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NHS
Humber and
North Yorkshire
Integrated Care Board (ICB)

Humber Acute Services Programme

Decision-Making Business Case

July 2024

Version Control

Version	Date	Changes	By whom	Where
0.1	15/04/24	Compling case studies outputs and consulation feedback	LC	
0.2	25/05/24	Addition of amendments and record of consideration of feedback and review of alternative proposals	LC	Throughout
0.3	04/04/24	Addition of Executive Summary	LC	Exec Summary
0.4	13/06/24	Addition of revenue impact table	LC/BS	Section 5.5.6
0.5	24/06/24	Addition of modelling output appendices	LC	10.10 - 10.12
0.6	01/07/24	Update to financial summary (following NHSE review)	LC/BS	Sections 5.4 and 5.5.6
		Finalise section numbering and references	LC	Throughout
		Addition of appendices	LC	10.13 to 10.18
0.7	04/07/24	Clarification of revenue funding narrative	LC	5.5.6

Contents

Executive Summary

Background

In September 2023, the NHS Humber and North Yorkshire Integrated Care Board (ICB) launched a public consultation on a proposal to change the way some more complex medical, urgent and emergency care and paediatric (children's) services are delivered at hospitals in Scunthorpe and Grimsby (Scunthorpe General Hospital and Diana Princess of Wales Hospital, Grimsby). The proposed changes were designed to tackle a range of problems and challenges and deliver more sustainable hospital services that would meet the needs of patients across the region.

The consultation was designed to seek out the views of those most likely to be impacted by change and ensure that everyone who wanted to take part and share their views was given sufficient opportunities, sufficient information and sufficient time to do so. Over the 14 and a half weeks of the consultation process, a wide range of activities were undertaken to ensure this goal was achieved, including a range of engagement events, targeted focus groups, questionnaire, social media advertising and targeted leaflet drops, supported by a comprehensive communications and marketing strategy.

Consultation Feedback

Almost 4000 people responded to the consultation questionnaire and thousands more were engaged through the programme of events. Written submissions were also received from a range of stakeholders.

The **main reasons people supported the proposed model of care** were based on:

- faster and better access to specialist care
- overcoming long-standing recruitment and retention challenges
- consolidating staff to enhance skills and competencies
- delivering more sustainable future services

The **main reasons people were concerned about the proposed model of care** included:

- Concerns about the impact on the system's ability to respond to major incidents.
- Safety concerns related to the potential need for out of hours emergency surgery.
- Impact of the proposed change to paediatric care on children, young people and families, particularly those most vulnerable to change (e.g., children with complex needs such as Long-Term Ventilation or young people with an eating disorder).

The **main concerns in relation to the proposed location of services** were linked to:

- Travel and access, in particular, the impact on families and loved ones in more deprived areas or who might otherwise struggle to travel the additional distance to visit.
- Ambulance impacts, linked to concerns with current performance times.
- Capacity and infrastructure at Diana Princess of Wales Hospital, Grimsby (DPoW)
- Staffing issues, including the impact on current staff of any proposed move.
- Impact on the future of Scunthorpe General Hospital (SGH) and concern that other services may change in the future.

Consultees also put forward suggestions for **alternative approaches** to addressing system challenges, which broadly encompassed: variations of maintaining the status quo, suggestions regarding alternative locations for consolidating services – most often to bring some or all services together at Scunthorpe instead of Grimsby – and some suggestions that more radical changes were needed.

The key **equalities impacts** were also explored through the consultation (and are detailed more fully in the Integrated Impact Assessment)[1]. Most of the reported impacts were in relation to transport and access, and in particular the challenge associated with travelling to Diana Princess of Wales Hospital, Grimsby (DPoW) to visit loved ones who have been transferred there for treatment, which would impact most on people living in deprived communities and/or belonging to other health inclusion groups.

Proposed Way Forward

Following consideration of the views and evidence provided during the public consultation, alongside other material information – such as changes to policy, regulations or clinical standards and updated activity and workforce modelling – a revised proposal has been developed.

The revised proposal seeks to deliver the maximum benefit, whilst mitigating, wherever possible, any potential negative impacts that may arise as a result of the proposed change.

The proposed way forward is summarised in the table below.

Service area	Original Proposal	Revised proposal
Trauma Unit	Consolidate to DPoW	Consolidate to DPoW
Emergency surgery	Consolidate to DPoW	Consolidate to one site (mixed approach)
– *Trauma and Orthopaedics*		– Consolidate to DPoW
– *Acute General Surgery*		– Consolidate to DPoW
– *Urology*		– Consolidate to SGH
– *ENT*		– Consolidate to DPoW
– *Ophthalmology*		– Consolidate to HRI
– *Gynaecology*		Retain on both sites – align to obstetrics review
Some medical specialities	Consolidate to DPoW	Consolidate to DPoW
– *Cardiology*		
– *Respiratory*		
– *Gastroenterology*		
Paediatric overnight (inpatient) care	Consolidate to DPoW	Retain inpatient beds on both sites but work towards a reduction in beds through implementation of community-based paediatrics model

Table 1.1 Summary of revised proposal

Benefits, impacts and mitigations

The proposed change will deliver a **range of benefits** including:

- Delivery of 7-day services and key clinical standards.
- Reduction in length of stay and improved clinical outcomes.
- Improved theatre productivity and reduced impact on elective lists from UEC pressures.

[1] See section 6

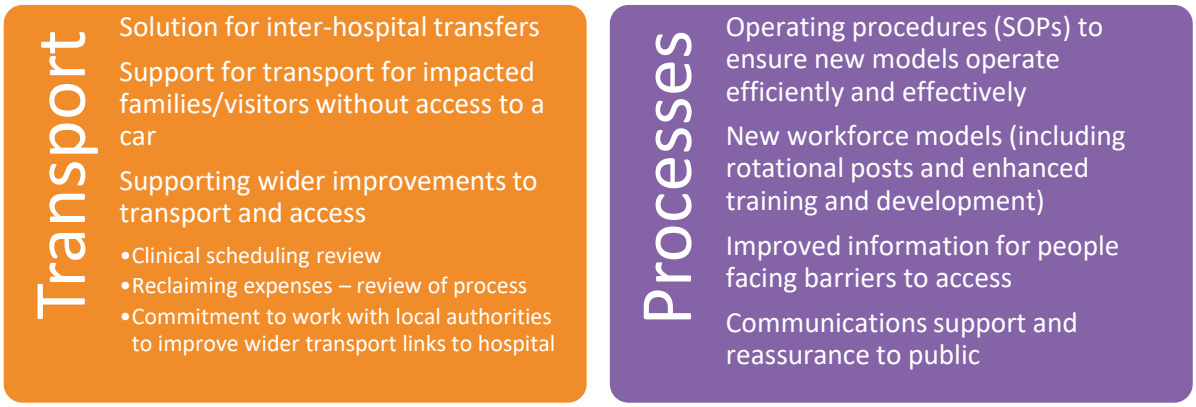
- Improved efficiency through consolidation of specialist teams and equipment.
- Improved recruitment and retention, development of specialist centres and more attractive offer for clinical staff.
- Enhanced opportunities for learning and skills development.

Summary impacts

- c.7 patients per day transfer from Scunthorpe (SGH) to Grimsby (DPoW) for their inpatient care.
- Net reduction of 60 inpatient beds across the two sites against a do-nothing / forecast position (increase in bed capacity at DPoW and a decrease in bed capacity at SGH),
- Capital cost to deliver of £9.2 million (excluding BLM/CIR)
- Revenue saving of £4.099 million against a do-nothing / forecast position.
- Provides platform for future change and productivity gains and accelerates delivery of future service change.

Mitigations

The mitigations proposed within the business case include support for transport and putting in place the right processes and operating procedures in advance of any service moves to ensure the new models of care work effectively and efficiently.



Implementation

Implementation will be phased over a two-year period, with Year 1 focused on implementing the key enabling projects and developing detailed pathways and processes to ensure safe and effective changes. Once key enabling changes are in place, implementation of the proposed service moves will be phased over Year 2 – with changes to medical specialty inpatients being undertaken first, followed by changes to surgical specialties.

	Year 1				Year 2				Year 3	
	2024/25		2025/26				2026/27			
	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Enablers										
Medical Specialties										
Trauma Unit										
Emergency Surgery										

Recommendation

The NHS Humber and North Yorkshire Integrated Care Board (ICB) is recommended to:

- Endorse the proposed way forward for service change (as set out above), which has been developed following their review of the consultation feedback and takes account of key issues and concerns raised by consultees.
- Work with key partners to deliver the proposed Transport Action Plan, including increasing support to the existing community transport provider.

1. Background and Context

Hospital services across the Humber face a number of challenges. Current models of care are not sustainable. Services do not deliver constitutional standards or clinical standards in a number of areas, there are significant vacancies and recruiting specialist skilled staff continues to be a challenge and as a result agency and locum use is significant, furthermore, services operate from an ever-deteriorating estate. These challenges impact on recruitment and retention of staff and on the local NHS's ability to deliver high quality services.

- Only two thirds of patients were seen and treated within 4 hours in Emergency Departments in Northern Lincolnshire.
- In the financial year 2022/23, over £37 million was spent on temporary (agency and locum) staffing in NLaG to cover gaps in rotas to ensure services continue to be delivered safely.
- Backlog maintenance issues would cost in excess of £100 million across Grimsby and Scunthorpe to address.
- Healthy life expectancy (HLE) is significantly lower than national average – at just 56 years for women in North Lincolnshire (compared with 64 years for England as a whole).
- In 20 years' time nearly one third of the local population will be aged 65 and over (compared to around a fifth today).

The NHS Humber and North Yorkshire Integrated Care Board launched a public consultation on its proposal to change the way some more complex medical, urgent and emergency care and paediatric (children's) services are delivered at hospitals in Scunthorpe and Grimsby (Scunthorpe General Hospital and Diana Princess of Wales Hospital, Grimsby). The proposed changes were designed to tackle a range of problems and challenges and deliver more sustainable hospital services that would meet the needs of patients across the region.

Summary Box 1.1

1.1 Background

1.1.1 Introduction

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) – now the NHS Humber Health Partnership.[2] The aim of the review was to design new ways of providing hospital services that would ensure they are safe, accessible and meet the needs of local people now and in the future.

In July 2023, a Pre-Consultation Business Case (PCBC) was approved by the NHS Humber and North Yorkshire Integrated Care Board.[3] The PCBC set out a proposal to change the way some more complex medical, urgent and emergency care and paediatric (children's) services are delivered at our hospitals in

[2] In November 2022, the Trust Boards of Hull University Teaching Hospitals NHS Trust (HUTH) and Northern Lincolnshire and Goole NHS Foundation Trust (NLaG) made separate decisions to move to a group structure with a single Executive Team overseeing both trusts. A joint executive was appointed during 2023 and the new Group operating model came into effect from 1st April 2024. The Group is called the NHS Humber Health Partnership.
[3] Humber and North Yorkshire Health and Care Partnership (2023), *Humber Acute Services Review - Pre-Consultation Business Case (PCBC)* Pre-Consultation Business Case

Scunthorpe and Grimsby (Scunthorpe General Hospital and Diana Princess of Wales Hospital, Grimsby). The PCBC also set out a series of enabling changes to care provided outside of hospitals that would support the proposed new model of care.

