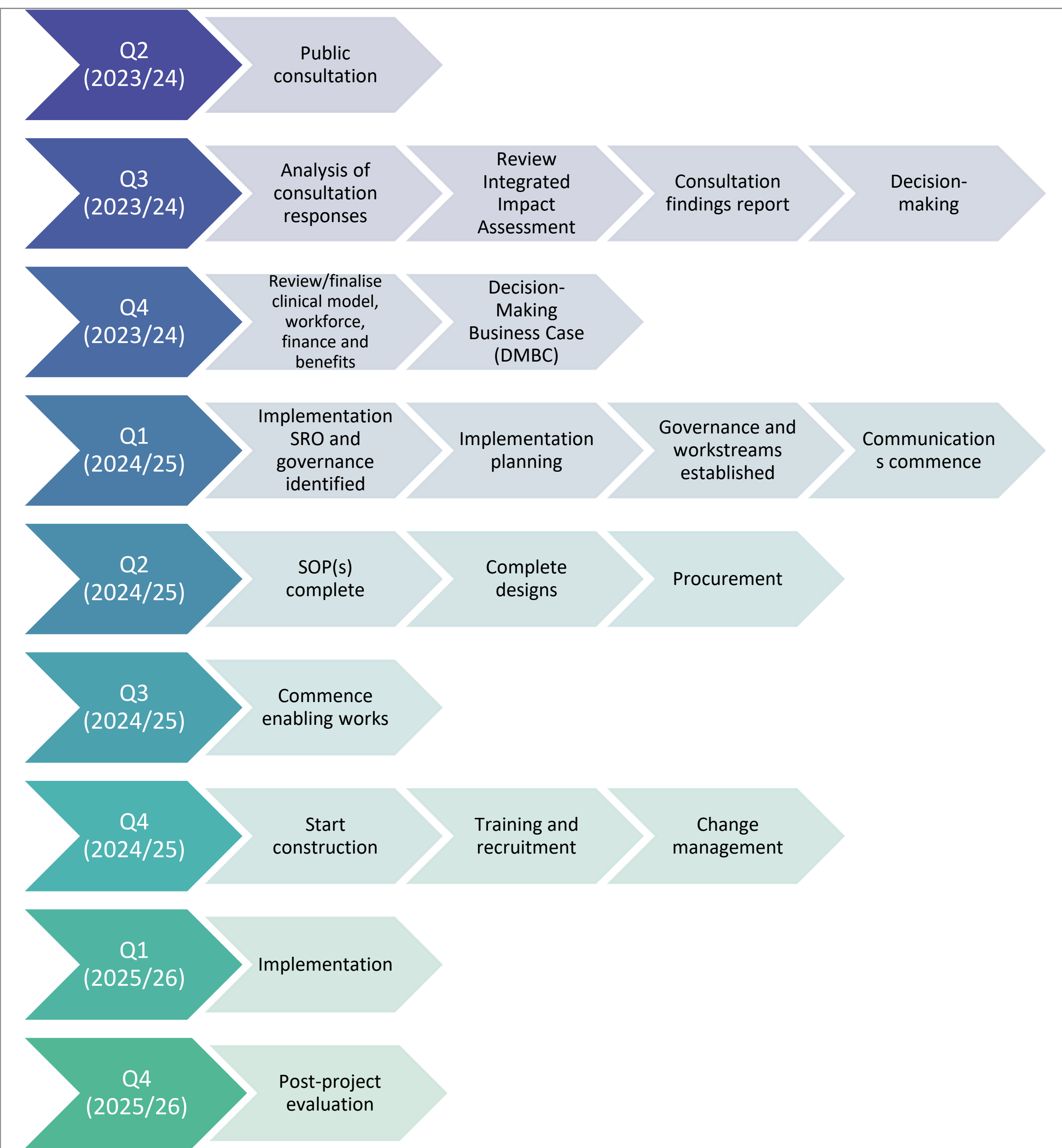


Figure 9.4 Indicative timeline for implementation

Potential changes may be phased over a period of time and therefore not all elements of the change proposals would be implemented according to the milestones set out below. The detailed phasing of projects will be described within the implementation plan when it is developed.

We want to continue to provide the best care for those living in our region and invest in the many specialist services our hospitals provide. As a collective of hospitals working better, together, we can provide improved services and care for all. But to do so, **things need to change**.

Our health and care system is facing unprecedented challenges. We face chronic shortages of doctors, nurses and hospital support staff. We can’t recruit enough new staff or support our existing staff to keep up with the specialist skills required to provide the quality and safety you deserve.

Sitting back and doing nothing is not an option.

The proposals set out within this business case will help us to improve **recruitment and retention**, reduce the burden on our current staff and reduce how much we spend on expensive agency staff, deliver high quality clinical **care**, **reduce waiting times** by providing more efficient services and provide more care at home or **close to home**.

Public consultation will support good decision-making by providing a clearer understanding of the potential impacts of each of the different options for change.

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A. Background Information

10.1 List of Health and Care Organisations in Humber

Primary Care Networks	***North East Lincolnshire***	Freshney Pelham
		Meridian Health Group
		Panacea
		Apollo
		Genesis
	North Lincolnshire	East Care Network
		South Care Network
		West Care Network
		North Care Network
	Hull	Hull Association of Similar Practices (HASP)
		Haxby
		Marmot
		Medicas
		Modality
		Symphonie
		Venn
	East Riding of Yorkshire	Beverley
		Bridlington
		Cygnet
		Harthill
		Holderness
		River and Wolds
		Yorkshire Coast and Wolds
Community Services Providers		Care Plus Group
		NLaG - Community Health Services
		City Healthcare Partnership (CHCP)
		Lincolnshire Community Health Services NHS Trust
Mental Health Providers		Navigo CiC
		Rotherham Doncaster and South Humber NHS Foundation Trust
		Humber Teaching NHS Foundation Trust
		Lincolnshire Partnership NHS Foundation Trust
Ambulance Trusts		East Midlands Ambulance Service NHS Trust
		Yorkshire Ambulance Service NHS Trust
Social Care Providers, supported by Local Authorities		North East Lincolnshire Council
		North Lincolnshire Council

	Hull City Council
	East Riding of Yorkshire Council
	Lincolnshire County Council
Secondary Care Partners	Sheffield Teaching Hospitals NHS Foundation Trust
	York and Scarborough Teaching Hospitals NHS Foundation Trust
	United Lincolnshire Hospitals NHS Trust
	Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust
	Sheffield Children's NHS Foundation Trust
	Leeds Teaching Hospitals NHS Trust
Voluntary and community sector partners	A wide range of partners supporting people and communities across the Humber (an estimated 13,500 registered and unregistered groups across Humber and North Yorkshire)
Commissioners	NHS Humber and North Yorkshire Integrated Care Board (ICB)
Neighbouring Systems	NHS Lincolnshire Integrated Care Board (ICB)
	NHS South Yorkshire Integrated Care Board (ICB)
Place-based partnerships *incorporating many of the organisations listed above*	North East Lincolnshire Place Board
	North Lincolnshire Place Board
	Hull Place Board
	East Riding of Yorkshire Place Board

10.2 Current Service Configuration

10.2.1 Service provision by site

Specialty	Hull Royal Infirmary (HRI)	Castle Hill Hospital (CHH)	Diana Princess of Wales Hospital (DPoW)	Scunthorpe General Hospital (SGH)	Goole District Hospital (GDH)
Emergency Department	✓		✓	✓	
Acute Medicine	✓		✓	✓	
Cardiology	Diagnostics	✓	✓	✓	Outpatients
Respiratory	✓	Outpatients	✓	✓	Outpatients
Gastroenterology	✓		✓	✓	Outpatients
Elderly Care/Geriatric Care	✓		✓	✓	Outpatients
Stroke	Hyperacute Stroke Unit		Rehabilitation	Hyperacute Stroke Unit	Rehabilitation
Endocrinology	✓		✓	✓	Outpatients
Dermatology		✓	✓	✓	✓
Neurology	✓		✓	✓	
Oncology/Haematology		✓	✓	Day care/outpatients	
Rheumatology	✓	Outpatients	✓	✓	Outpatients
Renal Service	✓	✓	✓ (led by Hull)	✓ (led by Hull)	
Critical care	✓	✓	✓	✓	
General Surgery	✓	✓	✓	✓	✓
Colorectal		✓	✓	✓	Outpatients
Upper GI	Day case/outpatients	✓	✓	✓	
Urology	Outpatients	✓	✓	✓	✓
Trauma	Major Trauma		✓	✓	
Orthopaedics	✓	✓	✓	✓	✓
Ophthalmology	✓	day case only	✓	✓	✓

ENT/Audiology	✓	✓	✓	Day case/outpatients	Outpatients
Oral Maxillofacial		✓	✓	✓	Outpatients
Breast Surgery		✓	✓	✓	
Gynaecology	✓	✓	✓	✓	✓
Gynaecology Oncology	✓	✓	✓	✓	
Anaesthetics	✓	✓	✓	✓	✓
Endoscopy	✓	✓	✓	✓	
Cardiac Surgery		✓	Outpatients	Outpatients	
Thoracic Surgery		✓	Outpatients	Outpatients	
Neurosurgery	✓			Outpatients	
Plastic Surgery		✓			
Vascular Surgery	✓				
Maternity	✓		✓	✓	Outpatients/birthing unit
Neonatal	✓		✓	✓	
Paediatrics Medicine	✓		✓	✓	Outpatients
Paediatric Surgery	✓				
Radiology/diagnostics	✓	✓	✓	✓	✓
Complex Rehabilitation		✓			✓
Infectious Diseases		✓			
Immunology	✓	Outpatients	Outpatients	Outpatients	Outpatients
Allergy		Outpatients			

Table 10.1 Service provision by hospital site (HUTH and NLaG)

B. Process – how we developed the proposals

10.3 Developing the potential models of care

10.3.1 Timeline and Approach

In line with the Humber Acute Services principles established at the outset of the programme, the development of solutions has been clinically-led and evidence-based. A wide range of stakeholders have been involved in shaping the potential models of care set out in this document.

The diagram below sets out the approach that has been taken to developing the models of care and potential options for change. This has been an iterative and dynamic process to ensure multiple stakeholders have had the opportunity to be involved and to help shape the outputs of the process. As new information and insight has been gathered, the models under consideration have been adapted, new models have been added and other models have been discounted at various stages.

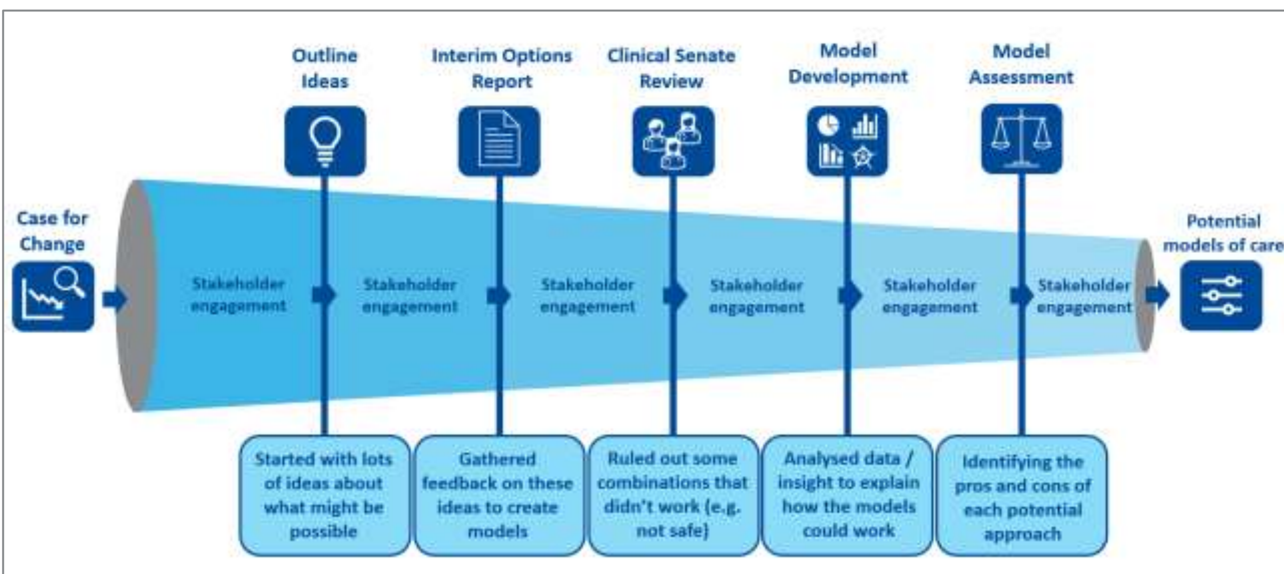


Figure 10.1 Process to develop potential models of care

10.3.2 Developing Outline Ideas (July to Nov 2019)

From July to November 2019 clinical, public and stakeholder engagement was undertaken to clarify current challenges (which were documented in the Case for Change) and identify outline ideas that might address those challenges across the three core service areas or 'building blocks' of hospital services:

- Urgent and Emergency Care
- Maternity and Paediatrics
- Planned Care

Some early concepts came through stakeholder engagement including during the first round of clinical design sub-group workshops for each service area and the Case for Change research. Other models of care (from other parts of the UK and beyond) that could help address the challenges identified in the Humber area were reviewed and used to generate outline ideas for wider testing. These possible approaches were displayed along a continuum from least to most change and covered a wide range of possible service configurations across the Humber region. These outline ideas were discussed with

clinical representatives across both trusts, Clinical Commissioning Groups (CCGs) and other health and care partners and shared with patients and their representatives at a series of open events.

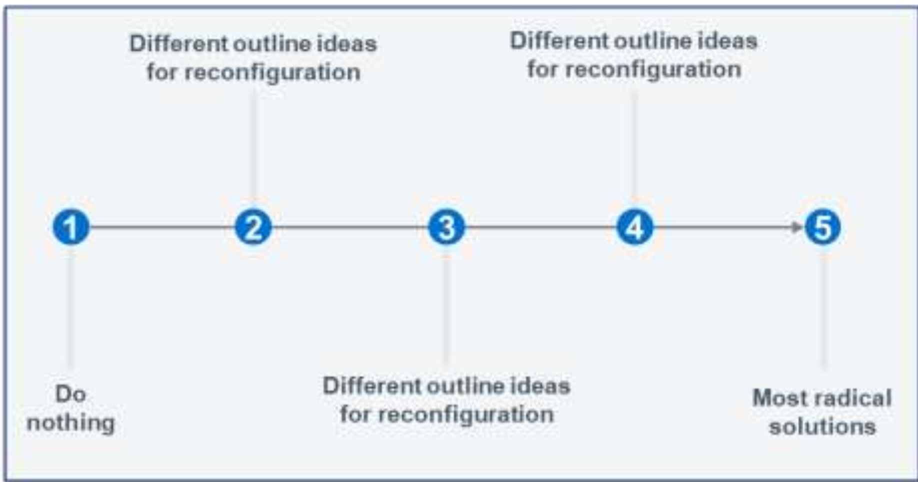


Figure 10.2 Approach to developing early ideas[239]

10.3.2.1 Clinical Engagement

Two rounds of clinical design workshops occurred (between August and October 2019) and were well attended with clinical and operational representation from our health and care partnerships and organisational members across both trusts as well as the stakeholders such as Humber, Coast and Vale Health and Care Partnership's clinical and professional leads, Clinical Commissioning Groups (CCGs) and Ambulance Trusts. These workshops highlighted concerns and potential solutions, which in turn shaped the clinical models that were developed. The following provides a snapshot of these suggestions and ideas and how they shaped the potential models of care considered.

Challenges identified	Ideas suggested	Action taken/impact
Small specialties are difficult to sustain	use hub and spoke models to deliver care throughout the region	inform planned care potential models
Insufficient doctors to run the services as we would like	concentrate obstetric-led care in NLaG onto one site	inform MNP potential models
	invest in upskilling current staff in UEC	inform UEC potential models and workforce planning
Split site working can be inefficient	consolidate NLaG inpatient paediatric care on one site, with PAU at other site	inform MNP potential models
	move to Hot/Cold site models to reduce duplication of out of hours staffing	inform UEC, MNP and planned care potential models
Meeting national standards is currently challenging	develop planned care 'Centres of Excellence'	inform planned care potential models
	improve Surgical Assessment Unit (SAU) to bypass ED	inform UEC potential models

[239] *Interim Options Report* (January 2020) – see document library

Both Trusts have high backlog maintenance lists	build a new hospital	inform capital investment plans *(SOC in development)*
	invest in estates	
It's difficult to recruit staff	joint contracts and recruitment across the Humber	*work in progress*
Limited digital maturity	joint digital solutions – providing access to notes between the trusts	*work in progress*
	develop digital outpatient software to reduce face-to-face	*work in progress/build on implementation through COVID-19*
Rural population and distances between hospitals is a challenge for staff and patients	improve hospital transport links	*work in progress* – transport group established (see section 8.4)

***Table 10.2 Summary of clinical engagement on early ideas*[240]**

10.3.2.2 Public engagement

In parallel, a series of public workshops took place (throughout October 2019), to enable service-users and members of the public to feed into the development of the long-list of potential models of care. The events took place in various locations across the Humber area in accessible venues and were attended by a total of 77 people (excluding facilitators).

This engagement provided rich insight and a range of perspectives in relation to the different ideas and whether they would have a positive or negative effect on them and their families. Some of the key themes that emerged were:

- **Quality and safe services –** the thing that was most important to most people was getting good quality and safe care and having the best possible chance of getting well.
- **The right workforce –** participants recognised the pressures on staff and identified opportunities to develop and make the best use of staff.
- **Access and travel** – many participants said they were willing to travel further, particularly to access specialist services, however, raised concerns about the impact for people living far away. Using technology (including telephone) to reduce the need for people to travel to hospital was suggested.
- **Digital technology –** participants had ideas such as increasing the use of virtual consultations to reduce travel; improving information sharing (e.g. health records) and using technology to provide better information (e.g. live waiting times).
- **Give patients more information and knowledge –** recent patients were eager for hospitals to manage their expectations around waiting times and get slicker at communicating with them.

The following provides a snapshot of key ideas that were used to help shape the long list of potential models – a full write-up of responses is provided in the feedback report.[241]

[240] *Interim Options Report* (January 2020) – see document library
[241] Humber, Coast and Vale Health and Care Partnership (2019) *Hospital Services for the future – Patient Workshop Feedback Report* Feedback Report

Challenges identified	Ideas suggested	Action taken/impact
Hospital waiting times are too long	We are willing to travel further if we know we are getting the highest quality care	inform planned care potential models
Lengthy travel times is a huge issue for patients	Invest in better patient transport	*work in progress* – transport group established (see section 8.4)
	Work with local authority to improve transport infrastructure	
	Technology could be used for video consultations to save patients travelling and consultants time	inform planned care potential models (high volume services close to home)
Workforce shortages	Having centres of excellence would make the roles more appealing and attract more staff	inform potential models
	appoint staff to the whole Humber region not just a particular hospital	*work in progress (ongoing)*
	upskilling staff and allowing them training and development opportunities would help retain them	inform workforce plan
Multiple sites won't solve the staffing issue	Build a purpose-built centre on the south bank, somewhere near Brigg or Barnetby Top to provide an equitable service	inform UEC/MNP potential models of care
Communication is poor	Improve information to patients about what services are available	*work in progress (ongoing)*
Continuity of carer is not available everywhere – feels like a postcode lottery	Implement continuity of carer in maternity services across the region	inform MNP potential models of care

***Table 10.3 Summary of public engagement on early ideas*[242]**

At the workshops (both clinical and public facing), participants provided detailed feedback on the strengths and weaknesses of the different clinical models that were set out in the sessions. This feedback has been incorporated into our evaluation process alongside more recent feedback on advantages and disadvantages of the different clinical models (see section 10.4).

There are a number of ways in which this involvement influenced thinking, as highlighted above. In particular, we have responded to the perspectives shared on travel and access (and continued to engage on this topic to gather more views from more people). In designing how any potential future models of care are implemented, a critical success factor will be thinking about the accessibility of services in the round. This includes thinking differently about the location of one-off treatments versus locations for ongoing and follow-up care. The insights gained in relation to workforce have helped to shape our workforce strategy (see section 8.3.4), in particular, building on the support of local people to market our region and work to encourage more young people into careers in health and care.

[242] *Interim Options Report* (January 2020) – see document library

10.3.3 Developing a Long List – Interim Options Report (Nov 2019 to Jan 2020)

Drawing on evidence from elsewhere in the UK and beyond, the outline ideas gathered through the workshops were refined to develop a set of potential models of care for consideration. These focused initially on models of care for acute services (Urgent and Emergency Care, Maternity, Neonatal and Paediatrics) with the intention of incorporating further work in respect of Planned Care later in the programme. The process undertaken to develop these potential models of care is detailed in the Interim Options Report (January 2020)[243] and summarised briefly below.

Potential models of care for urgent and emergency care and maternity, neonatal and paediatrics varied from 'do nothing', to differentiation of services between the two south bank hospital sites (providing a particular range of services on one site and a different range of services on the other), to development of a new single site either for the whole of the Humber or for the south bank only.

Stakeholder feedback was used to refine the service models to those that were most workable and had the potential to address the challenges identified in the case for change. This process is documented in the Interim Options Report.[244]

Led by the Clinical Design Group, the interdependencies of clinical specialties, specifically within the Humber area, were considered. Developing a comprehensive view of the clinical interdepedecies as they apply to the local area was an important step in refining the potential models of care and enabling some combinations to be ruled out. A detailed matrix of clinical interdependencies, and how they were arrived at, is set out in the Interim Options Report.[245]

Exploring clinical interdependencies at the workshops demonstrated that the greatest number related to services that were required to be co-located in order to support Urgent and Emergency Care provision. Three high-level service models for Urgent and Emergency Care were identified:

1. **Acute Care Hubs** at each of any of the current Emergency Departments
2. **Hot-Warm**: One NLaG site provides a wider range of inpatient acute services, the other NLaG site provides a 'local emergency hospital' model
3. **Hot-Cold**: One NLaG site provides all inpatient acute services, the other NLaG site has an Urgent Treatment Centre[246]

In addition, Maternity and Paediatrics services have strong interdependencies with neonatal care and when combined this created six site-agnostic combinations or high-level service models for maternity, neonatal care and paediatrics.

1. **NICU differentiation + Hot-Warm paeds**: One NLaG site with an OLU with level 2 neonatal care and acute paediatric service, the other NLaG site with an OLU and level 1 neonatal care and paediatric assessment unit
2. **NICU differentiation + Hot-Cold paeds**: One NLaG site with an OLU with level 2 neonatal care and acute paediatric service, the other NLaG site with an OLU and level 1 neonatal care (no acute paediatric services)

[243] *Interim Options Report* (January 2020) – see document library
[244] *Interim Options Report* (January 2020) pp. 31-37 – see document library
[245] *Interim Options Report* (January 2020) pp. 39-43– see document library
[246] As the models have been developed further, this model has been amended such that the Urgent Treatment Centre/ Urgent Care Service (UTC/UCS) could be provided at the hospital site or in another location within the same town.

3. **Hot-Warm maternity + Hot-Warm paeds**: One NLaG site with an OLU with level 2 neonatal care and acute paediatric service, the other NLaG site with an standalone MLU, level 1 neonatal care and paediatric assessment unit
4. **Hot-Warm maternity + Hot-Cold paeds**: One NLaG site with an OLU with level 2 neonatal care and acute paediatric service, the other NLaG site with an standalone MLU (no acute paediatric services)
5. **Hot-Cold maternity + Hot-Warm paeds**: One NLaG site with an OLU with level 2 neonatal care and acute paediatric service, the other NLaG site with a paediatric assessment unit (no facilities for births)
6. **Hot-Cold maternity + Hot-Cold paeds**: One NLaG site with an OLU with level 2 neonatal care and acute paediatric service, the other NLaG site with no acute paediatric services and no facilities for births

Bringing together potential models of care for Urgent and Emergency Care, Maternity (including neonatal care) and Paediatrics generated a matrix with 18 possible high-level combinations. Each combination had up to eight theoretically possible variants when applied to the specific sites across the Humber, which meant at this stage there were a **total of 120 potential variants** to be considered.

Checks of the extent to which models were considered sufficient to address the challenges set out in the Case for Change, and were compatible when configured on a site together, identified those service models that warranted further detailed consideration.

This produced a preliminary list of 12 high level site-specific variants as set out in the diagram below, which were explored through a number of further engagement events.

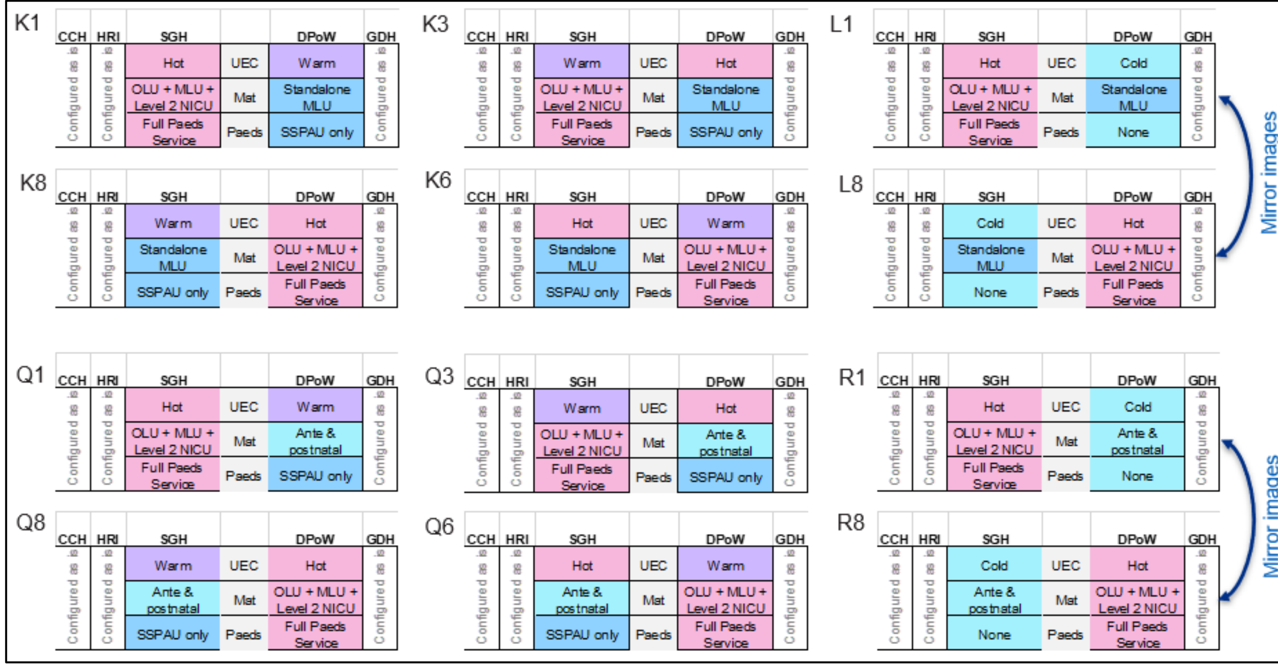


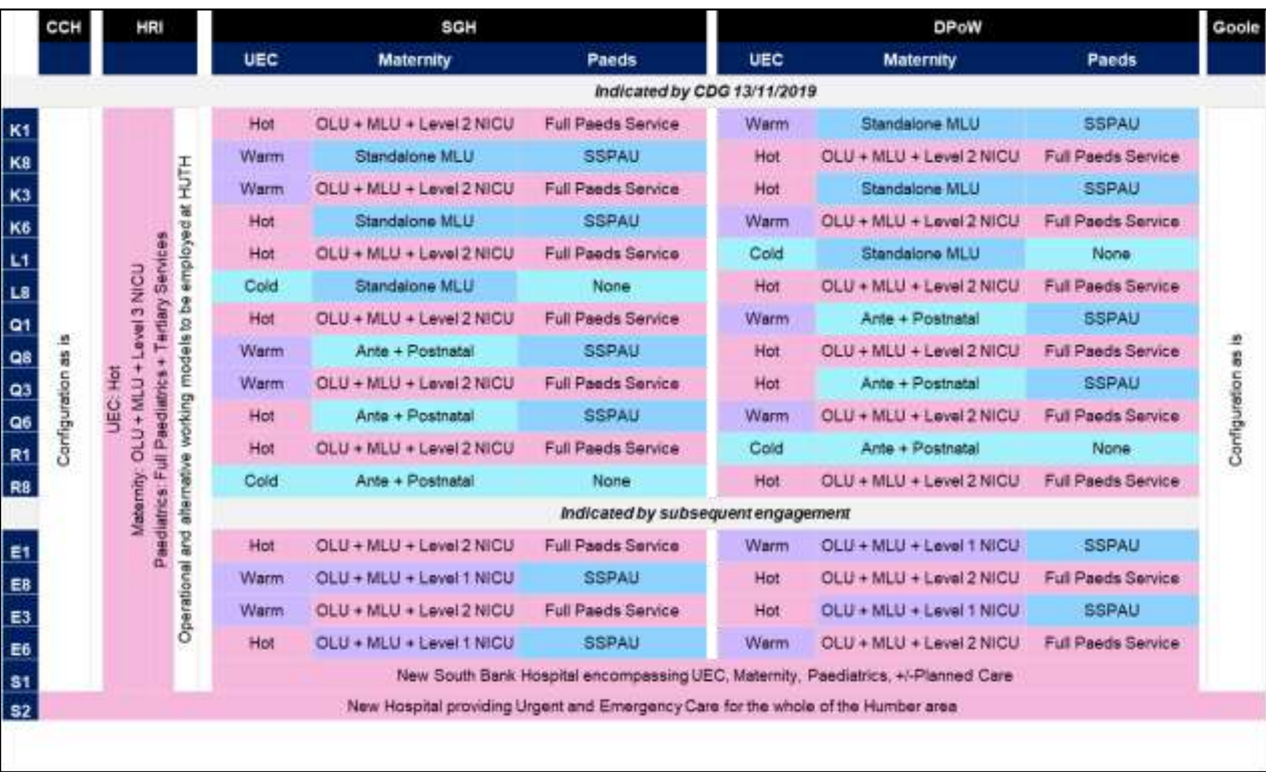
Figure 10.3 Preliminary Long List (12 site-specific variants) [247]

[247] *Interim Options Report* (January 2020) p.59 – see document library

Further engagement[248] resulted in three additional models being added to the long list for further consideration. These were:

1. Continuing to consider the idea of a **new hospital for the South bank**, in principle at a yet to be determined location somewhere between Scunthorpe and Grimsby.
2. Continuing to consider the idea of a **new hospital for Urgent and Emergency Care for the whole of Humber**.
3. Continuing to consider a **Maternity Service Model** which involves the differentiation of neonatal care (Level 2 at one site, Level 1 at the other) at two Obstetric-Led Units on the NLaG sites.

As a result, an additional six variants were added, making a final "long list" of 18 potential models of care for modelling and assessment, as set out in the diagram below:



	CCH	HRI	SGH			DPoW			Goole
			UEC	Maternity	Paeds	UEC	Maternity	Paeds	
	Indicated by CDG 13/11/2019								
K1	Configuration as is	UEC: Hot; Maternity: OLU + MLU + Level 3 NICU; Paediatrics: Full Paediatrics + Tertiary Services; Operational and alternative working models to be employed at HUTH	Hot	OLU + MLU + Level 2 NICU	Full Paeds Service	Warm	Standalone MLU	SSPAU	Configuration as is
K8			Warm	Standalone MLU	SSPAU	Hot	OLU + MLU + Level 2 NICU	Full Paeds Service	
K3			Warm	OLU + MLU + Level 2 NICU	Full Paeds Service	Hot	Standalone MLU	SSPAU	
K6			Hot	Standalone MLU	SSPAU	Warm	OLU + MLU + Level 2 NICU	Full Paeds Service	
L1			Hot	OLU + MLU + Level 2 NICU	Full Paeds Service	Cold	Standalone MLU	None	
L8			Cold	Standalone MLU	None	Hot	OLU + MLU + Level 2 NICU	Full Paeds Service	
Q1			Hot	OLU + MLU + Level 2 NICU	Full Paeds Service	Warm	Ante + Postnatal	SSPAU	
Q8			Warm	Ante + Postnatal	SSPAU	Hot	OLU + MLU + Level 2 NICU	Full Paeds Service	
Q3			Warm	OLU + MLU + Level 2 NICU	Full Paeds Service	Hot	Ante + Postnatal	SSPAU	
Q6			Hot	Ante + Postnatal	SSPAU	Warm	OLU + MLU + Level 2 NICU	Full Paeds Service	
R1			Hot	OLU + MLU + Level 2 NICU	Full Paeds Service	Cold	Ante + Postnatal	None	
R8			Cold	Ante + Postnatal	None	Hot	OLU + MLU + Level 2 NICU	Full Paeds Service	
	Indicated by subsequent engagement								
E1			Hot	OLU + MLU + Level 2 NICU	Full Paeds Service	Warm	OLU + MLU + Level 1 NICU	SSPAU	
E8			Warm	OLU + MLU + Level 1 NICU	SSPAU	Hot	OLU + MLU + Level 2 NICU	Full Paeds Service	
E3			Warm	OLU + MLU + Level 2 NICU	Full Paeds Service	Hot	OLU + MLU + Level 1 NICU	SSPAU	
E6			Hot	OLU + MLU + Level 1 NICU	SSPAU	Warm	OLU + MLU + Level 2 NICU	Full Paeds Service	
S1			New South Bank Hospital encompassing UEC, Maternity, Paediatrics, +/-Planned Care						
S2	New Hospital providing Urgent and Emergency Care for the whole of the Humber area								

Figure 10.4 Final long list (18 site specific variations)[249]

This "longlist" underwent its first evaluation on 16th December 2019, details of which are contained within the Interim Options Report.[250] Following this early evaluation, the Yorkshire and Humber Clinical Senate was asked to review the work to date and provide recommendations on the next steps.

10.3.4 Clinical Senate Review (Jan to March 2020)

The Interim Options Report was agreed by the Executive Oversight Group in January 2020. The work was also subject to a review by the Yorkshire and Humber Clinical Senate in early 2020. Supporting documentation was shared with the Senate and distributed to the clinical panel in mid-November (2019), prior to a site visit, which took place on 17th January 2020. The Clinical Senate was asked to

[248] This included clinical engagement events on 13th and 14th November 2019 at Northern Lincolnshire and Goole NHS Foundation Trust (NLaG), an Urgent and Emergency Care engagement event at Hull University Teaching Hospitals NHS Trust (HUTH) on 25th November 2019 and a Citizen's Panel meeting on 21st November 2019.
[249] *Interim Options Report* (January 2020) p.68 – see document library
[250] *Interim Options Report* (January 2020) pp. 85-99 – see document library

provide an independent clinical assessment of whether the potential models of care currently under consideration were clinically feasible and sustainable given the volumes of activity, case mix, local health needs and constraints presented in the case for change and whether any other models or combinations thereof should be actively considered.

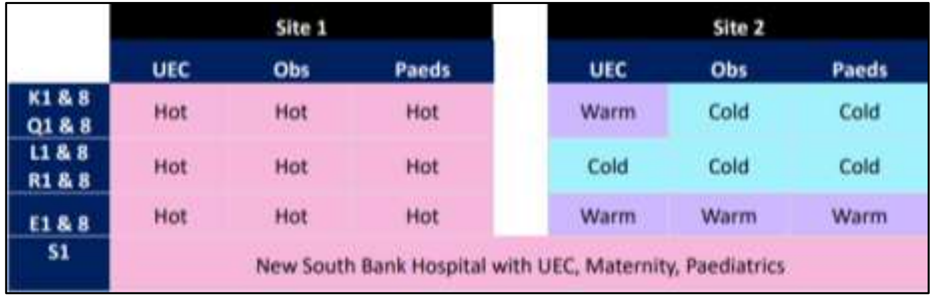
The recommendations of the Clinical Senate following that review are set out in detail in the report.[251] A number of these have already been taken up and implementation is underway, for example, the recommendation to improve compatibility of IT between the two trusts. Other recommendations were instrumental in moving from a long list of high-level models to workable models of care, as set out in this document. Notably, the Senate recommended:

- reducing the number of options under consideration as rapidly as possible in order to maintain momentum and allow the development of detailed proposals.
- working with neighbouring health economies to understand the impact of any changes.
- focusing options development for Urgent and Emergency Care in Northern Lincolnshire on exploring a two-site model of an acute site and a less acute site.
- putting in place a number of specific actions/mitigations in relation to maternity, neonatal and paediatric services.

Following the Clinical Senate review, the Clinical Design Group met in February 2020 to review the 18 potential models of care currently under consideration and, following the advice of the Clinical Senate, worked to reduce these to a more manageable number to allow for the development of detailed proposals.

The Clinical Design Group agreed not to do any further development of the model for a single Humber-wide urgent and emergency care hospital. It was not considered to be a viable clinical model because on-site essential clinical services would not be available in order to deliver a safe service. Specifically, it was highlighted by the Clinical Design Group that it would not be possible under this model to safely provide paediatric services and obstetric-led maternity services on the existing hospital sites which would effectively have a 'Cold' urgent and emergency care offer under this model. In addition, it was noted that the model would potentially clash with other services (not in scope) such as major trauma and tertiary services, which would require those regional services to co-locate to the new Humber-wide centre, having a knock-on effect on services that are out of scope of the programme.

Further application by the Clinical Design Group of clinical interdependencies – between urgent and emergency care services and maternity, neonatal and paediatric services – reduced the 18 (site-specific) potential models of care down to seven (site-specific) or four (site-agnostic) models:



	Site 1			Site 2		
	UEC	Obs	Paeds	UEC	Obs	Paeds
K1 & 8 Q1 & 8	Hot	Hot	Hot	Warm	Cold	Cold
L1 & 8 R1 & 8	Hot	Hot	Hot	Cold	Cold	Cold
E1 & 8	Hot	Hot	Hot	Warm	Warm	Warm
S1	New South Bank Hospital with UEC, Maternity, Paediatrics					

Figure 10.5 Preliminary short list for detailed modelling

[251] Yorkshire and Humber Clinical Senate (November 2020) *Clinical Senate Review of Humber Acute Services on behalf of Humber, Coast and Vale Health and Care Partnership* Senate report

Responding to the Clinical Senate recommendation, this smaller number of potential models of care enabled the programme to move forward with more detailed modelling to develop and refine the potential solutions that could address the challenges within the Case for Change and meet the future healthcare needs of the Humber population.

This detailed, next step of the programme was due to commence in March 2020 but was temporarily suspended in response to the onset of the COVID-19 pandemic within the UK and the need for NHS partners to respond to the immediate pressures and challenges brought about by the pandemic.

10.3.5 Developing the Potential Models of Care (Sept 2020 to Nov 2021)

Following a short hiatus in the initial period of responding to the COVID-19 pandemic, work continued to develop detailed potential models of care across all three core hospital service areas – urgent and emergency care; maternity, neonatal care and paediatrics and planned care and diagnostics – based on the outline models developed in 2019 and feedback from the Clinical Senate.

In August 2020, the programme's Executive Oversight Group recommended not developing the model S1 (a new South Bank Hospital for urgent and emergency care, maternity neonatal care and paediatrics) through the detailed modelling phase, but instead to focus on two-site models across Northern Lincolnshire, building on feedback from the Clinical Senate and Clinical Design Group. This model was, however, reconsidered within the evaluation process that took place from November 2021 to November 2022 to ensure a consistent approach to evaluation was applied to all the potential models of care.

The next phase of clinical design work was undertaken through an iterative process of extensive co-production, involving clinicians, partners, patients, service-users, the public and their representatives, supported by a comprehensive programme of communications and engagement.

To effectively model the impact of potential models of care, the clinical design process was undertaken in parallel for the three service areas, then brought together into potential service models, which were then evaluated to determine which would address the challenges most fully and provide the optimum configuration of services across the Humber. Building on the remaining high-level models described in the Interim Options Report, clinical and public engagement was used to refine these into workable solutions and identify the likely impact of each model on different cohorts of the Humber population. This work was supported by detailed data modelling (set out in appendix section D) and ongoing engagement with clinicians, patients, service-users, the public and other stakeholders (see appendix section C).

10.3.5.1 Urgent and Emergency Care – Potential Models

10.3.5.1.1 Clinical engagement/design

In the domain of urgent and emergency care, detailed modelling and clinical design of potential models of care took as its starting point the two high-level models for urgent and emergency care described in the Interim Options Report:

- **Hot-Warm**: One NLaG site provides a wider range of inpatient acute services, emergency care and trauma, the other NLaG site provides a 'local emergency hospital' model
- **Hot-Cold**: One NLaG site provides all inpatient acute services, emergency care and trauma, the other NLaG site (or another site within the same town) has an Urgent Treatment Centre

In addition, it built on the detailed recommendations from the Clinical Senate in relation to urgent and emergency care, which included the following:

- To focus option development on the south bank to the options of exploring a two-site model of an acute site and a less acute site or the option of one acute site on the south bank.
- Both sites could deliver an emergency service that will operate using different clinical models. This could include:
    - emergency medicine consultant service for defined hours and/or a same day or ambulatory emergency care service for defined clinical pathways on the less acute site.
    - a walk-in service utilising both GPs and Advanced Care Practitioners (ACPs) with appropriate referral to secondary care clinicians in medicine and surgery.
    - ambulance patients would go directly to a secondary care assessment and both units should have a co-located frailty service.
    - The need for the models to support sustainable staffing from the anaesthetic and critical care perspective.
- All sites need to offer "front of house" frailty service to allow frail elderly patients to be seen and assessed immediately.
- There are alternative roles that can be further considered particularly in terms of avoiding admissions and unnecessary attendance at Emergency Departments.
- There are developing models where Emergency Department care can be run by an interdisciplinary medical team with support from specialists when needed.

Further engagement with clinicians, patients and the public facilitated the development and refinement of a series of potential models of care that could address the challenges faced within urgent and emergency care.

Taking the high-level models as a starting point, multidisciplinary clinical design workshops – supported by detailed data modelling – developed and assessed the variations of models of care that could be applied to the Scunthorpe General Hospital (SGH) and Diana Princess of Wales Hospital (DPoW) sites based upon the challenges of providing duplicate services across both sites as detailed in the case for change.

The focus of the variations was on the potential different 'warm' models of care that could be provided. This was based on examples of services currently provided across the country ranging from limited opening times of ED to 24/7 opening but with consolidation of specialty services. Detailed modelling of clinical interdependencies, transfer conditions and potential staffing models was undertaken to support the development of the potential models of care.

The first workshop was held in September 2020 which commenced the assessment of the various models with a wide range of expertise across the acute hospitals, primary, community and ambulance stakeholders. This was followed by an extensive series of workshops and other engagement activities bringing together a wide range of key stakeholders to support, inform, confirm and challenge the development and output of the proposed models.[252] In total 12 workshops took place in support of the urgent and emergency care programme with a total attendance across the workshops of 401 people.