A formal public consultation, seeking views on the proposed changes, was launched on Monday 25th September 2023. The consultation ran for 14 and a half weeks, closing on Friday 5th January 2024.

Throughout the consultation period, 3,956 people provided feedback via the online consultation questionnaire, 28 partners and key stakeholders provided written submissions. In total, 65 events took place, and a further 32 briefing meetings were held with stakeholders and key partners. Approximately 2500 people were engaged or involved in discussing the proposal and/or providing feedback through one of the consultation events. In addition, there was widespread media coverage of the consultation process with more than 30 articles appearing in local press and TV news and more than 250,000 people (around half of the northern Lincolnshire population) were informed of the consultation via social media, online marketing and door-to-door direct marketing.

The views and evidence provided during this public consultation, have been considered alongside other material information – such as changes to policy, regulations or clinical standards and updated activity, workforce and bed modelling – to develop this decision-making business case and inform the recommendations put forward to the NHS Humber and North Yorkshire Integrated Care Board.

1.1.2 Document outline

This Decision-Making Business Case sets out:

- the process that was undertaken to gather views on the proposal.
- a summary of the findings of the consultation.
- details of how issues and concerns raised through consultation have been considered – including where alternative approaches or changes to the proposal have been suggested.
- information setting out the impacts on future activity, bed requirements, workforce and finance of the proposed changes.
- an overview of the proposed plans for implementation, including enabling changes in out of hospital care.
- a summary of the updated Integrated Impact Assessment that has been undertaken of the revised proposal and recommended way forward.
- a recommendation to the Integrated Care Board in relation to each of the service areas covered by the proposal for change.

1.1.3 Purpose of Consultation

The NHS Humber and North Yorkshire Integrated Care Board (ICB) undertook formal public consultation to understand the views of key stakeholders concerning the proposal to change the way some more complex medical, urgent and emergency care and paediatric (children's) services are delivered at our hospitals in Scunthorpe and Grimsby (Scunthorpe General Hospital and Diana Princess of Wales Hospital, Grimsby).

The consultation was undertaken so that the ICB can make a decision about the best way to provide complex medical, urgent and emergency care and paediatric hospital services across Northern Lincolnshire to ensure Northern Lincolnshire and Goole NHS Foundation Trust (NLaG), Hull University Teaching Hospitals NHS Trust (HUTH) and health and care partners across the Humber continue to provide high quality, safe hospital services that will be sustainable in the long term and meet the needs

of patients across the region. Details of the scope and purpose of the consultation are set out within the Consultation Mandate agreed by the ICB Board in July 2024.[4]

Dialogue with stakeholders has been ongoing throughout the consultation process – details of engagement and interactions have been included within the appendices and detailed feedback report.[5] The feedback gathered through consultation has been independently analysed,[6] carefully considered by clinical and managerial leaders from both the ICB and the hospital trusts and is presented to the Integrated Care Board (ICB) as part of this Decision-Making Business Case (DMBC) to inform their decision-making on the most appropriate way forward in relation to the proposed changes.

> "Consultation is the dynamic process of dialogue between individuals or groups, based upon a genuine exchange of views, with the clear objective of influencing decision, policies or programmes of action."[7]

1.2 Context

1.2.1 Strategic Context – the Humber Health and Care System

The NHS Humber and North Yorkshire 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.[8]

The Humber is served by a complex health and care economy comprised of a wide range of NHS organisations, social enterprises and other public, private and voluntary sector providers. Throughout the programme of change, partners from across the system have been engaged and involved in developing and providing feedback on the change proposals.[9]

Organisations across the system have a strong track record of collaboration and partnership working, which has enabled the proposal for change to be co-produced with partners from across the whole health and care system in the Humber. Greater collaboration within hospital services has also been developing over recent years and has supported the development of the proposed model of care. The providers of acute hospital services across the region – Hull University Teaching Hospitals NHS Trust (HUTH) and Northern Lincolnshire and Goole NHS Foundation Trust (NLaG) – formed a Group structure, with the appointment of a new Group Chief Executive in May 2023. The development of the new group

[4] Humber and North Yorkshire Integrated Care Board (July 2023) *Consultation Mandate – Humber Acute Services* Consultation Mandate
[5] Opinion Research Services (May 2024) *Changes to Some Services Provided by Scunthorpe and Grimsby Hospitals – Public Consultation Feedback Report* see ICB Board Page for final report
[6] Opinion Research Services (ORS), a leading social research company specialising in public sector consultations, was appointed to independently analyse and report the consultation outcomes.
[7] Rhion Jones and Elizabeth Gammell (2009) *The Art of Consultation: Public Dialogues in a Noise World* London: Biteback Publishing Ltd. p.115
[8] Further details of the strategic and policy context in which the proposals were developed can be found within the Pre-Consultation Business Case (pp. 22-29).
[9] A comprehensive list of all organisational responses is provided in Opinion Research Services (May 2024) *Changes to Some Services Provided by Scunthorpe and Grimsby Hospitals – Public Consultation Feedback Report* Appendix III: Written Submissions see ICB Board Page for final report

operating model and integration of clinical teams across the Humber will support delivery of the proposed way forward set out within this Decision-Making Business Case (DMBC).

1.2.2 Population Context – health inequalities and the Humber population

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 due to higher-than-average rates of cardiovascular disease, diabetes and other long-term health conditions as well as higher-than-average rates of smoking, obesity and other public health risk factors.[10]

The challenges of providing hospital-based services that meet nationally set clinical standards mean that patients in the Humber region often wait longer to access the right level of specialist care and have longer lengths of stay in hospital than in other parts of the country. This can contribute to poorer outcomes for some patients and exacerbate underlying health inequalities.

Improving the quality and sustainability of hospital-based services will have a positive impact on health inequalities by ensuring the needs of those impacted by poor health in local communities are met. 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.

Many groups, families and individuals within the Humber population face additional barriers to accessing health and care provision, which can exacerbate existing inequalities in health outcomes. The 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.

The consultation process sought to develop a deeper understanding of both the positive and negative impacts of the proposed changes on existing health inequalities and identify mitigations or potential changes to the proposals to ensure any changes to hospital services would not further exacerbate existing health inequalities. A comprehensive Integrated Impact Assessment (IIA)[11] was carried out prior to consultation and has been reviewed and updated to incorporate relevant findings and considerations as these have arisen through consultation. In addition, a multi-agency transport group has worked throughout to develop potential solutions and mitigations in relation to transport and access.[12]

1.3 Case for Change

The proposals put forward for consultation were developed to address significant and enduring challenges within acute hospital services across Northern Lincolnshire,[13] including:

- Having the right workforce, in the right place, to meet the demand
- Ensuring the future quality and safety of some hospital services
- Providing the right care for our growing ageing population
- Meeting the needs of our population
- Investing in our buildings

[10] Further details of the Humber population and underlying health inequalities can be found within the Pre-Consultation Business Case (pp. 30 to 45).
[11] Further details of the IIA process, outcomes and recommendations can be found in section 6
[12] Further details of the recommendations from the non-statutory transport group can be found in section 7.2.3
[13] Humber and North Yorkshire Health and Care Partnership (2023), *Humber Acute Services Review – Case for Change* Case for Change

- Using our financial resources in the most efficient way

These key challenges shaped the options that were developed and helped to rule out a number of potential solutions because they were not able to sufficiently address any of the key challenges facing acute services in Northern Lincolnshire.

In considering the feedback provided through the consultation, reviewing the proposals for change and developing implementation plans for the revised proposals, the key drivers for change have been referred back to throughout to ensure the proposed way forward can still help to address the underlying challenges within acute hospital services across Northern Lincolnshire.

1.4 Proposal for Change

In response to the significant challenges faced within the local health and care system, a new model of care was proposed for urgent and emergency care services across Northern Lincolnshire's hospitals. The services where changes were proposed are primarily for patients who need more complex emergency diagnosis, treatment and care after receiving an assessment through one of our Emergency Departments. The proposal also covered paediatric (children's) inpatient services, where a child would need to be admitted to hospital for a period over 24 hours. The aim of the proposed change was to improve services for those with the most urgent and complex needs, keeping them safe and of high quality in the long term.

The proposal that was consulted on, recommended bringing the following services together at one hospital:

- **Trauma Unit** – for people with injuries requiring specialist care (typically brought by ambulance) and who might need an operation or observation by a trauma team.
- **Emergency surgery (overnight)** – for people who need an operation in the middle of the night or who need to stay in hospital overnight and be looked after by teams with surgical expertise.
- **Some medical specialities (inpatient)** – for people who need a longer stay in hospital (more than 3 days) and to be looked after by a specialist team for their heart, lung or stomach condition.
- **Paediatric overnight (inpatient) care** – for children and young people who need to stay in hospital for more than 24 hours.

Bringing these services together in one hospital provides access to dedicated services 24 hours a day, 7 days a week, with more specialised skills always being available. This would help to address critical shortages in workforce by organising teams more effectively and help more patients to be seen and treated more quickly and stay in hospital for less time.

Within the proposed model, 24/7 Emergency Departments (A&E) would continue to be delivered at both Diana Princess of Wales Hospital, Grimsby and Scunthorpe General Hospital and the vast majority of patients would continue to be seen and treated in the same hospital they are now. Those who would need to be treated at a different hospital would arrive in an ambulance or be taken by free inter-hospital transport.

Proposed model of care at a glance

Services to be brought together at one hospital	Services to remain at both hospitals
☑ 24/7 Trauma Unit, for people with injuries requiring specialist care and who might need an operation or observation by a trauma team.	☑ 24/7 Emergency Department (A&E). ☑ 24/7 Urgent Care Service (in the A&E) for patients with minor injuries and illnesses. ☑ 24/7 assessment units. ☑ Short stay emergency care (up to 72 hours).
☑ 24/7 Emergency surgery and inpatient (overnight) care (more than 24 hours).	☑ Emergency surgery (during the day).
☑ 24/7 Speciality medical inpatient care (for longer stays more than 72 hours) including gastroenterology (stomach), cardiology (heart) and respiratory (lung) medicine.	☑ Assessment and short-stay care with specialist 'in-reach' input.
☑ 24/7 Paediatric overnight (inpatient) care (for longer stays more than 24 hours).	☑ 24/7 Paediatric (children's) Assessment Unit (up to 24 hours).
	☑ Overnight (inpatient) care for elderly and general medical patients (for stays longer than 3 days) ☑ 24/7 maternity and neonatal care. ☑ Outpatient appointments.

Picture 1.1 Proposed model of care at a glance

The proposal for change was developed through a comprehensive options development and appraisal process. It involved extensive engagement with more than 12,000 people including clinicians, staff, patients, the public, and other stakeholders over multiple years.