Ongoing engagement also identified a number of opportunities to improve access to and/or strengthen provision of urgent and emergency care outside of a hospital setting to better meet the needs of the population in the future. Out of hospital enabling changes and proposed new integrated pathways – in and out of hospital – were developed in parallel to support delivery of the potential models of care.

[252] See engagement timeline (section 10.15)

10.3.5.1.2 Public engagement

To support the development of potential models of urgent and emergency care, a better understanding of what drives behaviour and demand for urgent and emergency care services in our region was required. In particular, we wanted to understand:

- What motivates people to go to an Emergency Department (ED).
- The extent to which people know about alternative urgent care services such as NHS 111, Urgent Treatment Centres and other treatment options such as Pharmacy, etc.
- What the barriers are to using alternatives to ED.

Public engagement and insight work was undertaken to answer these questions and also to gather ideas and perspectives on the potential ways forward for urgent and emergency care provision across the Humber.

During July to August 2020, an engagement exercise was undertaken across the Humber, Coast and Vale (HCV) area to understand the reasons why people attend Emergency Departments (ED) in our region. The engagement exercise was designed in partnership with the Humber, Coast and Vale Urgent and Emergency Care Network to provide insight to support the rollout of the NHS 111 First Campaign across the region and the Humber Acute Services Programme to inform the modelling work within the Urgent and Emergency Care workstream.

A hybrid approach was adopted which involved using paper surveys and promotional posters in Emergency Departments supplemented by an online survey promoted through a targeted social media advertising campaign. In total, 2008 people responded to the survey, of which around half had used one of the three Emergency Departments within the Humber: Scunthorpe General Hospital (271 responses), Diana Princess of Wales Hospital, Grimsby (311 responses) and Hull Royal Infirmary (331 responses). The findings provided rich feedback on their experiences of Urgent and Emergency Care and views on using alternative provision. Full details of the approach taken and findings from the engagement are set out in Feedback Report.[253]

This engagement exercise was supplemented by additional engagement undertaken in person at the three Emergency Departments by Healthwatch across the Humber. Healthwatch staff and volunteers visited the three Emergency Departments (EDs) 11 times in total between 17th and 26th November, providing an independent opportunity for people to share their views and experiences face-to-face through a trusted third-party. This helped to ensure we heard from those without the means to take part in earlier online engagement. Healthwatch spoke to around 153 people about their experiences and produced a report on their findings.[254]

Some of the key findings that influenced the development of potential models for urgent and emergency care include:

- **Most people attended ED because someone advised them to**, most commonly NHS 111 or a GP.
- **Levels of awareness of alternative provision are mixed**, with lower awareness of urgent care provision in Grimsby and Scunthorpe than amongst people in Hull.

[253] Humber, Coast and Vale Health and Care Partnership (October 2020) *Accident & Emergency/Emergency Department Patient/Public Survey Feedback Report* Feedback Report
[254] Healthwatch Humber Network (January 2022) *Emergency Department Enter and View Report* Healthwatch Report

- **People are willing to use alternative provision *if they are confident* that it is appropriate for their needs**. Most respondents who attended ED felt it was the most appropriate place for their needs.

Further detail of engagement with recent patients and the public in relation to urgent and emergency care is provided in appendix 10.7.

10.3.5.2 Maternity, Neonatal Care and Paediatrics – Potential Models

10.3.5.2.1 *Clinical engagement/design*

Working in parallel to urgent and emergency care, detailed modelling and clinical design for maternity, neonatal care and paediatrics took as its starting point the two high-level maternity, neonatal care and paediatrics described in the Interim Options Report:

- **Hot/Hot-Warm/Warm**: One NLaG site with an OLU with level 2 neonatal care and acute paediatric service, the other NLaG site with an OLU, level 1 neonatal care and paediatric assessment unit
- **Hot/Hot-Cold/Cold**: One NLaG site with an OLU with level 2 neonatal care and acute paediatric service, the other NLaG site with outpatient maternity and paediatric services only

In addition, it built on the detailed recommendations from the Clinical Senate in relation to maternity, neonatal care and paediatrics, which included the following:

- Any proposals to redesign the services which retain either 2 Obstetric Led Units, or a Local Neonatal Unit, in Northern Lincolnshire must include actions that mitigate the concerns highlighted with workforce availability, critically interdependent services and levels of activity.
- Any proposals which include a freestanding Midwifery Led Unit in Northern Lincolnshire must demonstrate that the activity will be sufficient to ensure the sustainability of both the MLU and the Northern Lincolnshire neonatal service.
- To fully consider the workforce, resuscitation, stabilisation and transfer skills needed to support the paediatric model which will be required for an inpatient paediatric service at one Northern Lincolnshire site.
- To develop the community paediatric services to support the hospital-based service

Further engagement with clinicians, midwives and other professionals, service-users, patients, parents, carers and the public facilitated the development and refinement of a series of potential models of care that could address the challenges set out in the case for change.

Beginning in September 2020, a series of co-production workshops took place with clinical staff across the Humber. In the first workshop attendees reviewed the longlist of clinical models and Clinical Senate review feedback to produce a shortlist based on the Senate recommendations. As a result of the first workshop additional variations were introduced.

This was followed by a series of further workshops and other engagement activities bringing together a wide range of key stakeholders to support, inform, confirm and challenge the development and output of the proposed models (details of the workshops undertaken can be found within appendix 10.15). In total 14 workshops took place in support of the maternity, neonatal care and paediatrics programme with a total attendance across the workshops of 417 people.

Consideration was given through the workshops to how patient pathways may change and implications for delivery of care out of hospital. Attendees also considered workforce implications, changes in skill

mix, opportunities for the development of new roles and any educational implications. The workshops also considered any additions/changes needed to the clinical models, for example, consideration of standalone and/or alongside midwifery-led units.

Ongoing engagement also identified multiple opportunities to improve access to and/or strengthen provision of maternity and paediatric care outside of a hospital setting to better meet the needs of the population in the future. Out of hospital enabling changes and proposed new integrated pathways – in and out of hospital – were developed in parallel to support delivery of the potential models of care.

The MNP programme secured independent clinical reviews from a Consultant Obstetrician/ Gynaecologist, Consultant Obstetric Anaesthetist and an Independent Midwife to undertake independent assessments of the shortlisted options and advise on any clinical risks or safety concerns. They also provided advice and ideas on potential new ways of working and future workforce models. The outputs from the reviews were used to develop further the clinical models. Independent reviews for paediatrics and neonatology were not obtained due to the suspension of such work by the Royal College of Paediatrics and Child Health during the COVID-19 pandemic.

***10.3.5.2.2** Public engagement – maternity and neonatal care*

To support the development of different clinical models for maternity and neonatal care, a better understanding of how new and expectant mothers, women trying to conceive, surrogates and other birthing people in our region feel about the different choices available to them was needed. These choices range from home births, standalone midwifery led units, midwifery-led units within/alongside a hospital to obstetrician-led maternity units. In particular, we wanted to understand:

- Where people having babies, their partners and support people would prefer to give birth and why.
- What concerns women and birthing people have around the different birthing options and what could be put in place or provided differently to alleviate those concerns.
- What influences peoples' choices on where to give birth.
- What services (e.g. access to pain relief or a birthing pool) are a priority to them when deciding where to give birth.
- What is important to them when choosing their birthing environment (e.g. Home-from-home feel, or a private room).
- What women and birthing people perceive to be important to them, should their baby(ies) require neonatal care when first born, or what was important to them if they have lived experience of neonatal care.

An engagement exercise to capture the views and experiences of women and birthing people was co-produced in partnership with the service-user led Maternity Voices Partnerships (MVPs) across the region. The questionnaire, engagement artwork and animated video was designed by the working group, which was made up of the North & North East Lincolnshire MVP Chair, Lincolnshire MVP Chair, York & District MVP Chair, representatives from Hull MVP and East Riding MVP, the Humber, Coast and Vale Local Maternity System Lead, a parent with neonatal experience and the Humber Acute Services programme engagement manager. The co-design group helped ensure service user feedback was gathered by testing materials with friends and MVP members as well as with clinical staff and midwives.

Due to COVID-19 restrictions in place at the time the engagement was undertaken, the majority of the engagement was undertaken digitally (though an online questionnaire and virtual focus groups) and promoted through social media. Paid-for Facebook advertising was used to promote the survey (to

those living in areas of greatest deprivation and younger mums in areas with higher rates of teenage pregnancies) as well as utilising existing communication channels across all partner organisations and the MVP network. In total, 1,133 people completed the digital questionnaire, 753 of whom provided a postcode within the Humber region, 11 from the Lincolnshire area and 13 from Doncaster.

To ensure those unable to access the digital survey could still take part, the opportunity to request a paper copy and alternative formats and languages of the questionnaire, or take part in a telephone interview, was highlighted wherever the survey was promoted. Using population health data, children's centres, schools and nurseries located within areas of highest deprivation (IMD score of 1) were identified and posters, with details of how to be involved, were posted out to them to be displayed in waiting areas and areas with high footfall. In addition, a series of targeted focus groups were set up to provide opportunities for Young Families, Families from BAME backgrounds, Dads / Partners / Co-Parents and Families with lived experience of neonatal care to have their say. Full details of the approach taken and findings from the engagement are set out in the Your Birthing Choices – Feedback Report.[255]

Some of the key findings that have influenced the development of potential models of care for maternity and neonatal services include the following:

- **Alongside Midwifery-led Units were the most popular option overall**, but not everyone's first choice. For Northern Lincolnshire women, Obstetric-led units were a more popular choice.
- **Preferences were not uniform** across the different geographical areas.
- Views on **standalone midwifery units** were equivocal.
- **The facilities and services available were comparatively more important** than the physical environment and location when making decisions about where to give birth.
- **Safety was comparatively more important** to maternity service-users than the public as a whole.

Working collaboratively with the Maternity Voices Partnership group and Local Maternity System across Humber, Coast and Vale has also provided a wealth of other insight, which has been drawn upon to support development of potential models of care for maternity and neonatal services. This includes a number of surveys carried out by the MVP network from 2019 to 2021, which gathered views from over 1800 women and birthing people in total on a range of topics including:

- The impact of and experiences during COVID-19 (540 responses)[256]
- Continuity of carer – peoples' experiences and expectations (778 responses)[257]
- The use of virtual/telephone appointments in pre- and post-natal care (1319 responses)[258]
- Making informed choices in pregnancy and in relation to birthing choices (559 responses)[259]

[255] Humber and North Yorkshire Health and Care Partnership (June 2022) *Hospital Services for the future – Your Birthing Choices Feedback Report* Your Birthing Choices Report
[256] Humber, Coast and Vale Maternity Voices Partnership (Sept 2020) *The impact of and experiences during COVID-19* see document library
[257] Humber, Coast and Vale Maternity Voices Partnership (Nov 2021) *Continuity of carer – peoples' experiences and expectations* see document library
[258] Humber, Coast and Vale Maternity Voices Partnership (Mar 2021) *The use of virtual/telephone appointments in pre- and post-natal care* see document library
[259] Humber, Coast and Vale Maternity Voices Partnership (June 2020) *Making informed choices in pregnancy and in relation to birthing choices* see document library

The feedback reports from each of these engagement activities helped to inform the development of clinical models. Some key findings that have influenced the development of potential models of care for maternity services include:

- Maternity service-users show a **strong preference for face-to-face interaction** and would not want to see a continuation to virtual appointments that were used during the pandemic.
- There is **strong support for 'continuity of carer'** amongst women who have experienced this model of care.

Further detail of how engagement with service-users has shaped the potential models of care for maternity and neonatal services and the feedback they have given is provided in appendix 10.13.

10.3.5.2.3 Public engagement – Children and Young People

To support the development of different clinical models for paediatrics, a different approach was needed to gather views and ideas from existing and future patients of paediatric services and their parents and carers. In particular, we wanted to understand:

- What matters most to children and young people about their care.
- What concerns children and young people have about coming to hospital and how we could respond to these in our design of future services.
- What improvements children and young people think we could make to our paediatric provision.

To undertake this engagement effectively and ensure younger people could respond in a way that was meaningful to them, a child-friendly approach was developed in partnership with play specialists in the two hospital trusts. For young children (aged approximately 5-11) a fun activity booklet was developed featuring drawing, matching activities and space to write or leave comments. For older children/young people (aged approximately 12-17) a bespoke questionnaire was produced with simplified questions and open space to provide free text or drawings. Participation was incentivised with a prize giveaway and parental consent was built into the survey design.

Picture 10:A Children's feedback booklet

Both resources were thoroughly tested by a reference group of children and young people of a variety of ages to ensure accessibility and appropriateness. Patient experience teams and nurse specialists within both trusts delivered the engagement activity to ensure any patients coming onto the paediatric wards at Hull, Grimsby or Scunthorpe had the opportunity to take part. In addition, the online survey was promoted via social media and other channels (e.g. staff and stakeholder newsletters), targeted particularly at parents and carers seeking their support to enable their children to take part. Additional offline methods were used to reach out to children and young people in more deprived communities and those who might face other barriers to access, for example, working with local kid's club providers to distribute paper copies of the booklet.

A parent and carer survey and campaign to promote it was also used to give parents and carers an opportunity to share their perspectives. This utilised the What Matters to You Survey but with a bespoke communications campaign to promote the opportunity to parents and carers across the Humber.

In total, 63 children and young people took part by completing a booklet or the online questionnaire and 277 parents and carers responded to the online questionnaire. Full details of the approach taken and findings from the engagement are set out in the feedback reports.[260]

Some key findings that have influenced the development of potential models of care for paediatric services include:

- **Being kept safe and well looked after was the most important thing** to parents, carers and guardians and for children and young people themselves.
- **Accessibility and experience** were also very important (e.g. waiting times, car parking, local services).
- The **building and physical environment was comparatively more important** to children and young people than the population as a whole.
- **Better communication** – clear and consistent information presented in an understandable way – was important to both parents and carers and children and young people.

Further detail of how engagement with children, young people and their parents and carers has shaped the potential models of care for paediatric services is provided in appendix 10.8.

10.3.5.3 Planned Care – Potential Models

10.3.5.3.1 *Clinical engagement/design*

Early work on potential models for planned care was undertaken in parallel to development of the Case for Change in late 2019. A series of outline conceptual models for planned care were also presented to the Clinical Senate for review, alongside the potential models for urgent and emergency care and maternity, neonatal care and paediatrics.

In relation to planned care, the Clinical Senate provided positive feedback on the work to date and made one key recommendation:

[260] Humber, Coast and Vale Health and Care Partnership (March 2022) *What Matters to You – Children and Young People; patient and stakeholder engagement feedback report* CYP Feedback Report AND Humber, Coast and Vale Health and Care Partnership (March 2022) *What Matters to You – Parents, Carers & Guardians; public and stakeholder engagement feedback report* Parents, Carers and Guardians Feedback Report

- To take action ahead of the wider reconfiguration, particularly in ophthalmic surgery, urology and ENT to develop clinical networks working across Hull and East Riding and Northern Lincolnshire to change the way that the workforce delivers care.

With respect to planned care the Senate identified a recurrent theme of stretching the workforce too thinly across multiple sites, particularly when delivering out of hours care. The Senate supported models that split elective (planned) care from urgent care, which would enable elective care to be provided more efficiently. The Senate also identified a need for increased integration and collaboration across the trusts, centralising the workforce, supported by regional multi-disciplinary teams (MDTs) for specialties and standardised pathways of care.

Taking the split of planned and unplanned care as a starting point and building on the feedback provided by the Clinical Senate, further engagement with clinicians, patients and the public was undertaken to develop and refine a series of potential models of care that could address the challenges set out in the case for change.

This began with the first planned care workshop in March 2021 and continued through a series of further workshops exploring the drivers for change and what potential models of care could be developed to address the issues described in the case for change. In total 12 workshops took place in support of the planned care programme with a total attendance across the workshops of 359 people.

The potential models of care were also reviewed and refined through the Planned Care steering group, the Executive Oversight Group and the Clinical Design Group.

Potential models of care and proposed new pathways were initially developed for the six specialties identified within the Case for Change. The original Case for Change, however, was completed prior to the onset of the COVID-19 pandemic, which has had a significant impact on delivery of planned care across the region.

The Elective Recovery programme – and efforts to respond to the pressures in the system exacerbated by the COVID-19 pandemic – will drive changes in how planned care is delivered in the Humber (and nationally) over the coming months and years. We have therefore worked closed with the Elective Recovery programme and colleagues working to address the backlog that has built up as a result of the pandemic to collectively design the potential models and concepts for planned care (see section **Error! Reference source not found.** for further details of our system-wide work on elective recovery). The work undertaken in preparing this Pre-Consultation Business Case sets out the broader, long-term vision for planned care, that will underpin the delivery of elective recovery in the here and now as well as providing a more sustainable platform for planned care services to develop future models of care delivering within and outside of hospital settings.

Ongoing engagement identified multiple opportunities to improve access to and/or strengthen provision of planned care outside of a hospital setting to better meet the needs of the population in the future. Out of hospital enabling changes and proposed new integrated pathways – in and out of hospital – were developed in parallel to support delivery of the potential models of care.

10.3.5.3.2 *Public engagement – planned care*

In developing the potential models of care for planned care services, we wanted to understand what was most important to people in terms of how they access hospital care and to understand what makes a positive experience of planned care. Because of the extensive potential patient-base for planned care, broad-based public engagement was undertaken to supplement the engagement that was undertaken

earlier in the programme with current patients in particular specialties. In addition, we drew upon existing intelligence and insight gathered by partners to provide additional ideas to help shape potential models for planned care. In particular, we wanted to know:

- What matters most to people accessing planned care (including operations, outpatient appointments, diagnostic tests, and support for long-term conditions).
- What ideas and concerns people have about accessing aspects of their care in an 'out of hospital' setting (including remotely via telephone or video conferencing).
- Whether people were willing to travel, and if so under what conditions, to access care and treatment.

To ensure anyone with an interest in hospital services was able to share their views and experiences at an early stage, a broad-based questionnaire was designed and promoted through a public campaign asking, "What Matters to You?". Initially, the campaign ran from March to May 2021 and the survey re-opened in August 2021 until the end of November. The *What Matters to You?* engagement exercise had two main purposes:

1. to gather ideas and suggestions about how future models of care could best meet peoples' needs.
2. to gather views and perspectives from a wide range of stakeholder on their priorities and preferences in relation to hospital care, or which factors are relatively more important than others.[261]

A range of methods was used to gather the views of different stakeholders. Given the continuation of restrictions at the time this exercise was carried out, the methods adopted included a digital questionnaire and a series of (virtual) workshops with identified stakeholder groups. To increase accessibility particularly amongst those facing digital exclusion, the opportunity to request a paper copy of the questionnaire was highlighted wherever the survey was promoted. People were also offered the opportunity to compete the questionnaire over the telephone or via a video call and were given the opportunity to request the survey in different languages and formats. The survey was also promoted using paid-for social media advertising, targeted to reach those living in areas of highest deprivation (IMD bottom decile).

The online questionnaire was initially open for five weeks, from 8th March to 12th April 2021. A total of 3883 people completed the online questionnaire over that period. The *What Matters to You?* questionnaire was reopened in August and received a further 148 responses.

In addition to the questionnaire, six stakeholder workshops took place between February and May 2021, which included members of the following stakeholder groups (63 people in total attended one of the workshop sessions):

- Citizen's Panel
- Local Councillors (from the four Humber Local Authorities)
- NLaG Trust Governors
- Non-Executive Directors from both hospital trusts

Of those who responded to the survey, more than half (60%) had used planned care or diagnostic services within the last two years. Around half (53%) had used Accident and Emergency services and a

[261] The feedback on priorities and preferences is covered in more detail below – see section 10.4.2.1.

small proportion had experience of maternity or paediatric services (11% and 9% respectively).[262] Full details of the approach taken and findings from the engagement are set out in the *What Matters to You? – Feedback Report*.[263]

In addition to engagement undertaken through the What Matters to You survey, a number of other sources of feedback and/or insight helped to shape thinking about the future strategy for planned care:

- Targeted engagement undertaken to support the programme.
- Survey on virtual outpatient appointments undertaken by HCV outpatient transformation programme (2778 participants).[264]
- Healthwatch hospital survey (37 responses).[265]
- Surveys to gather views from current or recent patients and staff using/working within a number of specific specialties where temporary service changes had been made, namely: Urology, ENT, Oncology and Haematology (524 responses).[266]
- Focus groups to gather views from current or recent patients of a number of specific specialties, namely: Neurology, Cardiology, Critical Care, Complex Rehabilitation and Stroke (77 participants).[267]

To support the introduction of virtual (video) consultations implemented in response to the COVID-19 pandemic in Spring/Summer 2020, the acute trusts across Humber and North Yorkshire gathered feedback from patients who had used virtual outpatient appointments during the COVID-19 pandemic. This feedback was used to improve the service in real time and also brought together and analysed to help inform work to transform outpatient care for the longer term across the region. Feedback from those using the service was largely positive with 89% of patients who had attended a virtual appointment at NLaG saying they would recommend video consultations to friends and family.[268]

Healthwatch designed a survey targeted at current patients, in particular those who are currently on a waiting list for hospital services. The survey was launched in October 2021 and continued through to Spring 2022. Interim findings were provided to the programme team to inform the developing models for planned care.

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[262] Note: it was possible to select more than one option if respondents had used more than one service therefore the percentages do not add up to 100.
[263] Humber, Coast and Vale Health and Care Partnership (May 2021) *What Matters to You: public, staff and stakeholder engagement feedback report* What Matters to You AND Humber, Coast and Vale Health and Care Partnership (January 2022) *What Matters to You – Revisited: public, staff and stakeholder engagement feedback report* What Matters to You – Revisited
[264] Humber, Coast and Vale Outpatient Transformation Programme (Nov 2020) *Outpatient Transformation engagement: listening to and acting on patient feedback* – see document library
[265] Healthwatch Humber Network (March 2023) *COVID-19 Impact Survey Report* Healthwatch Report
[266] Humber, Coast and Vale Health and Care Partnership (October 2020) *Review of temporary changes to Oncology Services* Oncology Feedback Report; Humber, Coast and Vale Health and Care Partnership (March 2022) *Review of temporary changes to ENT Services* ENT Feedback Report; Humber, Coast and Vale Health and Care Partnership (March 2022) *Review of temporary changes to Urology Services* Urology Feedback Report AND Humber, Coast and Vale Health and Care Partnership (March 2022) *Review of temporary changes to Haematology Services* Haematology Feedback Report
[267] Humber, Coast and Vale Health and Care Partnership (April 2019) *Hospital Services for the future – Focus Group Feedback Report* Focus Group Feedback Report
[268] Humber, Coast and Vale Outpatient Transformation Programme (Nov 2020) *Outpatient Transformation engagement: listening to and acting on patient feedback* – see document library

Some key findings that have influenced the development of thinking about the future of planned care across the Humber include:

- **Compassionate and caring staff were the most common reason for a positive experience of care**, highlighting the need to develop appropriate and effective staffing models that give staff time to care.
- **Accessibility of services – in the broadest sense – matters**, highlighting the need to think about travel and accessibility in the round and not just focus on distance travelled.
- **On the whole, there is willingness to travel for care** where it is necessary (i.e. the benefits are significant and well understood) and well-supported (i.e. appointment times are sensible and car parking is available).
- Patients recognise and welcome the opportunity to **reduce unnecessary appointments.**
- **Those who have used virtual appointments have, on the whole, found them positive.**
- **Communication needs to improve**, particularly between different parts of the NHS.

Further detail of how engagement with patients and the public has shaped thinking about planned care is provided in appendix 10.9.

10.3.6 Summary of Potential Models of Care

The extensive engagement, modelling and development work that was undertaken resulted in three potential models for urgent and emergency care, three potential models for maternity neonatal care and paediatrics and four potential models for planned care.

The potential models for urgent and emergency care, maternity neonatal care and paediatrics included:

- Model 1 – Acute / Local Emergency Hospital (LEH)
- Model 2 – Acute / Local Emergency Hospital (LEH) variation
- Model 3 – Acute / Elective

In addition, four potential models for planned care were initially developed, including:

- Model PC1 – operations in 3 hospitals, day case in all five
- Model PC2 – operations in 3 hospitals (including Goole)
- Model PC3 – operations in 2 hospitals
- Model PC4 – one hospital for all operations (Humber-wide hub)

Initially planned care models were developed for the six priority specialties identified within the Case for Change. As a result of feedback gathered during step 1 of the evaluation process, and in response to wider changes in the strategic context (specifically, the pandemic impact and the requirements of the elective recovery programme), the planned care programme was broadened to consider all planned care specialties, developing the core principles and outline strategy described in section 7.1.

To ensure a robust and consistent process was followed, all possible combinations of the models developed through the clinical design phase for urgent and emergency care and maternity, neonatal care and paediatrics, were combined and taken through step 2 of the evaluation process (unless there was a clear rationale from step 1 to discount). This approach was adopted to ensure all models and potential variations were considered objectively. This included reviewing some previously discounted ideas (such as a new central hospital for Northern Lincolnshire).

In all, 15 different scenarios were considered through the evaluation process, which included:

- Acute / Local Emergency Hospital model (x6 variations, 12 site-specific scenarios)
- Acute / Elective model (x2 variations, 3 site-specific scenarios)

10.3.6.1.1 Acute / Local Emergency Hospital Model

The Acute / Local Emergency Hospital model is based upon the Hot-Warm model from the Interim Options Report and describes a scenario whereby one of the sites in Northern Lincolnshire – Diana Princess of Wales Hospital, Grimsby (DPoW) or Scunthorpe General Hospital (SGH) – would be an Acute Hospital with a Trauma Unit, the other would be a Local Emergency Hospital. Hull Royal Infirmary would continue to operate as a specialist acute hospital and the Major Trauma Centre.

Within this model, six potential variations of the Local Emergency Hospital remained following step 1 of the evaluation. This included the following considerations (and combinations thereof):

- Provision of General Medical and Care of the Elderly inpatient beds (post-72 hours) on the Local Emergency Hospital *and* Acute Hospital site **or** on the Acute Hospital site only.
- Provision of Obstetric-Led Unit on the Local Emergency Hospital *and* Acute Hospital site **or** on the Acute Hospital site only.
- Provision of Standalone Midwifery-Led Unit on the Local Emergency Hospital.

In addition, each variation could be applied to either site configuration option – either Diana Princess of Wales Hospital, Grimsby as the Acute hospital or Scunthorpe General Hospital as the Acute hospital. This resulted in 12 different site-specific scenarios that were considered through the evaluation process.

Acute / Local Emergency Hospital Model

Acute Hospital	Local Emergency Hospital	Specialist Acute Hospital
– Emergency Department and Trauma Unit – Urgent Care Service – Assessment/Same Day Emergency Care (SDEC)/Short stay (<72 hours) – Specialty Medical Inpatients – General Medical Inpatients – Care of the Elderly Inpatients – Acute Surgery Inpatients – Paediatric Assessment Unit – Paediatric Inpatients – Obstetric-Led Unit (+Midwife-Led Service) – Neonatal Levels 1&2 – Critical Care/Anaesthetics – Outpatients for all specialties	– Emergency Department – Urgent Care Service – Assessment/Same Day Emergency Care/Short stay (<72 hours) – General Medical Inpatients – Care of the Elderly Inpatients – Day Case Emergency Surgery – Paediatric Assessment Unit – Obstetric-Led Unit (+Midwife-Led Service) – Neonatal Level 1 – Critical Care/Anaesthetics – Outpatients for all specialties variations: With or without: – General Medical Inpatients – Care of the Elderly Inpatients – Obstetric-led Unit – Midwife-led Unit – Neonatal Level 1	– Emergency Department and Major Trauma Centre – Urgent Care Service – Assessment/Same Day Emergency Care (SDEC)/Short stay (<72 hours) – Specialty Medical Inpatients – General Medical Inpatients – Care of the Elderly Inpatients – Acute Surgery Inpatients – Paediatric Assessment Unit – Paediatric Inpatients – Obstetric-Led Unit (+Midwife-Led Unit) – Neonatal Levels 1-3 – Critical Care/Anaesthetics – Outpatients for all specialties

Figure 10.6 Summary of Acute / Local Emergency Hospital Model

10.3.6.1.2 Acute / Elective Model

The Acute / Elective model is based upon the Hot-Cold model from the Interim Options Report and describes a scenario whereby one of the sites in Northern Lincolnshire (DPoW or SGH) would be an Acute Hospital with a Trauma Unit, the other would be an Elective Hospital. Urgent Care Services would be provided in Scunthorpe, Grimsby and Hull (in addition to other localities with existing UTCs), which may be located at a different site to the hospital (e.g. in a town centre location). In this model, as with the others, Hull Royal Infirmary would continue to operate as a specialist hospital and the Major Trauma Centre. In the Acute / Elective model maternity care, neonatal care and paediatric services would be consolidated onto a single site in North and North East Lincolnshire. Hull Royal Infirmary would continue to operate as a specialist hospital providing Obstetric-led maternity care (OLU), with an alongside midwifery-led unit (MLU), level 3 neonatal intensive care (NICU) and paediatric inpatient services.

This model could be applied to either site configuration option – either Diana Princess of Wales Hospital, Grimsby as the acute hospital or Scunthorpe General Hospital as the acute hospital. In addition, the potential variation of having a single acute site at a new location in Northern Lincolnshire (between the two towns) was also considered. This resulted in 3 different site-specific scenarios that were considered through the evaluation process.

Acute / Elective Model

Acute Hospital

- **Emergency Department and Trauma Unit**
- **Urgent Care Service**
- **Assessment/Same Day Emergency Care (SDEC)/Short stay (<72 hours)**
- **Specialty Medical Inpatients**
- **General Medical Inpatients**
- **Care of the Elderly Inpatients**
- **Acute Surgery Inpatients**
- **Paediatric Assessment Unit**
- **Paediatric Inpatients**
- **Obstetric-Led Unit (+Midwife-Led Service)**
- **Neonatal Levels 1&2**
- **Critical Care/Anaesthetics**
- **Outpatients for all specialties**

Elective Hospital

- **Urgent Care Service**
- **Critical Care/Anaesthetics**
- **Outpatients for all specialties**

Specialist Acute Hospital

- **Emergency Department and Major Trauma Centre**
- **Urgent Care Service**
- **Assessment/Same Day Emergency Care (SDEC)/Short stay (<72 hours)**
- **Specialty Medical Inpatients**
- **General Medical Inpatients**
- **Care of the Elderly Inpatients**
- **Acute Surgery Inpatients**
- **Paediatric Assessment Unit**
- **Paediatric Inpatients**
- **Obstetric-Led Unit (+Midwife-Led Unit)**
- **Neonatal Levels 1-3**
- **Critical Care/Anaesthetics**
- **Outpatients for all specialties**

Figure 10.7 Summary of Acute / Elective Model

10.4 Evaluating the models of care

10.4.1 Overview

In line with the programme principles, the evaluation of the potential models of care in this Pre-Consultation Business Case (PCBC) was clinically-led, evidence-based and influenced by the involvement of a wide range of stakeholders, including patients and service-users, clinicians, staff and partners across the health and social care sector, local authorities, voluntary and community sector organisations, the public and their representatives.

An iterative, multi-faceted process was adopted to gradually narrow down the possible solutions to the options that are most able to address the issues identified within our Case for Change and provide the best possible solutions for our population. A comprehensive evaluation framework was co-produced and continually refined through ongoing engagement with staff, partners, patients, the public and other interested stakeholders. The evaluation framework reflects the key priorities and preferences of stakeholders and asks questions to help identify which of the potential solutions best meets the needs and expressed priorities of our local populations.

10.4.1.1 Timeline and approach

The potential clinical models were refined and evaluated based on evidence and insight gathered through data modelling, clinical consideration and ongoing stakeholder engagement. The following key assumptions underpinned the approach that was taken:

- Evaluation is an iterative and continuing process (not a simple tick-box exercise).
- Not every criterion requires evaluation at the same time.
- Certain groups are better placed to contribute to some aspects than to others; for example, patients and service users may be more confident in contributing to assessing patient experience than cost effectiveness.
- The evaluation has both qualitative judgement-based elements as well as quantitative elements supported by an analytical model.
- The evaluation framework is a dynamic tool which will be used iteratively throughout the evaluation process and can undergo further refinement as and when required.

Grounded in these assumptions, an extensive and multifaceted approach to evaluation was adopted utilising a number of different analytical models to explore the likely impact of the different potential models of care and the extent to which they can address the challenges in the Case for Change.

This work was undertaken through a number of key stages:

- Developing (and refining) the evaluation framework (January 2021 to January 2022)
- Evaluation Step 1 Workshops (October to December 2021)
- Evaluation Step 2 Workshops (February to March 2022)
- Evaluation Step 2 Multifaceted Analysis (September 2021 to January 2023)
- Financial and Affordability Analysis (January to May 2023)

Throughout each stage of the process, we have engaged with a range of stakeholders on an ongoing basis, responding to feedback and refining the approach continuously. The diagram below provides an overview of the evaluation process at a high level.

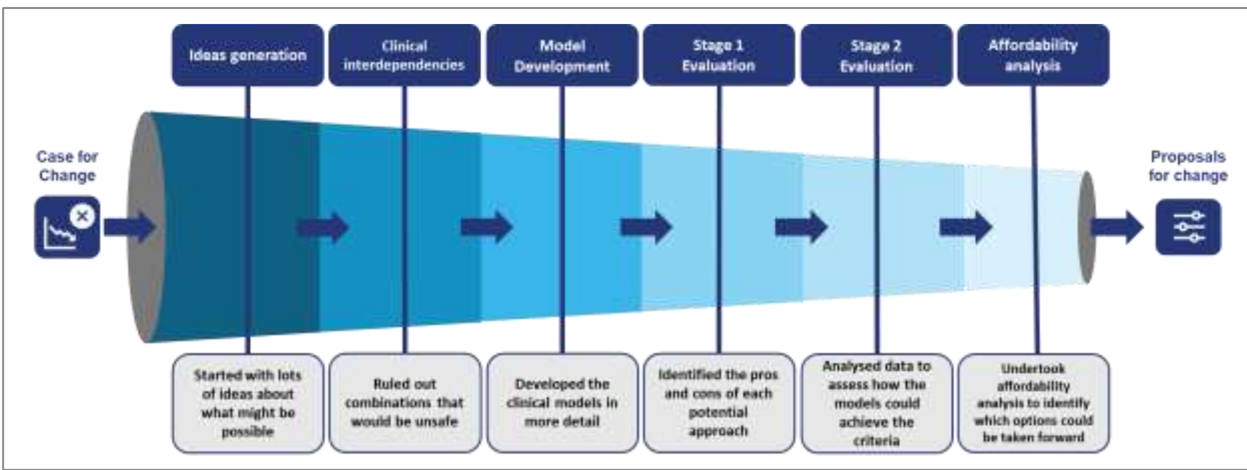

Figure 10.8 Overview of Evaluation Process

Some elements of work were undertaken concurrently and at each stage stakeholder engagement helped to shape the process and outcomes.

10.4.1.2 Stakeholder engagement

Stakeholder engagement helped to shape the work of the programme in a number of important ways. During the evaluation phase, engagement activities served to:

- **Identify / aid understanding of impact.**
  - Ongoing engagement with clinicals teams, patients and the wider public has helped to build our understanding of the likely impact of each of the potential models of care.
  - Involvement with a range of stakeholders, including local authorities, overview and scrutiny committees and other public representatives, has informed the development of the evaluation framework and helped to identify priorities for areas to be analysed and assessed.
  - Stakeholder engagement helped us to understand how impacts might differ between different population cohorts and how they might, in turn, impact upon regional health inequalities.
- **Support evaluation**.
  - Engagement and involvement activities have also helped us to develop a better understanding of the priorities and preferences of people in our communities and how these differ between different population cohorts and groups such as staff.
  - Understanding priorities and preferences has enabled us to build an evaluation framework to assess the things that are most important to our local populations and also supported our evaluation of the potential models of care against those priorities.
  - Stakeholders have also been actively involved in assessing the potential models of care and providing their perspective on the relative advantages and disadvantages of each model, through workshops, focus groups and other engagement opportunities.

Almost 250 stakeholders from a wide range of backgrounds and perspectives were actively involved in evaluating the potential models of care through multiple rounds of evaluation workshops.[269]

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[269] Humber and North Yorkshire Health and Care Partnership (July 2022) *Hospital Services for the future: Evaluation Workshops Feedback Report* Evaluation Feedback Report

The approach undertaken to engagement and findings from our work have been shared regularly with local authority overview and scrutiny committees and the approach to early engagement was endorsed by members. We listened to their suggestions and requests in relation to mapping travel impact, in particular, and providing detailed information on the potential impact of any changes to their local residents.[270] Ongoing dialogue with OSCs will continue and we will continue to seek advice from elected members as plans for consultation are developed.

10.4.2 Co-producing the Evaluation Framework

The evaluation framework used to assess the potential models of care was built through an extensive process of listening and engaging with the public, patients, service-users, staff, partners, governors, elected members and other key stakeholders. **Over the course of the programme, we have engaged with over 12,000 people, helping to shape the potential models of care and the framework used to evaluate them.**

10.4.2.1 Understanding priorities and preferences

A key facet of involvement activity through the programme has been focused on gathering views about what is *most* important to patients, staff and other stakeholders when it comes to their hospital care. This element of engagement activity continued throughout the programme and generated a significant volume of data and insights helping to shape the potential models of care and support the evaluation process.

A variety of approaches was adopted to gather views from stakeholders on their priorities, preferences and key issues and concerns. This included forced ranking questions, free text questions which ask participants to identify the most important (or top 3 or top 5) factors to them and a distributive voting system whereby participants had a fixed number of votes that they could distribute amongst the different categories according to which were most important.

The consistent focus on priorities and preferences means it is possible to track broad themes over time and draw conclusions about the relative importance of various factors to different stakeholder groups. These conclusions helped to inform the approach taken to evaluating the potential models of care, alongside other important factors such as national policy, local strategies, resource availability (especially workforce) and other local priorities.

10.4.2.2 Co-designing the evaluation framework

Building on early involvement work that was undertaken in the Case for Change phase of the programme[271], a high-level evaluation framework was co-designed with the programme team, capital development team and Citizen's Panel in early 2021. This framework set out nine key criteria against which potential models of care would be evaluated to assess the extent to which they would deliver the optimal solution for the local population.

[270] See appendix 10.5.6 for further details.
[271] Humber, Coast and Vale Health and Care Partnership (October 2018) *Hospital Services for the future: Public Engagement Feedback Report* Issues Paper Feedback
Humber, Coast and Vale Health and Care Partnership (April 2019) *Hospital Services for the future – Focus Group Feedback Report* Focus Group Feedback Report

To enable us to engage with a wider group of stakeholders and understand what was most important to them, the Citizen's Panel helped to devise a clear and easy-to-understand set of headings (I statements) that correlated with each of the criteria.

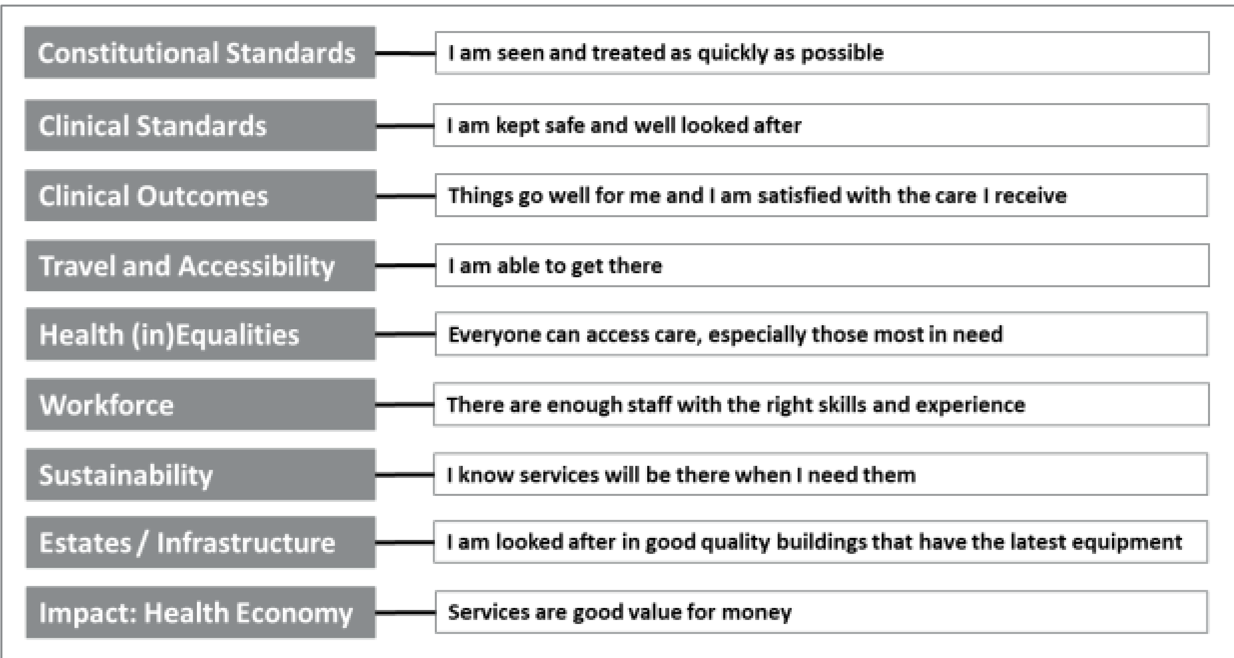

Figure 10.9 Evaluation Framework - I statements

These statements – and the nine evaluation criteria they correspond to – were agreed at the start of 2021 and used throughout the engagement work that supported the development of this Pre-Consultation Business Case (PCBC).

In the *What Matters to You?* questionnaire a ranking question was used. Respondents were asked to rank the nine decision-making criteria in order of importance to them. In the focus groups and workshops an online instant survey tool called Mentimeter was used, enabling participants to provide feedback in real-time on their priorities and preferences.

In total the *What Matters to You?* survey reached 4029 people. In addition, the same '*What Matters to You?*' question was incorporated in all other questionnaires and engagement activities undertaken throughout 2021, including:

- Your Birthing Choices (1133 responses)
- Parents and Carers (277 responses)
- Children and Young People (63 responses)[272]
- Specialty patient surveys (466 responses)
- Staff surveys (241 responses)

The Mentimeter exercise was repeated in many of the clinical and thematic workshops held throughout 2021 with a wide range of stakeholders including clinicians, lay members, elected members, voluntary sector partners and others.

[272] Our engagement with children and young people used an adapted version based on user testing. Six simple statements were provided, linking to the more popular categories from the other engagement undertaken to date, and participants were asked to give a gold, silver and bronze medal to the best three.