The appraisal process yielded an initial long list of 120 possible scenarios for change, all of which were scrutinised. Various approaches, including making no changes, were discounted because they are not viable solutions to address the identified challenges. The detail of this process is described in the Pre-Consultation Business Case (PCBC) which was available throughout the consultation, along with other key documents.[14]

Bringing these specific services together at Diana Princess of Wales Hospital, Grimsby was considered the only viable solution because it would impact directly on fewer people, compared to the other

[14] Further details of the options development and evaluation process can be found within the Pre-Consultation Business Case (pp. 246-294).

options considered. Additionally, this option would make best use of financial resources – it was the only option that could be delivered within the capital funding available to the local health and care system.

In response to the significant challenges faced within the local health and care system, a new model of care was proposed for urgent and emergency care services across Northern Lincolnshire's hospitals.

Over the course of the 14-and-a-half-week consultation process, patients, service-users, members of the public, NHS staff members, organisations and other stakeholders were invited to give feedback on the proposal.

The feedback gathered has been independently analysed, carefully considered by clinical and managerial leaders from the NHS Humber and North Yorkshire Integrated Care Board (ICB) and the NHS Humber Health Partnership (the Group) and is presented to the ICB Board alongside this Decision-Making Business Case to inform their decision on the most appropriate way forward in relation to the proposed changes.

Summary Box 1.2

2. How We Have Listened

An ICB-led public consultation was launched in September 2023 on the proposal to change the way some more complex medical, urgent and emergency care and paediatric (children's) services are delivered at hospitals in Scunthorpe and Grimsby (Scunthorpe General Hospital and Diana Princess of Wales Hospital, Grimsby).

The consultation was designed to seek out the views of those most likely to be impacted by change and ensure that everyone who wanted to take part and share their views was given sufficient opportunities, sufficient information and sufficient time to do so.

Over the 14 and a half weeks of the consultation process, a wide range of activities were undertaken to ensure this goal was achieved. The consultation process was adapted throughout in response to feedback and challenge from stakeholders regarding the process itself.

Whilst some consultation activities were promotional and did not gather specific feedback, the consultation as a whole gathered a significant response from multiple engagement strands, including:

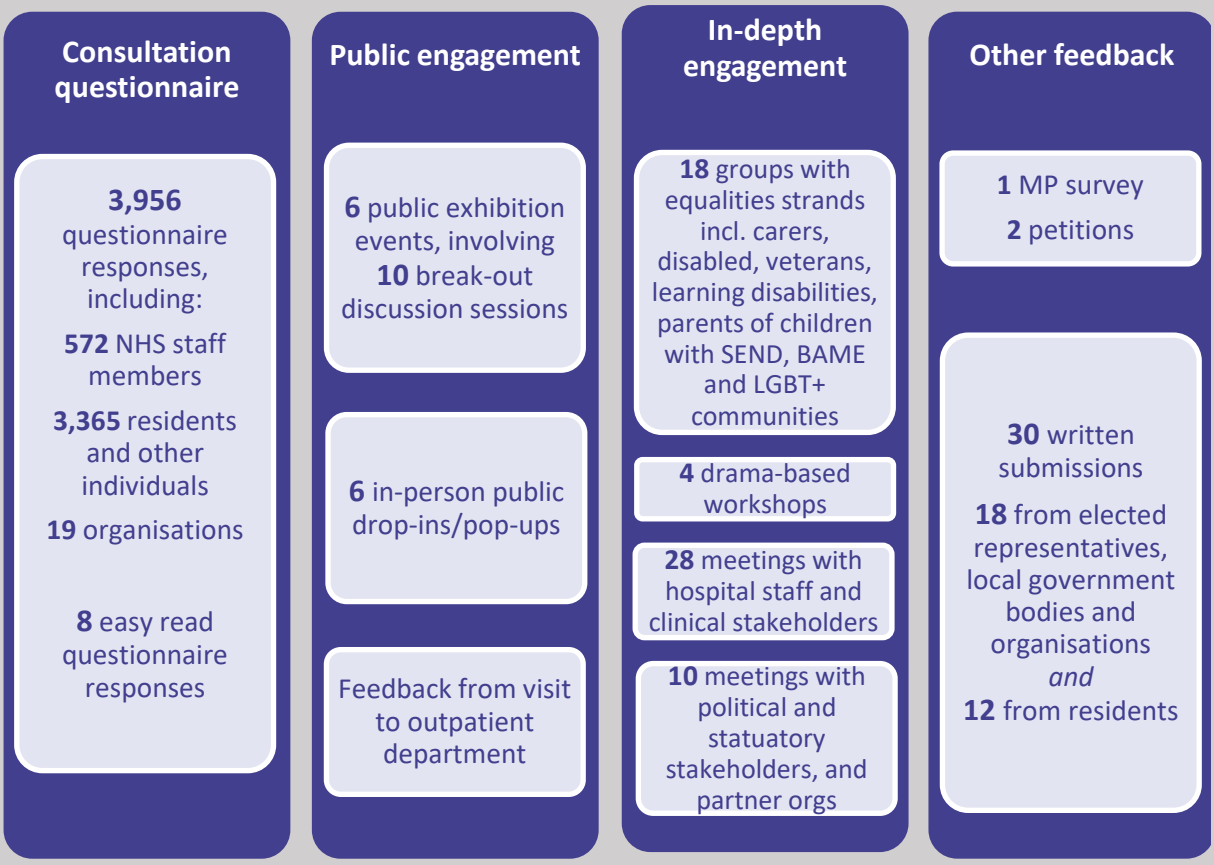


Figure 2.1 Summary of consultation response

Summary Box 2.1

2.1 Consultation approach

The Consultation approach was shaped by guidance, best practice standards and learning from others to ensure it was undertaken in an open and inclusive manner. **The consultation was designed to seek out the views of those most likely to be impacted by change and ensure that everyone who wanted to take part and share their views was given sufficient opportunities, sufficient information and sufficient time to do so.** The approach was independently assured by the Consultation Institute (tCI) as meeting best practice guidelines and evaluation of feedback was undertaken by an independent organisation Opinion Research Services (ORS).

Underpinned by key principles to be open, inclusive and accessible, the consultation approach:

- Identified the appropriate target audiences and adapted methods of engagement to meet their needs and expectations.
- Was innovative and creative, going beyond the traditional 'town hall' approach and getting out into communities.
- Relied on independent expertise to ensure a robust approach to collection and analysis of data.

The approach to consultation design that was adopted is outlined in the diagram below.

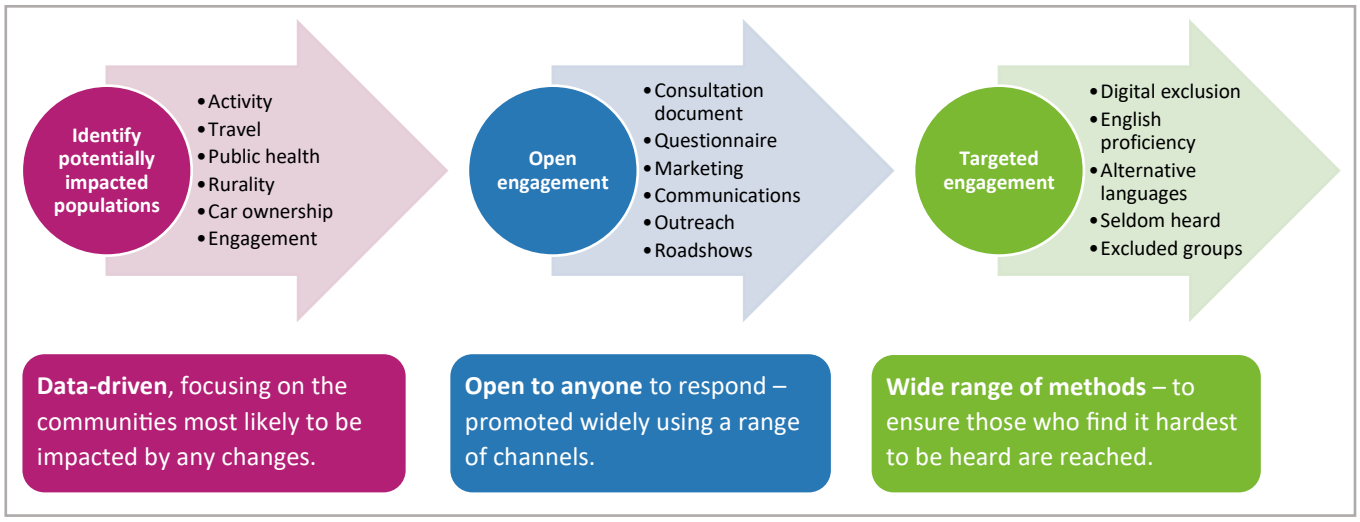


Figure 2.2 Approach to consultation design

In designing the consultation, detailed analysis of activity data, travel modelling, population health information and recent census data was undertaken to identify target cohorts based on age, gender, locality, deprivation and other relevant socio-economic factors to shape decisions about areas of focus and methods used to engage.[15]

The detailed stakeholder analysis that was undertaken ensured the consultation was appropriately targeted to those communities most likely to be impacted by the proposal to change the way some more complex medical, urgent and emergency care and paediatric (children's) services are delivered at our hospitals in Scunthorpe and Grimsby.

A tiered approach to consultation activities was adopted to ensure effective targeting of priority stakeholder groups.

[15] Humber Acute Services Programme (July 2023) *Population Analysis and Prioritisation for Targeted Engagement* Consultation Planning Population Mapping