Furthermore, the nine 'I Statements' (criteria) were used to group and analyse feedback gathered through a wide variety of sources, including: responses to open text questions posed within questionnaires, questions asked through the staff, partner and public-facing online question portals and feedback provided via informal briefing sessions.

Adopting the *What Matters to You* I statements as an analytical framework helped to ensure consistency in feedback reporting and also provided ongoing, real-time updates of the key themes and issues emerging from engagement as it was being undertaken. This approach enabled the evaluation framework and approach to assessment of the potential models of care to be refined to ensure it accurately reflected the priorities and preferences of stakeholders and the key issues and concerns they raised.[273]

10.4.2.3 Priorities – key issues and themes

The **public** told us that the most important thing to them was being **seen and treated quickly**.[274] Being kept safe and well looked after and having sufficient staff with the right training and skills were also considered very important.

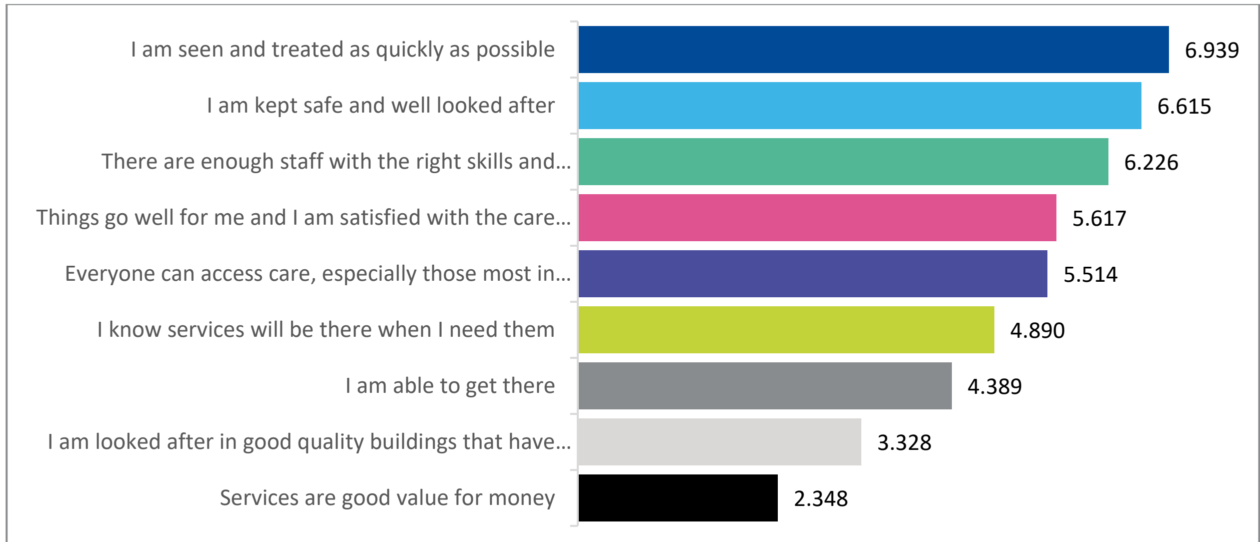

Figure 10.10 What Matters to You? Priorities and Preferences[275]

Safety was comparatively more important to women and birthing people who responded to the Birthing Choices questionnaire. **Of all the cohorts of service-users, patients and public, those who were interested in maternity services prioritised safely most highly.** This is also reflected in the qualitative feedback provided throughout the engagement undertaken on maternity and neonatal services.

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[273] A summary report of findings across all engagement streams on priorities and preferences was produced: *What Matters to You? – Combined Summary Responses* (see document library)
[274] Participants were asked to rank the nine criteria in order of importance from most (score of 9) to least (score of 1) important. The numbers provided in the bar charts present the weighted average score calculated for each answer for all participants and provides an indication of the relative importance of each criterion.
[275] Humber, Coast and Vale Health and Care Partnership (May 2021) *What Matters to You: public, staff and stakeholder engagement feedback report* What Matters to You

Figure 10.11 Your Birthing Choices - Priorities and Preferences[276]

Children and young people, their parents and carers, also prioritised **safety** more highly than the population as a whole. **Being kept safe and well looked after was comparatively more important to parents, carers and guardians** who completed the *What Matters to You?* questionnaire and was also ranked very highly by the children and young people themselves in their bespoke questionnaire. The physical environment was also comparatively more important to children and young people than other stakeholder groups.

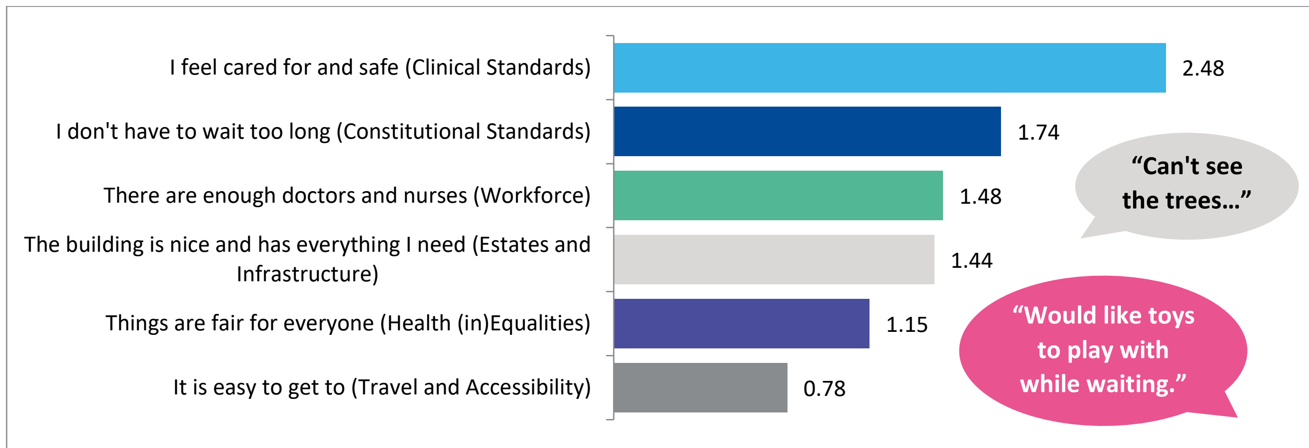

Figure 10.12 Children and Young People - Priorities and Preferences[277]

Whilst within survey responses travel and accessibility consistently ranked in the bottom three across all stakeholder groups, concerns about **travel, transport and accessibility** were consistently raised in focus group and workshop discussions demonstrating that it is an area of concern for patients, staff and other stakeholders. Other areas of concern highlighted through ongoing engagement include digital exclusion, wider health inequalities and barriers to accessing care.

The findings from the *What Matters to You?* engagement (and other ongoing engagement activities) were used to inform the development of the evaluation framework and approach. It is important to note, however, that the rankings were not applied numerically to weight the different criteria within the

[276] Humber and North Yorkshire Health and Care Partnership (June 2022) *Hospital Services for the future – Your Birthing Choices Feedback Report* Your Birthing Choices Report
[277] Humber, Coast and Vale Health and Care Partnership (March 2022) *What Matters to You – Children and Young People; patient and stakeholder engagement feedback report* CYP Feedback Report

framework. Whilst the engagement undertaken was extensive and wide-reaching, the total number and demographic spread of responses is such that the findings cannot be considered to be statistically significant and therefore it would not be appropriate to weight the criteria on this basis. Instead, they have been used to inform and refine the overall approach to evaluation and the manner in which the information is presented to stakeholders and decision-makers.

When displaying the outputs from the various stages of evaluation, the nine criteria have been listed in order of importance (as expressed by our stakeholders) to enable stakeholders and decision-makers to make their own judgements on the overall acceptability of the different models of care based on their relative performance against each of the criteria.

10.4.2.4 Refining the Evaluation Framework – developing the questions

Upon completion of the *What Matters to You?* engagement activities, further work was undertaken to refine the evaluation framework. This refinement was undertaken to ensure the framework could be applied robustly to all potential models of care and provide a complete picture about the relative strengths and weaknesses of each potential solution.

The nine evaluation criteria and 'I statements', which had been defined with support from the Citizen's Panel, were developed into a framework with questions, definitions, benefit statements and clear scoring definitions. This work was undertaken to support stakeholders to provide an assessment of the different potential models of care against the questions within the framework, using the definitions set out within it.

The questions and definitions were built through a process of engagement with clinical leads and key partners (such as public health colleagues), taking into account feedback from the Citizen's Panel and other lay members. For each criterion, a set of sub-questions was developed, based on relevant national policy or guidance, and linked to the issues within the Case for Change. The policy and guidance documents drawn upon include (but are not limited to):

- The NHS Constitution[278]
- The National Outcomes Framework[279]
- Royal College workforce recommendations e.g. *Facing the Future*[280]
- Nationally defined clinical standards *e.g. for trauma, neonatal care*[281]
- National guidance e.g. *Urgent actions to address inequalities in NHS provision and outcomes*[282]

These sub-questions were used to develop a richer understanding of how each model might perform and deliver improvements in the areas for improvement identified within the Case for Change. The questions, definitions and benefit statements are set out in the table below. The detailed sub-questions and scoring definitions can be found within the document library.[283]

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[278] NHS England (2021) *The NHS Constitution for England* NHS Constitution
[279] Department of Health (2016) *NHS Outcomes Framework: at a glance* NHS Outcomes Framework
[280] Royal College of Paediatrics and Child Health (2015) *Facing the Future: Standards for Acute General Paediatric Services* Facing the Future
[281] A wide range of NIEC quality standards, Royal College guidance and standards from other national clinical bodies was considered, including, for example; NICE (2018) *Quality Standard – Trauma [QS166]* Trauma QS.
[282] NHS England (2020) *Implementing phase 3 of the NHS response to the COVID-19 pandemic* Urgent Actions to address inequalities
[283] Combined evaluation questions and definitions – see document library

Evaluation Criteria	Question	Definition	Benefit statement(s)
Constitutional Standards	**Does the model deliver Constitutional standards?**	We are confident that the model will deliver the relevant standards as listed in the NHS Constitution	**I am seen and treated as quickly as possible** – waiting times for treatment and care will be reduced – fewer people will be waiting for treatment and care overall
Clinical Standards	**Does the model deliver Clinical standards?**	We are confident that the model will deliver services that meet Clinical standard(s) and are better able to meet standards referred to in clinical guidance	**I am kept safe and well looked after** – services will be provided safely 24/7 (I will receive care of the same standard at all times of day) – the people looking after me will have the right level of training and get enough experience/ practice to maintain their skills
Workforce	**Does this model enable sufficient recruitment and retention** (to address workforce challenges within the case for change)?	We are confident the model will address the current workforce challenges and enable the Humber health and care system to recruit and retain the workforce required to staff this model of care	**There are enough staff with the right skills and experience to look after me** – there are enough of the right staff to provide the care I need – the people treating me have time to care
	Does this model provide sufficient flexibility to meet our wider workforce ambitions (e.g. improve training opportunities, R&D)?	We are confident the model will be flexible enough to enable our workforce to access a range of wider opportunities and achieve wider ambitions	– we provide the best training, development and research opportunities for our teams
Clinical Outcomes	**Does the model deliver good patient outcomes?**	We are confident that the model will deliver good outcomes for patients and support delivery of the National Outcomes Framework	**Things go well for me…** – I am given the best possible chance of recovering from illness or injury – my care and treatment will help me to have a good quality of life
	Does the model deliver good patient experience?	We are confident that the model will ensure people have a positive experience of care	**… and I am satisfied with my care** – when I do need to go to hospital, it will be the best possible experience
Health (in)Equalities	**Does the model improve equity of access to services?**	We are confident that the model reduces barriers for those who find it more difficult to access care	**Everyone can access care, especially those most in need** – care and treatments are of the same standard for all patients regardless of where they live – people who find it most difficult to access care are prioritised to ensure their needs are met – ways of working help to improve the life chances of people in our more deprived areas
	Does the model contribute to reducing health inequalities in the Humber?	We are confident the model can contribute to reducing health inequalities in the Humber in the longer term	

Sustainability	**Is the model sustainable to implement and deliver in the long term?**	We are confident the model will "future-proof" services	**I know services will be there when I need them** – services are fit for the future and can be maintained in the longer-term
	Does the model have a negative impact on partners or other providers?	We are confident the model will not destabilise neighbouring health systems or put significant extra pressure on partners within the Humber health and care system	– changes made in one area won't cause other services to be overwhelmed or disappear
Travel & Transport	**Does the model improve transport and accessibility of care?**	We are confident that transport will be available for patients and carers to get to the place of care	**I can get there (and park)?** – services will be easy to get to – transport will be available
	Does the model impact on travel times for patients?	We are confident that overall patients and service-users will be able to get to the place of care	– people in need will be able to get to where they need to be
	Is there any travel impact on blue light services	We are confident the model will not have a negative impact on overall demand for ambulance services	– ambulances will be able to get to people in need
Estates and Infrastructure	**Is the infrastructure needed to support the model available?**	We are confident that the physical and digital infrastructure will be there to enable the model to work, and the scale of investment required is realistic and achievable in current circumstances	**I am looked after in good quality buildings that have the latest equipment** – buildings are improved so that services can work better – digital systems can talk to each other and are more efficient
Finance	**Is the option affordable?** **Will the model be cost effective to implement and deliver in the long term?**	We are confident that the model can be delivered within the resource envelop available	**Services are good value for money**

Table 10.4 Evaluation Framework

10.4.3 The Evaluation Process

The evaluation process was iterative and responsive to feedback and issues raised through our engagement. The process adopted ***a multi-step, multi-faceted approach***, to gradually narrow down the possible solutions to the options that are most able to address the issues identified within our Case for Change and provide the best possible solutions for our population.

Evaluation Workshops – Step 1 (October to December 2021)

- Workshop approach to consider advantages and disadvantages of high-level models.

Evaluation Workshops – Step 2 (February to March 2022)

- Balanced room workshops to assess a range of possible combinations and variations.
- Use of small multiples approach.

Multifaceted Analysis (September 2021 to January 2023)

- Safety of maternity models (Ockenden review)
- Travel and accessibility
- Displacement impact on neighbouring health economies
- Economic and Social impact
- Workforce modelling

Financial Affordability Analysis (January to May 2023)

- Capital impact assessment
- Revenue impact analysis

Summary Box 10.1 – overview of evaluation process

10.4.3.1 Step 1 Workshops – Advantages and Disadvantages

Following the development of the potential models of care for Urgent and Emergency Care, Maternity, Neonatal Care and Paediatrics and Planned Care, an assessment of the models and site-specific options commenced in late 2021.

A series of workshops took place during November and December 2021 involving clinicians and wider partners from across the health and care sector to provide analysis of the strengths and weaknesses of each of the different potential models of care. Over 150 stakeholders were invited via email to take part in the workshops. This included:

- Clinicians from both acute trusts, primary and community care across the Humber.
- Managerial and other non-clinical professionals from acute trusts, CCGs and other providers.
- Citizen’s Panel members, patient representatives, voluntary sector partners and other lay members including representation from neighbouring counties.

In total, five workshops took place involving approximately 117 people. This included three clinical workshops, a workshop with the Programme’s Citizen’s Panel and other VCSE stakeholders[284] and an

[284] Due to adverse weather conditions, this workshop was cancelled. However, two participants still attended, and their feedback was captured and detailed in the Evaluation Feedback Report. The same participants were invited to take part in the workshops as part of Step 2.

additional workshop with the Humber, Coast and Vale Maternity Voices Partnerships (MVP) Group[285] to specifically consider the models for Maternity, Neonatal Care and Paediatrics. Further details of the workshops can be found within the engagement report.[286]

Clinicians, managerial teams and public and service-user representatives were asked to identify the key advantages and disadvantages of each of the potential models of care across the three workstreams. Three high level models for Urgent and Emergency Care and Maternity, Neonatal care and Paediatrics were evaluated together and strengths and weaknesses of each considered; Planned Care models were considered separately.

As a result of the feedback, some models / variations were not taken forward into the next stage of evaluation and some previously discounted models were reconsidered for further evaluation. The workshops undertaken during step 1 of the evaluation also helped to identify key areas of focus for the remaining phases of evaluation.[287]

The actions taken and outcomes from this stage of evaluation are summarised in the table below.

Timeline	Action Taken	Outcomes
October to December 2021	Five workshops reviewed the high-level models for Urgent and Emergency Care, Maternity, Neonatal Care and Paediatrics and Planned Care. Advantages and Disadvantages of each model identified by multi-disciplinary stakeholder group.	Some models ruled out based on strong clinical consensus regarding safety (hurdle criteria) and effectiveness of the service model.

Table 10.5 Summary of Evaluation Process Step 1 Workshops

10.4.3.2 Step 2 Workshops – Small Multiples

The next stage of the evaluation process was undertaken from January to May 2022. This involved multiple workshops, following a balanced room approach.

In total, five workshops took place during March 2022. Over 300 stakeholders from a range of different perspectives were invited to take part to ensure a wide range of perspectives across clinical, non-clinical and public/patient representation. This included:

- Clinicians, nurses and allied health professionals from acute, primary and mental health care
- Managerial and other non-clinical professionals from acute trusts, CCGs, local authorities, universities and wider partners
- Citizen's Panel members, patient representatives, voluntary sector partners and other lay members

[285] Maternity Voices Partnerships (MVPs) are teams of women and their families, commissioners and providers, working together to review and contribute to the development of local maternity care. MVPs serve the needs of local women and families, gathering feedback and advising those planning and delivering services from a service-user perspective.
[286] Humber and North Yorkshire Health and Care Partnership (July 2022) *Hospital Services for the future: Evaluation Workshops Feedback Report* Evaluation Feedback Report
[287] *Evaluation Summary Report* v0.4 (June 2022) see document library

A total of 130 people participated in the workshops and stakeholders also had the opportunity to access the scoring process outside of the workshop if they were unable to attend. A small number of individuals took up this opportunity.

To increase participation and accessibility, a hybrid approach to the workshops was adopted with both virtual and in-person options for people to join. Attendees used the co-produced evaluation framework and questions to methodically evaluate and score all of the models, potential variations and site options using small multiples to provide a judgement on how well each model/variation met the different criteria based on their particular area of knowledge and expertise. Participants were encouraged to discuss their proposed scoring and reasoning within their small groups (minimum of 2 participants and maximum of 10).

Within the workshops, participants were asked to use small multiples to express their views on the relative benefits and disbenefits of each model.[288] This approach has been adopted due to the variation of objective and subjective evaluation criteria. In general, the small multiples that were applied within the evaluation process can be defined as:

These were applied to each of the models of care and site options supported by:

- Key questions against each category (criterion)
- Definition against each key question
- Definition against each small multiple

A comprehensive evaluation evidence pack was shared with all participants involved in advance of the workshops to support them to participate. The evidence pack included supporting data and references specific to each of the criteria.[289]

To ensure a robust and consistent process to evaluation was undertaken, step 2 of the evaluation process reviewed all possible combinations of the models for urgent and emergency care and maternity, neonatal care and paediatrics, unless there was a clear rationale from step 1 to discount the model/variation. This included reviewing some previously discounted models/variations.

As a result of the feedback and scoring provided, key areas for further analysis were identified in order to complete step 2 of the evaluation process and confirm the models of care to be taken forward for public consultation. The outputs of the Step 2 evaluation workshops are set out in detail within the feedback report.[290]

The actions taken and outcomes from this stage of evaluation are summarised in the table below.

[288] Small multiples are a mechanism of displaying multiple forms of analysis compared in an array side by side or grouped to allow for a simple visual comparison of options. They are based upon a simple definition and use a consistent form of representation to allow the reader to interpret impact.
[289] *HASR Evaluation Evidence pre-reading pack* – see document library
[290] Humber and North Yorkshire Health and Care Partnership (July 2022) *Hospital Services for the future: Evaluation Workshops Feedback Report* Evaluation Feedback Report

Timeline	Action Taken	Impact
January to March 2022	Five workshops reviewed the possible models (site-specific options) for Urgent and Emergency Care and Maternity, Neonatal Care and Paediatrics. Small multiple analysis of each model undertaken.	Proposed some models be ruled out based on strong clinical consensus regarding safety (hurdle criteria) and effectiveness of the service model. Identified areas of focus to complete evaluation.

Table 10.6 Summary of Evaluation Process Step 2 Workshops

10.4.3.3 Multifaceted Analysis – approach

To provide a fully rounded evaluation of each of the potential models of care, detailed modelling work was undertaken in a number of key areas. Some of this work took place prior to the evaluation workshops, some was undertaken concurrently, and some was commissioned following the workshops, based on feedback that identified some areas as requiring further information/analysis.

A **comprehensive library of assumptions** was developed and agreed, across all key stakeholders to underpin the modelling work undertaken.[291] The assumptions were tested and sense-checked against strategies and plans in parallel programmes of work to ensure consistency of ambition and strategic direction across the Humber health and care system, taking account of a range of factors, including:

- Natural population growth using ONS projections.
- Non-demographic specialty-specific growth.
- Changes to demand based on pathway changes or other interventions.

The following areas of analysis were undertaken to support evaluation of the potential models of care:

- Ockenden review – reassessment of safety within the maternity models
- Displacement impact on neighbouring health economies
- Travel and accessibility
- Economic and social impact and health inequalities
- Workforce modelling

These analyses were undertaken to support application of the evaluation framework that was co-produced through our engagement with clinicians, patients, the public and other stakeholders.

10.4.3.3.1 Ockenden review

The findings, conclusions and essential actions from the independent review of maternity services at the Shrewsbury and Telford Hospital NHS Trust report (the Ockenden report), was published on 30th March 2022.[292] The majority of the work undertaken to develop the potential models of care took place prior to the publication of the report. It was important therefore to review the models in light of the report and its recommendations.

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[291] Assumptions Log – see document library
[292] Ockenden, Donna (2022) *The independent review of maternity services at the Shrewsbury and Telford Hospital NHS Trust* The Ockenden Report (part 2)

The key recommendations include requirements in relation to:

- **Training and development –** Ensuring sufficient staffing capacity to provide the required training and development opportunities for midwives at all stages of their careers and ensure all staff have up to date skills training and know how to handle common obstetric emergencies.
- **Risk management –** ensuring women with additional risk factors are provided with the specialist care they need, ensuring all women have access to information to make informed choices about where to give birth and putting in place safe staffing models.
- **Staff skills and safer care –** ensuring staff with relevant skills in neonatal care and high dependency maternity care are always available where women are birthing babies.

The potential models of care (and variations) were reviewed against the recommendations from the Ockenden Report, in particular those relating to workforce, training and skills. Workforce modelling and assumptions were re-worked, based on the recommendations and these were tested with a multi-disciplinary group of clinicians and key stakeholders. A workshop took place in May 2022, bringing together obstetric and midwifery teams, the programme team and other key stakeholders and partners to review the key Ockenden recommendations and confirm the models of care (and variations) that could be safely delivered in light of those recommendations and findings.

This work confirmed the views expressed by staff, service-user representatives and other stakeholders through the evaluation workshops that a Standalone Midwifery-led unit (MLU) could not be delivered safely on the Local Emergency Hospital site and therefore should not be included as an option within the proposals taken to consultation.

10.4.3.3.2 Displacement impact on neighbouring health economies

Detailed activity modelling was undertaken to provide an understanding of the impact of each of the potential models and site options on patients. This activity modelling provided the foundation for mapping the travel impact, identifying the workforce and estates requirements to deliver the different models of care, and identifying the potential impact on neighbouring providers of healthcare services.

Using 2019/20 patient-level activity data, data models were built to support assessment of the different potential models of care as these were developed by clinical teams.[293] The activity modelling for Urgent and Emergency Care and Planned Care potential clinical models was undertaken using a bespoke data model designed by our in-house analytical teams.

Activity modelling within the maternity, neonatal care and paediatric workstream utilised a data model developed by Deloitte, which was commissioned specifically for the Humber Acute Services Review and developed during the Case for Change stage of the programme. There were parts of the Deloitte model which did not provide the necessary functionality and therefore additional analysis was undertaken locally. This including the following:

- **Neonatal care provision**: The Yorkshire and Humber Neonatal Operational Delivery Network (ODN) were already modelling this provision in response to the national Neonatal Critical Care

[293] 2019/20 was used as the baseline year because this was the latest complete year of data that was available to the programme that was not skewed by the impact of the COVID-19 pandemic. 2019/20 activity data was used throughout the development of clinical models to ensure consistency across the different workstreams.

Review. To ensure consistency and avoid duplication of effort, it was agreed to use the outputs of the ODN modelling.

- **Paediatric Assessment Unit (PAU)**: the Deloitte model was not configured in such a way to model PAU activity so local analysis had to be undertaken outside of the model and factored back in to the model.

Activity data was aggregated from postcode level to LSOA (Lower Layer Super Output Area) which is a geographic hierarchy used for reporting small area statistics to ensure anonymity of patients, particularly in small post-code areas. Drive times for each LSOA to hospital site were applied to establish the nearest sites for each scenario. This was used to determine displacement and out of area impact as well as travel time impact of each scenario.

Postcode sensitivity analysis was applied to the activity modelling to identify the numbers of patients per specialty that could be displaced to a neighbouring hospital due to the service configuration changes under each of the shortlisted options, each of which were mapped against their nearest hospital to understand impact by each provider and site. Attendance numbers were divided by the average admission rate and multiplied by the average length of stay to give the number of bed days increase this would mean over a year. The potential increase in bed days was then divided by 365 to give the expected number of additional beds that would be required in each scenario.

Assumptions regarding admission rates and average length of stay were discussed and agreed through regular liaison meetings with Lincolnshire and Doncaster systems and acute trust representatives. The impact of displacement on neighbouring trusts was reviewed during regular liaison meetings to identify the threshold whereby neighbouring systems could be destabilised.[294]

The substantial impact on neighbouring providers in Lincoln and Doncaster of displaced activity was a key factor in ruling out the potential Acute / Elective model.

10.4.3.3.3 *Travel and accessibility*

All patient journeys within the baseline year (2019/20) were mapped against the patient's postcode and activity type to develop models that could be used to quantify the impact of each model in terms of increase or decrease to average patient journey time to existing or new sites for care. [295]

This baseline has been used to measure the impact of each of the potential future models of care in terms of travel time for patients to access care. Under the different potential models of care, travel times are likely to increase for some patients and decrease for others and these impacts are different for each model and site option.

Journey time changes were grouped into categories to support analysis:

[294] A summary of the outputs from this analysis is set out in appendix 0.
[295] All modelling was undertaken using postcode-level analysis to calculate travel distances between patient postcodes and the hospital sites. To enable the travel impact of the new central site model to be undertaken, the postcode DN38 6DW, near Barnetby Top, was utilised. It is important to note that land in this area is not owned by the local NHS nor have any site evaluations been undertaken regarding the feasibility of the site for a hospital to be built there. The postcode was used for modelling purposes only.

Definition	Description	Label
Positive impact (all)	Reduction in journey time by more 10 minutes	< -10mins
Neutral	Reduction in journey time by less than 10 minutes and/or increase in journey time by less than 10 minutes	-10 mins to < 10mins
Negative impact (moderate)	Increase in journey time by 10 to 30 minutes	10 mins to 30 mins
Negative impact (significant)	Increase in journey time by more than 30 minutes	> 30 mins

Table 10.7 Journey time categories

Travel time impacts were mapped across all the potential models of care to provide a total impact for each potential model (variation) on a site-specific basis.[296] The models (variations) were then ranked from least to most impact across all of the different site options. Travel impact maps were created for all models.[297]

Alongside travel time mapping for patients accessing care themselves, we also considered the impact on ambulance services of the potential models of care. A specialist organisation ORH (Operational Research in Health Ltd) was commissioned to model the impacts of the potential clinical models on the operations of our ambulance service provider in Northern Lincolnshire – East Midlands Ambulance Services NHS Trust (EMAS). The review undertaken by ORH involved modelling changes to services provided at Grimsby Diana Princess of Wales (DPoW) and Scunthorpe General Hospital (SGH).

2019/20 EMAS clinical impression data was collected to determine patients who would no longer travel to either DPoW or SGH as a result of the potential models and proposed changes. The 2019/20 EMAS clinical impression data included diagnosis from clinicians on scene, which enabled the programme team to determine which patients would be taken to the Acute site or Local Emergency Hospital within the different potential clinical models. Within the Acute/Elective model, emergency ambulance transport is effectively removed from the Elective hospital site.

The programme team also identified the number of secondary transfers that would be required from the Local Emergency Hospital to the Acute hospital based on historical activity data and clinical review of transfer conditions within each model. It was assumed (based on historic activity data) that 20% of these transfers would be undertaken by EMAS emergency crews, with the remaining 80% on a separate contract and not included within the ORH modelling.

Using their simulation model, ORH modelled the changes to patient flows in each of the different scenarios, including the impact of secondary transfers and the additional demand this would create for EMAS. This provided an assessment of the impact of each model on ambulance response times, travel times and hospital flow against the potential models of care. The outputs also provide an assessment of any additional resourcing required to mitigate any impacts. [298]

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[296] Impact was measured in terms of ***change to*** existing travel times and the outputs of the analysis are expressed as increases or decreases on the current travel time rather than as absolute or total travel times. This means that within the category of "significant negative impact", where the patient's journey time has increased by more than 30 minutes, the real time impact could vary substantially between different individuals. For example, the impact for one individual could be an increase from a current travel time of 5 minutes to a new travel time of 40 minutes and for another individual it could represent an increase from a current travel time of 60 minutes to a new travel time of 95 minutes.

[297] Details of the travel modelling outputs are set out in appendix 10.18.1.

[298] A summary of the outputs from this analysis is set out in appendix 0.

In addition to any impact on patients of having to travel to a different hospital site, it was also important to consider the impact on staff of the different potential models of care. Analysis and geo-mapping of where all existing staff live by service and type was undertaken to enable consideration of the impacts of different potential models on different staff groups to be undertaken at a high level.[299]

The substantial impact on patients, carers and staff of additional travel time and the impact on the ambulance service were key factors in ruling out the potential Acute / Elective model (including the scenario involving a New Hospital for Northern Lincolnshire).

The impact on patients, carers and staff of additional travel time and the significant number of secondary transfers required were key factors in ruling out the potential variation to consolidate Care of the Elderly and General Medical inpatient beds within the Acute / Local Emergency Hospital model.

10.4.3.3.4 Economic and social impact and health inequalities

Another important aspect of the evaluation framework was identifying the impact of the models on our local economy and the potential impacts in relation to existing health inequalities, that we are seeking to address through improved pathways and provision of better, more joined up care.

Access to healthcare services, particularly acute hospital care, plays only a small role in tackling health inequalities. However, hospitals can play a significant role in addressing some of the social determinants of health, particularly in their roles as employers. Hospitals are significant players in their local economies, contributing value to the economy through the provision of jobs and wages that can be spent in local businesses, generating demand for (and spend in) ancillary industries and providing training and development opportunities for local people.[300]

By far the biggest driver of economic impact is the role the hospital trusts play in creating employment opportunities for people living in the local area. The provision of jobs, careers and good employment opportunities generates direct benefits to the local economy such as:

- increased household disposable income that can be spent in the local economy.
- increased tax revenue from income tax and NI receipts.
- reduced reliance on taxpayer-funded benefits, such as Job Seekers Allowance.

It also generates a number of indirect benefits (that can be harder to quantify / measure), such as:

- improvements to health and wellbeing of those in work, specifically the benefits of ‘good work’.
- increased retention of local talent through better opportunities for local people.
- increased revenue for educational institutions.

To support the evaluation of the potential models of care, the existing workforce was mapped using their home postcode by function and by band to determine the likely impact on staff of moving services from their current site, particularly those on lower incomes (bands 1-4).[301]

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[299] Details of the staff geo-mapping outputs are provided in appendix 10.18.3.
[300] See section 1.2.2.1 for further details.
[301] The outputs from the staff travel mapping are set out in appendix 10.18.3.

In addition, we undertook additional analysis of the outputs of the travel analysis to provide a deeper level of understanding as to whether the models would have a disproportionate impact on people from more deprived communities. The travel mapping outputs were analyses against IMD index of deprivation to provide an overview of the differential impact on more deprived communities in terms of additional travelling time.[302]

The potential negative impact on health inequalities and impact on the local economy in Scunthorpe and Grimsby was a factor in ruling out the New Hospital for Northern Lincolnshire potential model.

10.4.3.3.5 Workforce modelling

Extensive workforce modelling was undertaken to determine the impact of each of the potential models of care on the workforce challenges faced. In addition, it provided vital information to support the financial analysis of the models. A nine-step approach to workforce modelling was adopted, relying heavily on clinical input/stakeholder engagement, the application of critical reference points (such as the various Royal College safer staffing standards and Ockenden recommendations) combined with traditional gap analysis and feasibility testing.

Figure 10.13 Summary of workforce modelling methodology

[302] The outputs from this analysis – showing the total number of people impacted within each scenario mapped against IMD deciles – is set out in appendix 0.

Underpinning the nine-step methodology is a 'Zero Basing' approach where the workforce plan has been built from the ground up. This purposeful approach was taken so inefficiencies in the current workforce, including non-compliance with workforce standards, are not carried forward into any future workforce plan. This resulted in increases to some staff groups against the current baseline in order to meet key standards that are not currently being delivered.

Within the nine-step approach, wherever possible, recognised workforce planning methodologies were used, such as the Safer Nursing Care Tool (SNCT), HUTH/NLaG patient acuity audits and recognised Health Education England (HEE) establishment modelling tools. Where established tools could not be used for zero-basing[303] current workforce plans/budget establishments were adapted using a percentage upscaling approach, using evidence from contemporary business cases. Finally, the methodology utilised the activity modelling undertaken through the programme to define the required workforce for the anticipated future levels of activity.

To develop the workforce plan key assumptions were agreed and consistently applied to the development of the plans.

Medical staffing was calculated using the following assumptions:

- Consultants/SAS WTE was calculated on National Standard 10PA job plan contract (40hr week).
- Consultant time was modelled on 8 PAs per week providing direct clinical care and associated duties (DCC) and 2 PAs per week for leadership, training and other responsibilities (SPA entitlement).
- Specialist and middle grade doctors were modelled on 1PA per week for SPA time and the remaining 9 on providing direct clinical care and associated duties (DCC).

Nursing and AHP staffing requirements were calculated using the following assumptions:

- Ward configuration was assumed at a maximum of 28 bed per ward in order to calculate the nursing requirements per bed.
- The Safer Nursing Care Tool (SNCT) and recognised workforce methodology was utilised for calculating the establishments required, which takes account of patient acuity levels within different settings and specialties and provided a recommended nursing requirement for each model. Outputs were triangulated via the Chief Nurse team.[304]

An uplift was applied across all workforce modelling to account for absence due to sickness and training – the respective uplift for each workforce cohort was calculated based on recent trends.[305] Staffing excluded community midwifery, community paediatric nursing, CNS's, ward managers. Elective staffing levels were modelled using GiRFT standards and these were applied to both BAU and all models.

Workforce modelling outputs show that the potential models of care will help to address the workforce challenges set out within the Case for Change.

[303] For example, BirthRate+ methodology is NHS endorsed but not widely available, SNCT tool for EDs is not presently available.
[304] Ward staffing proposed is based on Dec 2021 acuity (the last audit available at the time of modelling).
[305] Full details of the assumptions used within the workforce modelling are included within the assumptions log. (see document library). Outputs from the workforce modelling are set out in appendix 10.19.

10.4.3.3.6 Summarising evaluation outputs

To provide a better overall picture of the impacts of each of the potential scenarios considered, all outputs from the evaluation workshops, activity modelling, travel mapping, economic and workforce analyses were brought together into a single evaluation matrix. This work was undertaken iteratively and, as a result, not every scenario has an output for every line of evaluation as different scenario were excluded at different stages in the process.

A RAG rating system was used, combined with the summary numbers of each of the elements of modelling to provide a visual summary of the evaluation outputs. These outputs were incorporated alongside the used in addition to the scoring provided by stakeholders through the evaluation workshops. The table below describes the thresholds used to produce the RAG rating.

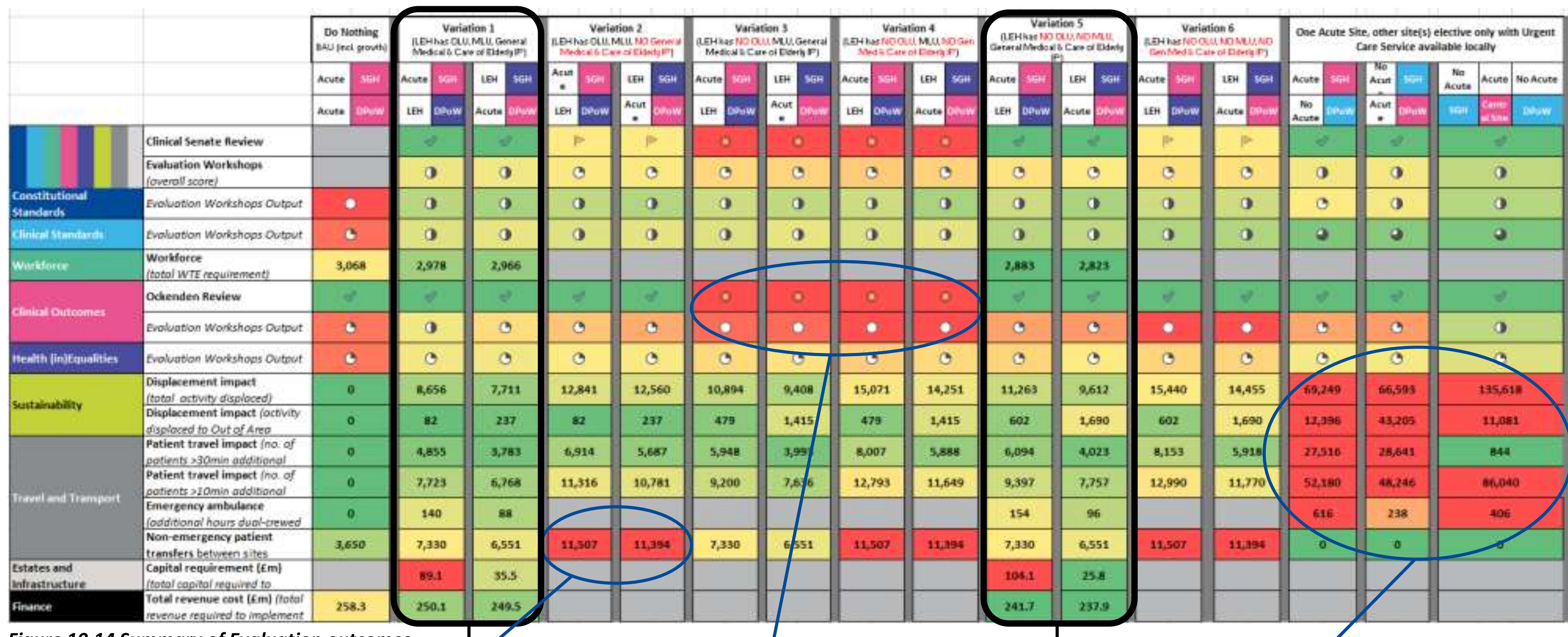
Criterion	Measure	Thresholds		
All	**Clinical Senate Review (2022)**	No concerns	Some concerns	Significant concerns
Workforce	**Workforce** *total WTE requirement*	BAU -5% (2915)	BAU 'do nothing' (3068)	BAU + 5% (3221)
Clinical Outcomes	**Ockenden Review**	high degree of confidence can comply with recommendations		little or no confidence can comply with recommendations
Sustainability	**Displacement impact** *(total activity displaced)*	<1% of all patient activity impacted	5% of all patient activity impacted	10% of all patient activity impacted
Sustainability	**Displacement impact** *(activity displaced to Out of Area hospitals)*	no additional activity (0)	5 additional patients per day (1825)	10 additional patients per day (3650)
Travel and Transport	**Patient travel impact** *(no. of patients >30min additional travel)*	<1% of all patient activity impacted	5% of all patient activity impacted	10% of all patient activity impacted
Travel and Transport	**Patient travel impact** *(no. of patients >10min additional travel)*	<1% of all patient activity impacted	5% of all patient activity impacted	10% of all patient activity impacted
Travel and Transport	**Emergency ambulance** (*additional hours dual-crewed ambulance/week*)	no additional ambulance hours (0)	one additional ambulance 24/7 (168)	2 additional ambulances 24/7 (336)
Travel and Transport	**Non-emergency patient transfers** between sites	no journeys (0)	10 additional journeys per day (7,300)	20 additional journeys per day (10,950)
Estates and Infrastructure	**Minimum capital requirement**	Affordable within internal capital		Unaffordable with internal capital
Finance	**Revenue cost** *(£m)*	BAU -5% (245)	BAU 'do nothing' (258)	BAU + 5% (271)

Table 10.8 Thresholds used within evaluation matrix

Timeline	Action Taken	Impact
September 2021 to January 2023	Comprehensive and wide-ranging analysis of the impacts and benefits of each of the potential models of care.	15 (site-specific) potential solutions were considered; 11 variations were discounted.

Table 10.9 Summary of Evaluation Process Step 2 – Multifaceted analysis

The table below summarises the outputs from across all evaluation streams and highlights key factors that enabled some of the potential models to be ruled out.