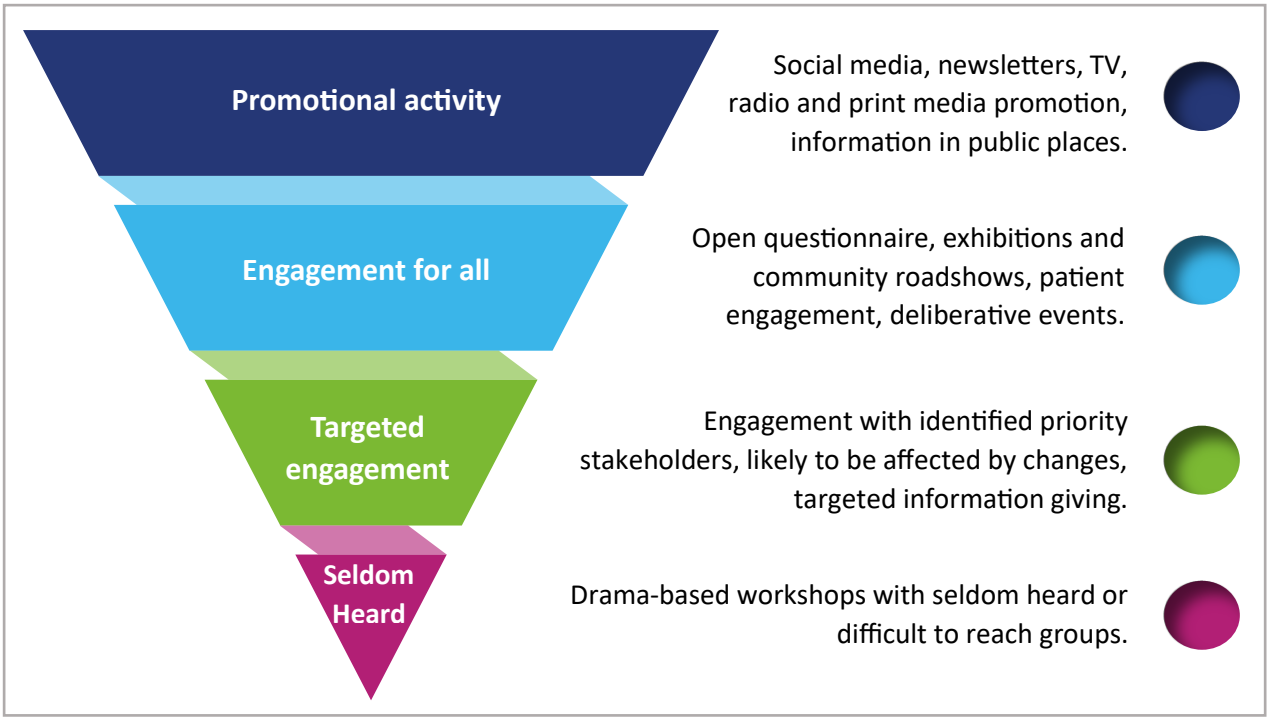


Figure 2.3 Summary of Consultation Approach

Throughout the consultation period, 3,956 people provided feedback via the online consultation questionnaire, 28 partners and key stakeholders provided written submissions. In total, 65 events took place, and a further 32 briefing meetings were held with stakeholders and key partners. Approximately 2,500 people were engaged or involved in discussing the proposal and/or providing feedback through one of the consultation events. In addition, there was widespread media coverage of the consultation process with more than 30 articles in local press and TV news and more than 250,000 people (around half of the northern Lincolnshire population) were informed of the consultation via social media, online marketing and/or door-to-door direct marketing.

The consultation provided a wide range of opportunities for people to learn more about the proposed change, to ask questions and to provide feedback on the proposal and how they might be impacted by it.

The programme of targeted engagement undertaken in parallel helped to ensure a wide range of views and voices were included within the feedback for consideration by the Integrated Care Board.

2.2 Promotional activity

A comprehensive media and marketing strategy was developed to ensure the consultation was widely promoted to all potential consultees. Information about the proposal was widely circulated and made accessible throughout the consultation period to ensure anyone who wished to take part had access to relevant information about the proposal for change and the process through which it was developed. A summary of key promotional activity is set out in the box below.

Summary leaflets and posters delivered to c.120 community locations (libraries, GP practices, children's centres, community groups).

Consultation document and questionnaire shared with c.30 statutory consultees and c.200 VCSE groups and networks for onward sharing and promotion.

Media launch and proactive press releases generating coverage in local radio, TV, print and specialist media (>30 articles).

North Lincs Council magazine article (distributed to every household in North Lincolnshire).

Newsletter sent out weekly (c.1000 subscribers).

Paid for social media advertising targeted at demographics with lower response rate.

Summary box 2.2 Promotional Activity

2.2.1 Consultation document and provision of information

A consultation document was produced, containing the relevant information about why change was necessary, the proposed model of care for the future, the potential impacts of that model and the process through which it was arrived at, including alternative solutions that were considered and discounted. The consultation document also signposted to further information within the Pre-Consultation Business Case and supporting documentation.

The consultation document, summary leaflet and consultation questionnaire were tested with a user panel made up of lay people, local community representatives and Healthwatch volunteers to ensure readability and accessibility for the required audiences. All three documents were refined and updated based on this user feedback.

A dedicated consultation website was launched to provide a simple, easy to access platform for all relevant information regarding the proposal for change.[16] This included a comprehensive document library with the Pre-Consultation Business Case and other supporting documentation. All key documents from the document library were also made available in hard copy at consultation exhibitions and on request. The website also provided details of how to give feedback on the proposals and get involved in the consultation through events and other activities.

2.2.2 Marketing and promotion

Ongoing engagement with local media was used extensively to publicise the consultation to as wide an audience as possible across the region. This generated more than 30 articles in newspapers (print and online), local radio and TV news over the course of the consultation.[17] Promotional efforts were amplified further by working with NHS, local authority and voluntary, community and social enterprise (VCSE) sector partners to cascade information about the consultation through their networks and channels. This included, for example, information about the consultation being shared through the North Lincolnshire Council magazine, which is distributed to every household in North Lincolnshire, and via the NHS Lincolnshire ICB engagement bulletin, which has over 10,000 subscribers across Lincolnshire. In total information was shared with over 395 organisations for onward distribution to their networks.[18]

[16] The dedicated consultation website is available at: https://betterhospitalshumber.nhs.uk/
[17] A full list of media coverage is provided in appendix 10.5
[18] A detailed list of organisations and networks information was cascaded to is provided in appendix 10.4

Social media was used extensively throughout the consultation process to:

- raise awareness of the consultation
- direct potential consultees to the questionnaire and other methods for getting involved (e.g. promoting events)
- correct misinformation or misunderstandings that had arisen through consultation
- direct interested stakeholders to up to date information on the consultation website (including a regularly updated FAQ section).

A combination of organic social media – sharing information on existing channels (Facebook, Instagram and X, formerly twitter), including ICB and partner channels – and paid-for advertising was used to maximise the reach and influence of the promotional activity.[19] In total nearly 250,000 people (around half of the northern Lincolnshire population) saw information about the consultation on their social media accounts and the paid-for campaign generated more than half a million impressions during the consultation.

	No. of posts	Impressions	Reach[20]	Link Clicks
HNY Partnership organic	24	-	9,387	42
NLaG Trust organic	68	-	107,764	7,366
Pay-per-click advertisements	-	536,631	125,887	5,589
TOTAL	**92**	**536,631**	**243,038**	**12,997**

Table 2.1 Summary of social media impact

In addition to online information, copies of the consultation document, summary leaflets, posters and printed questionnaires were distributed to around 120 different community venues across northern Lincolnshire, Goole and surrounding areas including GP practices, children's centres and libraries to ensure that digital exclusion was not a barrier to participation in the consultation. Documents were also made available in a range of formats on request and approximately 2,250 items (including leaflets, posters, questionnaires) were distributed over the course of the consultation period.[21] Trackable QR codes were used to measure the number of unique usages of the QR codes to determine which marketing approaches were most effective and this information was used to adjust the approach later in the consultation period.[22]

2.3 Engagement for all

Open engagement opportunities were provided to ensure any member of the public, member of staff or other interested party could find out more information and provide feedback on the proposal.

[19] A detailed report of social media activity is provided in *Public Consultation Feedback Report supporting documents* HAS Organic social media report; Media and Social Media report and Website analytics and PPC comments see ICB Board Page for final report and supporting documents

[20] Reach describes the number of unique user accounts that a post is viewed on, Impressions refers to the number of times a post appeared – with paid-for advertising a post could appear multiple times on the same user's account.

[21] A detailed list of which documents were sent where is provided in appendix 10.4.

[22] A summary of the QR code data is provided in appendix 10.7.

Consultation questionnaire available online and offline (c.3,950 responses)

6x Exhibition Events (Goole, Grimsby, Scunthorpe, Gainsborough) – c.350 attendees

16x pop-up engagement roadshows (in rural, urban and deprived communities)

3x patient engagement sessions in outpatient areas (Scunthorpe, Goole and Grimsby hospitals)

Online deliberative meeting

Summary box 2.3 Open Engagement Activity

2.3.1 Questionnaire Design

The consultation questionnaire was designed to gather structured feedback (with appropriate use of closed questions and open-text responses) from the public, service users and other interested stakeholders. To ensure a robust process and minimise the risk of challenge, the questionnaire was designed by external contractors and industry experts Opinion Research Services (ORS) with input from the consultation delivery team, tCI and NHS England.

To ensure respondents had access to relevant information to enable them to make an informed response to the consultation, relevant summary information was included before each question, as well as regular signposting to the relevant section in the consultation document.

The questionnaire also included relevant and proportionate equalities profiling questions, which enabled near real-time equalities monitoring of *online* questionnaire responses to ensure that a broad cross-section of the population of Northern Lincolnshire and any relevant neighbouring areas were responding and enable the delivery team to take rapid action to address any potential gaps in insight with additional engagement activities and targeted research.

A limited number of open-ended questions were used to help maximise response levels, which are typically higher with shorter, less onerous questionnaires, and to minimise the scope for challenge about length and complexity being a barrier to participation. An Easy Read version of the questionnaire was also designed to encourage participation from people with learning difficulties and was also used in engagement with children and younger people to increase participation.

It is also important to note that the questionnaire was just one part of a comprehensive multi-strand programme of activities. The wider programme of engagement activities was designed to ensure that detailed 'in-depth' feedback was gathered, particularly from groups who might not respond to the questionnaire or who may be particularly affected by proposed changes.

2.3.2 Roadshows and consultation events

Three large-scale exhibition events were initially planned, one in each main locality – Scunthorpe, Grimsby and Goole. These took place over a whole day and provided the public with an opportunity to read information about the proposals, ask questions of clinical and executive leaders, join an independently facilitated session to discuss the proposal and share views and receive support to complete the questionnaire or provide feedback in another way. Around 200 people attended across the three events.

A further three events were added to the schedule to provide additional opportunities for people living in and around Scunthorpe and communities in West Lindsey who might not have been able to attend one of the initial events. Nearly 200 more people engaged with the consultation through these events.

A programme of pop-up engagement roadshows was undertaken targeting areas with high footfall in communities likely to be impacted by the proposed changes. A total of 16 sessions took place at a variety of times, including weekends, reaching nearly 1,000 people across Northern Lincolnshire, East and West Lindsey and the East Riding of Yorkshire.

In addition, pop-up sessions were held in outpatient areas, hospital entrances and canteens – at Scunthorpe General Hospital, Goole and District Hospital and Diana Princess of Wales Hospital, Grimsby – to raise awareness of the consultation and provide an opportunity for people to have their say. The hospital patient experience team ensured that leaflets were made available in all outpatient areas, canteens and staff rooms across the Trust throughout the consultation.

Picture 2.1 Pop-up engagement, Scunthorpe General Hospital

An independently facilitated online discussion session (deliberative event) was also organised and widely promoted.

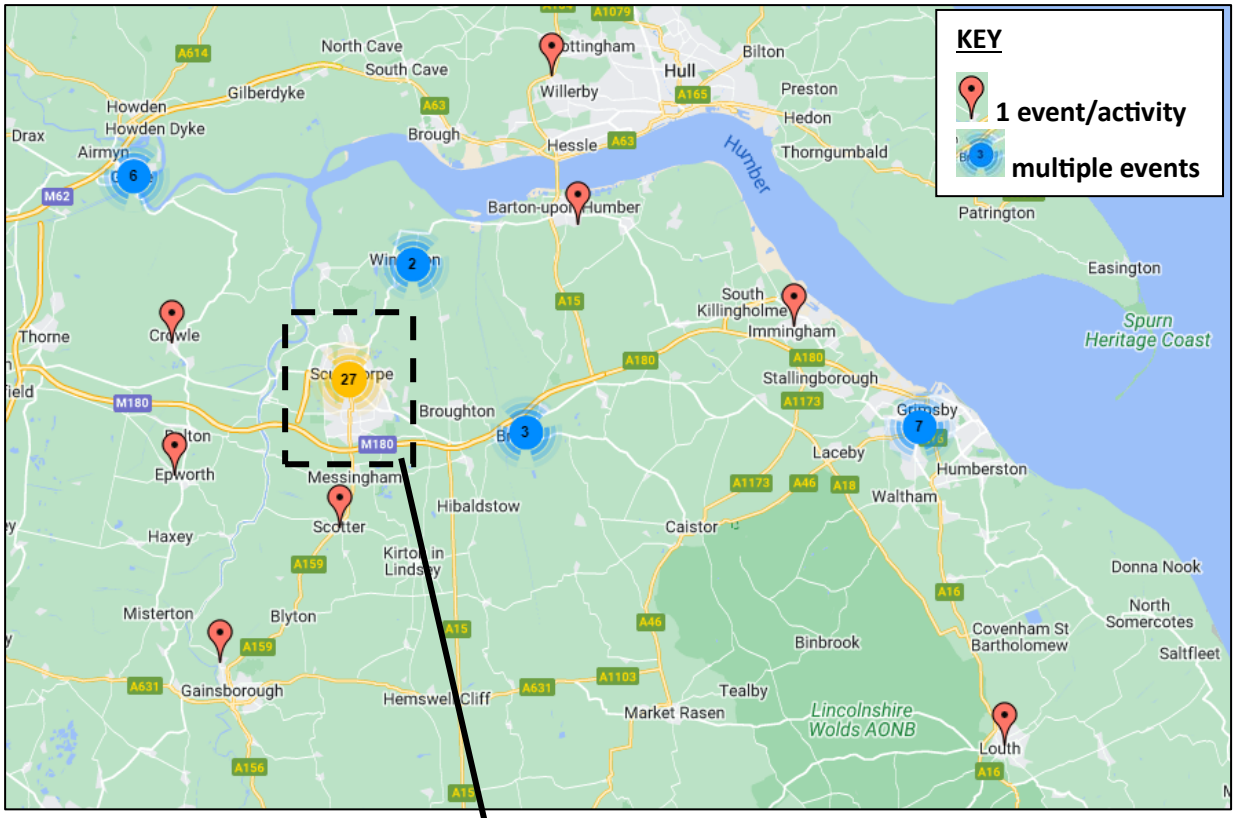
The comprehensive programme of engagement events and roadshows sought to provide a range of opportunities in different communities across North and North East Lincolnshire, West and East Lindsey and relevant parts of the East Riding of Yorkshire. The locations of engagement events are shown on the following maps.[23]

Picture 2.2 Community Roadshow, Immingham Civic Centre

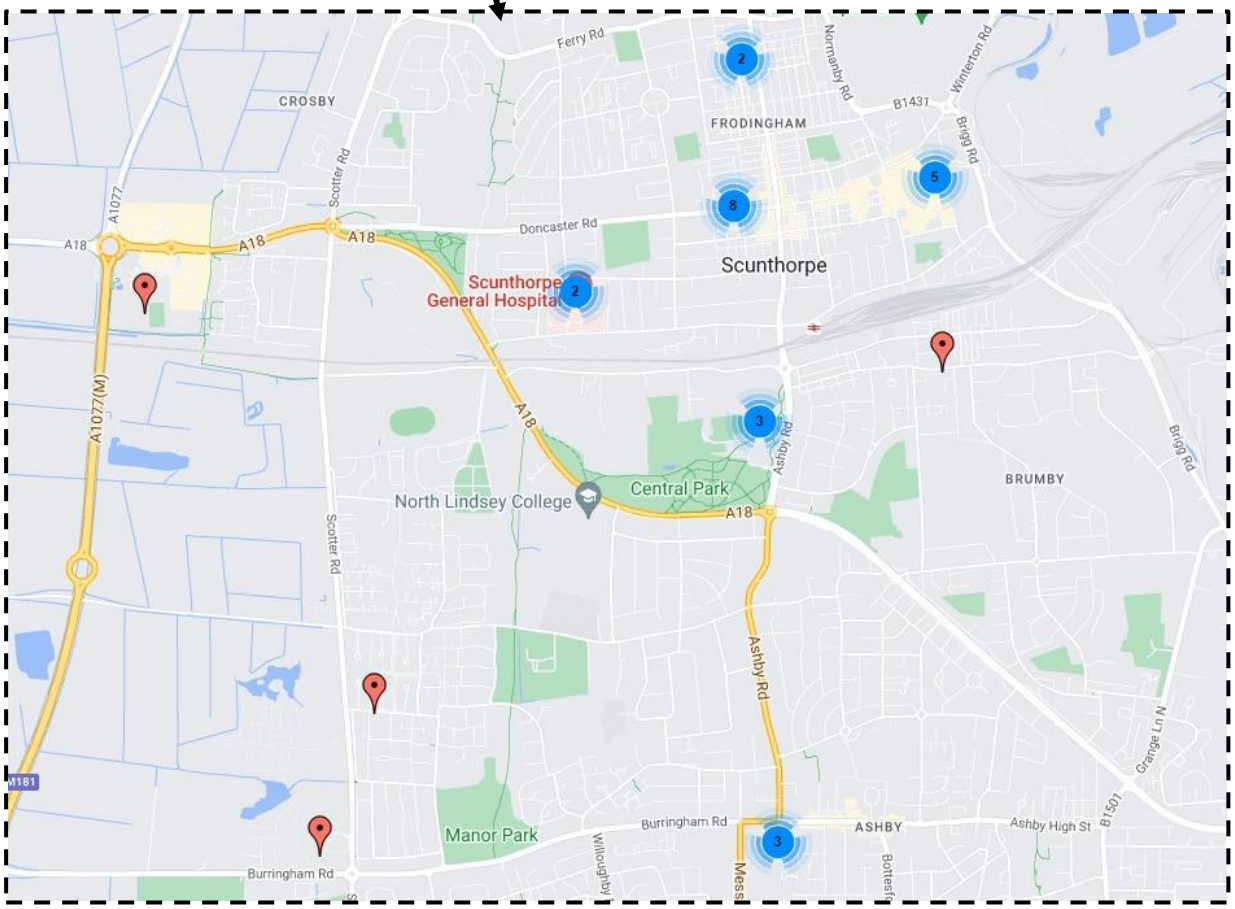
Feedback gathered through conversations at these events was captured by note-takers and is included in the feedback report.[24]

[23] Further maps are available in appendix 10.2

[24] Opinion Research Services (May 2024) *Changes to Some Services Provided by Scunthorpe and Grimsby Hospitals – Public Consultation Feedback Report* see ICB Board Page for final report



Picture 2.3 Map of engagement locations



Picture 2.4 Map of engagement locations - central Scunthorpe

2.4 Targeted engagement

Targeted engagement was undertaken to ensure the views of potentially impacted populations and those most likely to be affected by underlying health inequalities or barriers to access were fully understood and taken into account by decision-makers. A wide range of methodologies were used to adapt to the needs and expectations of each population group. A summary of activity undertaken is provided in the box below.

14x focus groups (including carers, disabled people, veterans, people with learning disabilities, parents of children with special educational needs and disabilities (SEND), Black, Asian and Minority Ethnic communities, and LGBT+ communities)

4x drama-based workshops with children, young people, people with learning disabilities and other vulnerable adults (e.g. people affected by homelessness and/or substance misuse)

3x staff drop-in sessions in hospital canteens, **2x online staff Q&A** sessions, 5x targeted briefings for potentially impacted staff groups, 3x forums with staff-side and union representatives and the inclusion assembly (a meeting of equality network chairs, equality, diversity and inclusion leads)

c.11,000 multilingual leaflets delivered to neighbourhoods with low English proficiency

c.12,000 summary leaflets delivered to neighbourhoods with high levels of digital exclusion

c.200 Easy Read questionnaires distributed to groups and individuals with learning disabilities and young people

Summary box 2.4 Targeted Engagement Activity

2.4.1 Targeted engagement activity

The purpose of undertaking targeted focus groups and discussion sessions was to gather qualitative data and informed feedback from groups and individuals less likely to engage through open sessions. Working with Local Authority and VCSE sector partners, a total of 14 sessions took place covering the following population cohorts:

- people living in deprived communities
- carers, including parent-carers
- disabled people
- older people
- people with learning disabilities (LD)
- veterans and armed forces communities
- men
- people affected by mental health conditions
- parents of children with special educational needs and disabilities (SEND)
- Black, Asian and Minority Ethnic communities
- faith-based communities
- people from LGBT+ communities

In addition to the focus groups delivered by the ICB engagement team and independent contractor Verve Communications, a specialist drama-based company called Playing ON[25] were commissioned to

[25] Further information is available on the Playing ON website: Playing ON

provide targeted engagement with children and young people and vulnerable adults. Playing ON use games, storytelling and improvisation to help historically marginalised groups to share their experiences.

In total, four sessions took place, involving the following groups of people:

- Children and young people aged 7 to 14 (across 2 sessions).
- Scunthorpe-based group for people with learning disabilities.
- People with experience of homelessness and/or substance misuse, hosted by Scunthorpe-based homelessness project.

Over the course of the programme of engagement, nearly 200 people from under-represented and historically marginalised groups took part in the consultation and shared their views on the proposal for change.

2.4.2 Targeted promotion

Additional efforts were also made to ensure key target populations were informed about and had the opportunity to respond to the consultation.

A multi-lingual leaflet[26] was developed to promote the consultation in English alongside the five most commonly spoken languages across Northern Lincolnshire and surrounding areas: Polish, Romanian, Lithuanian, Arabic and Bengali.[27] The leaflet was delivered by Royal Mail leaflet drop to approximately 11,800 households across neighbourhoods in North Lincolnshire and Goole. The areas for distribution were selected by identifying neighbourhoods where 10% or more of the population have poor English proficiency based on Census data (approx. 3,900 households) and targeting the relevant high-level postcode areas. This included a significant number of additional households in neighbouring streets.

Digital exclusion was highlighted as a potential barrier to participation by some stakeholders. To ensure those without access to digital or online means to take part in the consultation, a range of additional promotion was undertaken. This included a targeted leaflet drop of approximately 12,000 households across North and North East Lincolnshire. The areas for distribution were selected based on analysis undertaken in preparation for the 2021 Census, which identified neighbourhoods (LSOAs) based on their level or access and use of digital technology. Areas identified as least digitally able (with an HtC index of 4 or 5)[28] were prioritised for the targeted leaflet drop.

In addition, posters providing details of exhibition events were shared with libraries, GP practices, children's centres, local places of worship and other community buildings throughout the consultation period.[29]

2.4.3 Staff engagement

A comprehensive programme of staff engagement accompanied the other engagement streams, to ensure clinical and non-clinical staff in Northern Lincolnshire and Goole NHS Foundation Trust (NLaG)

[26] Humber Acute Services Programme (July 2023) *Promotional Leaflet (multi-lingual)* Multi-lingual leaflet
[27] Humber Acute Services Programme (July 2023) *Population Analysis and Prioritisation for Targeted Engagement* Consultation Planning Population Mapping
[28] Digital domain of the Hard to Count (HtC) index for the 2021 Census measures ability to respond, driven by access and use of digital technology where 1 = most digitally able and 5 = least digitally able.
[29] See appendix 10.3 for a list of localities where information was shared.

and staff across the wider health and care system had opportunities to have their say on the proposal for change and raise any concerns they might have.