		Do Nothing BAU (incl. growth)	Variation 1 (LEH has OLU, MLU, General Medical & Care of Elderly IP)		Variation 2 (LEH has OLU, MLU, NO General Medical & Care of Elderly IP)		Variation 3 (LEH has NO OLU, MLU, General Medical & Care of Elderly IP)		Variation 4 (LEH has NO OLU, MLU, NO Gen Med & Care of Elderly IP)		Variation 5 (LEH has NO OLU, NO MLU, General Medical & Care of Elderly IP)		Variation 6 (LEH has NO OLU, NO MLU, NO Gen Med & Care of Elderly IP)		One Acute Site, other site(s) elective only with Urgent Care Service available locally		
		Acute SGH	Acute SGH	LEH SGH	Acute SGH	LEH SGH	Acute SGH	LEH SGH	Acute SGH	LEH SGH	Acute SGH	LEH SGH	Acute SGH	LEH SGH	Acute SGH	No Acute SGH	No Acute / Acute / No Acute
		Acute DPoW	LEH DPoW	Acute DPoW	LEH DPoW	Acute DPoW	LEH DPoW	Acute DPoW	LEH DPoW	Acute DPoW	LEH DPoW	Acute DPoW	LEH DPoW	Acute DPoW	No Acute DPoW	Acute DPoW	SGH / Centre of Site / DPoW
	Clinical Senate Review																
	Evaluation Workshops *(overall score)*																
Constitutional Standards	*Evaluation Workshops Output*																
Clinical Standards	*Evaluation Workshops Output*																
Workforce	Workforce *(total WTE requirement)*	3,068	2,978	2,966							2,883	2,823					
Clinical Outcomes	Ockenden Review																
	Evaluation Workshops Output																
Health (in)Equalities	*Evaluation Workshops Output*																
Sustainability	Displacement impact *(total activity displaced)*	0	8,656	7,711	12,841	12,560	10,894	9,408	15,071	14,251	11,263	9,612	15,440	14,455	69,249	66,593	135,618
	Displacement impact *(activity displaced to Out of Area*	0	82	237	82	237	479	1,415	479	1,415	602	1,690	602	1,690	12,396	43,205	11,081
Travel and Transport	Patient travel impact *(no. of patients >30min additional*	0	4,855	3,783	6,914	5,687	5,948	3,99[illegible]	8,007	5,888	6,094	4,023	8,153	5,918	27,516	28,641	844
	Patient travel impact *(no. of patients >10min additional*	0	7,723	6,768	11,316	10,781	9,200	7,6[illegible]6	12,793	11,649	9,397	7,757	12,990	11,770	52,180	48,246	86,040
	Emergency ambulance *(additional hours dual-crewed*	0	140	88							154	96			616	238	406
	Non-emergency patient transfers between sites	3,650	7,330	6,551	11,507	11,394	7,330	6,551	11,507	11,394	7,330	6,551	11,507	11,394	0	0	0
Estates and Infrastructure	Capital requirement (£m) *(total capital required to*		89.1	35.5							104.1	25.8					
Finance	Total revenue cost (£m) *(total revenue required to implement*	258.3	250.1	249.5							241.7	237.9					

Figure 10.14 Summary of Evaluation outcomes

Consolidation of Gen Med and Care of Elderly discounted due to

- Impact on frail, elderly patients of secondary transfers.

Standalone Midwifery-led Unit discounted due to

- Safety concerns of Clinical Senate, staff, service-users.
- Low anticipated demand.

Acute / Elective Model discounted due to

- Destabilising impact on neighbouring providers.
- Significant impact on patient and staff travel.

Acute / Local Emergency Hospital (both with OLU)

Acute / Local Emergency Hospital (without OLU)

10.4.3.4 Financial analysis

Financial analysis of the proposals was undertaken after the other elements of the evaluation process had been completed. Financial analysis was only undertaken on those models and variations that were considered clinically viable and able to improve the quality and sustainability of services and address the issues highlighted within the Case for Change. The financial case has been made on the basis that the options identified should deliver a financial position which is better than the current business as usual (BAU) or 'do nothing' scenario. These financial considerations fall into two main areas – capital investment and revenue affordability.

10.4.3.4.1 Capital Affordability

All of the potential models of care evaluated would require some changes to site configuration either on a small or larger scale and as such there are associated capital and revenue impacts. Service provision requires capital investment to ensure any change in configuration of the hospital services are:

- Fit for purpose.
- Right-sized to ensure capacity meets the change in demand.
- Reconfigured to meet the required building and quality standards (HBN/HTM).

Assumptions were taken into consideration based on existing service provision, forecast change in the near future (e.g. Emergency Department builds in DPoW and SGH that were nearing completion) and the space requirements and clinical adjacencies to achieve the future potential of models of care. Each of the potential models was reviewed against current service provision and whether investment would be required for new builds or refurbishment to ensure successful delivery of the services in the future. In undertaking this work, the following assumptions and considerations were made:

- The space requirements are based on the 'original Models 5yr growth' forecasted models.
- The existing bed space numbers/quantities for the UEC areas are based on the completion of both new Emergency Department projects at SGH and DPoW.
- There is a working assumption that the proposed capital solutions are operationally and technically deliverable, further feasibility work is required to provide a detailed technical solution.
- The calculations are based on retaining exiting bed/space/place/theatre quantities without undertaking further upgrades to achieve full HTM/HNB Compliance.
- There is a working assumption that the existing/generated spare capacity can be re-utilised to address shortfalls under each of the models.
- Goole and Castle Hill Hospital have not been modelled due to little/no change to the configuration of the services currently delivered from the sites.

The totals for bed requirements and outline costs are net of any investment that would be required to respond to growth in demand (not associated with the proposed service changes) or comply with legal or regulatory requirements.

The capital cost estimates for each of the potential options and variations was undertaken by Cost Advisors and these estimates follow best practice and the guidance within the NHS Capital Investment Manual. The expected range of capital investment required to deliver the options that were evaluated is summarised below.

Models		Capital		
		Est. cost (£m) for implementation (exc. BAU)	Approx. total (m^2) required	Approx. total m^2 cost (£000) variance
Business as usual (BAU at 2025/26)				
Acute / Local Emergency Hospital (both with OLU)	**DPoW as Acute SGH as LEH** (*with OLU*)	**35.5**	5,257	1,500 - 4,770
	SGH as Acute DPoW as LEH (*with OLU*)	**89.1**	12,998	1,500 - 4,770
Acute / Local Emergency Hospital (without OLU)	**DPoW as Acute SGH as LEH** (*without OLU*)	**25.8**	4,308	1,500 - 4,770
	SGH as Acute DPoW as LEH (*without OLU*)	**104.1**	14,090	1,500 - 4,770

Table 10.10 Summary of financial impacts - capital

Early in the programme it was envisaged that the Trusts would be successful with their bid against the New Hospitals Programme for substantial capital investment to upgrade the hospitals. Confirmation was received on 24th May 2023 that the Expression of Interest submitted in September 2021 was not successful in securing investment through the New Hospitals Programme and therefore change proposals would have to be delivered from within existing financial resources. There were only 5 from 128 submissions that could be accommodated within the national capital allocation, which were schemes prioritised based on significant safety concerns.

The minimum investment required to the existing infrastructure, with DPoW as the acute site, was estimated at £25.8m and this level of investment has been agreed to be prioritised from the Trust's existing capital programme. The minimum investment for SGH being the acute site was estimated at £89m. This level of investment is not deliverable within the Trust's internal resources.

NHS England require any service change to be financially affordable from within existing financial resource.

Based upon the capital affordability analysis, only one of the two site scenarios – where specialist urgent and emergency care and paediatric inpatient services are consolidated at Diana Princess of Wales Hospital, Grimsby (DPoW) – was considered viable to be taken forward for consultation.

10.4.3.4.2 Revenue Affordability

The Humber Acute Services programme was clinically driven, to ensure high quality, sustainable services can be provided into the future. The programme was not initiated in order to save money, however, it is important to recognise the challenging financial context that the health and care system across the Humber and North Yorkshire is operating within and seek to support system-wide efforts to address the financial challenge.

The current underlying combined deficit across the two trusts is over £83m. With the expected demographic changes, demand growth with no transformation, pathway changes and ongoing workforce challenges, this would deteriorate further. This position – continuing with services as

currently organised and applying expected growth in demand – was used as the comparator BAU against the options identified in the Pre-Consultation Business Case (PCBC).

Financial modelling was undertaken to determine the revenue impact of the potential models of care. This was undertaken as the final stage of the evaluation process. The financial modelling undertaken to support the PCBC focussed on staffing requirements for each of the models, linked to activity and growth assumptions since pay is generally 70% of the cost base.

Running duplicate services across multiple sites presents significant workforce challenges and can result in a poor employee experience for some of the Trust's medical and non-medical teams. This compounds an already challenging recruitment environment and leads to difficulty in recruiting the right substantive workforce to provide high quality safe care.

The current service configuration and the requirement for consultants and other specialist staff to cover all hospital sites can, at times, limit their ability to provide senior patient reviews. In addition, services are unable to achieve Royal College guidance standards in many areas. Challenges are similar for the non-medical workforce, with senior expertise split across a number of sites. In addition, the learning environment and provision of workforce development is challenging. The current configuration continues to create cost pressures for premium rate working, poor economies of scale and duplication of rotas as well as exacerbating the Trust's ability to resource 'hard to fill' posts.

The activity and growth assumptions, along with the changes proposed to pathways and configuration of services, drive the capacity requirements for the proposed future model of care. A significant element of a hospital's workforce is related to the bed base and ward establishments. There is a net reduction in bed requirements associated with the proposed model of care, which drives a reduction in the required workforce.

The proposed new model of care would result in a reduced staffing requirement of c.195 WTE against the baseline position and around 90.5 WTE compared with the BAU scenario.

Furthermore, the workforce models and transformation of acute services have been designed to foster a more attractive work environment, with reduced reliance on agency and premium staffing. The current level of agency spend at NLaG is over £30m and the financial models assume a reduction in the agency reliance by 50% by year 5, resulting in a net £4.6m saving in the premium element of pay as the substantive vacancies are reduced. In order to reduce the pay bill, the key drivers are:

- Activity and pathway driven changes in workforce e.g. improved pathways of care leading to faster diagnosis and treatment and reduced length of stay, bed reduction, improved rota management and removal of duplication, reducing reliance on high-cost temporary staffing.
- Productivity driven reductions in workforce, leading to fewer WTE to deliver a given quantity of activity e.g. use of technology and improved processes.
- Reduction in the cost per WTE of the future establishment e.g. ensuring that staff spend a greater proportion of their time conducting tasks appropriate to their grade through role re-design and the introduction of more advanced practitioner roles.
- More attractive place to work, innovative and therefore improving recruitment and retention, reducing agency use.

The gross impact on the revenue position of the proposed model of care is summarised below:

Models	Revenue cost est. (£m)	Saving from BAU (£m)
Business as Usual (do nothing)	258.3	-
Proposed model of care	249.5	↓8.8

Table 10.11 Summary of revenue impact

The cost of the 'do nothing' (BAU) position is approximately £258 million. The proposed model of care could be delivered at a cost of around £249.5 million. This represents a **gross** saving of £8.8 million.

We recognise that in moving services and implementing the enabling pathway changes there may need to be a transfer of revenue savings to community and/or primary care services and therefore the net saving to the system may be reduced. Detailed and costed plans for any potential re-investment of resources into out of hospital services will be developed as part of planning for implementation and will form part of the Decision-Making Business Case (DMBC).

As detailed above, the capital cost to deliver the changes is approximately £25 million, which is affordable and deliverable from within internal resources.

Financial modelling outputs show that the potential models of care will help to address the financial challenges set out within the Case for Change.

10.4.3.4.3 Review of Scope – de-coupling maternity and neonatal care

An informal review of the proposals by NHS England and the ICB took place in June 2023. A key issue identified was that the picture and landscape in relation to maternity services, both nationally and regionally, has changed significantly and remains dynamic. As such, it was deemed necessary to de-couple maternity and neonatal services from the other proposals within the Humber Acute Services pre-consultation business case (PCBC) in order to undertake a more comprehensive review of the current provision and future delivery of these services across the full ICB footprint.

This work will continue in parallel and build upon the detailed work and extensive engagement that was undertaken on maternity and neonatal care through the Humber Acute Services programme.

Following the decision to de-couple maternity and neonatal care from the other changes within the business case, the workforce and financial modelling was reviewed and updated in line with the change of scope. De-coupling maternity and neonatal care from the other proposals did not materially change the capital and revenue implications from those associated with the model that was evaluated which included maternity services on both sites. The updated financial and workforce modelling outputs have been included throughout the business case. All activity, displacement and travel modelling were undertaken separately in each service area and then aggregated up, taking account of all relevant interdependencies and therefore the relevant service lines only have been included in the PCBC.

This approach has been adopted to enable the proposals for changes to Urgent and Emergency Care and Paediatric Care to be taken forward for consultation whilst further work continues on maternity and neonatal services.

10.4.3.4.4 Summary and next steps

The financial modelling to date has focussed on the WTE numbers and the correlation with activity and growth assumptions. Detailed work will be undertaken on staffing rosters and the opportunities that some of the reconfigurations proposed will bring in terms of more efficient rostering and more attractive and sustainable rotas. This will help to provide assurance on the current assumed minimum level of savings compared with the BAU model. In addition, more work will be required to assess the impact of the changes on other support and corporate staff. The focus to date has been on medical, nursing, theatre staffing and midwifery.

As pay is generally 70% of the cost base, this has been the focus of the financial assessment at PCBC stage. More detailed work will be undertaken to assess the impact on non-pay costs, including clinical consumables, travel, equipment maintenance, facilities costs, including energy costs, depreciation and cost of capital.

The PCBC has clearly identified significant benefits and the benefits realisation plans will be enhanced as we develop our Decision-Making Business Case (DMBC). This further work with include quantification of benefits in terms of patient outcomes and experience, staff benefits, increased efficiency, reductions in risk and potential cost savings.

Timeline	Action Taken	Impact
January to May 2023	Financial analysis of potential models of care (capital and revenue impacts).	One potential site option discounted due to unaffordable capital requirements. Costed proposals for consultation confirmed.

Table 10.12 Summary of Evaluation Process Step 2 – Multifaceted analysis

Consolidation of specialist services will help to improve the quality and ensure long-term safety and sustainability of inpatient care ensuring everyone across the Humber can access the most highly skilled professionals when they need them.

The key benefits of the proposed model of care include:

- ✓ Make the best use of skilled workforce – reduce duplication.
- ✓ Ensure patients with most complex needs can access specialist care from well-supported teams of highly skilled professionals.
- ✓ Improve training and development opportunities for staff.
- ✓ Develop Centres of Excellence for specific services, building confidence in patients and staff.
- ✓ Support more people to stay well, be seen and treated at or close to home.

The proposed changes would enable us to address critical shortages in workforce, consolidate rotas and improve patient access, waiting times and length of stay, whilst maintaining the majority of services locally.

We recognise that any changes we make will have an impact on patients, carers and staff and for some people will mean longer journey times to access particular hospital services. Detailed impact analyses have been undertaken to quantify the likely impact and develop mitigations.

10.5 Reviews – recommendations and responses

10.5.1 Clinical Senate Review (2020)

	Recommendation	Response
General Recommendations	Reduce the number of options under consideration as rapidly as possible in order to maintain momentum and allow the development of detailed proposals	Long list was reduced following Clinical Senate review to enable detailed clinical modelling to take place
	Work with neighbouring health economies to understand the impact of any changes	Regular meetings established with Doncaster and Lincolnshire
	Focus option development on the south bank to the options of exploring a two-site model of an acute site and a less acute site or the option of one acute site on the south bank.	Provided focus for clinical modelling phase
Urgent and Emergency Care	Both (northern Lincolnshire) sites could deliver an emergency service that will operate using different clinical models. This could include: • emergency medicine consultant service for defined hours and/or a same day or ambulatory emergency care service for defined clinical pathways on the less acute site. • a walk-in service utilising both GPs and Advanced Care Practitioners (ACPs) with appropriate referral to secondary care clinicians in medicine and surgery. • ambulance patients would go directly to a secondary care assessment and both units should have a co-located frailty service. • The need for the models to support sustainable staffing from the anaesthetic and critical care perspective.	Recommendations for less acute site incorporated into Local Emergency Hospital model UCS model developed Frailty service in place Anaesthetics and critical care staffing requirements considered through modelling
	All sites need to offer "front of house" frailty service to allow frail elderly patients to be seen and assessed immediately.	Frailty service recommendations in place – ideas developed further to progress integrated frailty service in the community
	There are alternative roles that can be further considered particularly in terms of avoiding admissions and unnecessary attendance at Emergency Departments	Considerable work undertaken to look at new roles and services as models were developed (e.g. Hospital at Home / virtual wards)
	There are developing models where Emergency Department care can be run by an interdisciplinary medical team with support from specialists when needed.	Integrated Acute Assessment Model developed in Scunthorpe and Grimsby

Maternity, Neonatal and Paediatrics	Any proposals to redesign the services which retain either 2 Obstetric Led Units, or a Local Neonatal Unit, in Northern Lincolnshire must include actions that mitigate the concerns highlighted with workforce availability, critically interdependent services and levels of activity.	Workforce availability considered through detailed modelling phase and incorporated into proposed options
	Any proposals which include a freestanding Midwifery Led Unit in Northern Lincolnshire must demonstrate that the activity will be sufficient to ensure the sustainability of both the MLU and the Northern Lincolnshire neonatal service.	Model was considered, evaluated and discounted, taking these factors into account.
	To fully consider the workforce, resuscitation, stabilisation and transfer skills needed to support the paediatric model which will be required for an inpatient paediatric service at one Northern Lincolnshire site.	Detailed work undertaken as part of developing the clinical models (ongoing).
	To develop the community paediatric services to support the hospital-based service	Hospital at Home service piloted and being developed across the Humber to support the proposals.
Planned Care	To take action ahead of the wider reconfiguration, particularly in ophthalmic surgery, urology and ENT to develop clinical networks working across Hull and East Riding and Northern Lincolnshire to change the way that the workforce delivers care.	Work undertaken to progress this through the Interim Clinical Plan (Programme 1)

Table 10.13 Summary of Clinical Senate recommendations and response (2020)

10.5.2 Clinical Senate Review (2022)

	Recommendation	**Response**
Models of care	There will be a need to ensure there are robust links with a primary care system that has capacity to respond to system demands, especially out of hours, to ensure the success of many aspects of the acute care provision.	Joint working with the out of hospital programme to deliver enabling workstreams.
	Further in-depth travel and transport impact assessments will be required to fully understand the implications of each of the options on both patients, staff and the ambulance provider and with neighbouring hospital trusts to reach a common understanding of potential changes in patient flows as a result of any change.	Travel modelling undertaken and set out in appendix 0
	Consideration should also be given to the ambulance service's ability to respond to the patient transfers that may result from the options that were presented and whether a dedicated patient transport service would be of benefit. Any patients transfers from one site to another would need to be carried out in a timely way that did not result in delays to patient care	20% of transfers modelled within emergency ambulance impacts and non-emergency transfers modelled separated as part of an additional contract (details set out in appendix 10.18.2)
	There would be a need to ensure that there was sufficient available assessment, short stay and inpatient bed capacity,	Capacity modelling undertaken to support

	including at times of surge and increased demand, at the Acute Hospital and LEH sites, under those relevant options, to prevent delays or bottlenecks in patients accessing care.	workforce modelling, capital planning and to ensure services are right-sized.
	There would also be a need for well-developed plans on how patients will be discharged both quickly and safely, and for adequate capacity to be built out of hours to ensure throughput.	Joint working with the out of hospital programme to deliver enabling workstreams.
	It is imperative to assess the impact of the proposed options on the health inequalities in the local populations, a process which would normally be ongoing throughout a programme such as HAS, to ensure that any proposals do not lead to an adverse impact and that appropriate mitigations are put in place.	IIA work undertaken throughout (completed after 2022 review) – see document library
Workforce	The Senate agreed that the first order problem is the recruitment and retention of appropriate workforce for the services to be delivered and, whilst this was not presented as an option for the Senate to consider, it is possible that a new build, single site option might have the most benefit for workforce recruitment and retention.	
	The programme team are encouraged to undertake an in-depth staff travel and transport impact assessment to fully understand the effect of the options on staff displacements and the impact this would have on workforce retention as well as the ambition to be an Anchor organisation.	Staff travel impacts set out in appendix 10.18.3.
	To address recruitment and retention difficulties in some staff groups the panel encourages consideration of a system-wide, multi professional workforce model, incorporating new roles like advanced care practitioners and advanced paramedics able to work within the whole system and with an aim to avoid admissions.	Forms part of the workforce plan – see section 8.3
	To address current and future workforce constraints, the Senate encourages the Trusts to work closely with local universities and medical schools to encourage and promote more local people to train in health care professions. This will encourage a local supply of workforce more likely to remain in the area.	Forms part of the workforce plan – see section 8.3
Digital	The Trusts and partner organisations are encouraged to implement an electronic medical record system that would attain a digital maturity of level 5 against the Healthcare Information and Management Systems Society (HIMSS) standards. This would enable interoperability between systems that would support patient care in hospital and non-hospital settings.	Forms part of the digital plan – see section 0

	A high level of digitalization will be a key enabler to effective and efficient clinical care across both sites. In particular the development of telemedicine is encouraged to allow access to clinical expertise that would reduce the need for travel and patient transfers.	Forms part of the digital plan – see section 0

Table 10.14 Summary of Clinical Senate recommendations and response (2022)

The feedback provided by the Senate panel was considered as part of the final evaluation of the potential models of care. The advice from the Senate helped to confirm the exclusion of certain models (variations) from the options taken forward for consultation and supported the approach that was taken to carrying out the evaluation process (see section 10.4.3.3).

10.5.3 Clinical Senate Review (2023)

General Recommendations	The HAS team is advised to maintain focus on health inequalities on an ongoing basis to ensure they are not being made worse by the impacts of the programme. It is advisable to include in the programme an evidence-based view on capturing vulnerable people at "first contact" with services that are accessed, to prevent exclusion.	IIA work undertaken throughout and will continue through the consultation and into implementation planning.
	It is strongly recommended to gain an understanding from neighbouring organisations as to whether they can manage the impacts of the potential options.	Regular meetings ongoing with Doncaster and Lincolnshire – potential impact of each option on activity and beds numbers shared.
	It may be useful for the HAS team to undertake and demonstrate modelling undertaken to stress test bed occupancy in the different options to ensure there is sufficient capacity to meet demand.	Will be undertaken as part of developing the DMBC.
	It may be helpful for the HAS team to have a clear position that interdependencies will be managed strategically to deliver the ideal interdependencies going forward.	Joint working with the out of hospital programmes to deliver enabling independencies
	Continued engagement with colleagues in the local authority is advised to ensure all elements of the health and social care system are working in tandem towards the same goals and ambitions.	Continuous engagement is in place with local authority, Place and system partners.
Urgent and Emergency Care	The Humber Acute Services team are advised to consult with the Yorkshire Critical Care Network to ensure that it is supportive of the plans to maintain a level two critical care service on the LEH site.	Ongoing engagement with the North Yorkshire & Humber Critical care Network is in place to ensure it is aligned and supportive of plans to maintain a level two critical care service on both the Acute and LEH sites. Detailed demand and capacity forecasting being

		undertaken (for inclusion in DMBC).
Maternity, Neonatal and Paediatrics	The Senate has made clear that the maintenance of two obstetric units, with the required theatre and midwifery staffing on both sites remains at high risk of being undeliverable/unsustainable. If the HAS programme team wishes to consult on the provision of two Obstetric led units there must be a high degree of confidence that they are deliverable and sustainable, including that they can support two staffed theatres on two sites and can recruit and retain the necessary staff.	High-level workforce plans are in place and will continue to be developed (for inclusion in DMBC). The Senate's recommendation regarding the option for two Obstetric-Led Units will be shared through the consultation.

Table 10.15 Summary of Clinical Senate recommendations and response (2023)

10.5.4 Independent Clinical Review – Urgent and Emergency Care

Advice provided	Response
Supported the co-location of Urgent Treatment Centres/Urgent Care Services with Emergency Departments across the Humber to ensure equity of access to urgent care for the population and reduce demand on the Emergency Department.	Incorporated in models
To define the workforce modelling to support patient pathways including consistency of skill set, roles and training • focus on paramedic practitioners, emergency care practitioners, advanced nurse practitioners and urgent care practitioners • consider roles, training alignment and recognise the skill training required for both illnesses and injury • work these up and agree as a system so training can commence early (to be governed through provider collaboratives across the system)	The work has progressed alongside clinical modelling
To ensure the patient journeys within each of the potential of models of care and variations are clearly articulated and well understood	Patient journey graphics and narratives developed
Through the evaluation process, ensure the impacts of the Acute Hospital with Trauma Unit and Local Emergency Hospital model are clearly defined.	Comprehensive Integrated Impact Assessment undertaken – impacts described and refined through this work.

Table 10.16 Summary of independent UEC review and response

10.5.5 Independent Review – Maternity, Neonatal Care and Paediatrics

Advice provided	Response
Highlighted the positive impact of early engagement with various stakeholders such as local authorities, ambulance trusts and transport providers, academic institutions and members of the public alongside various user groups. In particular, the role Maternity Voices Partnerships have played in ensuring women and their families have been able to express their needs for future services and the challenges for if services were to be re-located.	Continued engagement with key stakeholders and joint working with MVPs.
The continued provision of local antenatal and postnatal services (with access to diagnostic ultrasound facilities, day assessment units and local community midwifery teams) should be a foundation for any future service configuration.	Taken into consideration in all models.
To consider travel impact for midwifery staff, particularly if changes come after new staffing models (e.g. continuity of carer teams) are embedded as this could be highly disruptive.	Current staff mapped by home postcode by staff cohort to enable detailed analysis of impact to be undertaken.
To consider service-user choice – highlighting that it is not unusual for women to choose a service other than their nearest provider if there are other benefits	Engagement with service-users sought views on factors shaping choice. This approach to continue through the consultation.
To look at staffing models and potential solutions to shortages within Obstetrics and Gynaecology such as development of resident consultant posts.	Considered through workforce planning.
That the programme reconsider provision of a stand-alone Midwife-Led Unit (MLU) at the less acute site.	Included at the evaluation stage and thoroughly reviewed. It was not recommended as a viable option due to the low levels of anticipated usage and safety concerns operating this model on a Local Emergency Hospital site.
Provides a number of potential mitigations for any scenarios that result in consolidation of obstetric services onto fewer sites than present.	Incorporated into Integrated Impact Assessment (IIA).

Table 10.17 Summary of independent MNP review and response

10.5.6 Feedback from OSCs

We have provided opportunities to update the Chair and Members of relevant Health Overview and Scrutiny Committees, through a combination of written updates, informal briefings and formal attendance at Health Overview and Scrutiny Committees:

East Riding of Yorkshire Council	Hull City Council	North East Lincolnshire Council	North Lincolnshire Council	Lincolnshire County Council
Dec 2022 (written update provided)	*Dec 2022 (written update provided)*	*Dec 2022 (written update provided)*	19th Dec 2022	*Dec 2022 (written update provided)*
July 2022 (written update provided)	*July 2022 (written update provided)*	*July 2022 (written update provided)*	*July 2022 (written update provided)*	*July 2022 (written update provided)*
7th Dec 2021	10th Dec 2021	24th Nov 2021	26th Nov 2021	15th Dec 2021
9th March 2021	12th March 2021	17th March 2021	19th March 2021[306]	
20th Oct 2020	16th Oct 2020	16th Sept 2020	15th Sept 2020	
10th March 2019				
11th Sept 2018	14th Sept 2018	12th Sept 2018	17th Sept 2018	
6th March 2018	16th March 2018	11th April 2018	26th March 2018	

Table 10.18 OSC briefing dates

Our ongoing engagement with Local Authority health scrutiny committees highlighted a number of key areas of focus which were either added to or undertaken in greater depth as part of the programme.

Theme	Recommendation	Response
Workforce	Ensuring clinical input to the design of future service models will be critical – maintain and prioritise involvement of staff	Design of future service models have been clinically-led (see section 10.3.2.1).
Access to services	Transport and access issues – understanding how patients might be impacted, what is the potential scale of any impact and what can be done to mitigate impact of any changes	All patient activity has been mapped by postcode to undertake comprehensive travel analysis. Ambulance journey mapping also undertaken. Transport group established to look at support and mitigations (see section 8.4).
	Care closer to home – what does this mean in practical terms?	Collaboration with out of hospital programme to develop a wide range of alternatives to hospital-based care (see section 7.2)
	What are the implications for individual places and communities – want to understand the impact for their local area not just aggregate, overall impact	Activity volumes mapped by site and local population characteristics considered through impact assessment (see Integrated Impact Assessment – document library).
	Digital inclusion – supporting individuals and communities to use digital	Humber and North Yorkshire Digital Inclusion strategy underpinning any changes (see section 8.1.3).
Communications and Engagement	Sharing plans – welcomed updates on engagement approach and continuation	Continued engagement with OSCs and other stakeholders

[306] *Meeting cancelled by OSC Chair due to unavoidable circumstances. Paper provided to all members of the Panel.*

	of ongoing and timely engagement with HOSCs	
	Ensure engagement approaches reach the right groups	Engagement and consultation activities targeted to reach potentially impacted communities (see section 3.2.2).
Focus on Delivery ***(make things happen, don't just talk about change)***	Deliver on improvement areas identified previously – turn plans into action	Plan for implementation developed as part of PCBC
	Technology / Digital Transformation	Digital enablers considered to ensure alignment with wider system plans
	Understanding proposals and implications	Clinical modelling / evaluation / IIA

Table 10.19 Summary of OSC feedback and responses

Feedback gathered through engagement with OSCs has helped to shape the potential future models of care as well as the engagement approach undertaken through the programme.

C. How we have Listened and what we have heard

10.6 Overview of what we have heard

Through surveys, focus groups and workshops we have listened to over **12,000** patients, service-users, staff, and other stakeholders to influence the design and evaluation of potential models of care.

What Matters to You – We wanted to know what was most important to people when accessing hospital services.

Overall, people said:

Being seen and treated as quickly as possible was their top priority.

It was also very important to people that:

They were kept safe and well looked after.

There were enough staff with the right skills.

The full feedback report and summary report are both available on our website.

Staff and teams – What Matters to you? – To enable us to better understand what really matters to our workforce we actively sought views from staff through a number of surveys. Overall, staff told us things most important to them are:

A healthy work-life balance.

Making a difference to patients.

Feeling appreciated for the work they do.

Everyone being treated respectfully and as equals.

Staff also said that staffing levels need to be increased to reduce stress and workloads.

Urgent and Emergency Care – We wanted to better understand what motivates people to go to an Emergency Department, their knowledge of alternative urgent care services and what the barriers are to using these alternatives. Overall, people told us:

They mostly attended an Emergency Department because someone advised them to (e.g., NHS 111 or their GP).

Levels of awareness of alternative provision are greater in Hull and East Riding of Yorkshire than in North and North East Lincolnshire.

Overall, people are willing to use alternative provision *if they are confident* that it is appropriate for their needs.

The findings are available to read in full here.

Children and Young People – We actively sought views from children and young people about what worried them about coming into hospital, what was ok and what they would change. Overall, they said:

Being kept safe and well looked after was most important

Nice food, cuddles with their parents, and technology (e.g. iPads) would help them to feel better quickly.

The worst things about being in hospital was not being able to see the trees, having blood tests and not being able to leave their room to interact with nature.

The full feedback report and summary report are both available on our website.

In addition, we asked parents, carers, and guardians to share their experiences. **277** responses were received.

Being kept safe and well looked after was most important

Being seen and treated as quickly a possible was also important

The full feedback report and summary report are both available on our website.

10.7 Key Findings – Urgent and Emergency Care

In responding to the challenges set out in the Case for Change, and detailed above, we have sought to gather views, experiences and ideas from a range of stakeholders to help shape our vision for the future and potential future models of care. The approach we took to engaging with clinicians, partners, patients and the public is set out in detail in section 10.3.5.1 and in the engagement timeline with copies of all relevant engagement reports included in the document library.

Some of the key findings from our engagement that helped to shape the vision for the future and have influenced the development of potential models for urgent and emergency care include the following:

- **Most people attend an Emergency Department (ED) because someone advised them to go.**

  The most common reason for attending the Emergency Department was that respondents were advised by a healthcare professional to attend. This was the case for 68% of respondents to the A&E Survey and 73% of responses to the follow-up Healthwatch report (*in the following, figures are given for both cohorts of respondents, firstly to the A&E survey followed by the Healthwatch data*).

  Of those who said they were advised to attend ED (599 and 112 people), this was most commonly via NHS 111 (39%, 29%), a GP at my local surgery (22%, 57%) or 999/ambulance service (22%, 0%). “I couldn’t get an appointment at my GP surgery” was selected by fewer than 6% of respondents as a reason for choosing ED in the A&E survey. When the follow-up Healthwatch work was undertaken, this had risen to 18.8% of respondents.

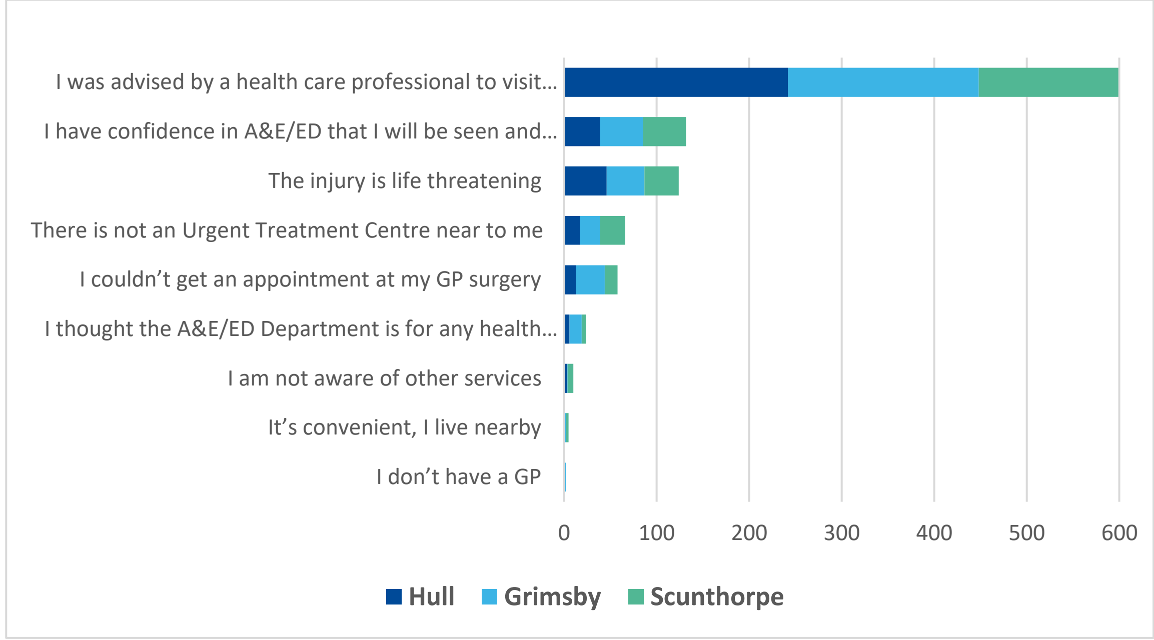


Figure 10.15 A&E survey - why did you choose ED?

- **Levels of awareness of alternative provision are mixed.**

  Most people had received information about when it is appropriate to attend the Emergency Department – Scunthorpe (72%), Grimsby (75%), Hull (86%) (A&E survey). When asked about specific types of provision, the levels of awareness and utilisation of Urgent Treatment Centres (UTCs) was significantly lower amongst respondents who used the Emergency Departments in Scunthorpe or Grimsby.

Figure 10.16 A&E survey - knowledge and views of UTCs

These inconsistent levels of knowledge or awareness of different services continued to be reflected in the engagement undertaken by Healthwatch.

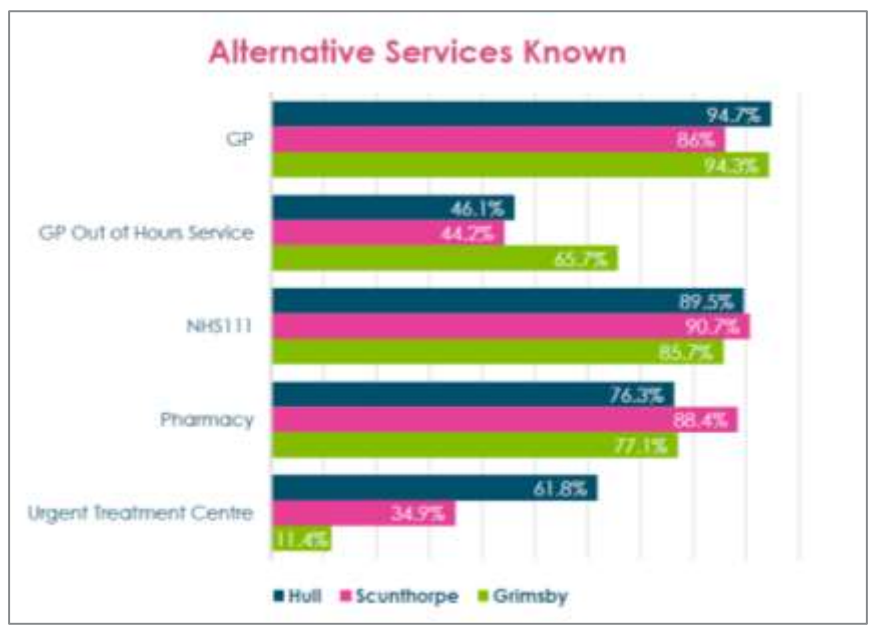


Figure 10.17 Knowledge of available services - Healthwatch report

- **People are willing to use alternative provision *if they are confident* that it is appropriate for their needs.**

  When asked “If a healthcare professional could see and treat you/the patient quicker, would you use an alternative service?”, very few people answered no. However, a large proportion of respondents did not believe the alternatives identified would have been appropriate for them or their condition.

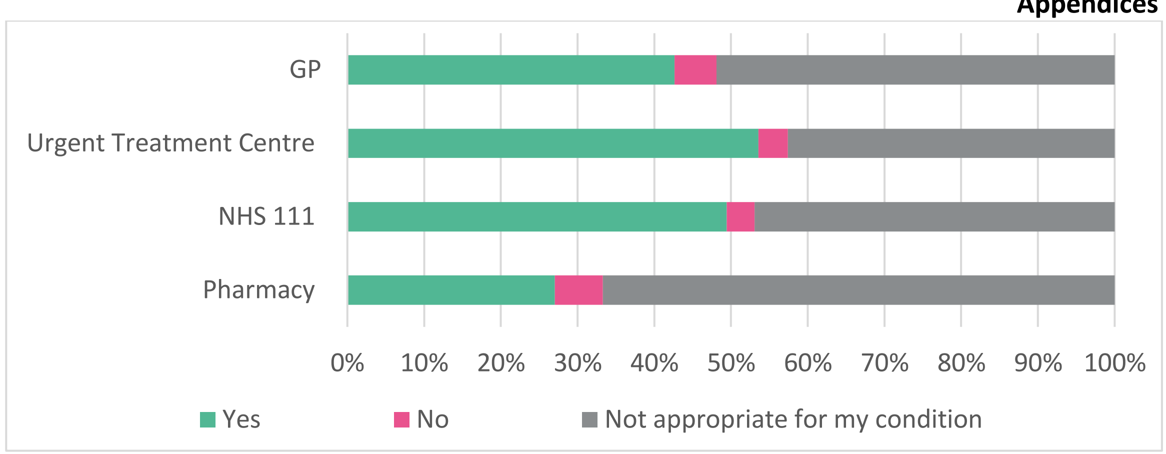


Figure 10.18 A&E survey - willingness to use alternatives to ED

The insight gathered through engagement with people who had recent experience of using one of the Emergency Departments in the Humber highlighted the following key factors that were taken into account when developing the overall vision and potential models of care:

- **Models of care for the future need to be simple and easy to understand**.
    - Most people were willing to utilise alternative provision, where they have confidence that it will meet their needs, but default to the Emergency Department where this is not the case.
    - The public must have a clear understanding of the services offered and have confidence they will meet their needs.
    - Urgent care services must be as easy to access as Emergency Departments if they are to be successful.

- There is an opportunity to tackle some of the challenges faced by **providing direct access to the services people need** (bypassing the Emergency Department) if services are better coordinated 'behind the scenes'.
    - Most of those surveyed sought advice before turning up at the Emergency Department, which means there is an opportunity to direct people to alternative services if these are available and easy to access when required.
    - NHS 111 was the most commonly used route for seeking advice, therefore there is an opportunity to work with partners to develop the NHS 111 service to support new models of care and supporting more people to access the right care.

The insights and ideas gathered from patients and the public have been used alongside extensive data modelling and learning from elsewhere to guide the development of potential models for urgent and emergency care. The overarching future vision seeks to simplify access points and make it easier for people to get to the right care in the right place at the right time.

10.8 Key Findings – Children and Young People

In addition to the wider 'What Matters to You' Engagement Exercise, the Programme also undertook a targeted engagement exercise to canvas the views of children and young people, their parents, carers and other important adults in their life. We asked them to tell us what worried them about coming into hospital, what is ok and what they would change.

A child-friendly approach was developed. For young children (aged approximately 5-11) a fun activity booklet was developed featuring drawing, matching activities and space to write or leave comments. For older children/young people (aged approximately 12-17) a bespoke questionnaire was produced with simplified questions and open space to provide free text or drawings. Parents and carers were provided with an opportunity to share their perspectives via an online survey.

Key findings from this engagement include

- **Being kept safe and well looked after was the most important thing** to children and young people as well as their parents, carers and guardians.

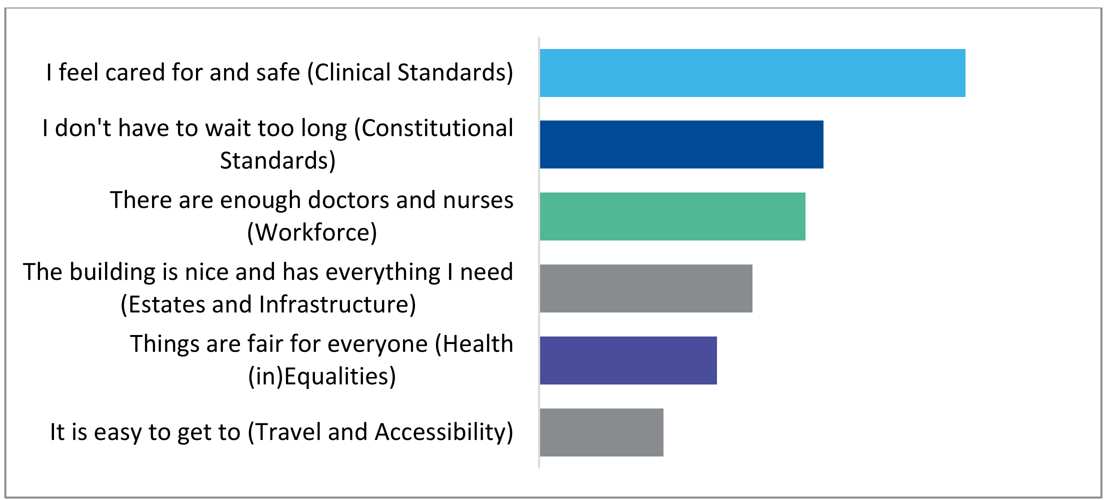


Figure 10.19 Summary of What Matters - Children and Young People

- **Accessibility and experience** were also very important.

  Parents and guardians provided feedback on how hospital visits can be stressful and made suggestions on how they could be improved. For example, many highlighted the importance of appointments running on time and short waiting times in A&E as it is difficult for children to wait and delays can lead to increased stress and anxiety. Parents highlighted the need for more experienced and well-trained paediatric staff working not only in EDs, but also across wards and clinics.

  Parents asked that more appointments are available after school or at more convenient times and for improvements to be made to car parking to make attending appointments easier. In addition, access to local services was highlighted as important by many respondents.