Drop-in sessions were held in the canteens at each of the three main hospital sites (Scunthorpe General Hospital, Diana Princess of Wales Hospital, Grimsby and Goole and District Hospital) over lunchtime, advertised in advance through intranets, regular all-staff bulletins and on staff Facebook pages. Open Question and Answer sessions were also hosted online and advertised in the same way.

In addition, targeted briefing sessions took place with the teams who deliver the services where changes are proposed to ensure they had the opportunity to ask questions and feedback on the change proposals. Engagement with clinical leaders and staff representatives through the range of existing forums also continued throughout the consultation period.

Feedback through these channels is set out in the feedback report, however, many more staff members chose to respond via the online questionnaire rather than engaging in these opportunities. The questionnaire responses from staff have been analysed and reported on separately within the feedback report.

Finally, a series of clinical workshops took place from October to December 2023, bringing together clinical, nursing and AHP teams from across each of the specialties impacted by the proposed changes to support development of this Decision-Making Business Case (DMBC).[30] These workshops provided clinical oversight and leadership to the development of draft clinical case studies, which were reviewed again in the light of the consultation feedback (see section 3), re-modelling of the activity, beds, workforce and finance requirements (see appendices 10.10 to 10.12) and undertaking detailed planning for implementation (see section 8). The outputs of the Case Study workshops have provided important evidence which has been considered alongside the consultation feedback to develop the recommendations within this DMBC.

2.5 Stakeholder engagement

Regular and proactive engagement with a wide range of stakeholders continued throughout the consultation process. This included statutory engagement with local authorities via their overview and scrutiny committees as well as engagement with a range of partners and boards, including:

- Clinical and professional boards (local)
- Partnership boards
- Regional Operational Delivery Networks (ODNs)
- Neighbouring health economies
- Other health and care providers and teams

Where feedback was provided in those meetings, it was recorded and shared with ORS for inclusion in the feedback report. In addition, many of the stakeholders engaged with provided formal written feedback, which has also been summarised and incorporated within the feedback report.[31]

[30] See appendix 10.8 for a timeline of clinical engagement that were undertaken to support development of the DMBC case studies.
[31] A comprehensive list of all organisational responses is provided in Opinion Research Services (May 2024) *Changes to Some Services Provided by Scunthorpe and Grimsby Hospitals – Public Consultation Feedback Report* Appendix III: Written Submissions see ICB Board Page for final report

2.5.1 Overview and scrutiny committees (OSCs)

In developing the proposal for consultation, regular and ongoing engagement with the five constituent local authority Health Overview and Scrutiny Committees (HOSCs) was undertaken.

- East Riding of Yorkshire Council
- Hull City Council
- Lincolnshire County Council
- North East Lincolnshire Council
- North Lincolnshire Council

In advance of launching the public consultation, the programme team worked with officers in the five local authorities involved to put in place the required mechanisms to enable formation of a mandatory Joint Health Overview and Scrutiny Committees (JHOSC). A draft Terms of Reference was developed in advance of the consultation launch date and was ratified at the first meeting of the committee.

The Joint OSC met on 17th October to review and discuss the proposals. A team of NHS representatives – including clinical and managerial leaders from the ICB and Northern Lincolnshire and Goole NHS Trust (NLaG) – attended the meeting to provide further detail on the proposals and respond to issues or concerns raised by the committee. Feedback from the meeting was provided to ORS for inclusion in the feedback report, alongside the formal response submitted by the joint committee.

In response to request from the local authorities, NHS representatives also attended meetings of individual scrutiny committees, Health and Wellbeing Boards, Council workshops and political group meetings to answer questions and provide further detail on the proposals put forward for consultation and also responded to written requests for information.

Meeting	Date
Joint Health Overview and Scrutiny Committee (JHOSC)	17/10/23
North East Lincolnshire Council Health Scrutiny Panel	04/10/23
North Lincolnshire Health, Integration and Performance Scrutiny Panel	03/10/23
Lincolnshire County Council Overview and Scrutiny Meeting	08/11/23
East Riding of Yorkshire Council – informal member workshop	28/11/23
North Lincolnshire Council Conservative Group/Cabinet	27/11/23
North Lincolnshire Council Labour Group	13/11/23
North Lincolnshire Health and Wellbeing Board	02/10/23 and 11/12/23

Table 2.2 Summary of Local Authority engagement

2.6 Assurance

The programme has continued to benefit from extensive involvement of external bodies to provide challenge, independent assessment and assurance. The consultation process has been reviewed and assured by multiple external bodies including the Consultation Institute and NHS England.

2.6.1 tCI Quality Assurance

The Consultation Institute (tCI) are the leading independent experts in consultation in the UK. They provide expert advice and assurance to organisations undertaking public consultation.

The consultation process was assured by the Consultation Institute (tCI) through their comprehensive six-step Quality Assurance process to ensure it met all required guidance and best practice. The aim of the Quality Assurance process is to provide an independent endorsement of the activities undertaken by a consultor, so that consultees, as well as the wider public can have confidence that the exercise meets a set of minimum standards as laid down by an established best practice Institute.

The Quality Assurance process reviews all aspects of the consultation, including scoping, planning, delivery of engagement activities, analysis and reporting across six key stages:

1. Scoping and Governance
2. Project Planning
3. Documentation Review
4. Mid-Consultation Review
5. Closing Date Review
6. Final Report

Throughout the consultation, the programme has received positive and constructive feedback from the Consultation Institute (tCI). The programme team received confirmation on 3rd June 2024 that the Institute has awarded the Consultation the endorsement of having **met Good Practice**.

The Good Practice award from the Institute demonstrates the process undertaken has met all the required standards providing confidence to ICB decision-makers that the information within this Decision-Making Business Case and the supporting documentation is sufficient to enable them to make a decision regarding their proposal for change.

2.6.2 NHS England

Assurance from NHS England (NHSE) was undertaken both formally and informally before, during and after the consultation. NHSE 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 regularly with NHSE colleagues to provide updates on progress of the work and assure the direction of travel and key milestones.

A further Gateway Assurance process was undertaken to review the Decision-Making Business Case (DMBC) to provide assurance of the engagement and consultation process followed and the content within the business case.[32] In addition, NHS England reviewed the DMBC to ensure the proposal continues to meet the five tests for service change – a self-assessment against these tests has been undertaken and is summarised in section 9.1.5.

No significant issues or concerns were raised during the Gateway process and confirmation of NHS England endorsement will be provided to the ICB Board at its decision-making meeting.

[32] Details of previous Gateway Assurance processes are set out in the PCBC, see: Humber and North Yorkshire Health and Care Partnership (2023), *Humber Acute Services Review - Pre-Consultation Business Case (PCBC)* Pre-Consultation Business Case (pp.95-96).

2.7 Adapting and responding to challenge

Consultation is an ongoing process of dialogue. Throughout the 14+ week dialogue window, the consultation delivery team adapted their approach to ensure key stakeholders were involved and their views captured through one or more of the feedback mechanisms offered. This involved accepting invitations to attend community meetings, local authority scrutiny panels, group meetings and member workshops and seeking out additional opportunities to reach out into local communities to ensure those less likely to engage could also have their views heard.

2.7.1 Midpoint Review

A midpoint review was undertaken during weeks 7 to 9 of the consultation. The purpose of the review was to understand the extent to which the dialogue methods being used were successfully engaging those individuals and groups that were originally identified as being important for the consultation to achieve its stated aims.

The midpoint review enabled the programme team to identify any potential gaps in insight and come up with appropriate mitigating actions to address those gaps. In addition, it provided an opportunity to review any complaints, concerns or process issues that had been raised and gain assurance of the course of action being taken from external advisors – the Consultation Institute – and NHS England.

The midpoint review was undertaken in three stages as set out in the table below.

Date	Purpose of Meeting	Participants
10/11/23	Review of questionnaire responses so far (reach and delivery against plan) and interim findings.	ORS, ICB, programme team
16/11/23	tCI review of progress against engagement plan, responses to date, complaints or process issues, actions and mitigations.	the Consultation Institute, ORS, ICB, programme team
20/11/23	NHS England review of progress, risks and issues.	NHS England, ICB, programme team

Table 2.3 Midpoint Review meeting log

In reviewing the questionnaire responses and engagement activities to date, no significant gaps or areas of concern were identified. However, a number of specific population cohorts were identified where the level of response via the questionnaire and involvement through other engagement methods to date had been lower. In response to these findings, a number of actions were taken to ensure potentially under-represented groups were targeted to ensure there were no gaps in the insight gathered and relevant communities were given further opportunities to share their views. A summary of these actions is provided in the table below.

Stakeholder group/cohort	Mitigating action	Where	When
Deprived communities	Additional promotional roadshow added	Asda superstore, Scunthorpe	28th Nov
	Additional targeted engagement added	Ashby Link Community Hub	6th Dec
	Workshop with VCSE sector leads *(organisations working in deprived communities)*	Online	8th Dec

Men	Additional targeted engagement added	Men in Sheds, Epworth	23rd Nov
	Additional targeted engagement added	Armed Forces Hub, Scunthorpe	13th Dec
	Additional paid-for social media advertising added	Online	w/c 11th Dec
Younger people	Additional Playing ON workshop for ages 8-14 added	Baths Hall, Scunthorpe	15th Nov
	Materials and information provided to North Lincs Youth Council	Scunthorpe	w/c 20th Nov
	Additional paid-for social media advertising added	Online	w/c 11th Dec
Digitally excluded	Leaflet drop to c.12,000 households rated highest for digital exclusion	Neighbourhoods in Scunthorpe and Grimsby	w/c 11th Dec
LGBT+ people	Additional targeted engagement (focus group) added	Navigo, Grimsby	19th Dec
	Additional targeted engagement (1:1 interview) added	Online	20th Dec

Table 2.4 Summary of mitigating actions following midpoint review

2.7.2 Process issues and complaints

Throughout the consultation, care was taken to consider and respond to any concerns or complaints raised about the process that was being undertaken to gather views on the proposal for change. The table below provides a summary of the key concerns that were raised throughout the consultation and the mitigating actions that were taken in response to these, where appropriate.

Issue/criticism	Raised by	Mitigating action/response
"No consultation event in Lincolnshire"	JHOSC meeting (Lincolnshire County Councillors)	x1 additional exhibition event was added in Gainsborough (West Lindsey). Rural roadshows in Louth (East Lindsey) and targeted engagement in Scotter (West Lindsey) – already on engagement plan.
"Veterans not included in consultation"	JHOSC meeting	x1 additional targeted engagement event added – Armed Forces Hub in Scunthorpe Additional promotion via armed forces networks in Lincs, NEL and NL.
Stormy weather during Scunthorpe consultation event	NL Council leader Scunthorpe MP	x2 additional exhibition events added in Scunthorpe in central locations (1 mid-week and 1 on a weekend).
Concern with the ways in which views were collected at the exhibition events	Scunthorpe MP	All suggested improvements were taken on board at future events (e.g. post box for questionnaires to be submitted).
Consultation is a "done deal" – ref. to assertion in Consultation Questionnaire that the proposal is the only financially viable option	North Lincolnshire Councillor	Further briefing provided to explain options appraisal process and financial analysis and confirm scope of consultation to influence the decision.