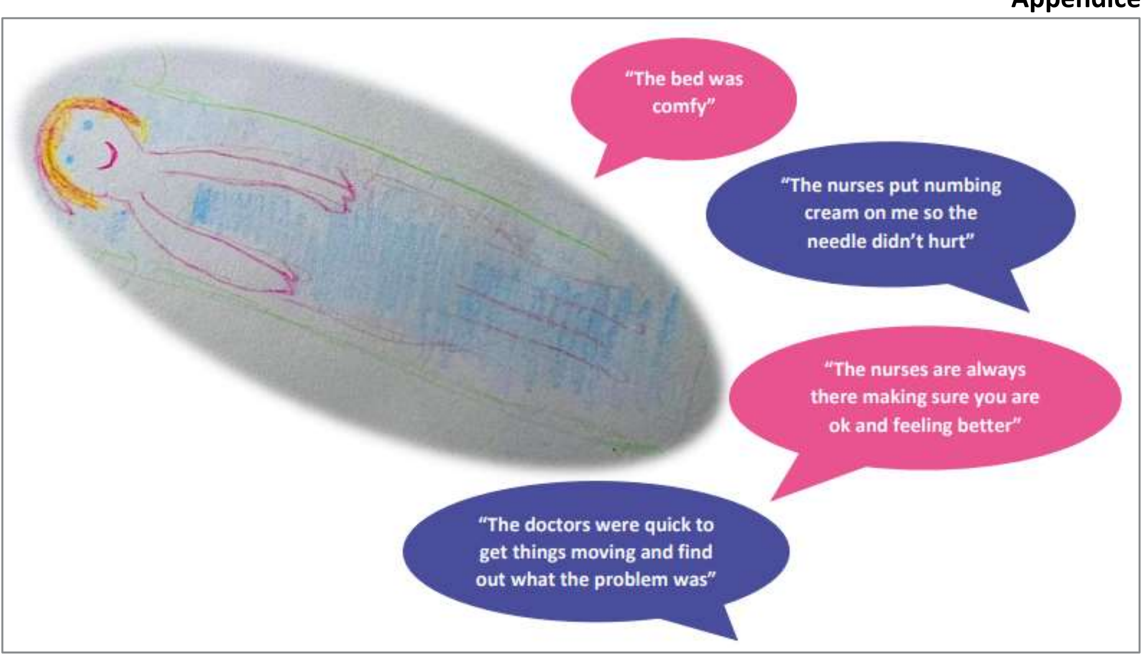


Figure 10.20 Summary of key themes - Children and Young People's feedback

- **The building and physical environment** was comparatively more important to children and young people than the population as a whole.

  Many comments from children and young people who responded to the surveys highlighted aspects about the physical environment that either improved their experience or made it worse. Examples included, sleeping in a comfy bed with friendly nurses and doctors working hard to look after them helped them to feel better quickly.

  Suggestions from children and young people for areas where improvements could be made, included better access to toys and digital technology, better food, and being able to interact with nature (e.g. not being able to see the trees from their hospital bed was a negative point raised).

- **Better communication** – clear and consistent information presented in an understandable way – was important to both parents and carers and children and young people. Parents also highlighted the need for more consideration from staff when communicating or looking after children with additional needs (SEND).

The insights gathered through engagement with children and young people, their parents, carers and other important adults in their lives across the Humber region highlighted a number of really important factors that have influenced the development of potential models of care for paediatric services in the future:

- Models of care for the future should **prioritise safety.**
    - The ability of the models to deliver safe care is a key factor within the evaluation of the models of care for paediatric services.
- Models of care for the future should be designed to **meet the needs of parents and families** as far as possible, particularly in relation to attending appointments and accessing care.
    - Service-users were clear that they would prefer greater choice when it comes to appointment times (e.g. after school), with appointments running on time to avoid increased stress and anxiety for children and young people.
    - Access to local services with ample accessible parking was very important to parents and carers.
- Models of care for the future of paediatric services need to consider the **building and physical environment**, as these factors are comparatively more important to children and young people than the population as a whole.
    - Preferences from children and young people included better access to toys and technology, comfy beds, better food and being able to interact with nature and see the trees from their hospital beds.
    - Wherever possible, children and young people should be included in the design of spaces where their care will be provided to ensure they are suitable and meet their needs and expectations.

10.9 Key Findings – Travel and Transport

Whilst travel and accessibility have consistently ranked as *comparatively* less important amongst all stakeholder groups, it continues to be an important theme emerging from the engagement work we have undertaken.

In our targeted engagement and work with health inclusion groups the topic of transport and accessibility was raised as an important area for consideration and similarly was highlighted by a large number of respondents to the *What Matters to You?* questionnaire.[307] In the *Your Birthing Choices* engagement exercise with maternity service-users, we gathered opinions on how they currently travel to access care and how far they felt was a reasonable distance to travel. Travel and transport were also key themes in engagement work undertaken on temporary service changes in oncology, haematology, urology and ENT (undertaken as part of the parallel work on the Interim Clinical Plan). Issues relating to travel and accessibility were also consistently raised in our engagement with elected representatives, through our *What Matters to You?* workshops and our ongoing dialogue with overview and scrutiny committees in particular.

Through this engagement it is possible to identify a number of key themes in relation to travel and transport:

People face a lot of existing barriers that make accessing care difficult.

Across the engagement work undertaken a range of barriers to access were highlighted by participants. These included:

- The cost of parking, particularly when appointments are delayed.
- The availability of car parking – trying to find somewhere to park when attending an appointment can be stressful.
- The lack of availability of transport (public and private) and/or the cost.
- Poor accessibility on the site, particularly for disabled people.

It is important to note that these barriers applied to experiences of accessing 'local' hospital services as well as those further afield, and also to out of hospital services such as primary care, recognising the low rates of car ownership within the region, particularly in parts of Hull and North East Lincolnshire (as detailed in section 1.4.2.5).

Travel and accessibility issues are not all about distance.

Across the engagement undertaken, the issues people raised to do with accessing care were often not linked to the overall distance to travel, but with things that affect the experience of travelling and ability to access care when arriving at the venue. For example:

- Does the venue have a bus shelter with comfortable seats and information about the wait times for the next service?
- If you are taking a poorly relative to an appointment, is there somewhere you can drop them off and someone you can leave them with while you go and park the car if they are not well enough to get themselves to where they need to go?
- Is it easy to get from where you have parked your car to the part of the hospital you need to be at? And how easy is it to find my way around?

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[307] In response to the question: "Is there anything we have missed?" 16% of responses (123 out of 775) related to travel and accessibility.

Participants were almost unanimous in their views that all of these access issues should be considered when looking at transport and access, not just overall distances between sites. Those taking part in the engagement exercises highlighted that going to hospital is often a stressful experience, they might be worried about the outcome of a test or anxious about a procedure, the person attending hospital can be quite unwell and this makes finding their way around and getting from A to B much more difficult. The way our hospitals have been built and developed and they way we utilise the sites can exacerbate these issues by making it more difficult for patients and their loved ones to get to where they need to be.

Many patients and service-users express a willingness to travel further for care under certain circumstances.

Participants in the targeted engagement undertaken by Humber and Wolds Rural Action reported that, in general, they were happy to travel from north bank to south bank, from east to west and out of area to receive specific treatments. For some people they preferred to travel further to gain what they considered to be a 'better experience' but this was based on practical aspects of parking, transport availability, cost and access to the building.[308]

Similarly, most respondents to the oncology survey said that despite the extra miles and time taken to get to and from appointments at the specialist cancer centre, they are happy to do so to receive such high-quality care.[309] However, overall they expressed a strong preference to receive their cancer care closer to home to avoid long journeys, which they described as painful, difficult and stressful. They also wish to avoid further inconvenience to family members who have to take more time off work to drive them to their appointments. Respondents are also worried about the financial impacts associated with changes in location, including additional fuel costs, taxi costs now they are unable to use public transport, parking costs and bridge tolls.

The views of women and birthing people on what they felt was an acceptable distance to travel to give birth varied quite significantly by area.[310] Those living in the more rural areas of North Lincolnshire, Lincolnshire County and East Riding were, on average, prepared to travel further than respondents from North East Lincolnshire and Hull.

Across all geographies, the travel distance people deemed to be acceptable was, on average, further than their current stated travel distance. However, it is important to note that over 50% of respondents stated that their current travel distance was 0-5 miles with a further 23.4% selecting 5-10 miles. The most popular selection for an acceptable travel distance was 5-10 miles (34.3%) followed by 10-15 miles (23.2%). Fewer than 10% of respondents currently travel 20 miles or more and only 7.5% thought that travelling 20 miles or more was an acceptable distance.

Simple changes could have a big impact.

Participants in our engagement highlighted some 'simple' changes that can make a real difference to accessing and experiencing acute hospital services, these included:

- Flexible visiting times (different times for each ward) reducing the demand for car parking at key times.

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[308] Humber and Wolds Rural Action (2020) *Humber Acute Services Review – Targeted Engagement Report* HWRA Report

[309] Humber, Coast and Vale Health and Care Partnership (October 2020) *Review of temporary changes to Oncology Services* Oncology Feedback Report

[310] Humber and North Yorkshire Health and Care Partnership (June 2022) *Hospital Services for the future – Your Birthing Choices Feedback Report* Your Birthing Choices Report

- Making buildings more attractive and welcoming.
- Removing glass screens from reception areas which make it difficult to communicate and removes confidentiality.
- ‘Meet and greet’ to welcome and assist people who are ‘lost’ or anxious.
- Signage (simple language and visual) which makes it easier to navigate around the site/building.
- Easier access to onsite facilities (location of accessible toilets was particularly important).
- Creation of a quiet, comfortable physical space to respond to people’s needs, enable them to relax and prevent escalation of behaviour.

The insights gathered through engagement with current and potential future patients across the Humber region highlighted a number of really important factors that have influenced the development of potential models of care:

- Where possible we should seek to **provide care close to or at home.**
    - Going to hospital is a stressful experience for individuals, their families and carers.
    - Wherever possible, we should design models of care that don’t require individuals to make multiple trips to hospital where it is not necessary.
    - We should consider the travel impact of any potential models of care that are developed as part of the evaluation process.
- Models of care for the future need to be **accessible.**
    - Whilst distance to care clearly does matter to our patients, it is also clear from the feedback that accessibility is about much more than distance from A to B.
    - It is important that future models of care consider *all aspects* of travel and accessibility and seek to provide as much care as is possible at or close to home.
    - When patients do have to travel, we should make that experience less complicated and stressful than it is today and consider how we can support people who face barriers to accessing the support they need.
- We need to **design our future hospitals with patients and their families in mind**, making it easy for them to find where they need to be.
    - When opportunities become available to develop new facilities, we should seek to involve end-users in their design to ensure they are as accessible as possible this.

Where changes can be made now, these have been considered by operational teams within both trusts. These ideas and insights will also be considered as part of any plans for implementation that may be drawn up following decision-making on the future models.

10.10 Key Findings – Estates and Infrastructure

10.10.1 Buildings and Equipment

Throughout our patient and public engagement *'being treated in good quality buildings that have the latest equipment'* was consistently ranked eighth out of the nine decision making criteria, suggesting that it relatively unimportant to the stakeholder groups we engaged with. *'Services are good value for money'* was the only criterion to consistently rank lower.

It was, however, comparatively more important to Children and Young people, ranking fourth out of the six criteria posed to them.

Despite being relatively less important than aspects such as safety or timeliness of care, a number of participants in the engagement activities provided feedback or comments in relation to buildings and infrastructure that have helped to shape our ideas. Key themes to emerge from the free-text comments provided by respondents during our *'What Matters to You'* and *'Your Birthing Choices'* engagement included:

- Respondents like to have their own rooms, particularly when using maternity services, and would like to see more rooms with en-suite facilities.
- Respondents were generally impressed with the cleanliness of the buildings, particularly during the COVID-19 pandemic.
- Respondents would like to see better signage, more facilities to get drinks and refreshments, better accessible toilets, and increased seating in busy waiting areas.
- There was a recognition that many of our buildings are old and need major investment, examples provided included a respondent seeing plaster falling off the walls.
- Respondents would like to be treated with modern equipment that isn't prone to breaking and to know that operating theatres are also well equipped with the latest equipment.

Children and young people told us that being able to sleep in comfy beds, have better access to toys and digital technology such as Wi-Fi, gaming devices and Netflix would help them to feel better quickly. Things that they didn't like about coming into hospital buildings included being on wards where they couldn't see the trees or interact with nature. Although the transformation plans will reduce the amount of time children need to be in hospital, there will always be a need for some, and addressing this will support their recovery.

10.10.2 Digital Technology

Throughout our engagement with different stakeholder groups, the use of digital technology has continued to be an important theme. Through the programme we have gathered a wealth of insight into the views of clinicians and staff, patients, service-users and the public on how digital technology could be used to transform and improve their experience of care. NHSx has also released a "What Good Looks Like" (WGLL) framework that forms the basis of the digital maturity assessment that will be used to track how providers are meeting the functionality required to deliver safe quality care. NHSx has also released a "What Good Looks Like" (WGLL) framework that forms the basis of the digital maturity assessment that will be used to track how providers are meeting the functionality required to deliver safe quality care.

In our targeted engagement and work with health inclusion groups participants commented on the use of digital technology, providing suggestions, ideas and raising issues. It was also a key theme explored through focus groups undertaken as part of early engagement as well as stakeholder workshops

undertaken as part of the *What Matters to You?* engagement exercise. In addition, insights gathered by our Maternity Voices Partnerships (MVPs), outpatient transformation programme and primary care partners provide a wealth of insight into changing views and perceptions of virtual consultations in particular and the use of digital more broadly.

Through this engagement it is possible to identify several key themes in relation to digital technology:

There is a strong willingness to engage in using new technology, but patients and service-users want us to do our bit and "get with the times."

In our early engagement[311] participants highlighted that they were keen to see hospitals making the most of technological innovations to improve services and make the most of scarce resources (especially workforce) and were frustrated by the sense that health and care services were 'behind the times' in terms of adopting technological solutions.

Using digital technology to improve how things work 'behind the scenes' was a common thread that has continued throughout more recent engagement as well. Some of the suggestions and comments from patients and service-users include:

- Support better cross-site working through the use of technology (for example, video conferencing between clinicians).
- Use technology to provide better, more timely information to patients (e.g. live waiting times for Emergency Departments, like systems used in theme parks, or the ability to track test results or appointments, similar to how you can track parcels).
- Invest in wearables and other technology to improve remote monitoring and make services more responsive.
- Get the basics right and keep things simple (why do we need to access multiple different online systems for GP appointments, hospital communications etc.?).

Patients, service-users and other stakeholders we have engaged with relate to other aspects of their lives where digital technology has improved their experience and question why these approaches have not been deployed in their health services.

Shared care records are a must.

Throughout our engagement work, participants were consistent in reinforcing the need for appropriate, relevant information to be shared across providers. This was particularly strong from those with long-term conditions or who access services more frequently, who had more experience of services not sharing information and the burden falling on them. Sharing information and having access to health and social care records was seen as critically important in all potential models of care when our Citizen's Panel and other stakeholder groups provided feedback on them at all stages.

Virtual appointments are broadly welcomed but views vary between different cohorts.

Both before and after the onset of the COVID-19 pandemic, we gathered a wide range of views on the relative pros and cons of virtual consultations (including online and telephone). On the whole, patients and service-users were positive about their use and the potential to reduce travel and improve services,

[311] Humber, Coast and Vale Health and Care Partnership (April 2019) *Hospital Services for the future – Focus Group Feedback Report* Focus Group Feedback Report; Humber and Wolds Rural Action (2020) *Humber Acute Services Review – Targeted Engagement Report* HWRA Report

however, this was not the case across the board and different groups of patients and service-users had different views and/or raised differing concerns. Views amongst clinicians were also varied.

Participants in our targeted engagement work, including conversations with health inclusion groups and people with protected characteristics, found that most people could see a place for the use of virtual consultations in reducing the need for outpatient and post-operative appointments. It was felt that these appointments were often a 'waste of time' for all concerned when there was no physical examination and after a few questions the patient was then discharged.

> *"I live near Scunthorpe and had to return to (Diana Princess of Wales Hospital) Grimsby three times to say "I'm okay" my daughter had to take three days off work to take me, could this just have been a telephone call, there was no physical examination on each occasion".*

The introduction of virtual appointments was also suggested by participants in focus group discussions that took place in 2019.

Following the widespread roll-out of virtual appointments in response to the COVID-19 pandemic a range of insights work was undertaken across Humber and North Yorkshire, which has been drawn upon by this programme to support the design of potential models of care.

- Those who had experienced an online consultation for acute hospital services reported positive experiences on the whole and were very supportive of this method of care.[312]
- Whilst most patients are generally willing to use virtual appointments, it is only the preferred method for a minority.
- On the whole, telephone calls are usually more acceptable than video calls.

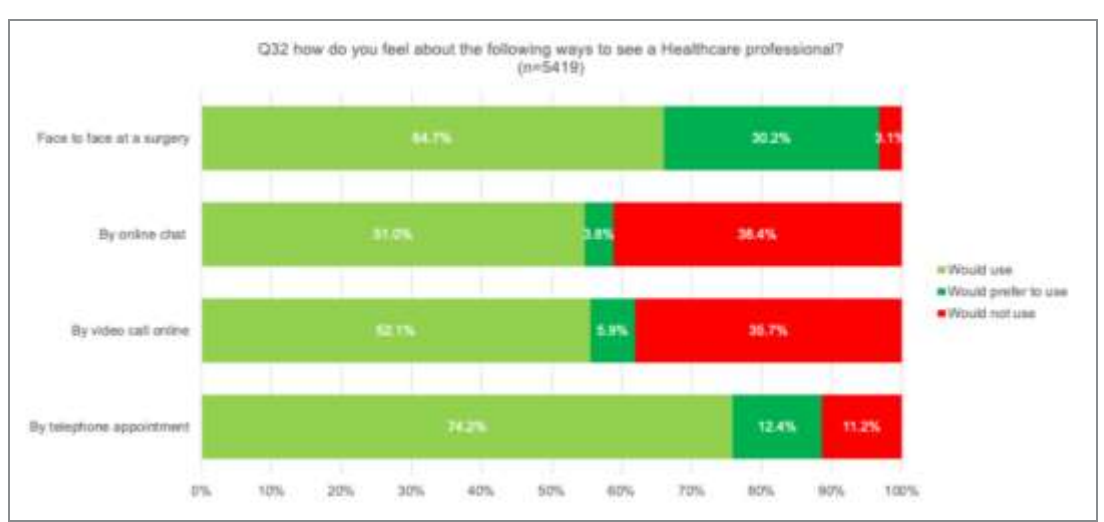


Figure 10.21 Reponses to Humber Primary Care survey - preferred method of access [313]

[312] Humber, Coast and Vale (Nov 2020) *Outpatient Transformation Engagement: listening to and acting on patient feedback* see document library

[313] Humber CCGs (Dec 2020) *Primary Care Response to COVID-19 Engagement Report* see document library (p.20)

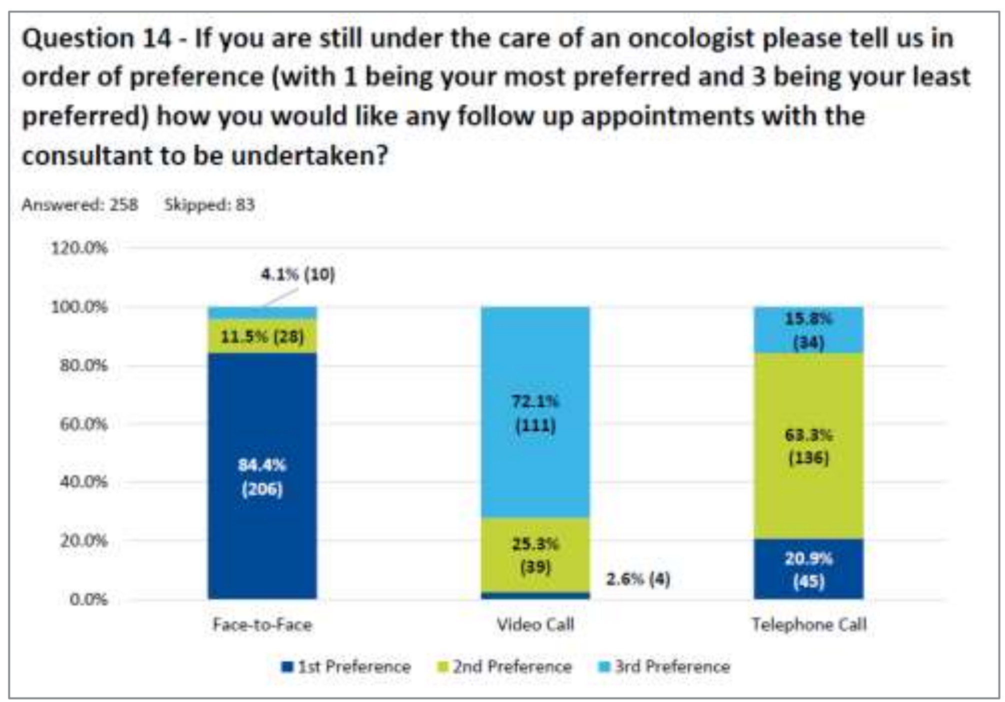


Figure 10.22 Patients' preferred method of follow-up care (Oncology) [314]

Maternity service users demonstrated a much stronger preference for face-to-face appointments for their pre- and post-natal care and did not want to see the continuation of virtual appointments that had taken place during the pandemic (see Document Library for full report). This is consistent with feedback from staff where home visits or seeing the mother and baby together physically in person can alert to various factors that need to be explored further.

In most cases (with the exception of maternity services), stakeholders were supportive of increasing the use of virtual consultations, where appropriate mitigations and support could be put in place. For example, some suggested providing video conferencing facilities in GP surgeries and community hospitals to provide supported access to specialists and reduce the need for patients to travel long distances to hospital sites. Through the *What Matters to You?* focus group discussions, a range of stakeholders noted the need to maintain patient choice and alternative methods of access to avoid widening health inequalities through digital exclusion (detailed in section 1.4.2.5) of those without the means or skills to access services digitally.[315]

[314] Humber, Coast and Vale Health and Care Partnership (October 2020) *Review of temporary changes to Oncology Services* Oncology Feedback Report (p.28)
[315] Humber, Coast and Vale Health and Care Partnership (May 2021) *What Matters to You: public, staff and stakeholder engagement feedback report* What Matters to You (p.42)

The insights gathered through engagement with current and potential future patients across the Humber region highlighted a number of really important factors that have influenced the development of potential models of care:

- We need to **improve our hospital buildings** and consider how we can provide better environments for patients and staff.
    - When opportunities become available to develop new facilities, we should seek to involve end-users in their design to ensure they are as accessible as possible this.
- In designing the future shape of hospital services we should seek to **radically improve our digital offer** but ensure non-digital options remain for those who need them.
    - Work 'behind the scenes' to connect services and clinical teams could reduce the burden on patients of having to travel.
    - Patients expect record sharing as standard and for their journey between different services to be seamless.
    - Many patients want to have more convenient services and a more customer-focused approach offering a choice of appointment times, virtual appointments, text reminders and live waiting time information.
- Consideration must be given to **digital exclusion** and plans put in place to address its impacts.
    - Stakeholders, particularly elected representatives and our Citizen's Panel stressed the need to ensure the increased use of digital supports more people to access care and doesn't exclude those unable to get online.
    - The reasons for digital exclusion are multifaceted and therefore a multifaceted approach to addressing this will be important.

Where changes can be made now, these have been considered by operational teams within both trusts. These ideas and insights will also be considered as part of any plans for implementation that may be drawn up following decision-making on the future models.

10.11 Key Findings – Staff Engagement

Throughout our pre-consultation engagement we have engaged with and listened to over 3,000 members of staff, through a variety of methods including workshops, focus groups, question and answer sessions, briefings, newsletters and surveys. This process of engagement is described in section 10.3.2.1.

Some of the key findings and how they have influenced the development of potential models of care include the following:

A healthy work/life balance and making a difference to patients is the thing that matters most to our staff. Consistently through our engagement we have heard from staff that they are values-driven and want to do the best for their patients and service-users. Many of the areas identified for improvements involve the removal of barriers that prevent staff from providing the care they want to give, most notably **work pressures** due to vacancies.

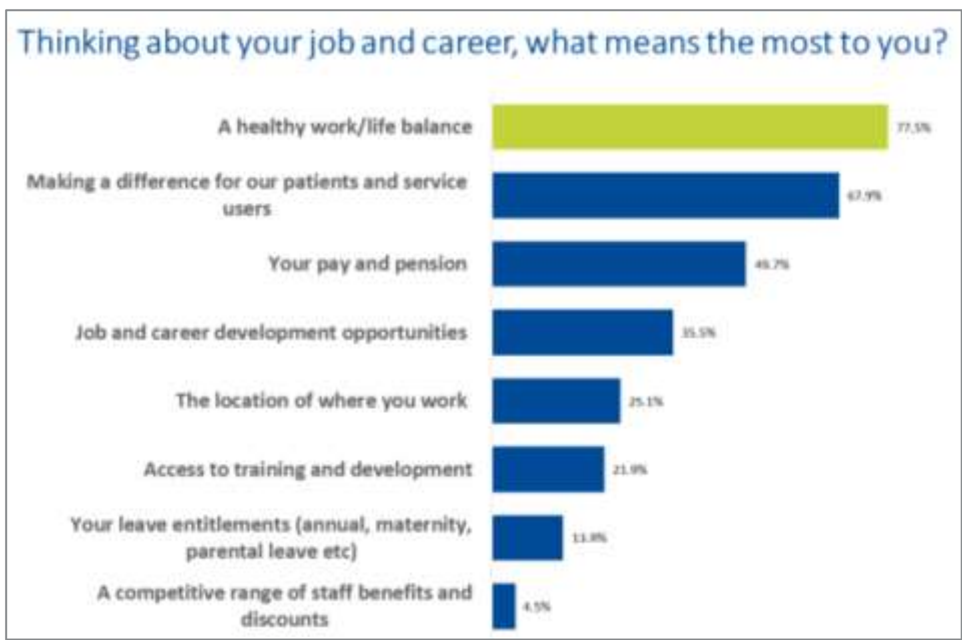


Figure 10.23 Staff What Matters to You? survey

- Staff were asked what the one thing was the HAS programme had to get right for them. 37% said **'Workforce'**, in particular **improving staff morale** and communication, addressing **staffing levels**, and better **HR and wellbeing support**.
- The barriers faced with shift patterns and childcare were also raised throughout ongoing staff engagement.
- The cost of travel for staff if their base were to change, especially as the country is experiencing a cost-of-living crisis, was raised by staff members who attended our drop-in sessions in late 2022.

Staffing levels and how any future models of care will be adequately staffed, continued to be a key theme throughout engagement with staff. There is also some scepticism amongst those we have engaged with about whether changes will actually happen due to the current pressures faced by the NHS.

Our workforce **wants to work differently and try new approaches**. We have held many workshops with different staffing groups, and all have ideas on how new roles and new ways of working could improve patient care and support a different workforce model for the future. Allied Health Professionals, in

particular, have a wealth of ideas on how their skills could be utilised to greater effect as part of multidisciplinary teams to streamline pathways and help address shortages of specialist staff in some service areas.

- Staff feel **more could be done** to **maximise the potential** of new roles.

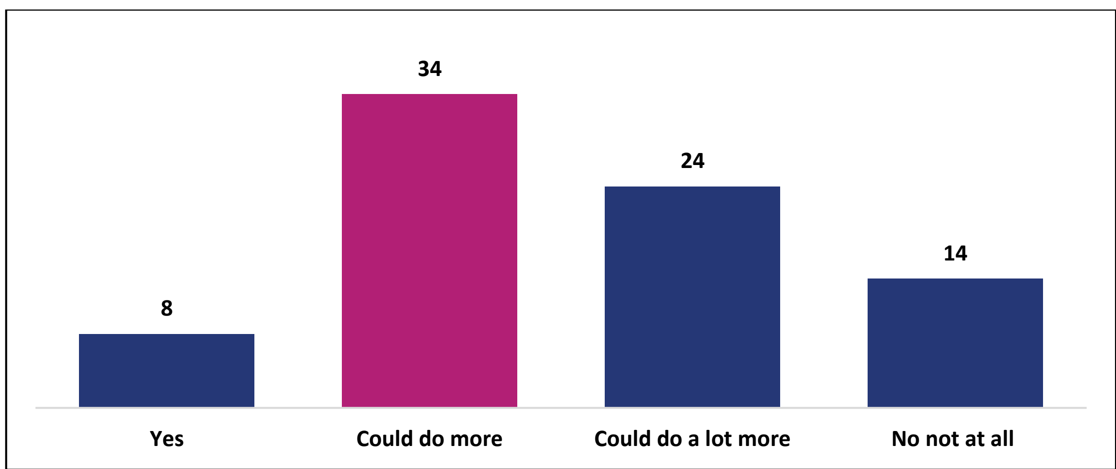


Figure 10.24 Joint Consultants Conference feedback

- **The opportunities** identified through our engagement include – maximising new roles could **increase productivity** and efficiency within teams, help to incentivise staff to stay as there would be more **career development** opportunities. Using the skills and expertise of ACP's and specialist nurses would allow consultants to have more capacity to see and treat more complex patients.
- At the drop-in sessions held in late 2022, staff identified that they wanted to see increased training and **career development opportunities** including bursaries and rotations (including working in the community) and explore the potential for **better integration** with primary care, mental health and community services.
- **Barriers** identified include – HR processes take too long, **lack of funding**, time and **capacity** for training is limited due to **staffing levels**, workload and **operational pressures**, morale amongst staff is also low so willingness to take on additional responsibilities or skills could be limited.

The desire to get **further engaged** and to have their **ideas listened to**, and to have the skills to make their service improvement ideas happen, consistently came through in the engagement undertaken with staff. This process of listening will continue throughout the consultation, as we recognise that by listening to our teams we can develop not only the best clinical pathways but also create conditions for our staff and teams to thrive

The insights gathered through engagement with current staff across the Humber hospitals highlighted a number of really important factors that have influenced the development of potential models of care:

- Models of care for the future need to **address workforce levels** and support a better **work-life balance.**
    - Greater focus on flexible, family friendly / agile working to support staff members with young families/caring responsibilities.
    - Increased training and career development opportunities which will help improve retention and recruitment.
    - Realistic workloads with opportunities to take annual leave and breaks.
    - Realistic workloads to allow staff time to provide high quality care and spend time with patients.
- Models of care for the future need to **support collaborative working.**
    - Provide an environment that allows for collaborative working and supports teams to work together towards a common goal.
    - Single Humber teams that share training, expertise and resources.
- The process taken to make decisions about and implement change needs to ensure **staff feel respected and valued with strong support from management.**
    - Visible managers who listen to staff and engage in honest communication with teams.
    - Empowering staff so they feel valued, respected and appreciated for work completed.

The proposals within this business case have been developed by clinical teams with significant input from staff and partners. Throughout the change programme, engagement with staff and teams will continue to be prioritised to ensure the people delivering care across our hospitals have an opportunity to shape the future of those services.

10.12 Key Findings – Planned Care

An extensive programme and engagement and involvement with the public, patients and clinicians was undertaken to support the development of a future direction for planned care services.

Some of the key findings and how they have influenced the development of potential models for planned care include the following:

- **Compassionate and caring staff were the most common reason for a positive experience of care.**

  The most common reason given by patients and their families for a positive experience was linked to the staff providing the care. Almost half of all the responses provided to the question – *what was the best thing about your experience?* – mentioned the staff providing the care (see *What Matters to You?* survey). Respondents highlighted how they felt listened to and supported throughout their treatment and care.

- **Being seen and treated quickly is most important (to the general public).**

  When asked what was most important to them in terms of their hospital care, overall, respondents to the *What Matters to You* survey said that being seen and treated quickly was most important. This is perhaps unsurprising in the context of record waiting times within our area and across the country for planned care.

- **Accessibility of services – in the broadest sense – matters.**

  Whilst participants in the *What Matters to You* survey undertaken in 2021, ranked travel and accessibility low (it consistently ranked 7 out of 9) compared with other factors such as being seen and treated quickly and being kept safe, when asked what could improve their experience of care a large proportion of responses were linked to peoples' experiences of travel and accessing care (12% of responses). The majority of respondents highlighted areas to do with practicalities of getting to appointments rather than the distance from their home. For example, not having enough car parking spaces created added stress at an already difficult time and the size and layout of hospital sites made it difficult, confusing and stressful getting themselves or their loved one from the car park to the part of the hospital they need to be in.

  In the targeted engagement undertaken with people with protected characteristics, the broad range of issues that need to be considered in relation to accessibility was also highlighted. In particular, the need to consider wider family, carers and support systems when making changes, and the importance of considering the availability of transport options even for things that are 'close to home' (close to home doesn't always mean easy to get to) (see HWRA Report within document library).

- **Communication, particularly between different parts of the NHS, needs to improve.**

  The impact of poor communication and disjointed services on people's experience of services and, sometimes, their outcomes were also highlighted through the *What Matters to You?* feedback report. For example, respondents noted that "communication between GP surgeries and the hospital needs to be improved upon."

In addition to engagement undertaken through the *What Matters to You?* survey, a number of other sources of feedback and/or insight helped to shape the potential models and high-level concepts for planned care. This includes:

- Targeted engagement undertaken to support the programme (as set out in section 3.2.2).
- Survey on virtual outpatient appointments undertaken by HCV outpatient transformation programme (2778 participants).
- Healthwatch hospital survey (136 responses).
- Specialty-specific surveys undertaken to gather views from current or recent patients and staff using or working within specific specialties where temporary service changes had been made, namely: Urology, Ear, Nose and Throat services, Oncology and Haematology (524 responses).
- Focus groups undertaken through programme as part of the early engagement to gather views from current or recent patients of a number of specific specialties, namely: Neurology, Cardiology, Critical Care, Complex Rehabilitation and Stroke (77 participants).

The feedback reports for each of these engagement activities are included in the document library. Some key findings that have influenced the development of potential models of care for planned care include:

- **On the whole, there is willingness to travel for care where it is necessary (i.e. the benefits are significant and well understood) and well-supported (i.e. appointment times are sensible and car parking is available).**

  A willingness to travel further for specialist care, in particular, was highlighted by participants in a number of engagement exercises. For example, during the focus groups undertaken in the early stages of the programme participants said they were happy to travel to the best place for specialist treatment – "we don't mind travelling to Hull from where we live in Cleethorpes if we get good treatment" – but were concerned about transport being available for all.

  Transport and access were discussed by most groups and participants shared stories about the challenges they have faced in terms of physically getting to appointments and accessing treatment and care. Often the access issues were not linked to the overall distance to travel, but with things that affect the experience of travelling and ability to access care when arriving at the venue. For example:

  - Is it easy to find a car parking space when you arrive, and will it be anywhere near the venue for your appointment?
  - Does the venue have a bus shelter with comfortable seats and information about the wait times for the next service?
  - If you are taking a poorly relative to an appointment, is there somewhere you can drop them off and someone you can leave them with while you go and park the car if they are not well enough to get themselves to where they need to go?

  Participants were almost unanimous in their views that all of these access issues should be considered when looking at transport and access, not just overall distances between sites. Similar views were expressed in later workshops and Citizen's Panel meetings regarding wider aspects of accessibility – details are within the engagement evidence pack (see document library).

  Interim findings from the hospital survey undertaken by Healthwatch across the Humber (Nov 2021 to March 2022) suggest that local people are more willing to travel for one-off treatments than for regular, ongoing care.

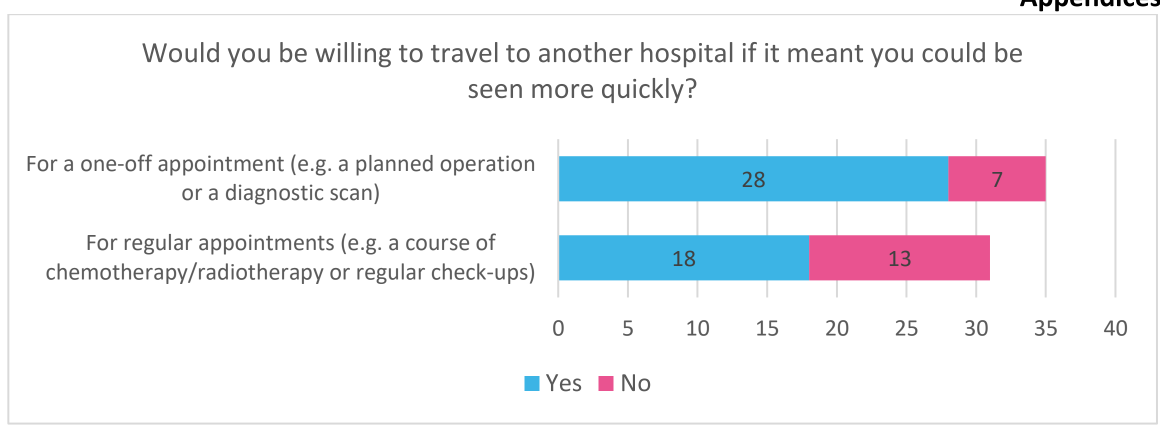


Figure 10.25 Healthwatch findings - willingness to travel

- **The majority of those who have experienced virtual appointments found them beneficial.**

  To support the introduction of virtual (video) consultations implemented in response to the COVID-19 pandemic in Spring/Summer 2020, the acute trusts across Humber and North Yorkshire gathered feedback from patients who had used virtual outpatient appointments during the COVID-19 pandemic. Feedback from those using the service was largely positive with 89% of patients who had attended a virtual appointment at NLaG saying they would recommend video consultations to friends and family.

  It is important to note that maternity service users gave a very different view in relation to this question and in general were not supportive of virtual consultations (see section 0).

  In early engagement work undertaken prior to the COVID-19 pandemic, a number of participants expressed a desire for more virtual or remote appointments. This was particularly relevant to people with long-term conditions who were required to travel long distances to attend regular check-up appointments. Many of them expressed a view that they were wasting their own time and their consultants' time by travelling to a routine appointment that could be conducted online or over the phone.

The insights gathered through engagement with current and potential future patients of planned care across the Humber region highlighted a number of really important factors that have influenced the development of potential models of care for planned care services in the future:

- Models of care for the future need to **ensure staff have time to care**.
    - Potential models of care for planned care have been designed to make the best use of the skills, talents and experience of the workforce, including those who will make up the workforce of the future.
    - The creation of dedicated facilities for planned care (not impacted by surges in demand for urgent care) should help to respond to this.
- Models of care for the future need to be **integrated** across primary, secondary and community care.
    - To respond to the priorities identified by patients in their feedback, the potential future models of care seek to provide seamless care for patients irrespective of whether they are being seen by a GP, a social worker, a consultant, a therapist, a nurse or any other health and care professional.
    - We must take the opportunity we have through this programme to build in effective communications from the outset as a fundamentally important part of providing good quality healthcare.
- Models of care for the future need to be **accessible**.
    - Whilst distance to care clearly does matter to our patients, it is also clear from the feedback that accessibility is about much more than distance from A to B.
    - It is important that future models of care consider *all aspects* of travel and accessibility and seek to provide as much care as is possible at or close to home. When patients do have to travel, we should make that experience less complicated and stressful than it is today.

The insights and ideas gathered from patients and the public have been used alongside extensive data modelling and learning from elsewhere to guide the development of potential models for planned care. The overarching future vision seeks to provide more responsive care, streamline diagnosis and treatment pathways, reduce waiting times, reduce unnecessary travel and improve the overall quality of care for patients.

10.13 Key Findings – Your Birthing Choices

We co-designed a programme of engagement with local Maternity Voices Partnerships (MVPs) to understand what is important to women and birthing people, birthing partners and support people when choosing where to give birth (see section 10.3.5.2.2),. Full details of the approach taken and findings from the engagement are set out in the Your Birthing Choices – Feedback Report, which contains over 100 pages of data and analysis (and is included in the document library).

A very brief snapshot of some of the key findings and how they have influenced the development of potential models for maternity and neonatal care is provided below:

- **Alongside Midwifery-led Units were the most popular option overall, but not everyone's first choice.**

  85.6% of respondents overall (85.9% of Humber respondents) said they would choose to give birth at an alongside midwifery-led unit. Most of the comments explaining this choice identified safety as the key factor and stated that an alongside unit feels a safer option with additional support close by if needed.

  When all preference were taken into account, alongside midwifery units were the most popular option overall, however, the most commonly selected first choice overall was a Hospital Maternity Unit (38.3%), followed by Alongside MLU (28.7%) then birth at home (21.3%) with Standalone MLU being the least popular first choice (selected by 11.4% of respondents).

  For women from North and North East Lincolnshire, a Hospital Maternity Unit was the most popular choice overall.

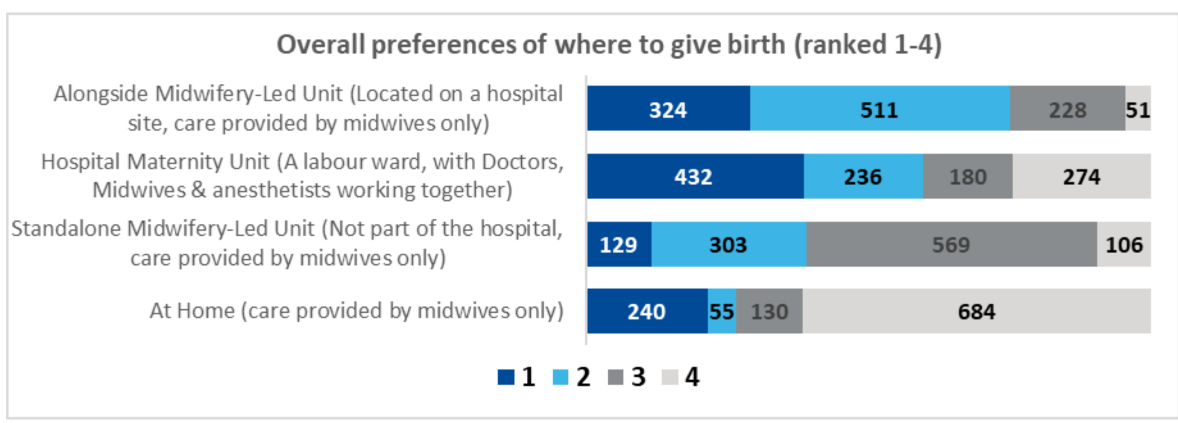


Figure 10.26 Overall birthing preferences (YBC survey)

- **Preferences were not uniform across the different geographical areas and views on standalone midwifery units were equivocal.**

  Overall respondents in North and North East Lincolnshire showed a stronger preference for giving birth at a Hospital Maternity Unit, followed by Alongside MLU, whereas for Hull and East Riding an Alongside MLU was more popular overall.

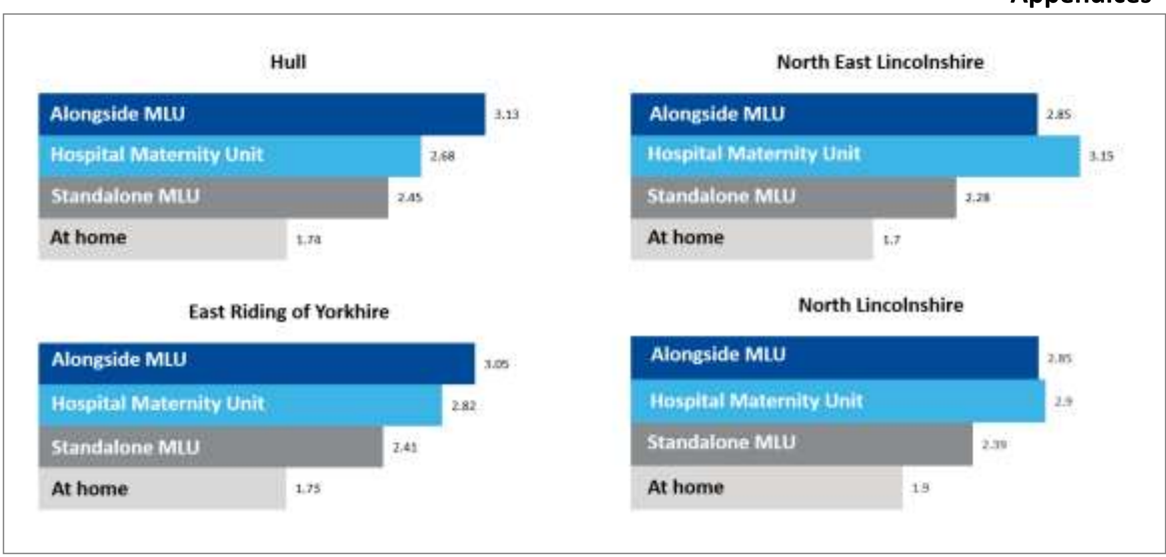


Figure 10.27 Birthing preferences by local authority area

When asked whether they would consider giving birth in a Standalone MLU, around half to two thirds of respondents said no, and results varied appreciably by area. The idea of birthing at a standalone MLU was least popular amongst women from East Riding, the only area within the Humber to previously have had such a facility.

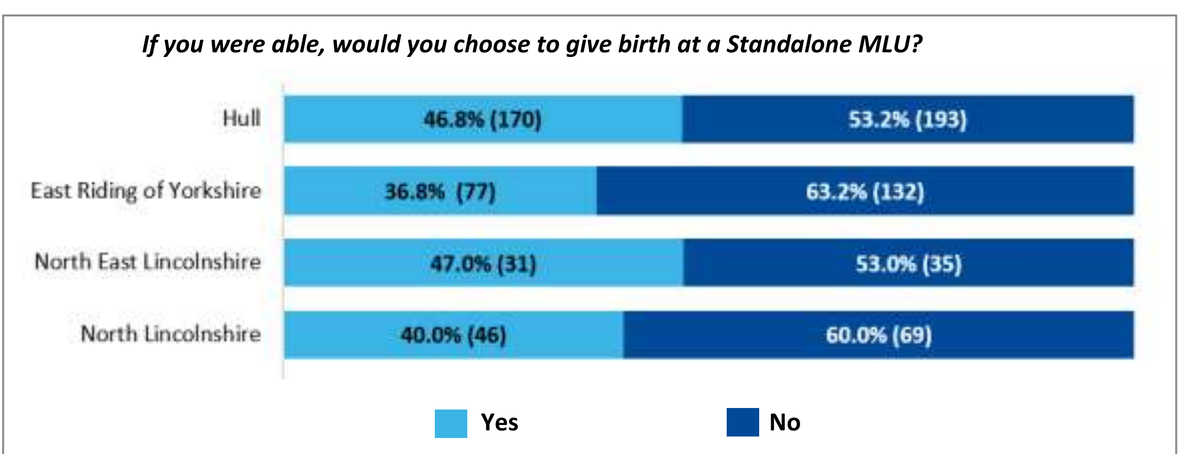


Figure 10.28 Views on standalone midwifery-led units by local authority area

- **The facilities and services available were comparatively more important than the physical environment and location when making decisions about where to give birth.**

When looking at the weighted average of responses, the most important factor in determining where to give birth was the availability of facilities for birthing partners to stay in the same room.

The availability of neonatal care was also a very important factor, ranked second most important overall and receiving the highest number of first choices. 70.5% of respondents said that if neonatal care was not available on the same site it would influence where they would choose to give birth. For respondents from North and North East Lincolnshire this figure was 76.7%.

Location and proximity to home was ranked second to last in the list of factors considered when making decisions about where to give birth (it was selected by just 2% of respondents as the most important factor in influencing where to give birth).

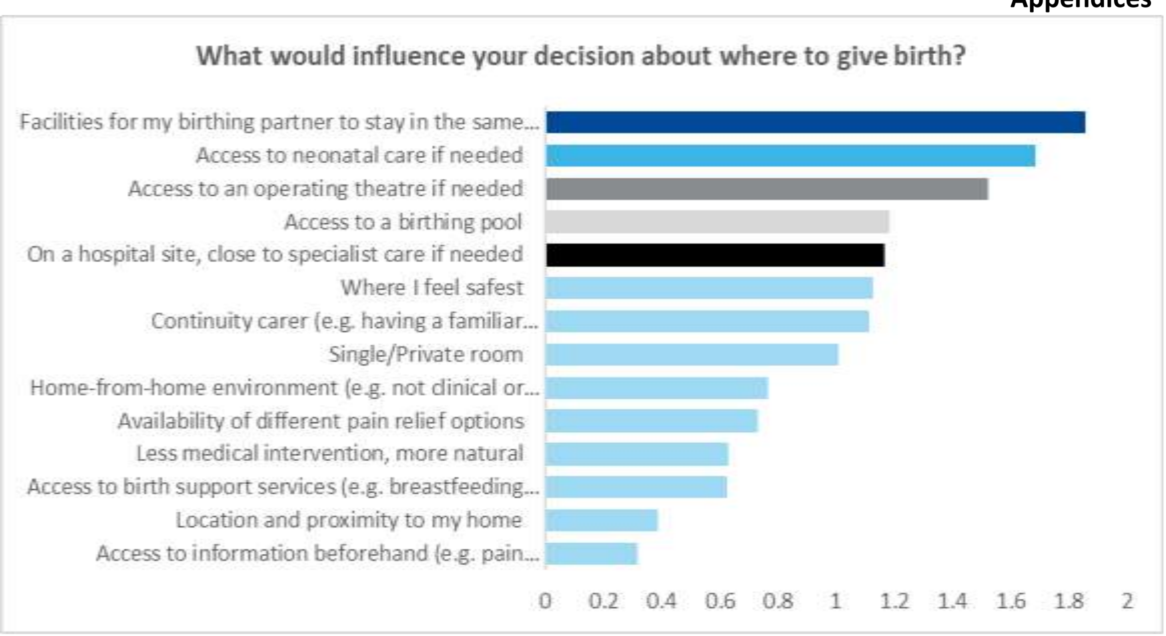


Figure 10.29 Influencing factors when choosing where to give birth

The views of women and birthing people on what they felt was an acceptable distance to travel to give birth varied quite significantly by area. Those living in the more rural areas of North Lincolnshire, Lincolnshire County and East Riding were, on average, prepared to travel further than respondents from North East Lincolnshire and Hull.

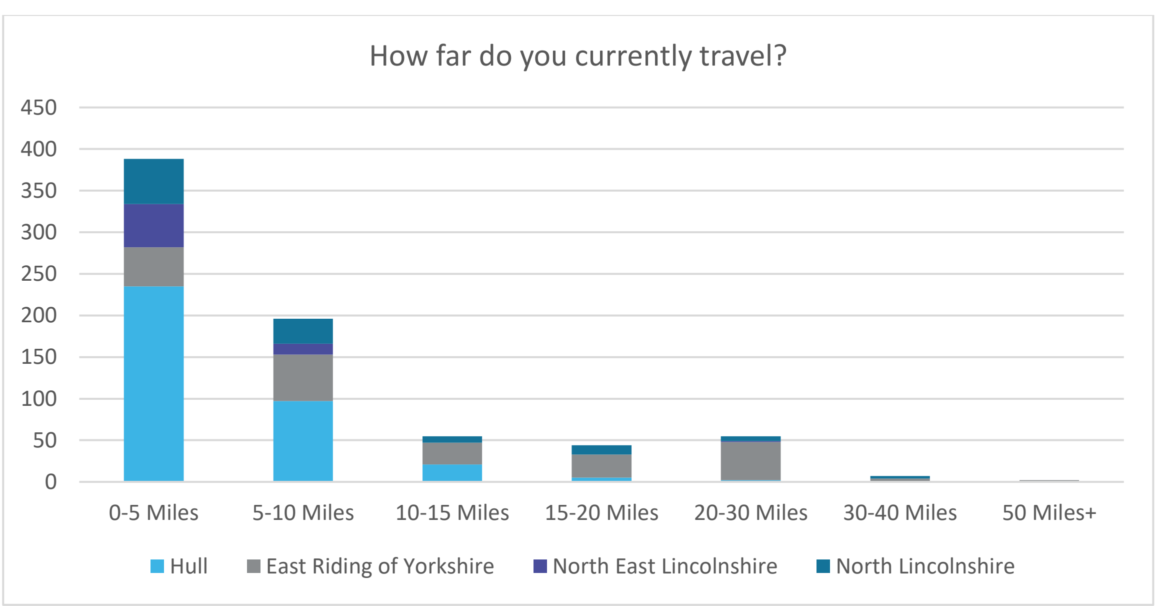


Figure 10.30 Current travel distances for maternity service-users (self-reported)

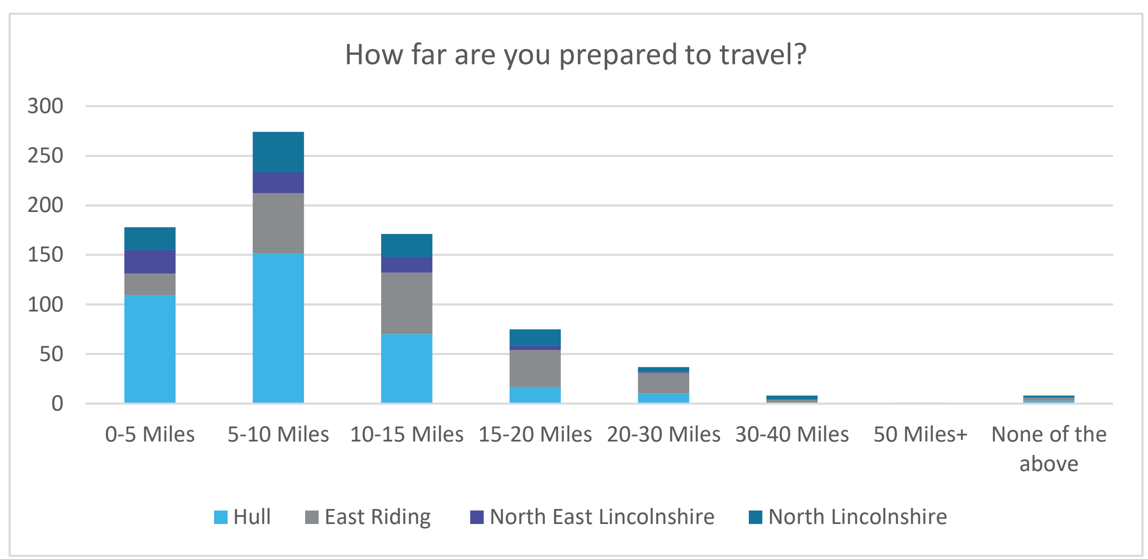


Figure 10.31 Preferred future travel distances for maternity service-users

Across all geographies, the travel distance people deemed to be acceptable was, on average, further than their current stated travel distance. However, it is important to note that over 50% of all respondents stated that their current travel distance was 0-5 miles. Fewer than 10% of respondents currently travel 20 miles or more and only 7.5% thought that travelling 20 miles or more was an acceptable distance.

- **Safety was comparatively more important to maternity service-users than the public as a whole.**

  In answering the question ***What Matters to You?*** respondents to the Birthing Choices survey ranked "I am kept safe and well looked after" as the most important factor to them. In wider responses to the What Matters to You survey (see 10.4.2.1), this criterion has consistently scored highly (either second or third place for most population cohorts), but it was comparatively more important to maternity service users.

  The theme of safety came through strongly throughout the engagement exercise. For example, the biggest concern amongst respondents about giving birth in a midwife-led setting (including at home) was the potential risk to mother and baby if complications arise during labour.

Working collaboratively with the Maternity Voices Partnership group and Local Maternity System across Humber and North Yorkshire has also provided a wealth of other insight, which has been drawn upon to support development of potential models of care for maternity and neonatal services. This includes a number of surveys carried out by the MVP network from 2019 to 2021, which gathered views from over 1800 women and birthing people in total on a range of topics. The feedback reports for each of these engagement activities are included in the engagement evidence pack. Some key findings that have influenced the development of potential models of care for maternity services include:

- **Maternity service-users show a strong preference for face-to-face interaction.**

  Engagement undertaken to seeking views of women and birthing people about their experiences of virtual appointments for both pre- and post-natal appointments (put in place in response to COVID-19), demonstrated a strong preference for face-to-face interaction. More than 60% of respondents would not be happy with a phone/video appointment for the 16-week midwife appointment and more than 80% of respondents prefer to see both their midwife and consultant (where applicable) in person.

- **There is strong support for 'continuity of carer' amongst women who have experienced this model of care**

  Responses to an MVP survey seeking views on the introduction of Continuity of Carer models across the region demonstrated an improvement in birthing women and peoples' experiences of care when supported by CofC teams. Whilst not seen as necessary by many people, women who knew a midwife present during labour and birth were comparatively happier with their experience.

The insights gathered through engagement with women and birthing people across the Humber region highlighted a number of really important factors that have influenced the development of potential models of care for maternity and neonatal services in the future:

- Models of care for the future should **prioritise safety**
  - The ability of the models to deliver safe care is a key factor within the evaluation of the models of care and clinical input has focused on the question of safety when developing the models.
- Models of care for the future should seek to maximise the opportunities for women and birthing people to **exercise informed choice**
  - preferences are varied both between and within geographies, therefore it is important that wherever possible opportunities to make choices about where to give birth are available and women and birthing people have the information they need to make informed decisions about what is best for them.
- Models of care for the future should consider how to provide **midwifery-led services and environments**
  - Alongside MLUs were a popular choice and are not currently available to many women and birthing people in the region. Many women described this as their preferred option because it was seen as safer as it is close to specialist care if complications arise, yet more relaxed and less clinical than a traditional hospital labour unit.
  - In response to the *Your Birthing Choices* feedback, midwifery-led units (both alongside and standalone) were considered for inclusion in the potential models of care. Different ways to deliver this type of care will be considered through the consultation depending on availability of capital investment for development of facilities.
- Models of care for the future need to give clear information and explanations about the **provision of neonatal care**
  - Service-users were very clear that they wanted information about the provision of neonatal care to enable them to make choices about where to give birth.

10.14 Citizen's Panel Involvement

To ensure our approach to engagement and involvement was effective and meaningful throughout, we recruited a Citizen's Panel to provide oversight and assurance throughout our design process. The Panel was established at the beginning of the programme to provide oversight and independent assurance of the programme and, in particular, its approach to engagement and involvement. The Panel is made up of citizen's from across the Humber – up to five from each local authority area – who represent a wide range of stakeholders, patient and public groups, including local voluntary organisations and community groups.

When the panel was established, the four Humber Clinical Commissioning Groups (CCGs) were responsible for recruiting four members each from their respective geographical areas to sit on the Citizen's Panel and represent the voices of their communities. Humber Wolds Rural Action were responsible for recruiting a number of panel members with protected characteristics as part of their targeted engagement work (see section 3.2.2) undertaken early in the programme. This was to ensure that a broad range of views and perspectives were able to inform and influence the development of potential models of care.

Initially, this approach did not result in a full complement of panel members and the Humber Acute Services Programme team had to re-recruit a number of times subsequently. As of November 2021 the Citizen's Panel had the following representation:

Area / Represented Group	Number of Panel Members
North Lincolnshire	3
North East Lincolnshire	4
Hull	2
East Riding of Yorkshire	4
Protected Characteristics / Health Inclusion groups	3 *(Carers, BAME and people with learning disabilities)*
CCG Lay Member	1 *(North Lincolnshire)*
Total Number	**17**

Table 10.20 Citizen's Panel membership

In addition to the geographical spread across the Humber area, the Panel includes representatives of the following specific stakeholder groups:

- Carers
- People with long-term conditions
- Children and young people (including those with disabilities and/or long-term conditions)
- Deprived communities
- People from Black, Asian and minority ethnic backgrounds

Panel members have been engaged throughout the programme to support in the design of engagement materials and communication resources – ensuring information is presented in a meaningful way to members of the public and free from jargon. In addition, they have been involved in early stages of evaluation and worked with us to test our approach to the development of the potential models of care.

Meeting Date	Location	Purpose
12th Dec 2018	Barton Upon Humber	Outlined aims and ambitions of the programme Understanding the role of the panel
20th March 2019	Barton Upon Humber	Evaluation of patient involvement events Co-produced feedback report Development of decision-making criteria
24th July 2019	Hessle	Evaluation of targeted engagement feedback report Speciality Discussions Co-produced public-facing documentation
21st Nov 2019	Hessle	Feedback on Case for Change
13th March 2020	Hessle	Evaluation of potential models (Interim Options Report)
9th July 2020	Virtual	Briefing on current position and impact of COVID-19
29th Oct 2020	Virtual	Co-produced public-facing documentation
18th Feb 2021	Virtual	Development of Decision-making criteria What Matters to You (co-produced workshop approach)
22nd Sept 2021	Virtual	Co-produced public-facing documentation
16th & 17th March 2022	Brigg and Willerby (option for virtual)	Balanced room evaluation workshops
11th October 2022	Humberside Airport	Co-production workshop – Integrated Impact Assessment

Table 10.21 Overview of Citizen's Panel involvement

The Citizen's Panel has provided invaluable insight into the needs and ambitions of our populations and helped to ensure the patients and service-users we serve remain at the heart of our design process. Details of the outputs and impact of the Citizen's Panel involvement are provided within the document library.

10.15 Engagement Timeline

The table below provides a comprehensive overview of the engagement activities undertaken to support the programme and shows how stakeholders have been involved in developing and evaluating the potential models of care.

Key	
(blue)	Clinical, Staff, and Partner engagement
(pink)	Public, Patient, and service-user engagement
(green)	Wider Stakeholder involvement

Timeframe	Engagement	Stakeholder Group(s)	Engagement method	Purpose/Scope	Who took part	Link to Report
Mar - Sept 2018	Issues Paper	Public, staff	Survey	To start a conversation about the issues and challenges facing the acute hospitals across the Humber.	393 responses	Issues paper feedback report
Mar - April 2018	Health Overview Scrutiny Committees	Elected Members – East Riding of Yorkshire Council, Hull City Council, North East Lincolnshire Council, North Lincolnshire Council	Meeting	Outline briefing to Health Overview and Scrutiny Committees on the forthcoming review of acute hospital services in the Humber area	37 attendees	March – April HOSC Meetings – HASR Briefing 06.03.2018 – East Riding of Yorkshire HOSC - Minutes 11.04.2018 – North East Lincolnshire HOSC – Minutes 16.03.2018 - Hull HOSC - Minutes 26.03.2018 – North Lincolnshire HOSC - Minutes
Sep 2018	Health Overview Scrutiny Committees	Elected Members – East Riding of Yorkshire Council, Hull City Council, North East Lincolnshire Council, North	Meeting	Briefing to Health Overview and Scrutiny Committees on the forthcoming review of acute hospital services in the Humber area	N/A	September HOSC Meetings – HASR Briefing 14.09.2018 - Hull HOSC - Minutes 12.09.2018 - North East Lincolnshire HOSC - Minutes 17.09.2018 - North Lincolnshire HOSC - Minutes

		Lincolnshire Council				27.09.2018 - East Riding of Yorkshire HOSC - Minutes
Oct 2018 - Apr 2019	Focus Groups – five specialties	Public Patients	Focus Group x8	Deliberative focus groups to support the development of change plans focusing on five specialties: Cardiology; Complex rehabilitation; Critical Care; Neurology; Stroke.	119 participants (Across 8 events)	Speciality Focus Group – Feedback Report
Dec 2018	Citizen's Panel	Public Health Inclusion Groups	Meeting	First Meeting - The Citizen's Panel will act 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.	14 members recruited	12.12 2018 – Citizen's Panel - Presentation Slides 12.12.2018 – Citizen's Panel - Feedback from meeting
Jan - Oct 2019	Targeted Engagement	Health Inclusion Groups	Focus group (x18)	Humber and Wolds Rural Action commissioned to undertake a series of targeted engagement activities with hard-to-reach groups/communities to understand the impact changes to services may have.	192 participants	Humber and Wolds Rural Action - Targeted Engagement Feedback Report
Mar 2019	Citizen's Panel	Public Health Inclusion Groups	Meeting	To support developing the wording of the HASR decision making criteria and evaluate patient involvement events providing insight on how they can be improved for the future.	N/A	20.03.2019 – Citizen's Panel – Presentation Slides 20.03.2019 – Citizen's Panel – Decision Making Criteria – Panel Rewording 20.03.2019 – Citizen's Panel - Evaluation of involvement events.pdf
March 2019 (10th)	Health Overview Scrutiny Committee	East Riding of Yorkshire Council	Meeting	Briefing to the Health Overview and Scrutiny Committee on the forthcoming review of acute hospital services in the Humber area	N/A	05.03.2019 - East Riding of Yorkshire HOSC - Minutes
Jul 2019 (9th)	Citizen's Panel	Public Health Inclusion Groups	Meeting	To review last meeting, consider the clinical senate report, and consider next steps.	N/A	24.07.2019 – Citizen's Panel - Agenda 24.07.2019 – Citizen's Panel - Presentation Slides.pdf

23 Aug 2019	Maternity, Neonatal and Paediatrics	Clinical Staff	Workshop	Workshop to establish potential models of care for Maternity, Neonatal and Paediatric care.	23 participants	August 2019 - Clinical Design Sub-Group - Pre Read Pack - Maternity Analysis August 2019 – Clinical Design Sub-Group – Pre Read Pack – Paediatric Analysis August 2019 - Clinical Design Sub-Group - Participant Feedback
3 Sep 2019	Urgent and Emergency Care, Planned Care Maternity and Paediatrics	CCG's, Acute Trust Leads, Primary Care Leads (clinical and operational)	Workshop	Clinical Design Workshop to generate a longlist of potential models of care	15 participants	September 2019 – Clinical Design Sub-Group - Urgent and Emergency Care – Pre Read Pack – Analysis September 2019 – Clinical Design Sub-Group - Urgent and Emergency Care – Review of existing service ambitions and targets – Slide Pack September 2019 – Clinical Design Sub-Group - Urgent and Emergency Care – Workshop Feedback
Oct 2019 (9th, 11th, 16th)	Urgent & Emergency Care Maternity and Paediatrics and Planned Care	Clinical Staff	Workshop	Clinical Design Workshop to longlist the potential models of care	15 participants	October 2019 – Clinical Design Subgroup – Outputs
Oct to Nov 2019	Workshops – core hospital services	Public Patients Health Inclusion Groups	Workshops x7	Workshops undertaken to gather patient and public feedback on long-list of models for core hospital services: Urgent and emergency care; Maternity and paediatrics Planned Care	77 participants	Hospital Services for the Future – Patient Workshop – Feedback Report
Oct 2019 (10th)	Maternity, Neonates & Paediatrics	Clinical Staff	Workshop	Workshop to establish potential models of care	c24 participants	October 2019 - Clinical Design Sub-Group - Maternity and Paediatrics – Participant Feedback
21 Nov 2019	Citizen's Panel	Public	Meeting	Feedback on Case for Change	N/A	21.11.2019 - Citizen's Panel – Meeting Feedback

		Health Inclusion Groups				
Nov 2019 (13th & 14th)	Clinical Engagement	Clinical Staff	Workshops x2	Further engagement on the longlist for potential models.	39 participants	13th and 14th November 2019 – NLaG Clinical Engagement Events – Presentation slides Output Pack
Dec 2019	Urgent and Emergency Care, Planned Care, Maternity, Neonates and Paediatrics	HAS models evaluation Clinical Staff (hosted by Deloittes)	Workshop	HUTH/NLaG/CCGs	c30 participants	Interim Options Report – Presentation Slides and Outputs
Jan 2020 (8th, 9th)	Planned Care workshops x 2 Service Model Development Part 2	Speciality Leads (hosted by Deloittes)	Workshops x2	To develop outline ideas through workshops and targeted engagement with speciality leads	27 participants	Workshop Feedback 08.01.2020 -Executive Oversight Group – Minutes
12 Feb 2020	Clinical Design Group Planned Care	Clinicians	Workshop	Reviewing Clinical Co-Dependency of Acute Services and Assessment against the Evaluation Criteria	15 participants	Clinical Design Group - Workshop Outputs
13 March 2020	Citizen's Panel	Public, Health Inclusion Groups	Meeting	Provide feedback on the different options from the perspective of access and experience	N/A	13.03.2020 – Citizen's Panel – Options Development – Judgement of the Citizen's Panel 13.03.2020 – Citizen's Panel - The story so far 13.03.2020 – Citizen's Panel - Panel experience Feedback Report
9 July 2020	Citizen's Panel	Public, Health Inclusion Groups	Meeting	Feedback session to update members on current position of review and apprise them of the work undertaken during Covid-19.	N/A	09.07.2020 - Citizens Panel - Discussion Notes

July to Aug 2020	Accident and Emergency Survey (HCV-wide)	Public, Patients	Survey	Online survey undertaken through the Humber, Coast and Vale Partnership to understand behaviours, attitudes and barriers to using alternatives to A&E across the region.	2008 responses	Accident & Emergency- Feedback Report (Full) Accident & Emergency - Executive Summary
18 Sep 2020	Urgent and Emergency Care Defining the models of care, workshop 1	NLAG/HUTH: Medical Directors, Clinicians, Nursing Leads, CCG's Other Partners, Ambulance Providers	Workshop	To define list of models of care. 6 proposed models were presented including 4 variations of a warm model	41 participants	18.09.2020 - Urgent and Emergency Care- Defining the models of care - Workshop 1 - Outputs
24 Sep 2020	Maternity, Neonatal and Paediatric Care Workshop 1	Clinicians, Department Leads, Nursing Leads	Workshop	To set the framework for the modelling of the next stages of a reduced number of options for Maternity, Neonates and Paediatrics	30 participants	24.09.2020 - Maternity, Neonatal and Paediatric Care - Workshop 1 - Outputs
Sep – Oct 2020	Health Overview Scrutiny Committee	Elected Members – East Riding of Yorkshire Council, Hull City Council, North East Lincolnshire Council, North Lincolnshire Council	Meeting	Provide members with an update on the progress of the Humber Acute Services Programme	N/A	15.09.2020 North Lincolnshire HOSC -Minutes 16.09.2020 North East Lincolnshire HOSC -Minutes 16.10.2020 Hull HOSC - Minutes 20.10.2020 East Riding of Yorkshire HOSC - Minutes September - October 2020 – Feedback from HOSCs
29 Oct 2020	Citizen's Panel	Public Health Inclusion Groups	Meeting	Developing public facing information; Review and update Terms of Reference	N/A	29.10.2020 - Citizens Panel - Discussion Notes

November 2020	Stage 1: Yorkshire and Humber Clinical Senate Review	Yorkshire and Humber Clinical Senate	Independent Expert Review	Independent review of Case for Change and early options development by Clinical Senate	N/A	Yorkshire and Humber Clinical Senate (November 2020) Clinical Senate Review of Humber Acute Services on behalf of Humber, Coast and Vale Health and Care Partnership Senate report
16 Dec 2020	Your Birthing Choices Working Group	Maternity Voices Partnerships Chairs	Focus Group	Initial meeting to begin developing our approach to engagement with women and birthing people.	6 participants	Your Birthing Choices Working Group – Meeting 1 – Feedback Notes
29 Jan 2021	Your Birthing Choices Working Group	Maternity Voices Partnerships Chairs	Focus Group	To co-produce engagement materials including questionnaire, animation, digital artwork and social media posts	N/A	Your Birthing Choices Working Group – Meeting 2 – Feedback Notes
25 Feb 2021	Maternity, Neonatal and Paediatric Care Workshop 2	Clinicians, Department Leads, Nursing Leads	Workshop	To consider how Maternity, Neonatal and Paediatric Services will look in 5-10 years' time and what that will mean for patients and staff	45 participants	25.02.2021 - Maternity, Neonatal and Paediatric Care - Workshop 2
26 Feb 2021	Urgent and Emergency Care Defining the models of care, workshop 2	NLAG/HUTH – Clinicians, CCG's, Other partners, Workforce, Ambulance trusts	Workshop	To define list of models of care with relevant people together supported by initial assessment of the 3 proposed models	62 participants	26.02.2021 Urgent and Emergency Care-workshop - Presentation 26.02.21 Urgent and Emergency Care workshop – Outputs
Feb 2021	Citizen's Panel – What Matters to You	Public Health Inclusion Groups	Meeting	Development of Decision-Making Criteria	N/A	18.02.2021- Citizens Panel - Presentation Slides 18.02.2021 - Citizens Panel - Discussion Notes Citizens Panel - Menti Data – What Matters to You Citizens Panel - Menti Data 2 – What Matters to You

Feb to May 2021	What Matters to You	Patients, Staff, public Workshops – Citizen's Panel, Councillors, Trust Governors, Non-Exec Directors.	Survey and Workshop x6	Engagement exercise undertaken to gather the views and perspectives of a range of stakeholders to enable decision-making within the programme to reflect the priorities and preferences of local people. The engagement took the form of an online survey and a series of focus groups.	3946 participants (3883 survey responses. 63 workshop participants)	What Matters to You - Feedback Report (Full) What Matters to You – Executive Summary *(Both linked to Public, Patient and Service-User Engagement)*
Mar 2021	Health Overview Scrutiny Committee	Elected Members – East Riding of Yorkshire Council, Hull City Council, North East Lincolnshire Council,	Meeting	Briefing on the forthcoming review of acute hospital services in the Humber area	N/A	March 2021 – HOSC Meetings – HAS Programme Update 09.03.2021 East Riding of Yorkshire HOSC -Minutes 12.03.2021 Hull HOSC - Minutes 17.03.2021 North East Lincolnshire HOSC - Minutes
18 Mar 2021	Planned Care Workshop - ENT, Orthopaedics, General Surgery, Urology	CCG Clinicians CCG Other partners Nurse leads	Workshop	Develop potential models of planned care	42 participants	18.03.2021 - Planned Care Workshop - ENT, Orthopaedics, General Surgery, Urology – Output slides
May to July 2021	Your Birthing Choices	Public Health Inclusion Groups	Survey and Focus Group x9	To support the development of options for maternity and neonatal care in the Humber and North Yorkshire area.	1136 (1133 survey responses. 3 Focus Group participants)	Your Birthing Choices - Feedback Report (Full) Your Birthing Choices – Executive Summary
17 June 2021	Planned Care Gastroenterology	CCGs,	Workshop	Determine potential models for Planned Care	43 participants	17.06.2021 - Planned Care Workshop - Gastroenterology – Presentation Slides

		Clinicians, Other partners Nurse leads				Emerging Themes – Output Pack
22 June 2021	Chief Executive's Question Time	Clinical Staff	Q&A	Online Question and Answer Session for Staff members with NLaG's Chief Executive	38 participants	Video recording of the Question-and-Answer session
25 June 2021	Urgent and Emergency Care Independent Clinical review	Clinicians, CCGs, other partners	Workshop	To undertake an independent assessment of the shortlisted options and advise on any clinical risks or safety concerns. To identify potential new ways of working that will improve outcomes. To provide advice/assurance on the planned activity shift into the community and primary care	6 participants	25.06.2021 Urgent and Emergency Care - Independent Clinical Review 25.06.21 Urgent and Emergency Care - Independent Clinical Review - summary
June – Jul 2021	Speciality Specific engagement to support Interim Clinical Plan	Patients, clinical staff, admin staff, partners	Survey	To review temporary changes made to speciality services: Haematology, Oncology, Urology and Ear, Nose and Throat (ENT) and understand the impact the changes have had on patients and staff	524 participants	Haematology Patient Feedback Report (Full) Haematology Staff Feedback Report (Full) Oncology Patient Feedback Report (Full) Oncology Staff Feedback Report (Full) Urology Patient Feedback Report (Full) Urology Patient Feedback – Executive Summary Urology Staff Feedback Report (Full) Urology Staff Feedback – Executive Summary Ear Nose and Throat Patient Feedback Report (Full) Ear Nose and Throat Patient Feedback – Executive Summary Ear Nose and Throat Staff Feedback Report (Full) Ear Nose and Throat Staff Feedback – Executive Summary

June – Aug 2021	Staff Briefing Sessions	Clinical staff, admin staff	Drop-in x28	open to all staff members to attend, to hear more about various aspects of the programme and ask any questions they might have had. Videos available to view afterwards and included in each staff newsletter edition since.	Video views: 1,323 (Via YouTube)	Session Videos: Programme One (Interim Clinical Plan) Programme Two (Core Hospital Services) Programme Three (Building Better Places) Our Engagement (What Matters To You) Maternity, Neonatal & Paediatric Services Urgent & Emergency Care Planned Care & Diagnostics
1 Jul 2021	Urgent and Emergency Care, Maternity Neonatal and Paediatrics, Planned Care and Diagnostics – Matrons, Ward Managers Deputies and CNS's - Workshop 1	Nurses, other staff	Workshop	To define the current proposed models of care and discuss pros and cons and supporting pathways Transport and transfer concerns (inc. anaesthetics); Travel distance for staff; Workforce impacts and opportunities; Community hubs more locally	43 participants	01.07.2021 - UEC, Maternity, Neonatal and Paediatrics - Matrons, Ward Managers, Deputies, CNSs - Workshop Outputs
Jul 2021	What Matters to You – Our Staff and Teams	Clinical Staff	Survey	To understand what is most important to staff when thinking about their day-to-day roles, their teams and their aspirations	563 participants	What Matters to You our staff and teams - Feedback Report
6 July 2021	Urgent and Emergency Care Workshop - Defining the Models of Care	NLAG/HUTH – Clinicians, CCG's, VCSE, Ambulance Providers VCSE groups, out of hospital providers	Workshop	Joint HASR/Out of Hospital Urgent and Emergency Care Network - to define list of models of care integrated with Out of Hospital programmes and develop pathway and joint workforce models to focus on specific areas (i.e. pathways, workforce)	26 participants	06.07.2021 - Joint Out of Hospital and HASR-Urgent and Emergency Care - Workshop Outputs *(Linked to Clinical, Staff and Partner Engagement)*
9 July 2021	Urgent and Emergency Care, Maternity Neonatal and Paediatrics, Planned Care and Diagnostics –	Nursing staff	Workshop	To define the current proposed models of care and discuss the pros/cons including supporting pathways	41 participants	09.07.2021 - Urgent and Emergency Care - Defining the models of care – Core Service Change – NLaG Inpatient Wards – Workshop Outputs

	Matrons, Ward Managers Deputies and CNS's - Workshop 2					
July 2021	Obstetrics Independent Review	David Howe, Clinicians	N/a	To consider the effects of the proposed changes on the provision of maternity care by their services and to comment on the proposed options for change.	N/A	Reconfiguration of Maternity and Gynaecology Services – Report Independent Review of Obstetric Anaesthetic Services - Report
July 2021	Maternity Independent Review	B. Kuypers, Clinicians	N/a	To Assess compliance of current service provision. Undertake an independent assessment of the shortlisted options and advise on any clinical risks or safety concerns. Identify potential new ways of working that will improve outcomes and assist with further modelling of the shortlisted options. Advise on future (midwifery) workforce models.	N/A	Independent Review of Maternity Services - Report
10 Aug 2021	Maternity, Neonatal and Paediatrics, Workshop 3	Clinicians, Nursing and Midwifery Staff, Admin staff	Workshop	To review the scenarios being modelled for Maternity, Neonatal and Paediatrics. To consider the interdependencies with other services and the potential impact that the scenarios may have on those services	38 participants	10.08.2021 - Maternity, Neonatal and Paediatrics - Workshop Outputs
19 Aug 2021	Urgent and Emergency Care Workshop: Defining the Models of Care - HASR/Integrated Frailty	Clinicians, partner agencies, Ambulance providers	Workshop	To review the existing Integrated frailty model and align to longer term proposals	29 participants	19.08.2021 - Joint Integrated Frailty and HASR - Urgent and Emergency Care – Workshop Outputs
Aug – Sep 2021	Our Staff and Teams - Making Your Voice Heard	Staff	Survey	To understand how staff and teams across HUTH and NLaG prefer to be communicated with to ensure they are provided with opportunities to get involved and have their say	183 participants	Our Staff and Teams – Making your Voice Heard – Feedback Report

Aug - Nov 2021	What Matters to You – Revisited	Patients, staff, public	Survey	Engagement exercise undertaken to continue gathering the views and perspectives of a range of stakeholders to enable decision-making within the programme to reflect the priorities and preferences of local people.	148 participants	What Matters to You - Revisited - Feedback Report (Full) What Matters to You – Revisited – Executive Summary *(Linked to Clinical, Staff and Partner Engagement)*
Oct - Dec 2021	What Matters to You: Equality Groups Targeted Engagement	Health Inclusion Groups	Drop in x3	Listening events with equality groups more likely to be adversely impacted by any changes (including sex workers, families living in areas of high deprivation, asylum seekers, refugees and migrants)	c12 participants	Equalities Groups – Combined Feedback Report
1 Sept 2021	Urgent and Emergency Care Workshop: Clinical Inter-dependencies	Clinicians	Workshop	To review the existing scenarios modelled for U&EC including the overview of Humber wide pathway redesign.	20 participants	01.09.2021 - Urgent and Emergency Care - Clinical Dependencies – Workshop Outputs
7 Sept 2021	Urgent and Emergency Care Workshop: Transport	NLaG, HUTH Ambulance Transport VCSE Groups, Local Authorities Public Transport Services, Public	Workshop	To understand the current challenges with transport and travel (non-emergency 999) across the community and to plan the future opportunities for the longer term	36 participants	07.09.2021 - Urgent and Emergency Care - Transport – Workshop Outputs *(Linked to Clinical, Staff and Partner Engagement)*
Sep 2021 7th and 17th Staff workshops	What Matters to You – Our Staff and Teams – Focus Groups	Staff	Workshops x2	What was most important to our staff when thinking about their day-to-day roles, their teams and their future career aspirations within the NHS or health and care	11 participants	What Matters to You our staff and teams - Feedback Report

21 Sept 2021	Urgent and Emergency Care Independent Clinical Review 2	Clinicians, partner agencies, out of hospital providers	N/a	To undertake a further independent assessment of progressed models of care, to confirm and challenge on inter-dependencies and any further clinical risks	7 participants	Independent Clinical Review - Urgent and Emergency Care
4 Oct 2021	Workshop: Mental Health	Hospital and local authority transport organisations	Workshop	To recognise the current situation and understand the current challenges with Mental Health Services across the community. To plan for the future and start to work up collaborative opportunities for the longer term.	44 participants	04.10.2021 Out of Hospital - Mental Health Services - Workshop Outputs *(Linked to Clinical, Staff and Partner Engagement)*
October to December 2021	Children and Young People's Engagement	Health Inclusion Groups	Survey	Targeted engagement with children and young people to find out what was important to them when visiting hospital.	63 participants	Children and Young People - What Matters to You - Feedback Report (Full) Children and Young People - What Matters to You - Executive Summary
October to December 2021	What Matters to You – Parents and Carers	Public Health Inclusion Groups	Survey	Targeted engagement with Parents and Carers to understand what is important to them when visiting hospital with a child or young person	277 participants	Parents, Carers and Guardians - What Matters to You - Feedback Report (Full) Parents, Carers and Guardians - What Matters to You - Executive Summary
Nov – Dec 2021	Health Overview Scrutiny Committee	Elected Members – East Riding of Yorkshire Council, Hull City Council, North East Lincolnshire Council, North Lincolnshire Council,	Meeting	Briefing on the forthcoming review of acute hospital services in the Humber area	N/A	November 2021 HOSC Meetings – HAS Programme Update 07.12.2021 East Riding of Yorkshire HOSC - Minutes 10.11.21 Hull HOSC - Minutes 24.11.2021 North East Lincolnshire HOSC - Minutes 26.11.2021 North Lincolnshire HOSC - Minutes

		Lincolnshire County Council				15.12.2021 Lincolnshire HOSC - Minutes
2 Nov 2021	Urgent and Emergency Care Workshop: U and EC Workforce Skills and Roles	NLAG/HUTH clinicians, non-clinical staff, CCG's, other partners	Workshop	To Identify the skills and roles needed to deliver the UEC services (both in and out of hospital)	46 participants	02.11.2021 - Urgent and Emergency Care - Workforce Skills and Roles – Workshop Outputs
Nov – Dec 2021 5th, 17th, 24th, 2 Dec	Step 1 Evaluation workshops	Clinicians, nurses, Citizen's Panel	Workshop X 4	Review current models and consider advantage / disadvantages to each	117 participants	November 2021 - Workshop 2a - Evaluation Overview *(Linked to Clinical, Staff and Partner Engagement)*
10 Nov 2021	Chief Executive's Question Time	Clinical Staff	Q&A	Online Question and Answer Session for Staff members with NLaG's Chief Executive	31 participants	Video recording of the Question-and-Answer session
15 Nov 2021	Planned Care/Diagnostic workforce workshop	Clinicians, nurses	Workshop	Consider what new roles / skill sets may be required to deliver the planned care models	49 participants	15.11.2021 - Mentimeter Results - Planned Care and Diagnostics - Workforce - Workshop
23 Nov 2021	Maternity, Neonatal and Paediatrics, Workshop 4	Clinicians, Nursing and Midwifery Staff, Admin staff	Workshop	Identifying the skills and roles needed to deliver the Maternity, Neonatal and Paediatric services (both in and out of hospital) Agreeing new roles, or different ways of doing things, that avoid the current 'system' and workforce issues	37 participants	23.11.2021 - Maternity, Neonatal and Paediatrics - Workshop Outputs
29 Nov 2021	Mental Health	HUTH, out of hospital providers, VCSE groups,	Workshop	To recognise the current situation and understand the current challenges with Mental Health Services across the community. To plan for the future and	22 participants	29.11.2021 Out of Hospital Mental Health Services – Workshop Outputs *(Linked to Clinical, Staff and Partner Engagement)*