Concern that events in Lincolnshire were "hastily organised" not allowing sufficient time for Lincolnshire residents to take part	Lincolnshire OSC	Events were shared with the Council and advertised through, local media and NHS networks c.3 weeks in advance (>10k people on Lincs ICB distribution list) and were only one part of a multi-strand approach to consultation.
Queried "the extent to which these events engaged with the public"	Lincolnshire OSC	All feedback was recorded and each event provided opportunities for people to engage in multiple ways.
Suggestion/request to leaflet every household	Lincolnshire OSC	Approach agreed at midpoint review was to undertake a targeted leaflet drop (in areas of highest digital exclusion) supplemented by paid for social media advertising – provided significantly more reach for the budget available.
Request to extend the consultation period by 6 weeks	Scunthorpe MP	Request was carefully reviewed, but it was not considered necessary to extend the window for dialogue at Closing Review.
Request to extend the consultation period	North Lincs Council Leader / Health and Wellbeing Board Chair	Agreed to make provision for the Board to submit its response late to enable the Board to follow its governance process and sign off a collective response to the consultation at its meeting on 15th January 2024.

Table 2.5 Summary of process complaints and responses

The process of consultation was responsive and agile, to ensure all interested stakeholders were enabled to take part and share their feedback on the proposal for change.

The consultation was designed to seek out the views of those most likely to be impacted by change and ensure that everyone who wanted to take part and share their views was given sufficient opportunities, sufficient information and sufficient time to do so.

Over the 14 and a half weeks of the consultation process, a wide range of activities were undertaken to ensure this goal was achieved.

c.4,000 questionnaire responses

c.23,000 leaflets delivered to households with low English proficiency or digital connectivity

c.2,500 people involved across **c.65** engagement events

more than **30** news articles in local radio, TV and print media

c.250,000 people involved through social media

c.200 people from seldom heard groups reached through targeted outreach

Summary box 2.5 Summary of engagement reach

3. What We Have Heard

The consultation gathered a significant volume of feedback from across diverse communities and a wide range of stakeholders. The responses have been independently analysed and reported on.

Many consultees recognised the need to address the identified challenges.

There was overall support for keeping most urgent and emergency care services for most patients at both hospitals, but less support for bringing together the four specific services at one hospital.

There were some concerns raised about specific aspects of the clinical model, in particular the proposals relative to paediatrics.

Most of the concerns raised were in relation to:

- travel and access
- ambulance impacts
- capacity and infrastructure at Diana Princess of Wales Hospital, Grimsby (DPoW)
- staffing issues
- impact on the future of Scunthorpe General Hospital (SGH)

Consultees also put forward some possible alternative locations or approaches to solve the identified challenges.

Equalities impacts were also explored through the consultation. Most of the concerns raised in relation to specific communities or population groups were linked to challenges relating to travel and access and the additional barriers faced by some communities in relation to travel.

Summary Box 3.1

3.1 Approach to analysis and reporting

During the planning phase of the consultation, NHS Humber and North Yorkshire ICB commissioned an independent organisation to support particular consultation and engagement activities and to independently analyse and report the consultation outcomes via an open competitive procurement exercise. This work was undertaken by Opinion Research Services (ORS), a company that originated from Swansea University, now with a UK-wide reputation for social research and major statutory consultations. The ICB also commissioned a specialist communications contractor – Verve Communications – to support the delivery of key consultation activities.

The consultation activities outlined above (see chapter 2) offered participants the opportunity to give feedback in structured or informal conversations, and/or to take away consultation documents and questionnaires to complete later. Not all of the activities and events gathered feedback, but where they did, Verve and/or the NHS engagement team took notes of the views and concerns raised and shared these with ORS for inclusion in the feedback report.

ORS undertook a systematic analysis of all the feedback streams, including:

- The consultation questionnaire
- Public engagement activities undertaken by NHS Humber and North Yorkshire ICB and Verve Communications.

- Independently facilitated in-depth engagement designed and conducted by Verve Communications, specialist drama-based company Playing ON and the NHS engagement team.
- Written and email submissions from residents, stakeholders and organisations.

The feedback has been analysed and summarised into an executive summary highlighting key themes, supported by a comprehensive feedback report which considers the feedback from each element of the consultation in turn, providing a full evidence-base for those considering the consultation and its findings.

The ORS feedback report presents an independent analysis of all types of feedback so that all of them may be taken into account. The report also identifies where strength of feeling may be particularly intense, either in relation to specific themes or possible outcomes, or coming from specific groups of respondents. A high-level summary of feedback is provided below, however, it should be read in conjunction with the full independent feedback report, which provides detailed analysis and a comprehensive explanation of the consultation response.

3.2 Summary of views on the proposal

3.2.1 Views on the need for change

Amongst consultees there was a good deal of recognition of the need for change to address the challenges identified. Consultees particularly acknowledged the staff shortages that make it difficult to provide every service at every hospital, and the need to address long waiting times for diagnosis and treatment.

There were geographical differences in views, however, with consultees living near Diana Princess of Wales Hospital, Grimsby (DPoW) being more likely to agree that change is needed than those living near Scunthorpe General Hospital (SGH).

Some consultees did not recognise the need for change and offered positive anecdotes about current standards of care as evidence and others expressed scepticism over the reasons for the proposed change with some questionnaire respondents and comments on social media suggesting the main purpose of the changes is to achieve financial savings.

3.2.2 Views on the proposed model of care

There was overall support for keeping the most urgent and emergency care services for most patients at both hospitals; but less for bringing together four specific services together at one hospital.

The main reasons people supported the proposed model of care were based on:

- faster and better access to specialist care
- overcoming long-standing recruitment and retention challenges
- consolidating staff to enhance skills and competencies
- delivering more sustainable future services

Summary Box 3.2 Support for the proposed model of care

Opposition was based mainly on scepticism that the proposed model of care would address specified challenges and the potential negative implications for service users. These included:

- concerns that access to services would be more difficult, meaning worsening health inequalities
- the change would result in financial and emotional burdens for service users
- increased confusion around which hospital patients should attend for what service

Summary Box 3.3 Concerns about the proposed model of care

Whilst much of the public response to the consultation raised general themes and concerns about the proposal as a whole, there were some specific concerns or views raised by some consultees around the specific clinical changes proposed.

Proposed service change	Specific concern or view raised
Trauma Unit	The system's ability to respond to major incidents (e.g., an industrial accident) could be compromised by a reduction in Trauma Units.
	Potential impact of increased activity on Emergency Departments in Doncaster and Bassetlaw Teaching Hospitals Foundation Trust (DBTH).
Specialist Medical Inpatients	Cardiology is needed at both sites due to high levels of cardiovascular disease in both populations.
	Specialty services e.g., emergency cardiac/respiratory care should be consolidated at 'super-specialty units' in Hull.
Emergency Surgery	Safety of out-of-hours transfers where life-or-limb emergency surgery is required (e.g., burst appendix/ruptured spleen).
	Specific concerns relating to gynaecology patients requiring emergency surgery and interdependencies with obstetric services.
Inpatient Paediatrics	Emotional impacts for children and young people being treated further away from home in an unfamiliar environment.
	Risks involved in transferring very unwell children between two hospital sites (those needing long-term ventilation, for example).
	Requirement for a specialist paediatric transfer team with a higher level of training and expertise.
	Increased distance to tertiary services at Sheffield (moving children in the 'wrong direction').
	Impact on children and young people with eating disorders or other mental health conditions of being moved out of area (as a result of disruption to local partnerships and ways of working).
	Interdependencies with obstetric and neonatal provision.

Table 3.1 Summary of service-specific feedback

3.2.3 Views on the proposed location of services

On the question of location, only a minority of respondents agreed that services should be brought together at Diana Princess of Wales Hospital, Grimsby (DPoW). There were stark differences in views according to location: more than four fifths (86%) of questionnaire respondents living closest to

Scunthorpe General Hospital (SGH) disagreed with the proposed location, whilst around two thirds (67%) of questionnaire respondents living closer to DPoW agreed with the proposed location.

A few participants at both the public and targeted events/meetings, as well as several written submissions, supported DPoW as the most appropriate location for the proposed service consolidation. They (along with questionnaire respondents who agreed that DPoW was the most appropriate location) considered the proposals logical both geographically, and because DPoW has more room for expansion and is more modern than SGH.

However, a greater number of consultees across all consultation strands disagreed with the logic of consolidating services in Grimsby, arguing that Scunthorpe is more centrally situated and accessible. Others argued that Scunthorpe should retain services because of its size and growing population, high deprivation, and because it has a number of large industrial sites with an associated higher risk of major incidents.

There was some support for consolidating certain services at Diana Princess of Wales Hospital, Grimsby (DPoW), but more disagreement. Some of the key concerns and issues raised are summarised below.

Theme	Key issues raised
Travel and access	Relatives and loved ones unable to visit due to cost/lack of transport.
	Difficulties for some getting home upon discharge due to lack of transport.
	Inter-hospital transfers meaning delays accessing specialist patient care.
	Unpleasant transfer experiences for patients/families (especially children with autism/ADHD, people with dementia, and people for whom English is a second language).
Ambulance impacts	Increased journey times negatively impacting on ambulance service performance, leading to treatment delays and poorer patient outcomes.
Capacity and infrastructure at Diana Princess of Wales Hospital, Grimsby (DPoW)	Insufficient beds/staff/wards at DPoW to manage additional patients.
	Additional ambulance traffic impacting on handover times and emergency department performance.
Staffing issues	Attracting staff to work in Grimsby could be more challenging due to its 'isolated' location.
	'Unfair' impact on Scunthorpe-based staff of additional travel and/or reduced career progression opportunities.
Impact on the future of Scunthorpe General Hospital (SGH)	Proposals could impact on the skills/capabilities of clinical teams in Scunthorpe and the longer-term viability of SGH.
	SGH could become less attractive to potential recruits.
	Other services could be withdrawn from SGH in future and/or concern that the proposal forms part of a wider plan to close SGH over time.

Table 3.2 Summary of key areas of concern

3.2.4 Equalities and health inequalities impacts

Throughout the consultation, consultees were encouraged to highlight any particular concerns they had in relation to health inequalities or the impact of the proposed changes on specific groups, especially those with protected characteristics under the Equality Act 2010.

The analysis of the questionnaire responses did not indicate particularly strong differences in views on the proposals, or specific additional concerns being expressed by respondents from groups with protected characteristics.

Nonetheless, concerns were identified through the consultation in relation to equalities impacts. These concerns mainly centred on travel and access, focusing on the ease with which patients, relatives and visitors are able to travel to Grimsby (DPoW) to access care or visit loved ones, especially in relation to inpatient Paediatric care.