		Ambulance providers		start to work up future opportunities for the longer term working with all providers.		
Oct to Dec 2021	Accident and Emergency engagement	Public VCSE groups	Survey	Collaboration with Healthwatch to undertake 'Enter and View' visits and gather insight from people attending A and E about their experiences. Gather further insight into behaviours and why people choose A and E and the barriers to using alternative provision.	153 participants	Healthwatch Humber ED Enter and View - Feedback Report
8 Dec 2021	Surgery in Children	Clinical Staff	Workshop		c20 participants	08.12.21 - Presentation Slides Workshop Outputs
9 Dec 2021	Transport Workshop 2	Ambulance providers	Workshop	To recognise the current situation and understand the current challenges with transport and travel (non-emergency 999) across the community. To build an action plan for the future and start to work up future opportunities for the longer term.	11 participants	09.12.2021 - Transport Workshop 2
March 2022	Healthwatch engagement (planned care)	Public, Patients	Survey	Collaboration with Healthwatch to undertake survey of current patients (particularly those on waiting lists) regarding their opinions and experiences of planned care.	37 participants	Healthwatch Humber – Accessing Planned Care Services – DRAFT – Raw Data *Please note, full report not yet published*
March 2022 4th, 7th, 16th, 17th	Step 2 Evaluation Workshops,	Clinicians, non-clinical staff, public, other partners	Workshop x4	Physical and virtual workshops were held to gather views and scoring on possible models based on the evaluation criteria	130 participants	Humber Acute Services Programme – Step 1 & Step 2 Evaluation - Feedback Report *(Linked to Clinical, Staff and Partner Engagement)*
May 2022	Maternity workshop (Ockenden Review)	Clinicians, nursing and midwifery teams, partners	Workshop	To work through the potential models of care, linking to all the inter-dependencies including anaesthetics, paediatrics and gynaecology and what	17 participants	22.05.22 - Workshop slides and Outputs

				these current potential models of care mean when applying Ockenden		
June 2022	Stage 2: Yorkshire and Humber Clinical Senate Review Report	Yorkshire and Humber Clinical Senate	Independent Expert Review	Independent review of shortlisted options and evaluation process by Clinical Senate	N/A	Yorkshire and Humber Clinical Senate (June 2022) Clinical Senate Review of Humber Acute Services at North Lincolnshire and Goole NHS Foundation Trust and Hull University Teaching Hospitals NHS Trust
July 2022	IIA: Equalities Groups	Health Inclusion Groups	Drop in (x1)	Experts By Experience Meeting - Targeted engagement with ex-carers, current carers, people with learning disabilities, mental health issues, autism, and communication difficulties	9 participants	Equalities Groups – Combined Feedback Report
Sept 2022	Joint Consultants' Conference	Clinical Staff	Workshop	Joint event bringing together consultants from HUTH and NLaG for training and development. The HAS Programme had a dedicated workshop gathering feedback on workforce transformation.	126 participants	Joint Consultants' Conference – Participants Feedback
Sept – Oct 2022	IIA: Equalities Groups	Health Inclusion Groups	1:1	1:1 session with an Imam from the Islamic Centre in Scunthorpe and VCSE worker supporting Sex Workers in Grimsby to gather feedback on what the impacts would be to these groups of people and communities if services were delivered differently in the future, to support the development of the Programme's IIA.	2 participants	Equalities Groups – Combined Feedback Report
Oct 2022	IIA: Lincolnshire Maternity Service Users	Patients, Public	Drop In (x4)	Listening events at various locations across Lincolnshire to gather feedback on what the impacts would be to these communities if maternity, neonatal and paediatric services were delivered differently in the future to support the development of the Programme's IIA.	33 Participants	Summary Feedback Report Outcomes
Oct 2022	IIA: Citizen's Panel Workshop	Public, Health Inclusion Groups	Workshop	To gather feedback on how any future changes to hospital services may impact groups of people and communities who	11 Participants	Equalities Group – Combined Feedback Report

				already face barriers and disadvantage, to support the development of the Programme's IIA.		
Oct 2022	IIA: Equality Groups	Public, Health Inclusion Groups	Drop In	Listening event at the Experts By Experience Meeting – representation included ex-carers, current carers, people with learning disabilities, mental health issues, autism, and communication difficulties around what the impacts would be to them and people they represent if hospital services were delivered differently in the future, to support the development of the Programme's IIA.	11 Participants	Equalities Group – Combined Feedback Report
Nov – Dec	IIA: Staff Engagement	Maternity, Neonatal, Paediatrics, Urgent and Emergency Care teams at NLaG	Drop-Ins X4	Targeted engagement with clinical teams to answer questions on the potential models of care, gather feedback on any concerns and ideas staff members have to help decision-makers understand the potential impacts of change and to inform the development of the Programme's IIA.	c54 Participants	****write up of feedback pending**** *** due to significant operational pressures, planned visits to Hull Royal Infirmary, Castle Hill Hospital, Goole Hospital, and virtual workshops with equality networks were postponed. The engagement with equality networks were rearranged for Spring 2023***
Dec	Health Overview Scrutiny Committees	Elected Members – North Lincolnshire Council	Meeting	Briefing update provided to North Lincolnshire Council's HOSC on progress to date of the HAS Programme and next steps. Briefing paper sent virtually to all other Humber HOSCS	N/a	HOSC Briefing Paper – November 2022
Jan 2023	AHP Engagement	Clinical teams	Workshop	A joint workshop led by AHP Leaders and the programme team to understand scope for AHPs training and development opportunities, ideas to improve recruitment and retention and what AHPs feel we should prioritise within our workforce plan.	32 Participants	Joint AHP Leaders Workshop

Jan 2023	Accord online engagement event	Public Health Inclusion Groups	Drop In	Update provided to members on the progress to date of the HAS Programme and next steps.	c40 participants	Presentation Slides – HAS Update
Jan 2023	IIA: Equality Groups	Public, Health Inclusion Groups	Drop In	Listening event with Winterton Seniors Forum – representation included elderly, ex-carers, current carers, people with dementia, and communication difficulties around what the impacts would be to them if hospital services were delivered differently in the future, to support the development of the Programme's IIA.	16 participants	Equalities Group – Combined Feedback Report
Jan 2023	Transport Survey	Patients, Staff, Partners, Public	Survey	Online survey to gather further feedback on the key themes, challenges and opportunities emerging around travel and transport from the Programme's engagement so far.	124 participants	****write up of feedback pending****
Feb 2023	Maternity Engagement	Patients	Drop In (x3)	Listening events at antenatal clinics at East and West Marsh Children's Centre and Goole Hospital to gather feedback on what the impacts would be to these communities if maternity services were delivered differently in the future to support the development of the Programme's IIA.	15 Participants	****write up of feedback pending****
Feb 2023	North Lincolnshire and North East Lincolnshire Health and Care Partnership Leadership Group Briefings	Staff, Primary Care, Local Authority Partners	Briefing Sessions	Briefing sessions for the North Lincolnshire and North East Lincolnshire Health Care Partnership members. The briefings were presented by the programme director with clinicians in attendance to answer questions and explain the proposed models.	North East Lincolnshire 9 participants North Lincolnshire 8 participants	NL and NEL HCP Briefings Presentation and Key Feedback Themes *(linked to Wider Stakeholder Involvement)*
Feb 2023	Factory Workers Engagement – Drop-in Session	Patients, Public	Drop-Ins (x2)	Drop in sessions at Cranswick Food Factory, Hull in partnership with Ask a Midwife and Infectious Disease Team to	5 participants	****write up of feedback pending****

				engage with factory workers, in particular Eastern European workers to understand the barriers faced when accessing hospital/health care		
April 2023	Stage 3: Yorkshire and Humber Clinical Senate Review Report	Yorkshire and Humber Clinical Senate	Independent Expert Review	Independent review of Pre-Consultation Business Case by Clinical Senate	N/A	Yorkshire and Humber Clinical Senate (April 2023) Clinical Senate Review of Humber Acute Services on behalf of Humber and North Yorkshire Integrated Care Board Senate Report
May 2023	Epworth and Cottage Beck – Maternity Engagement	Patients, Public	Drop-Ins (x2)	Visits to gather feedback on what the impacts would be to these communities if maternity services were delivered differently in the future to support the development of the Programme's IIA.	21 participants	****feedback report pending****
June 2023	Staff Equality Networks Engagement	Staff Equality Network Members	Workshops (x3)	Workshops held to hear the voices of the LGBTQ+, BAME and Disability equality network members.	4 participants	Humber Acute Services Equality Workshops Feedback
				Running Total (Approx.)	**13,008**	

D. Modelling Outputs

10.16 Activity

10.16.1 Proposed option and impacts

Proposed Models and Variance against BAU	Emergency Department Attendances						Acute Inpatient Discharges					
	DPoW		SGH		HUTH		DPoW		SGH		HUTH	
	Numbers	Variance	Numbers	Variance	Numbers	Variance	Numbers	Variance	Numbers	Variance	Numbers	Variance
BAU with Existing transformation and 5 year Growth AAU rules at NLaG only	**77,517**		**75,776**		**138,590**		**18,941**		**19,907**		**51,178**	
DPoW as Acute SGH as Local Emergency Hospital (both with OLU)	77,892	376	74,988	-788	139,003	413	23,102	4,161	13,700	-6,207	47,511	-3,667

Table 10.22 UEC Activity

Proposed Models and Variance against BAU	Paediatrics > 24 hrs					
	DPoW		DPoW		HUTH	
	Numbers	Beds	Numbers	Beds	Beds	Variance
BAU with Existing transformation and 5 year Growth AAU rules at NLaG only	**990**		**239**		**2,440**	
DPoW as Acute SGH as Local Emergency Hospital (both with OLU)	1,925	308	0	-935	2,440	0

Table 10.23 Paeds Activity

10.16.2 Discounted models and impacts

10.16.2.1 Urgent and Emergency Care

Proposed Models and Variance against BAU	Emergency Department Attendances						Acute Inpatient Discharges					
	DPoW		SGH		HUTH		DPoW		SGH		HUTH	
	Numbers	Variance	Numbers	Variance	Numbers	Variance	Numbers	Variance	Numbers	Variance	Numbers	Variance
BAU with Existing transformation and 5 year Growth AAU rules at NLaG only	**77,517**		**75,776**		**138,590**		**18,941**		**19,907**		**51,178**	
SGH as Acute DPoW as Local Emergency Hospital (both with OLU)	76,644	-853	76,217	441	139,003	413	12,277	-6,664	24,525	4,618	47,511	-3,667

Excluded potential models	Emergency Department Attendances							Acute Inpatient Discharges						
	DPoW		SGH		HUTH		Central	DPoW		SGH		HUTH		Central
	Numbers	Variance	Numbers	Variance	Numbers	Variance	Central	Numbers	Variance	Numbers	Variance	Numbers	Variance	
BAU with Existing transformation and 5 year Growth AAU rules at NLaG only	**77,517**		**75,776**		**138,590**			**18,941**		**19,907**		**51,178**		
DPoW as Acute SGH as Elective Hospital	80,793	3,276	36,063	-39,713	149,138	10,548	0	19,667	726	0	0	52,607	1,429	0
SGH as Acute Hospital DPoW as Elective Hospital	36,357	-41,160	109,082	33,306	139,627	1,037	0	0	0	32,333	12,426	47,923	-3,255	0
Central Hospital Site	36,357	-41,160	36,063	-39,713	138,912	322	73,045	0	0	0	0	47,550	-3,628	34,881
DPoW as Acute SGH as Local Emergency Hospital (with OLU) (General Medicine and Care of Elderly inpatients >72 hrs consolidated to Acute hospital)	77,892	375	74,988	-788	139,003	413	0	27,457	8,516	9,345	-10,562	47,511	-3,667	0
SGH as Acute DPoW as Local Emergency Hospital (with OLU) (General Medicine and Care of Elderly inpatients >72 hrs consolidated to Acute hospital)	76,644	-873	76,217	441	139,003	413	0	8,511	-10,430	28,291	8,384	47,511	-3,667	0

Table 10.24 UEC Activity - discounted models

10.16.2.2 Paediatrics

Proposed Models and Variance against BAU	Paediatrics > 24 hrs					
	DPoW		SGH		HUTH	
	Numbers	Variance	Numbers	Variance	Numbers	Variance
BAU with Existing transformation and 5 year Growth AAU rules at NLaG only	**990**		**935**		**2,440**	
SGH as Acute DPoW as Local Emergency Hospital (both with OLU)	0	-990	1,925	990	2,440	0

Excluded potential models	*Paediatric Assessment Unit*						*Paediatrics > 24 hrs*					
	DPoW		*SGH*		*HUTH*		*DPoW*		*SGH*		*HUTH*	
	Numbers	*Variance*	*Numbers*	*Variance*	*Numbers*	*Variance*	*Numbers*	*Variance*	*Numbers*	*Variance*	*Numbers*	*Variance*
BAU with Existing transformation and 5 year Growth AAU rules at NLaG only	***5,577***		***4,478***		***6,172***		***990***		***935***		***2,440***	
DPoW as Acute SGH as Elective Hospital	*5,918*	*341*	*0*	*-4,478*	*7,231*	*1,059*	*1,055*	*65*	*0*	*-935*	*2,685*	*245*
SGH as Acute Hospital DPoW as Elective Hospital	*0*	*-5,918*	*9,111*	*3,534*	*6,175*	*3*	*0*	*-990*	*1,762*	*827*	*2,442*	*2*
Central Hospital Site	*0*	*-5,577*	*0*	*-9,111*	*6,221*	*46*	*0*	*-990*	*0*	*-935*	*2,454*	*14*
DPoW as Acute SGH as Local Emergency Hospital with MLU	*5,918*	*5,918*	*0*	*0*	*7,231*	*1,010*	*1,055*	*65*	*0*	*-935*	*2,685*	*245*
SGH as Acute DPoW as Local Emergency Hospital with a MLU	*0*	*-5,918*	*9,111*	*9,111*	*6,175*	*3*	*0*	*-990*	*1,762*	*827*	*2,442*	*2*

Table 10.25 Paediatrics Activity - discounted models

10.17 Displacement

10.17.1 Proposed option and impacts

Proposed Models and Variance against BAU	Emergency Department Attendances			Acute Inpatient Discharges			UEC Combined			Paeds		
	DPoW	SGH	HUTH	DPoW	SGH	HUTH	DPoW	SGH	HUTH	DPoW	SGH	HUTH
	Numbers	Numbers	Numbers	Numbers	Numbers	Numbers	Numbers	Numbers	Numbers	Numbers	Numbers	Numbers
DPoW as Acute SGH as Local Emergency Hospital (both with OLU)	376	-788	413	5,438	-5,616	423	5,814	-6,404	836	935	-935	0

Table 10.26 Displacement – UEC and Paediatrics

Proposed Models	Displaced (OOA)						
	DPoW	SGH	HUTH	DRI	LCH	PHB	YTH
	Numbers						
DPoW as Acute SGH as Local Emergency Hospital (both with OLU)	6,373	-6,551	423	0	0	0	0

Table 10.27 Out of Area Displacement – UEC and Paediatrics

10.17.2 Discounted models and impacts

10.17.2.1 Urgent and Emergency Care

Proposed Models and Variance against BAU	Emergency Dept Attendances			Acute Inpatient Discharges			Combined		
	DPoW	SGH	HUTH	DPoW	SGH	HUTH	DPoW	SGH	HUTH
	Numbers	Numbers	Numbers	Numbers	Numbers	Numbers	Numbers	Numbers	Numbers
DPoW as Acute SGH as Elective Hospital	3,276	-39,713	10,548	1,822	-19,194	5,522	5,098	-39,713	16,070
SGH as Acute Hospital DPoW as Elective Hospital	-41,160	33,406	1,037	-18,528	14,102	840	-41,160	47,580	1,877
Central Hospital Site	-41,160	-39,713	-323	-18,528	-19,194	464	-41,160	-39,713	141
DPoW as Acute SGH as Local Emergency Hospital (with OLU) (General Medicine and Care of Elderly inpatients >72 hrs consolidated to Acute hospital)	376	-788	413	10,281	-10,459	423	10,657	-11,247	836
SGH as Acute DPoW as Local Emergency Hospital (with OLU) (General Medicine and Care of Elderly inpatients >72 hrs consolidated to Acute hospital)	-853	441	413	-10,517	10,493	423	-11,370	10,934	836
DPoW as Acute SGH as Local Emergency Hospital (without OLU) (General Medicine and Care of Elderly inpatients >72 hrs consolidated to Acute hospital)	376	-788	413	10,281	-10,459	423	10,657	-11,247	836
SGH as Acute DPoW as Local Emergency Hospital (without OLU) (General Medicine and Care of Elderly inpatients >72 hrs consolidated to Acute hospital)	-853	441	413	-10,517	10,493	423	-11,370	10,934	836
DPoW as Acute SGH as Local Emergency Hospital with MLU	376	-788	413	5,438	-5,616	423	5,814	-6,404	836
SGH as Acute DPoW as Local Emergency Hospital with a MLU	-853	441	413	-6,340	6,161	423	-7,193	6,602	836

Table 10.28 Displacement Discounted Models – UEC

Excluded potential models	DPoW	SGH	HUTH	central
	Numbers			
DPoW as Acute SGH as Elective Hospital	1,822	-19,194	5,522	0
SGH as Acute Hospital DPoW as Elective Hospital	-18,528	14,114	840	0
Central Hospital Site	-18,528	-19,194	464	35,391
DPoW as Acute SGH as Local Emergency Hospital (with OLU) (General Medicine and Care of Elderly inpatients >72 hrs consolidated to Acute hospital)	10,281	-10,459	423	0
SGH as Acute DPoW as Local Emergency Hospital (with OLU) (General Medicine and Care of Elderly inpatients >72 hrs consolidated to Acute hospital)	-10,517	10,493	423	0

Excluded potential models	DRI	LCH	PHB	YTH
	Numbers			
DPoW as Acute SGH as Elective Hospital	10,236	1,834	44	8
SGH as Acute Hospital DPoW as Elective Hospital	247	2,285	1,499	9
Central Hospital Site	248	153	1,459	7
DPoW as Acute SGH as Local Emergency Hospital (General Medicine and Care of Elderly inpatients >72 hrs consolidated to Acute hospital)	0	0	0	0
SGH as Acute DPoW as Local Emergency Hospital (with OLU) (General Medicine and Care of Elderly inpatients >72 hrs consolidated to Acute hospital)	0	0	0	0

Table 10.29 Out of Area Displacement Discounted Models – UEC

10.17.2.2 Paediatrics

Excluded potential models and variance against BAU	Paeds		
	DPoW	SGH	HUTH
	Numbers	Numbers	Numbers
DPoW as Acute SGH as Elective Hospital	406	-5,413	1,303
SGH as Acute Hospital DPoW as Elective Hospital	-6,567	5,460	5
Central Hospital Site	-6,567	-5,413	62
DPoW as Acute SGH as Local Emergency Hospital (with OLU) (General Medicine and Care of Elderly inpatients >72 hrs consolidated to Acute hospital)	935	-935	0
SGH as Acute DPoW as Local Emergency Hospital (with OLU) (General Medicine and Care of Elderly inpatients >72 hrs consolidated to Acute hospital)	-990	990	0
DPoW as Acute SGH as Local Emergency Hospital (without OLU) (General Medicine and Care of Elderly inpatients >72 hrs consolidated to Acute hospital)	935	-935	0
SGH as Acute DPoW as Local Emergency Hospital (without OLU) (General Medicine and Care of Elderly inpatients >72 hrs consolidated to Acute hospital)	-990	990	0
DPoW as Acute SGH as Local Emergency Hospital with MLU	935	-935	0
SGH as Acute DPoW as Local Emergency Hospital with a MLU	-990	990	0

Table 10.30 Displacement Discounted Models – Paediatrics

Excluded potential models	Displaced (OOA)		
	LCH	PHB	YTH
	Numbers		
DPoW as Acute SGH as Elective Hospital	92	0	6
SGH as Acute Hospital DPoW as Elective Hospital	334	183	1
Central Hospital Site	50	163	2
DPoW as Acute SGH as Local Emergency Hospital with MLU	84	0	6
SGH as Acute DPoW as Local Emergency Hospital with a MLU	310	165	1

Table 10.31 Out of Area Displacement Discounted Models – Paediatrics

10.18 Travel

10.18.1 Patient Travel Time impact

10.18.1.1 Urgent and Emergency Care

U&EC Emergency Department attendances (adults and children, exc. growth)							
	Acute/LEH		Acute/LEH (without COE & GM)		Acute/Elective		
	DPoW Acute	SGH Acute	DPoW Acute	SGH Acute	DPoW Acute	SGH Acute	Central Site
< - 10mins	3	13	3	13	1,527	1,642	3,635
-10 mins to < 10mins	52	27	52	27	5,350	3,714	17,293
10 mins to 30 mins	333	280	333	280	11,798	16,362	55,443
> 30 mins	575	614	575	614	18,905	17,219	506
Total Activity Impacted	**963**	**934**	**963**	**934**	**37,580**	**38,937**	**120,236**
Activity Not impacted or unrouteable	147,594	147,623	147,594	147,623	110,977	109,620	71,627
Total Activity	148,557	148,557	148,557	148,557	148,557	148,557	148,504

Table 10.32 Summary travel impact - ED Attendances

U&EC - Emergency Admissions (adult only, exc. growth, inc. transfer conditions)							
	Acute/LEH		Acute/LEH (without COE & GM)		Acute/Elective		
	DPoW Acute	SGH Acute	DPoW Acute	SGH Acute	DPoW Acute	SGH Acute	Central Site
< - 10mins	354	267	581	343	1,147	796	1,846
-10 mins to < 10mins	451	266	807	403	2,707	2,224	9,274
10 mins to 30 mins	2,244	2,382	3,998	3,916	6,650	7,661	26,090
> 30 mins	2,589	3,253	4,848	5,312	8,877	8,070	337
Total Activity	**5,638**	**6,168**	**9,870**	**9,974**	**19,381**	**18,751**	**37,547**
Activity Not impacted or unrouteable	79,990	79,460	75,758	75,654	66,247	66,877	48,081
Total Activity	85,628	85,628	85,628	85,628	85,628	85,628	85,628

Table 10.33 Summary travel impact - UEC inpatient activity

10.18.1.2 Paediatrics

Paediatrics admissions (>24 hrs, exc. growth)							
	Acute/LEH		Acute/LEH (time-limited PAU)		Acute/Elective		
	DPoW Acute	SGH Acute	DPoW Acute	SGH Acute	DPoW Acute	SGH Acute	Central Site
< - 10mins	17	35	17	35	17	35	127
-10 mins to < 10mins	75	24	75	24	75	24	575
10 mins to 30 mins	260	127	260	127	260	127	1,152
> 30 mins	550	768	550	768	550	768	1
Total Activity Impacted	**902**	**954**	**902**	**954**	**902**	**954**	**1,855**
Activity Not impacted or unrouteable	3,291	3,239	3,291	3,239	3,291	3,239	2,338
Total Activity	4,193	4,193	4,193	4,193	4,193	4,193	4,193

Table 10.34 Travel impact summary – Paediatrics

10.18.1.3 Travel time impact by deprivation

	Acute / Local Emergency Hospital Model (with OLU)		Acute / Local Emergency Hospital (without OLU)		Population Baseline
IMD_Decile	**DPoW = Acute | SGH = LEH (*with OLU*)**	**SGH = Acute | DPoW = LEH (*with OLU*)**	**DPoW = Acute | SGH = LEH (*without OLU*)**	**SGH = Acute | DPoW = LEH (*without OLU*)**	
1 (Most Deprived)	22.26%	27.64%	23.15%	30.28%	20.77%
2	12.97%	9.29%	14.39%	8.80%	8.21%
3	11.88%	16.23%	11.20%	15.61%	10.14%
4	8.50%	8.34%	8.04%	7.88%	8.21%
5	12.86%	5.50%	12.12%	5.50%	9.66%
6	6.33%	4.88%	6.40%	4.28%	7.73%
7	11.75%	9.41%	11.45%	9.04%	13.53%
8	4.00%	5.40%	4.08%	5.05%	8.70%
9	8.60%	10.79%	8.19%	11.08%	10.14%
10 (Least Deprived)	0.85%	2.51%	1.00%	2.49%	2.90%

Table 10.35 Travel impact summary by IMD decile

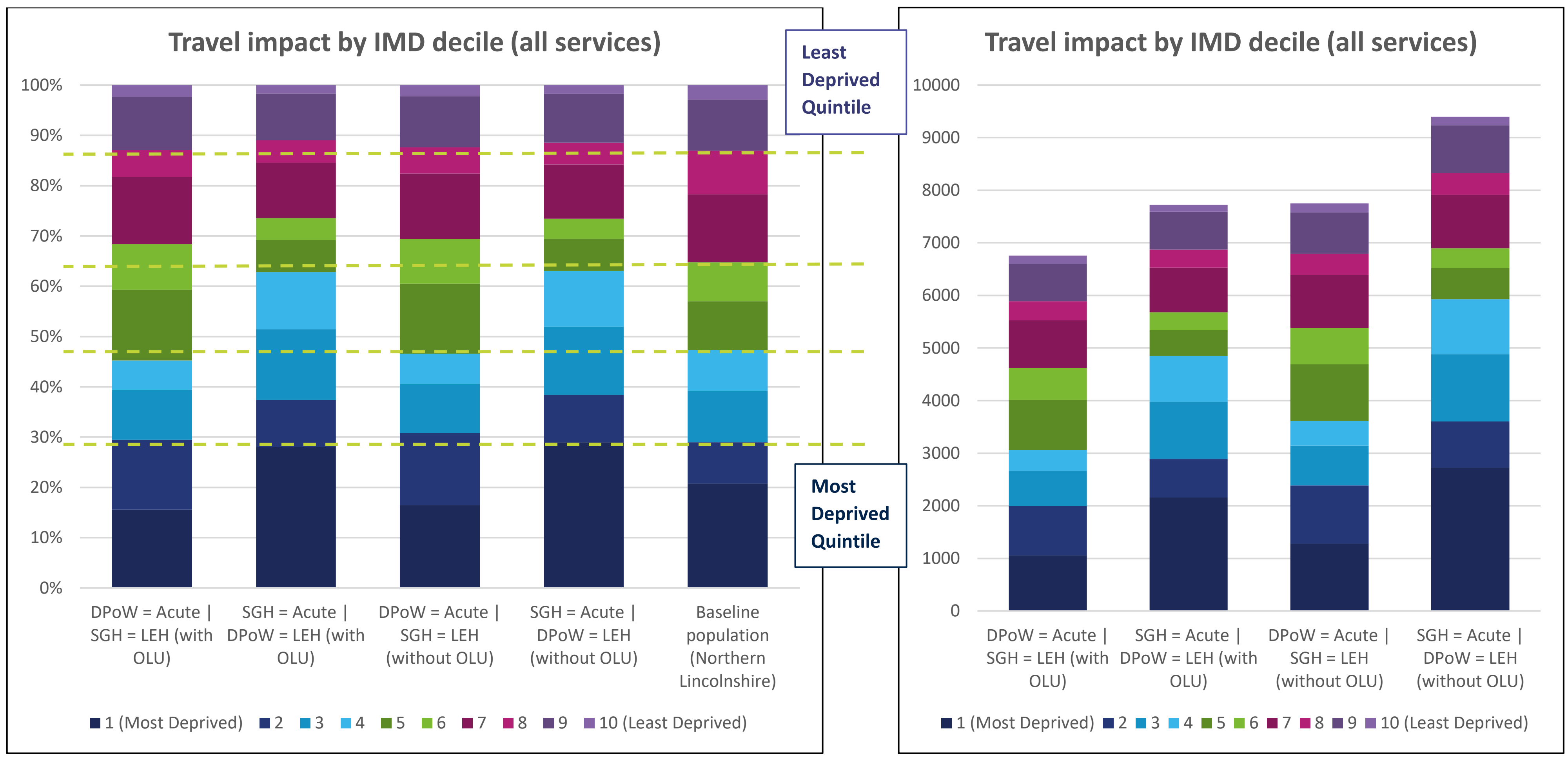


Figure 10.33 Travel impact by IMD decile - %age

Figure 10.32 Travel impact by IMD decile - numbers

10.18.2 Emergency transport

Ambulance impact summary							
	Acute/LEH		Acute/LEH (without OLU)		Acute/Elective		
	DPoW Acute	SGH Acute	DPoW Acute	SGH Acute	DPoW Acute	SGH Acute	Central Site
Total number of patients diverted	2,298	3,593	2,377	3,700	18,176	22,798	40,974
Additional DCA hours required[316]	88	140	96	154	238	616	406

Table 10.36 Emergency ambulance impact summary table[317]

ORH drew the following conclusions in relation to patient divert impacts from their analysis:

- More patients are diverted when SGH is the acute than DPoW; in the acute/elective model, 25% more patients are diverted than with DPoW as the acute.
- Due to the geography of the county and patient origins, travel time impacts are c.46% greater with SGH as the acute compared to DPoW as the acute.
- Arrival to handover was longer at SGH in 2019/20; diverted DPoW patients would experience longer times.
- The Barnetby Top site results in the largest number of diverts as patients from both Scunthorpe and Grimsby are affected.

ORH drew the following conclusions in relation to resourcing requirements from their analysis:

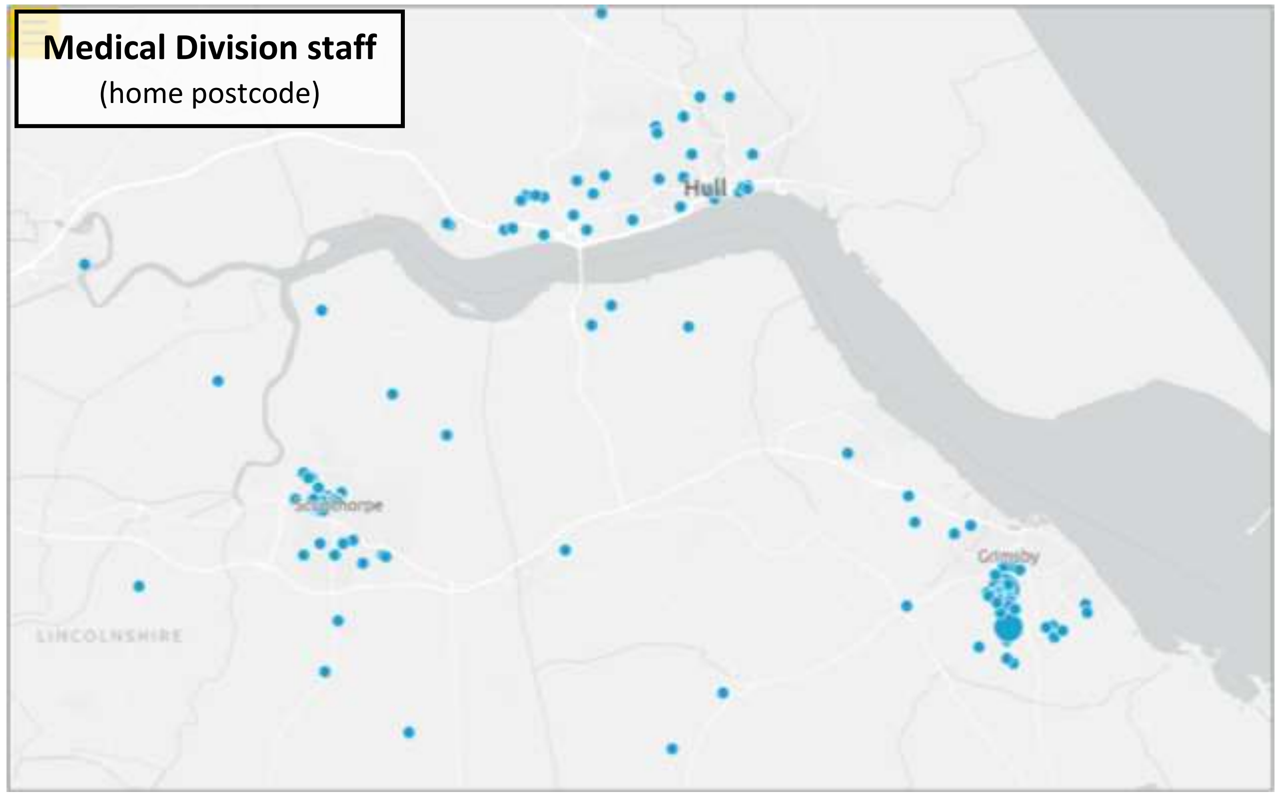
- As indicated by the patient divert modelling, the impacts on EMAS with SGH as the acute are much greater than with DPoW as the acute.
- This is particularly true for the acute/elective scenario, where the requirement of 616 additional ambulance hours per week is equivalent to a 9.3% increase in ambulance resourcing across Lincolnshire.
- The Central site model produces impacts between the two scenarios; volumes diverted are higher, but travel time impacts are lower as this provides a central location.

[316] DCA = double crewed ambulance; 168 hours = one 24/7 ambulance
[317] ORH modelling report – see document library

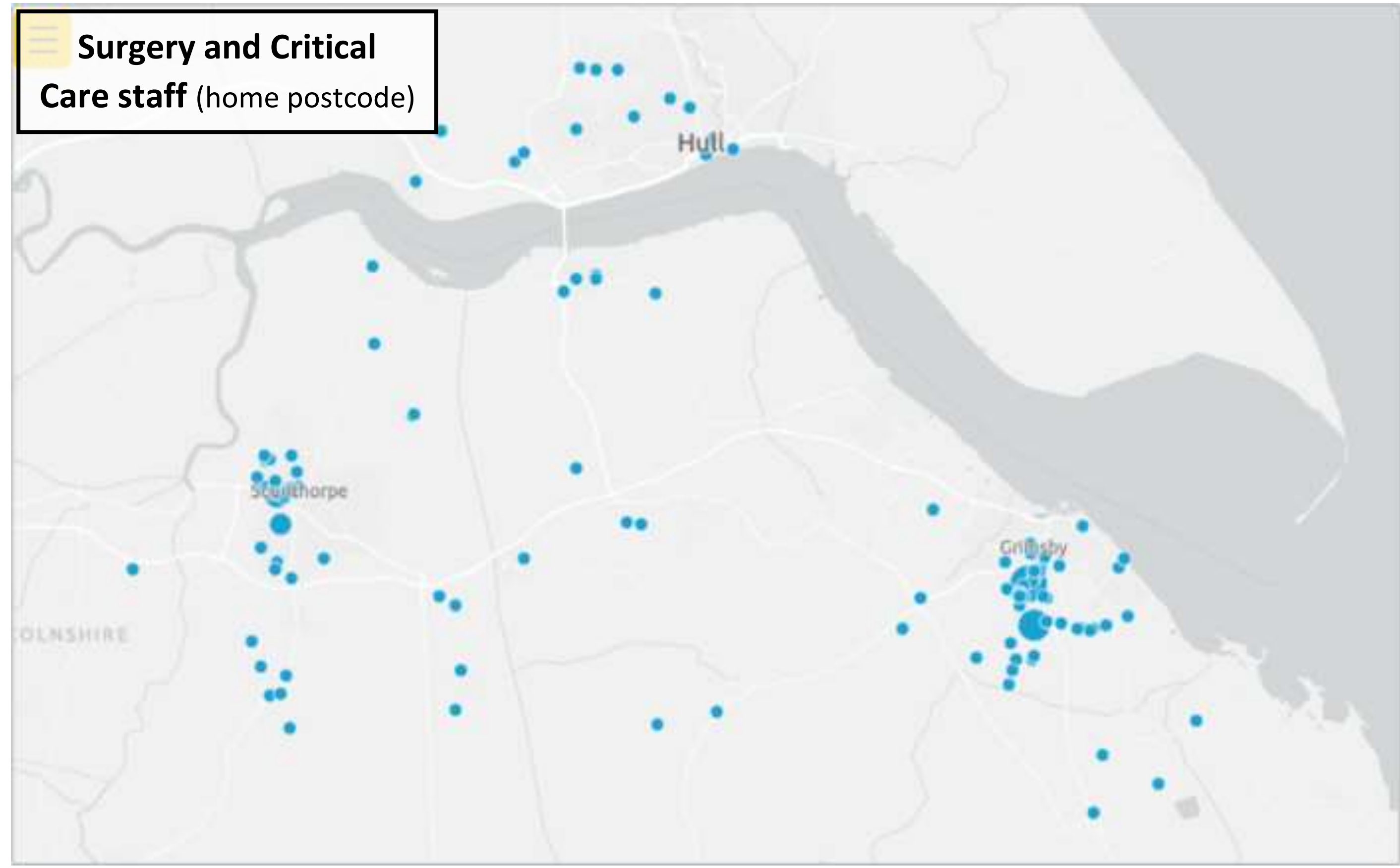
10.18.3 Staff travel

Current NLaG staff who might be impacted by proposed changes to clinical models outlined in this business case tend to live in North or North East Lincolnshire close to where they work. This is especially true for:

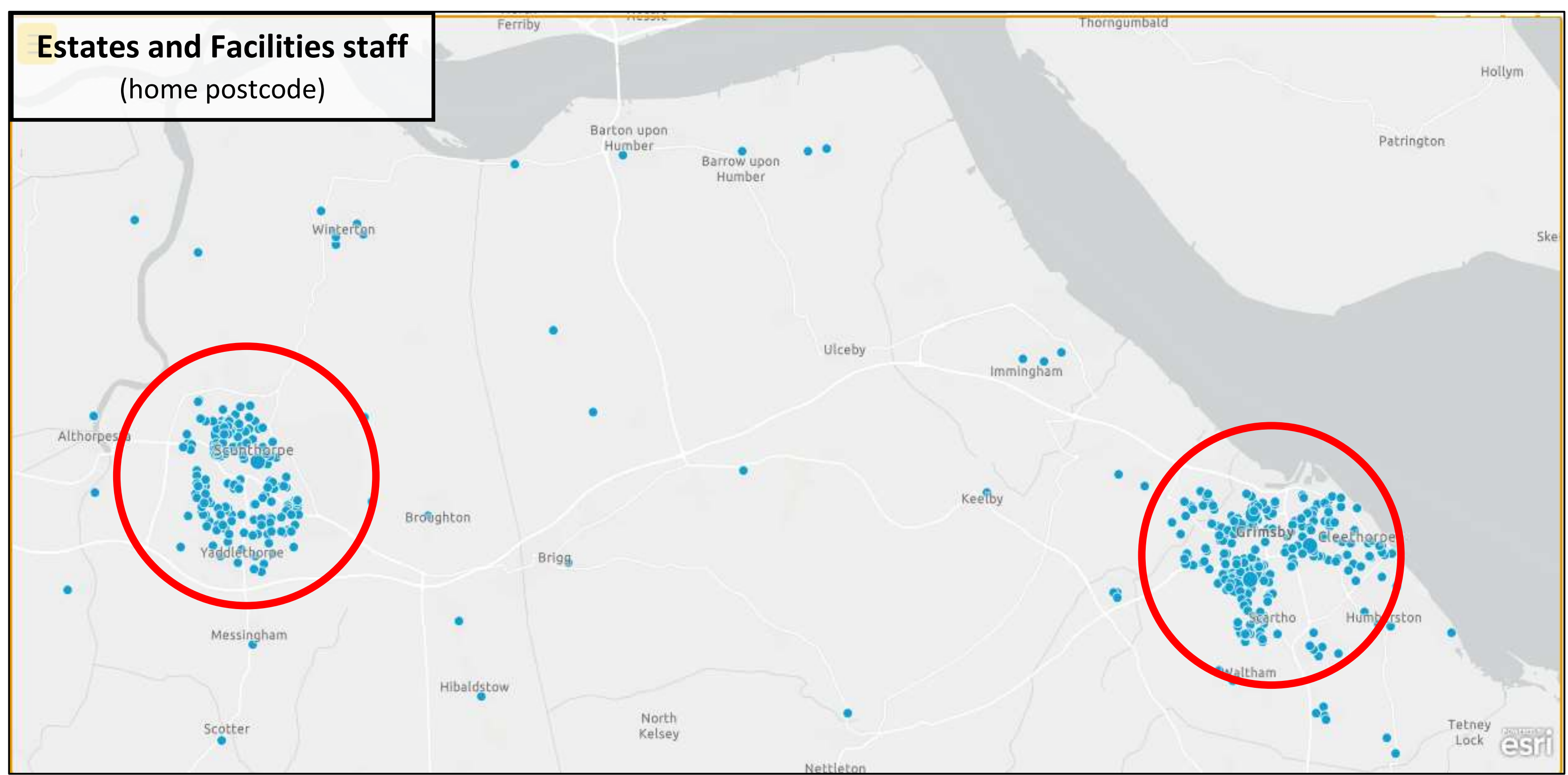
- **Medical Staff** (Consultants and SAS) due to contractual requirements.
- **Estates, clinical support and general administration staff** within pay bands 1 to 4 (for economic reasons).
- Registered Nurses, Midwives and Allied Health Professional (Therapists, ODPs and Radiographers) are more likely to live near the service they work in but live in a wider area, including away from the main Grimsby and Scunthorpe geographic locations.



Map 10.1 NLaG Medicine Division staff home postcodes



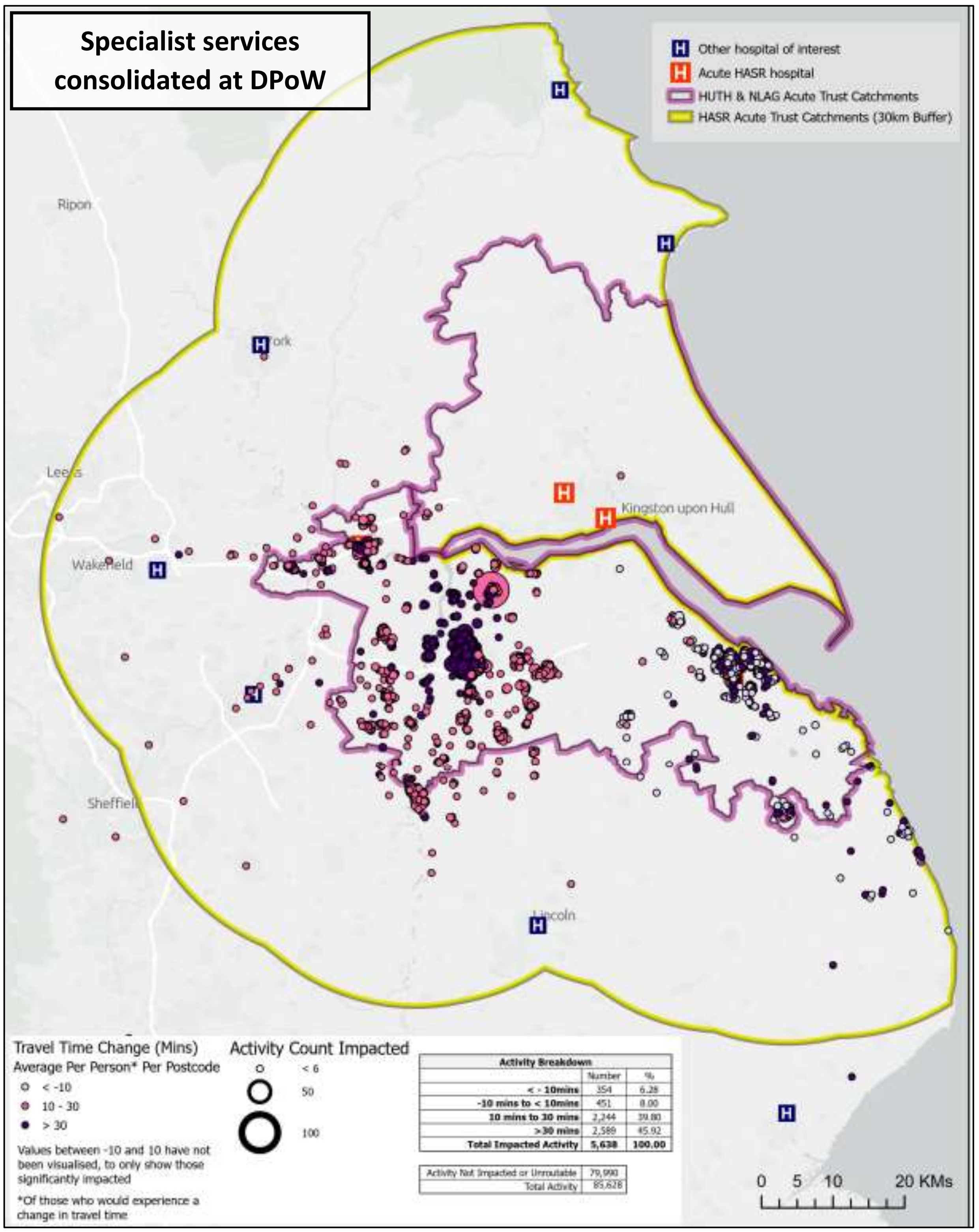
Map 10.2 NLaG Surgical and Critical Care staff home postcodes



Map 10.3 NLaG Estates and Facilities staff home postcodes

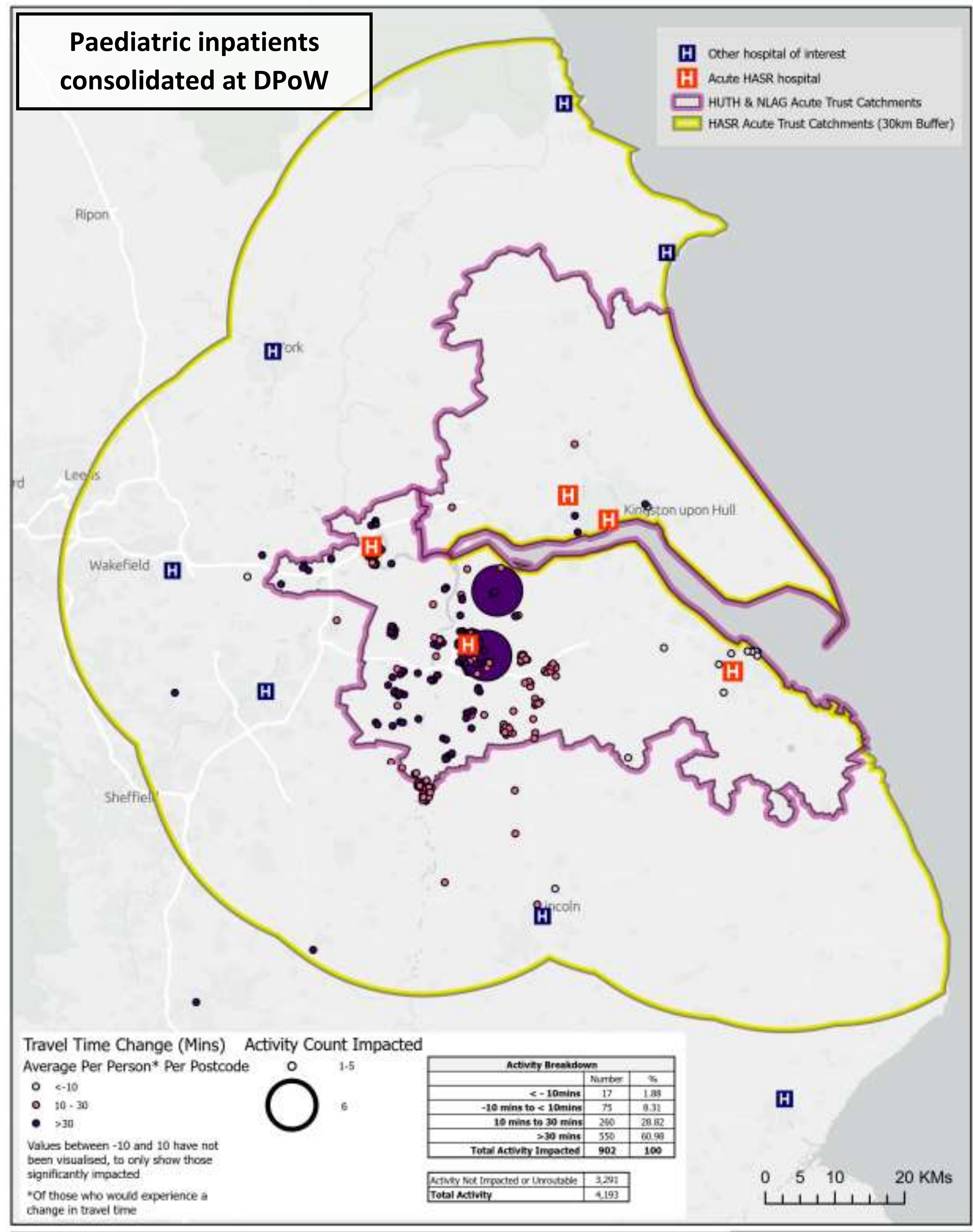
10.18.4 Travel Impact Maps

10.18.4.1 Proposed option – Urgent and Emergency Care



Map 10.4 Urgent & Emergency Care (UEC) Travel Time Impact – consolidated services at DPoW

10.18.4.2 Proposed option – Paediatrics



Activity Breakdown		
	Number	%
< - 10mins	17	1.88
-10 mins to < 10mins	75	8.31
10 mins to 30 mins	260	28.82
>30 mins	550	60.98
Total Activity Impacted	**902**	**100**

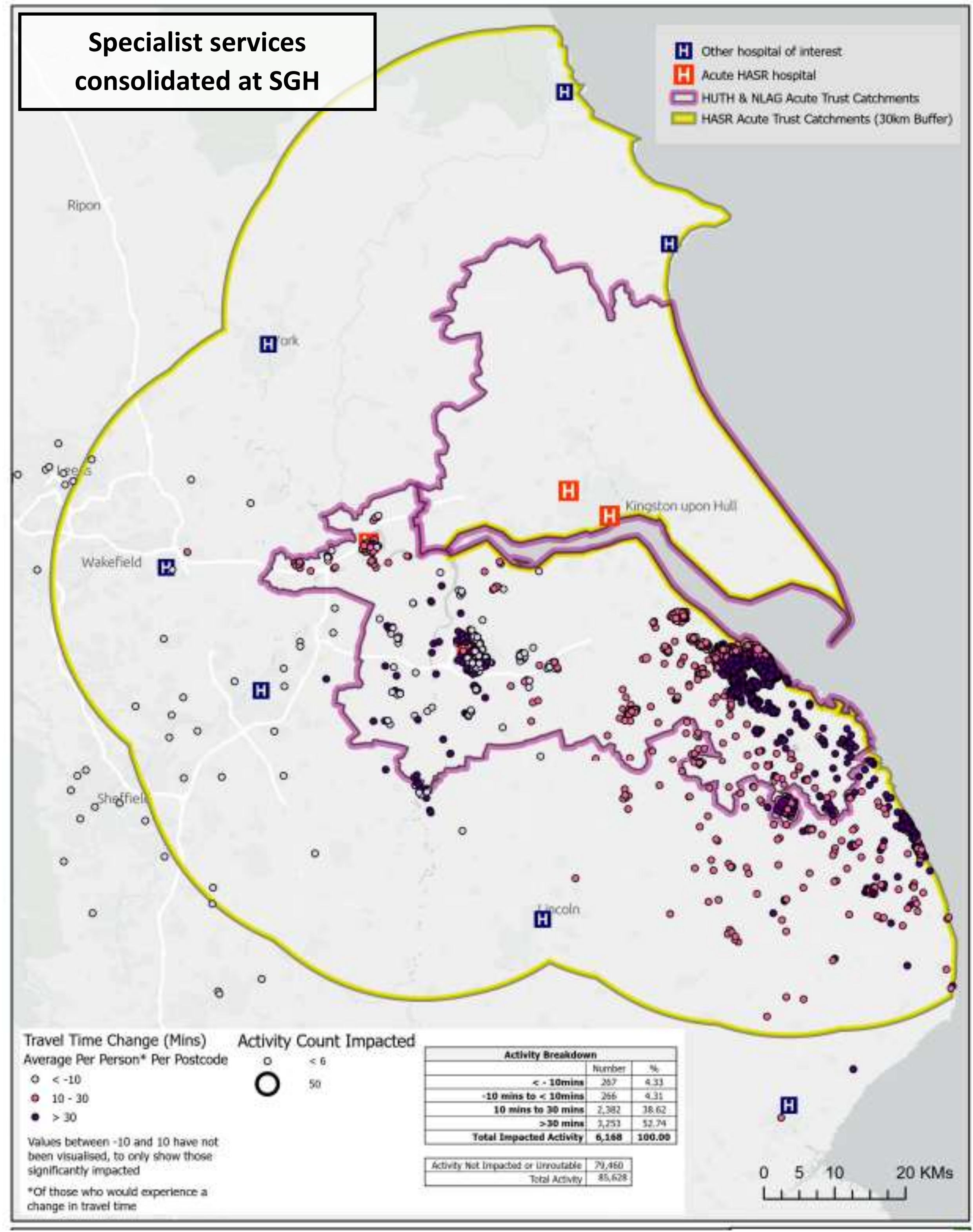
Activity Not Impacted or Unroutable	3,291
Total Activity	4,193

Map 10.5 Paediatrics Travel Time Impact – consolidated services at DPoW

NOTE: the different scale represented by the coloured dots

10.18.5 Discounted Models

10.18.5.1 Proposed UEC model of care – services consolidated at Scunthorpe

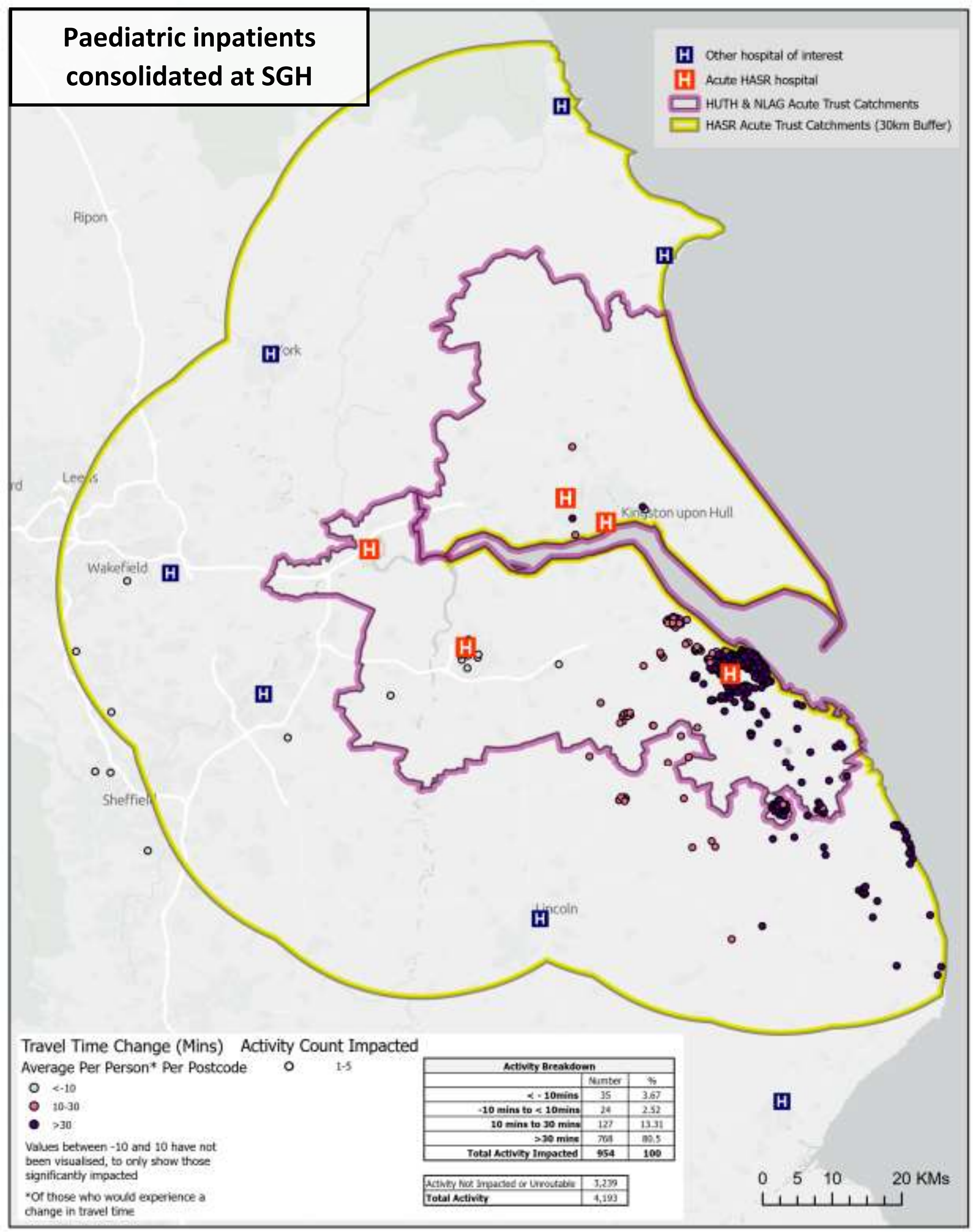


Activity Breakdown		
	Number	%
< - 10mins	267	4.33
-10 mins to < 10mins	266	4.31
10 mins to 30 mins	2,382	38.62
>30 mins	3,253	52.74
Total Impacted Activity	6,168	100.00

Activity Not Impacted or Unroutable	79,460
Total Activity	85,628

Map 10.6 Urgent & Emergency Care (UEC) Travel Time Impact – consolidated services at SGH

10.18.5.2 Proposed Paediatric model of care – services consolidated at Scunthorpe



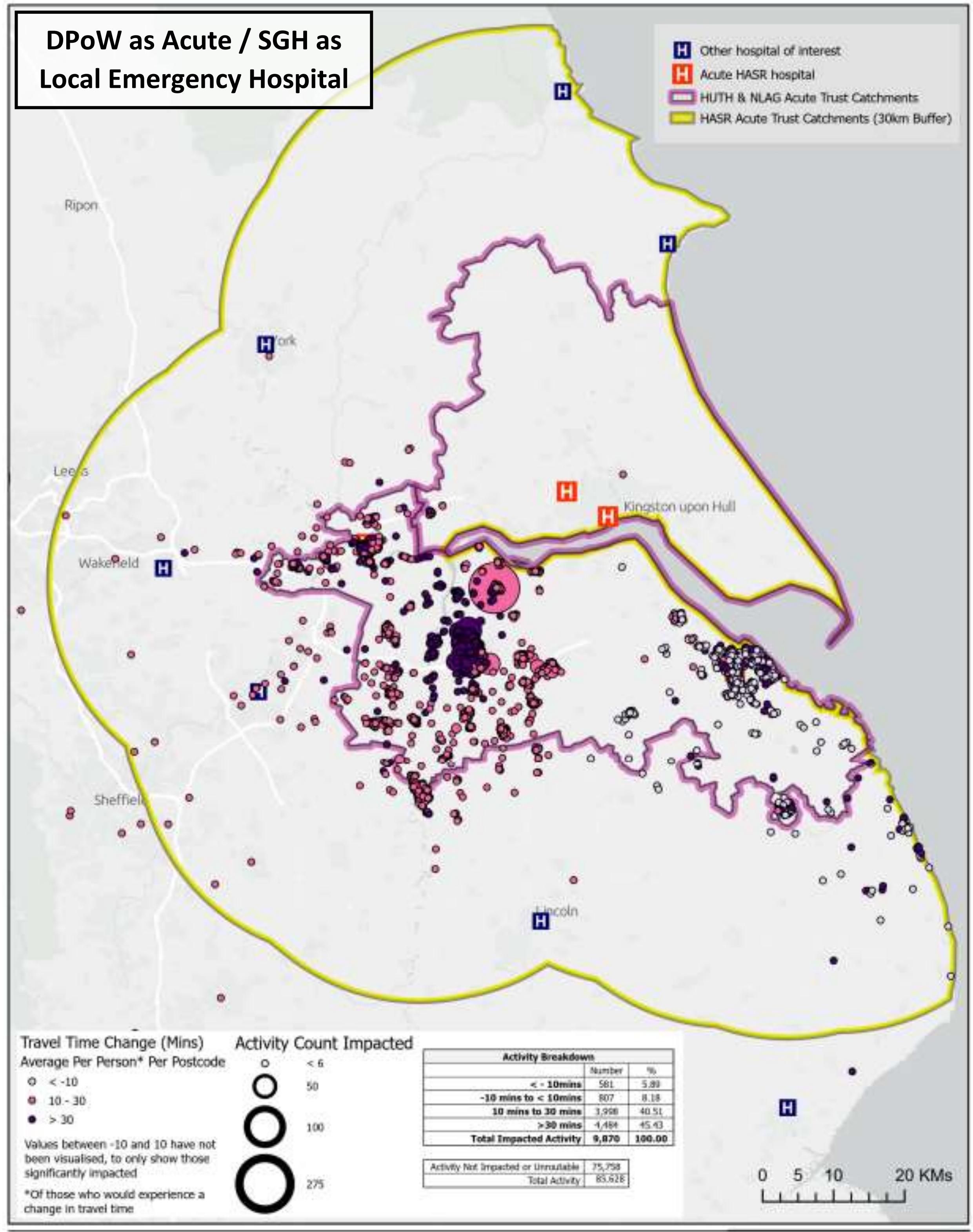
Activity Breakdown		
	Number	%
< - 10mins	35	3.67
-10 mins to < 10mins	24	2.52
10 mins to 30 mins	127	13.31
>30 mins	768	80.5
Total Activity Impacted	**954**	**100**

Activity Not Impacted or Unroutable	3,239
Total Activity	4,193

Map 10.7 Paediatrics Travel Time Impact – consolidated services at SGH

NOTE: the different scale represented by the coloured dots

10.18.5.3 Discounted models – Consolidation of General Medical and Care of the Elderly at DPoW

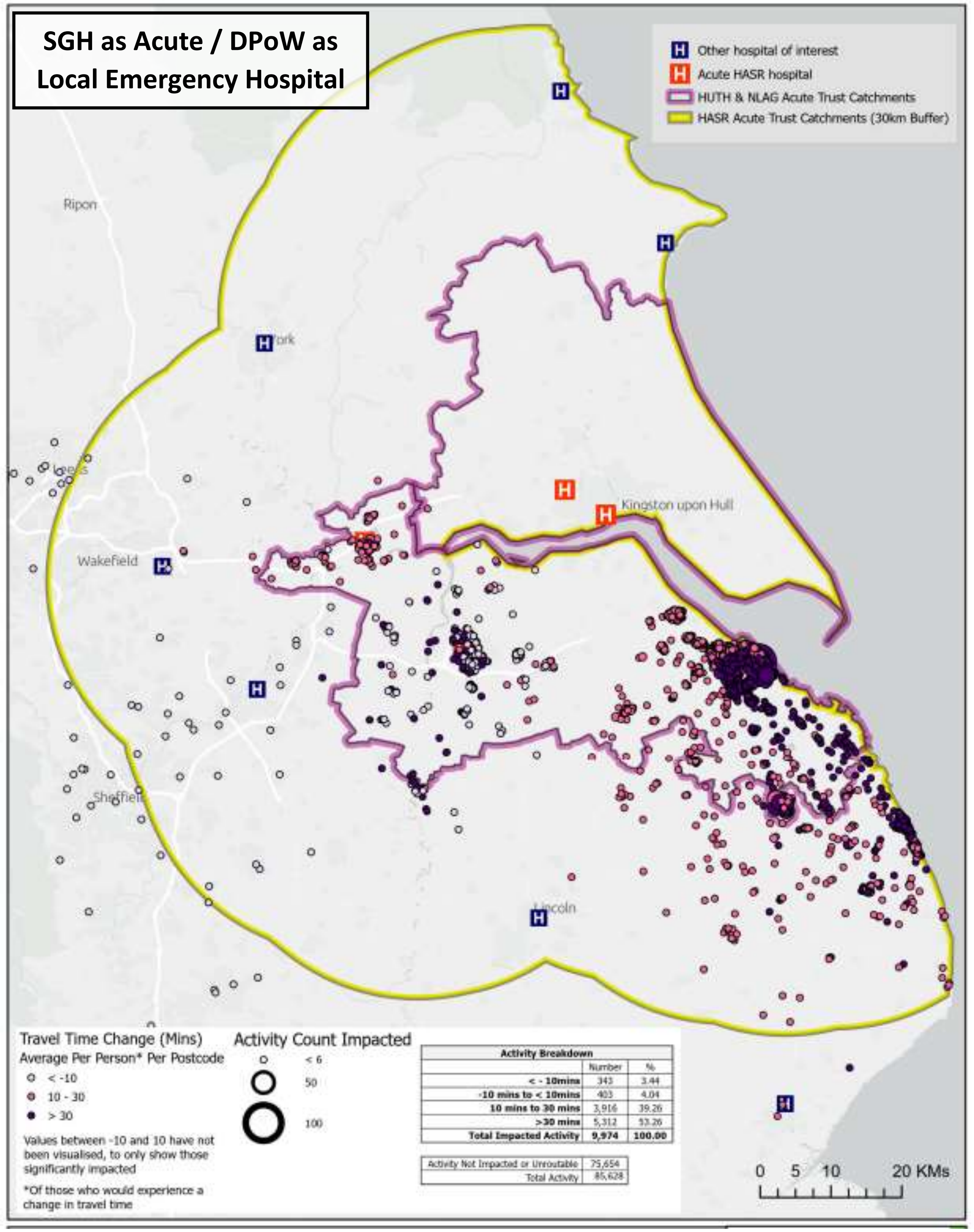


Activity Breakdown		
	Number	%
< - 10mins	581	5.89
-10 mins to < 10mins	807	8.18
10 mins to 30 mins	3,998	40.51
>30 mins	4,484	45.43
Total Impacted Activity	9,870	100.00

Activity Not Impacted or Unroutable	75,758
Total Activity	85,628

Map 10.8 Urgent & Emergency Care (UEC) Travel Time Impact - DPoW Acute / SGH Local Emergency Hospital

10.18.5.4 Discounted models – Consolidation of General Medical and Care of the Elderly at SGH

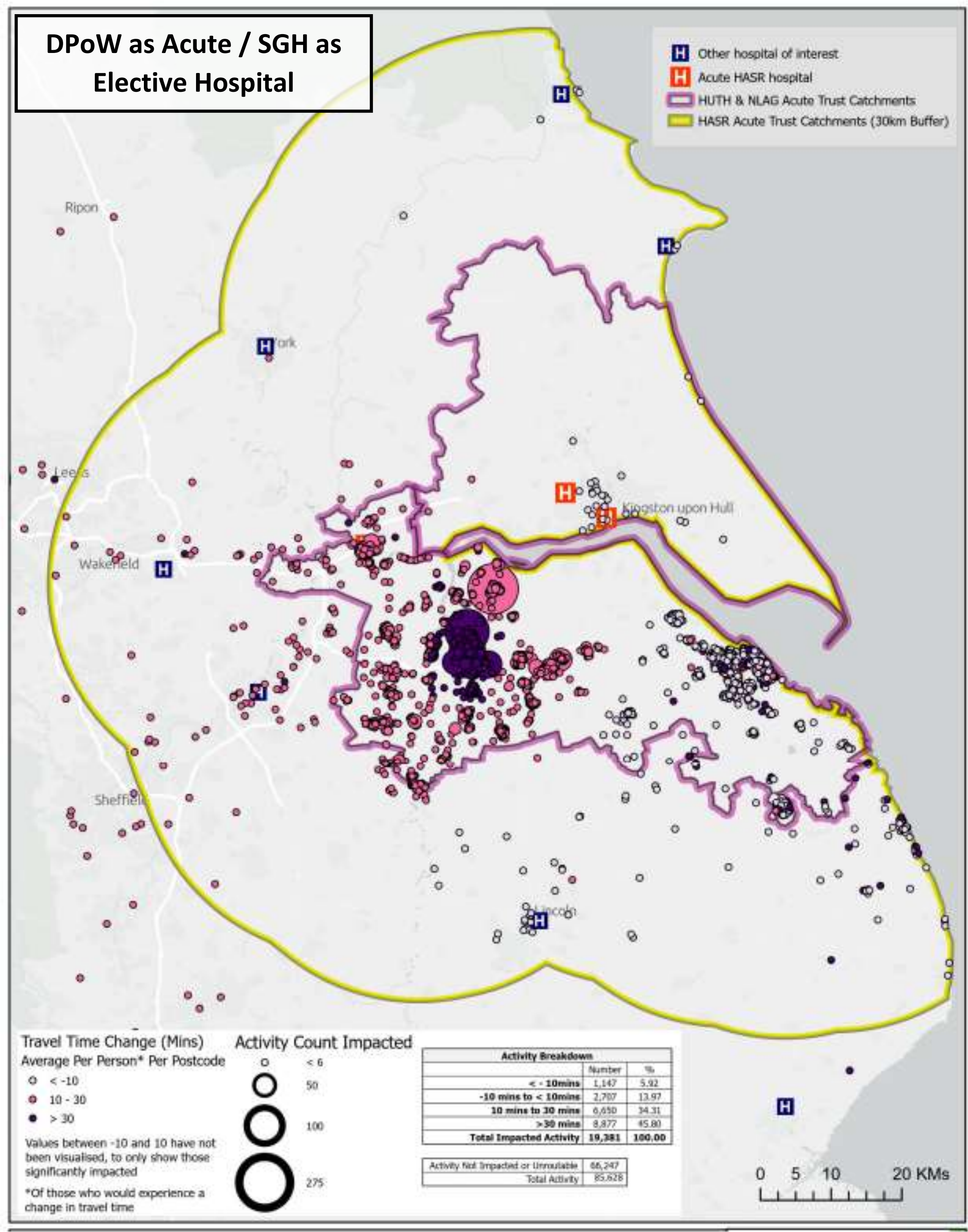


Activity Breakdown		
	Number	%
< - 10mins	343	3.44
-10 mins to < 10mins	403	4.04
10 mins to 30 mins	3,916	39.26
>30 mins	5,312	53.26
Total Impacted Activity	**9,974**	**100.00**

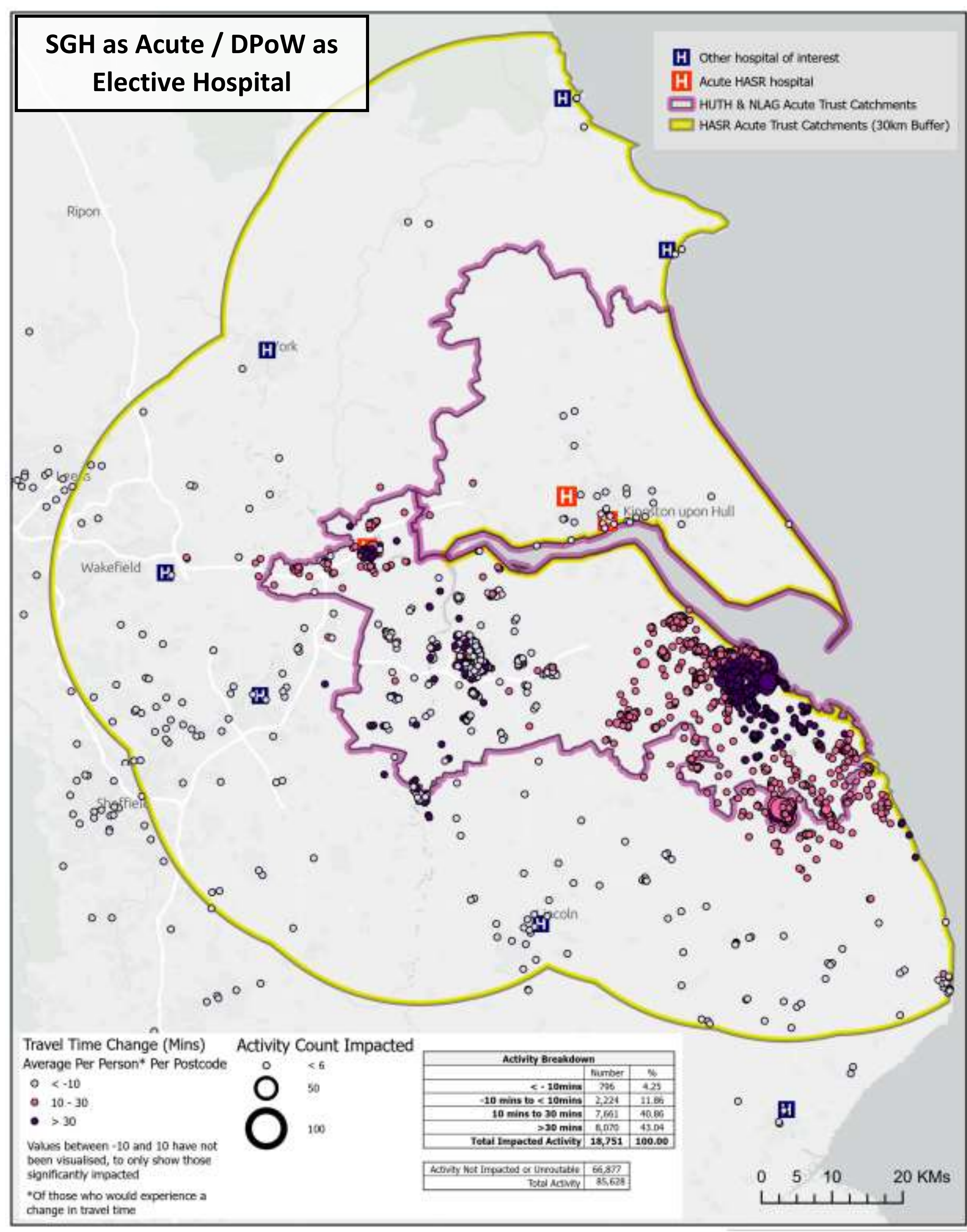
Activity Not Impacted or Unroutable	75,654
Total Activity	85,628

Map 10.9 Urgent & Emergency Care (UEC) Travel Time Impact - SGH Acute / DPoW Local Emergency Hospital

10.18.5.5 Discounted models – Complete Acute/Elective Split



Map 10.10 Urgent & Emergency Care (UEC) Travel Time Impact - DPoW Acute / SGH Elective Hospital



Activity Breakdown		
	Number	%
< - 10mins	796	4.25
-10 mins to < 10mins	2,224	11.86
10 mins to 30 mins	7,661	40.86
>30 mins	8,070	43.04
Total Impacted Activity	**18,751**	**100.00**

Activity Not Impacted or Unroutable	66,877
Total Activity	85,628

Map 10.11 Urgent & Emergency Care (UEC) Travel Time Impact - SGH Acute / DPoW Elective Hospital

10.19 Workforce and Finance

10.19.1 Summary impacts

	WTE staffing requirement		
	WTE required *(in hospital)*	Difference vs current	Difference vs BAU
Proposed model of care	2,634.76	↓195.33	↓90.52
BAU (do nothing)	2,725.28	↓104.80	0
Current budgeted workforce (Jan 2023)	2,830.09	0	-

Table 10.37 Summary of workforce modelling

	Revenue Cost		Capital		
	Total (£m)	Model vs BAU (£m)	Est. cost (£m) for implementation (exc. BAU)	Approx. total (m^2) required	Approx. total m^2 cost (£000) variance
Business as usual (BAU at 2025/26)	258.3				
Proposed model of care	249.5	**↓8.8**	**25.5**	5,257	1,500 - 4,770

Table 10.38 Summary of financial impacts

10.19.1.1 Key drivers for workforce and revenue savings

Narrative	Model vs BAU
Beds – reduced beds due to HAS model service changes	34 beds reduction (compared to yr 5 BAU forecast)
U&EC Medical staffing reductions due to consolidation of Speciality inpatients, Trauma and Acute Surgical inpatients at the Acute site	£5m (45.6 wte) reduction
U&EC Nursing staffing reductions due to consolidation of Speciality inpatients, Trauma and Acute Surgical inpatients at the Acute site	£1.7m (45.3 wte) reduction
Theatre staffing reductions due to consolidation of 24/7 emergency surgery at the Acute and day case emergencies only at the LEH reducing from two 24/7 on-call teams to one	£0.4m (11.2 wte) reduction
Paediatric Nursing staffing increased due to additional nursing for transfers between LEH to Acute site	0.3m (9.3 wte) increase
Paediatric Medical staffing increase due to applying additional clinical standards [318]	0.3m (2.3 wte) increase

Table 10.39 Financial impacts – key drivers

[318] NOTE: *no reduction in paediatric inpatient bed numbers was at this stage – more detailed modelling will be undertaken at DMBC stage, to reflect potential reductions in need for inpatient admissions supported by Hospital at Home and further pathway changes.*

10.19.1.1.1 Agency Savings

Estimated savings for agency spend *(based on vacancy rate assumptions)*					
Year	**Vacancy %**	**% vs Year 0**	**Total Agency Spend £m**	**Gross Agency Saving £m**	**Saving £m at 30% Premium**
Year 0 (current)	10.6%	100.0%	30.3	0.0	0.0
Year 1	9.5%	90.5%	27.2	3.1	0.9
Year 2	8.6%	91.4%	24.6	5.7	1.7
Year 3	7.3%	92.7%	20.9	9.4	2.8
Year 4	6.2%	93.8%	17.8	12.6	3.8
Year 5	5.3%	94.7%	15.2	15.2	4.6

Table 10.40 Agency spend savings – high level summary

	Current Jan 23
Current vacancies (wte)	709 wte
Current Agency spend (22/23) £m	**£30.3**

Table 10.41 Agency spend (NLaG)

Recruitment Improvement assumptions:

NLaG current vacancy rate is **10.6% *applied to agency spend reduction***

10% per year – for first two years – would increase for last three years as changes become more stable to 15% per year:

- Yr. 1 = 9.5
- Yr. 2 = 8.6
- Yr. 3 = 7.3
- Yr. 4 = 6.2
- Yr. 5 = 5.3

Future CIP plans will be aligned to the HAS savings year on year.

10.19.1.2 Capital implications and potential phasing of investment

Phasing					
Site	**Area**	**Reason**	**Cost (£million)**	**Year**	**CIR/ BLM**
DPoW	Paediatric & neonatal expansion	15 additional beds 1 additional cot Paediatric HDU	4.7	1	0.7
	Critical Care Unit Relocation	Co-located HDU and ITU Additional 8 beds	11.9	1/2	1.0
	Adult short stay relocation/Paediatric Assessment & SDEC	To enable beds on B floor for centralisation of Cardio/Resp/Gastro/Acute Surgery/Trauma/Paediatrics	7.5	3	1.2
	Family accommodation	5 flats to support Paeds/Crit Care and NICU	0.9	4	0.1
SGH	Family accommodation	3 flats to support Crit Care and NICU	0.5	5	0.3
Total:			**25.5**		**3.3**

Table 10.42 Capital implications and potential phasing

10.19.2 Summary impacts – discounted models

Models		**Capital**		
		Est. cost (£m) for implementation (exc. BAU)	Approx. total (m^2) required	Approx. total m^2 cost (£000) variance
Business as usual (BAU at 2025/26)				
Acute / Local Emergency Hospital (both with OLU)	**DPoW as Acute** **SGH as LEH** (*with OLU*)	**35.5**	5,257	1,500 - 4,770
	SGH as Acute **DPoW as LEH** (*with OLU*)	**89.1**	12,998	1,500 - 4,770
Acute / Local Emergency Hospital (without OLU)	**DPoW as Acute** **SGH as LEH** (*without OLU*)	**25.8**	4,308	1,500 - 4,770
	SGH as Acute **DPoW as LEH** (*without OLU*)	**104.1**	14,090	1,500 - 4,770

Table 10.43 Summary of financial impacts – capital

10.19.2.1 Capital implications and potential phasing of investment – discounted model (SGH Acute)

Phasing					
Site	**Area**	**Reason**	**Cost (£million)**	**Year**	**CIR/ BLM**
SGH	Ward Blocks x 2 new	Additional 100 beds for centralisation of Cardio/Resp/Gastro/Acute Surgery/Trauma	32.0		12.0
	Repurposing of current clinical area	To create 34 additional beds as per above	11.3		4.5
	Critical Care	Moves to current NICU and CDS suite and allows a unit of 20 beds as per requirement	8.6		3.0
	Paediatrics and Neonates	Redesign of current children's area to enable centralisation	11.5		4.7
	Obstetrics[319]	Creates obstetric unit on ground floor with obstetric theatres, and has to move to enable additional beds and critical care to be co-located	13.2		3.3
	Refurbishment of wards	Moves trauma and acute surgery into vacated obstetric areas	7.9		3.1
	Extension of theatres into vacated ITU	Required as an acute site	3.1		1.0
	Family Accommodation	X 5 flats For Paeds /NICU and Crit Care	1.0		0.4
DPoW	Family Accommodation	X 3 flats for NICU and Crit Care	0.5		0.1
Total:			**89.1**		**32.1**

Table 10.44 Capital implications and potential phasing – SGH Acute

[319] ***Relocation of Obstetrics Unit still required to facilitate UEC/Crit Care changes required by the model. The model is still unaffordable without any changes to maternity/neonatal services.*

E. Sources and Further information

10.20 List of Acronyms

A&E	Accident and Emergency
A&G	Advice & Guidance
AAU	Acute Assessment Unit
ACP	Acute Care Practitioner
ACSA	Anaesthesia Clinical Standards Accreditation
AHP	Allied Health Professional
AI	Artificial Intelligence
BAPM	British Association of Perinatal Medicine
BAME	Black, Asian and Minority Ethnic
BAU	Business as Usual
BI	Business Intelligence
BP	Blood Pressure
CAMHS	Children and Adolescent Mental Health Service
CAP	Collaborative of Acute Providers
CAS	Clinical Advisory Service
CCG	Clinical Commissioning Group
CDC	Community Diagnostic Centre
CESR	Certificate or Eligibility for Specialist Registration
CHCP	City Healthcare Partnership
CHH	Castle Hill Hospital
CHD	Coronary Heart Disease
CHN	Connected Health Network
CIR	Critical Infrastructure Risk
COPD	Chronic Obstructive Pulmonary Disease
CQC	Care Quality Commission
DC	Data Controller
DMBC	Decision Making Business Case
DPOW	Diana Princess of Wales
ED	Emergency Department
eFI	Electronic Frailty Index
EMAS	East Midlands Ambulance Service
ENT	Ear Nose and Throat
EPR	Electronic Patient Record
EQIA	Equality Impact Assessment
FE	Further Education
GDH	Goole District Hospital
GIRFT	Getting it Right First Time
GMC	General Medical Council
GP	General Practitioner
GPAS	Guidelines for the Provision of Anaesthesia Services
GPwER	GP with Enhanced Roles
HAS	Humber Acute Services
HASR	Humber Acute Service Review

HBN	Health Building Note
HCV	Humber, Coast and Vale
HDU	High Dependency Unit
HED	Health Evaluation Data
HEE	Health Education England
HEI	Higher Education Institute
HNY ICB	Humber and North Yorkshire Integrated Care Board
HOSC	Health Overview and Scrutiny Committee
HR	Human Resources
HRI	Hull Royal Infirmary
HtC	Hard to Count
HTM	Health Technical Memorandum
HUTH	Hull University Teaching Hospitals
HWRA	Humber and Wolds Rural Action
ICB	Integrated Care Board
ICC	Integrated Care Centre
ICS	Integrated Care System
IIA	Integrated Impact Assessment
IMD	Index of Multiple Deprivation
IT	Information Technology
JHOSC	Joint Health Overview and Scrutiny Committee
LA	Local Authorities
LEH	Local Emergency Hospital
LDRP	Labour Delivery Recovery Postnatal
LMS/LMNS	Local Maternity System / Local Maternity and Neonatal System
LNU	Local Neonatal Units
LoS	Length of Stay
LSOA	Lower Super Output Area
MCoC	Midwifery Continuity of Carer
MDT	Multi-Disciplinary Team
MH	Mental Health
MLU	Midwifery Led Unit
MNP	Maternity, Neonates and Paediatrics
MOU	Memorandum of Understanding
MP	Member of Parliament
MSK	Musculoskeletal
MTC	Major Trauma Centre
MVP	Maternity Voices Partnerships
NCCR	Neonatal Critical Care Review
NEL	North East Lincolnshire
NHSE	National Health Service England
NICE	National Institute of Clinical Excellence
NICU	Neonatal Intensive Care Unit
NLaG	Northern Lincolnshire and Goole
ODN	Operational Delivery Network

OLU	Obstetric Led Unit
ONS	Office for National Statistics
OOA	Out of Area
OP	Outpatients
ORH	Operational Research in Health
OSC	Overview and Scrutiny Committees
OT	Occupational Therapy
PA	Physicians Associates
PAS	Patient Administration System
PAU	Paediatric Assessment Unit
PCBC	Pre-Consultation Business Case
PCN	Primary Care Network
PHE	Public Health England
PHM	Population Health Management
PIFU	Patient Initiated Follow Up
PKB	Patient Knows Best
PMO	Programme Management Office
PPGs	Patient Participation Groups
RCOG	Royal College of Obstetricians and Gynaecologists
RFID	Radio frequency Identification
RTT	Referral to Treatment
SAS	Speciality and Specialist
SCU	Special Care Unit
SDEC	Same Day Emergency Care
SGH	Scunthorpe General Hospital
SLA	Service Level Agreement
SMI	Serious Mental Illness
SMR	Standardised Mortality Ratio
SOC	Strategic Outline Case
T&F	Task and Finish
TU	Trauma Unit
U&EC/UEC	Urgent and Emergency Care
UCR	Urgent Community Response
UCS	Urgent Care Service
UTC	Urgent Treatment Centre
VCSE	Voluntary Community and Social Enterprise
VLBW	Very Low Birth Weight
WHO	World Health Organization
WTE	Whole Time Equivalent
YAS	Yorkshire Ambulance Service

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