Several groups were considered particularly vulnerable to the travel and access impacts, including:

- People and families on lower incomes and/or without access to private transport.
- People living in rural isolation.
- Older people.
- People with disabilities.
- People living with dementia.
- People living with mental health issues.
- Carers.
- People living in particular geographies (like Scunthorpe and surrounding areas and rural North Lincolnshire).
- Single parents, especially those with no support network.
- Parents, especially single parents, with other children to care for.
- Patients with longer term conditions requiring repeat appointments.
- People (especially children and young people) with additional/complex needs like autism and their families.

Summary Box 3.4 Summary of equalities impacts raised

3.3 Alternatives and Mitigations

Many of those who disagreed with the proposals felt that some resolution could be achieved without reconfiguring services, but some consultees did put forward alternative proposals and/or proposed mitigations for the impacts of the proposed changes.

3.3.1 Alternative suggestions

Many suggested alternatives were to maintain the status quo in some form:

- Continue to deliver all services at both hospitals.
- Maintain inpatient services on both sites and move clinicians around or provide on-call rotas on alternate days/alternate emergency activity between sites.
- Consolidate some services but keep Paediatrics and Trauma Units at both sites.
- Stop Hospital@Home and use the resources to maintain inpatient Paediatrics on both sites.
- Address staffing and funding issues.

The most frequently suggested alternative service configurations included consolidating services at Scunthorpe instead of Grimsby and/or consolidating some services at DPoW and others at SGH. Some consultees suggested that Goole and District Hospital should be considered as part the proposals based on the hospital's accessibility and better proximity to major centres such as Sheffield and Hull. Others proposed that services should instead be consolidated at a completely new centre, to be built somewhere between Scunthorpe and Grimsby.

There was some support for a more radical consolidation of services (e.g., consolidating services in Hull, or reserving one site for elective work and minor conditions only).

3.3.2 Proposed mitigations

Consultees provided a range of views on potential actions that could be taken to mitigate the impacts of the proposed changes. The most common mitigations centred on travel and access, these and other suggestions are set out in the table below.

Theme	Suggested Mitigations
Travel and access	An improved Patient Transport System (particularly in terms of widening eligibility and allowing carers and family members to travel with patients).
	A shuttle bus between hospital sites.
	Expanding the voluntary driver service.
	Free car parking at DPoW.
	Simplifying the process of reclaiming travel expenses.
	Providing accommodation for the families of Paediatric inpatients.
Staff recruitment and retention	Offering incentives for those who train in the area to stay for a period of time once qualified.
	Encouraging more staff to join the NHS on a permanent basis, rather than working through an agency.
	Offering more local secondments and training placements.
	Removing the degree requirement for nursing and opening up alternative routes into the profession for local residents.
Paediatric services	Making better use of virtual appointments, particularly for children with autism and ADHD who struggle with the sensory experience of a hospital environment.
	Making hospitals more welcoming and less daunting, especially for children.

Table 3.3 Summary of mitigations suggested

Over the course of the consultation process, patients, service-users, members of the public, NHS staff members, organisations and other stakeholders provided wide-ranging feedback on the proposal.

Whilst there was broad recognition amongst consultees that services may need to change, the majority of respondents to the consultation raised concerns and/or cited their opposition to the proposed model of care and/or proposed location. Opposition was particularly strong from people living in and around Scunthorpe.

The main areas of concern and proposed mitigations raised through the consultation related to travel and access, through a broad range of other issues and concerns were raised by participants in the consultation process.

All feedback has been independently analysed and reported on and carefully considered by clinical and managerial leaders across the Integrated Care Board (ICB) and partner organisations.

Summary Box 3.5

4. How We Are Responding

A wide range of views and opinions on the proposal for change were gathered through consultation.

Following analysis and reporting of feedback, the issues raised have been conscientiously considered by clinical and managerial teams in the Integrated Care Board (ICB) and provider organisations and used to shape the revised proposal contained within this decision-making business case (DMBC).

In reviewing feedback, the programme has sought to alleviate key concerns using evidence and outcomes of planning exercises, to mitigate against negative impacts wherever possible and to respond to alternative suggestions and ideas that were put forward, making changes to the original proposals where it makes sense to do so.

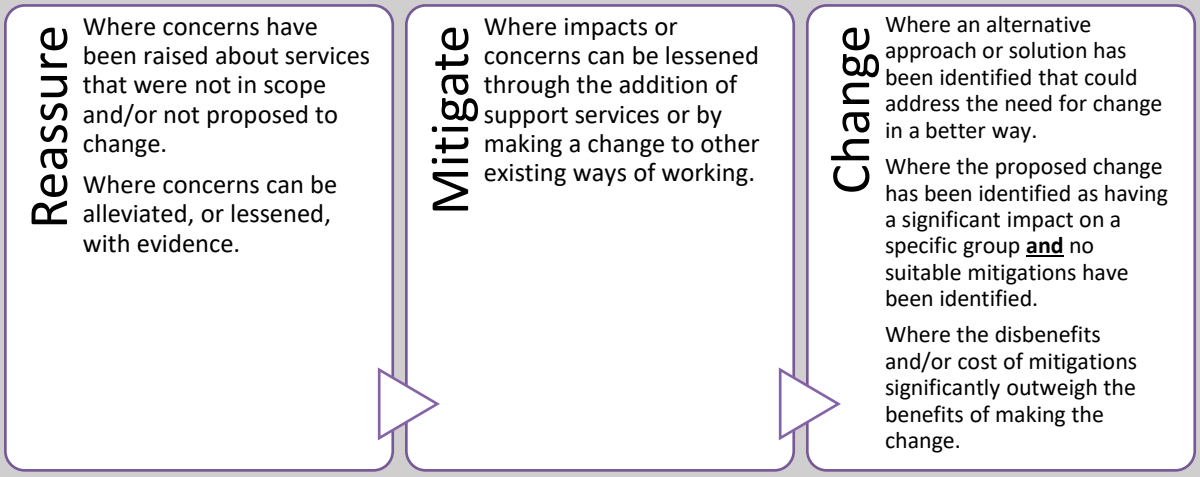


Figure 4.1 Summary of You Said, We Did approach

The revised proposal in this DMBC seeks to deliver the maximum benefits, whilst mitigating, wherever possible, the negative impacts that may arise as a result of the proposed change.

Summary Box 4.1

4.1 Approach to consideration of feedback

The purpose of the consultation was to gather views and feedback from a wide range of stakeholders on the proposal for change to hospital services in Grimsby and Scunthorpe. In particular, the goal was to support decision-makers to better understand the impact of the proposed changes and explore alternative approaches to solving the challenges set out in the case for change and/or mitigations for any potential negative impacts associated with the proposed changes.

To ensure all feedback was carefully and conscientiously considered, independent analysis of the feedback was undertaken to identify all relevant issues, challenges and concerns in relation to the proposal for change. In addition, the feedback report identified and reported on any equalities impacts

and concerns, potential ideas for mitigations and suggested alternatives to the proposed changes. These issues and themes are summarised in the chapter above and set out in full in the feedback report.[33]

The comments, ideas and feedback gathered through the consultation were reviewed by clinical and managerial leaders across the Integrated Care Board (ICB) and partner organisations. This iterative process of review and response underpins the recommendations made within this Decision-Making Business Case (DMBC) for each service area.

In parallel, the programme team continued to review plans for implementation across each of the service areas where changes were proposed. This included reviewing the assumptions, activity modelling, demand and capacity analyses (bed modelling), workforce modelling and financial implications.[34] This work was vital in providing more up to date and detailed information on the anticipated impact of the proposed changes.

4.1.1 Views on the proposal and key concerns

A wide range of views on the proposal for change were gathered through consultation. Some were about specific service areas or aspects of how the proposed changes might work, whilst others were about the proposal as a whole and how it might impact on individuals and/or groups within the population. Each issue or concern has been considered and grouped into three main categories to reflect how the amended proposal responds to the issues raised.

1. **Reassure**
    a. Where concerns have been raised by the public, staff and other stakeholders about services that were not in scope and/or not proposed to change.
    b. Where concerns can be alleviated, or lessened, with evidence of the anticipated impact (e.g., where the impact of a change is lower than expected or previously stated).

2. **Mitigate**
    a. Where impacts or concerns can be lessened through the addition of support services or by making a change to other existing ways of working.

3. **Change**
    a. Where an alternative approach or solution has been identified through engagement that could address the need for change in a better way.
    b. Where the proposed change has been identified as having a significant impact on a specific group or population cohort **and** where no suitable mitigations have been identified that would make the proposed change viable.
    c. Where the disbenefits and/or the mitigations that would be required significantly outweigh the benefits of making the change.

The descriptions are illustrative and responses to some issues raised straddle multiple categories, however, they have been used as a guide to identify how each issue raised has been conscientiously considered and responded to in coming to the recommendations within this Decision-Making Business Case (DMBC).

[33] Opinion Research Services (May 2024) *Changes to Some Services Provided by Scunthorpe and Grimsby Hospitals – Public Consultation Feedback Report* see ICB Board Page for final report
[34] See appendices **Error! Reference source not found.** to 10.12 for a summary of the assumptions, activity, bed m odelling, workforce and finance outputs.

4.1.2 Equalities and health inequalities impacts

Through the consultation, special attention was paid to ensuring the views and experiences from seldom heard groups and people more likely to face barriers to accessing care or other underlying health inequalities were gathered and understood. This work revealed some specific concerns associated with particular cohorts of the population and provided a clearer understanding of the groups and individuals who are more likely to be impacted negatively by the proposed changes.

Feedback and insight provided on equalities and health inequalities impacts was reviewed in detail by a cross-organisational group comprising public health experts, equalities, diversity and inclusion (EDI) leads, clinical leads and governance and commissioning colleagues to ensure all areas were considered and responded to. This work was incorporated into the Integrated Impact Assessment (IIA) which supports this Decision-Making Business Case (DMBC).

The IIA identifies possible positive and negative impacts of the proposed changes and set out a series of mitigations, particularly where changes have been identified as potentially having a disproportionate impact on one or more group with protected characteristics. The mitigation plans are set out in more detail later in this business case.[35]

4.1.3 Alternative proposals

In addition to comments on the proposal itself, some respondents to the consultation put forward alternative suggestions to the proposal that went out for consultation. In addition, the case study workshops held with clinical teams made suggestions about how the proposal could be implemented or, in some cases, put forward an alternative approach for their specialty.

All suggested alternative options or solutions were subjected to the same process of review, which is summarised in the charts below. The purpose of this check and challenge process was to ensure the alternatives were considered with the same rigour as the original proposal and all potential alternative options were conscientiously considered in the development of this Decision-Making Business Case (DMBC).

Suggested alternatives were reviewed to determine if they were the same as options already considered and evaluated out during the pre-consultation phase. This included suggestions that were similar/not materially different from those options. The second stage of the review process evaluated the remaining alternative suggestions, firstly against the hurdle criteria from the original options development process and any that remained after this were subjected to clinical review for full consideration.

[35] see sections 5.5.5 and 6.3

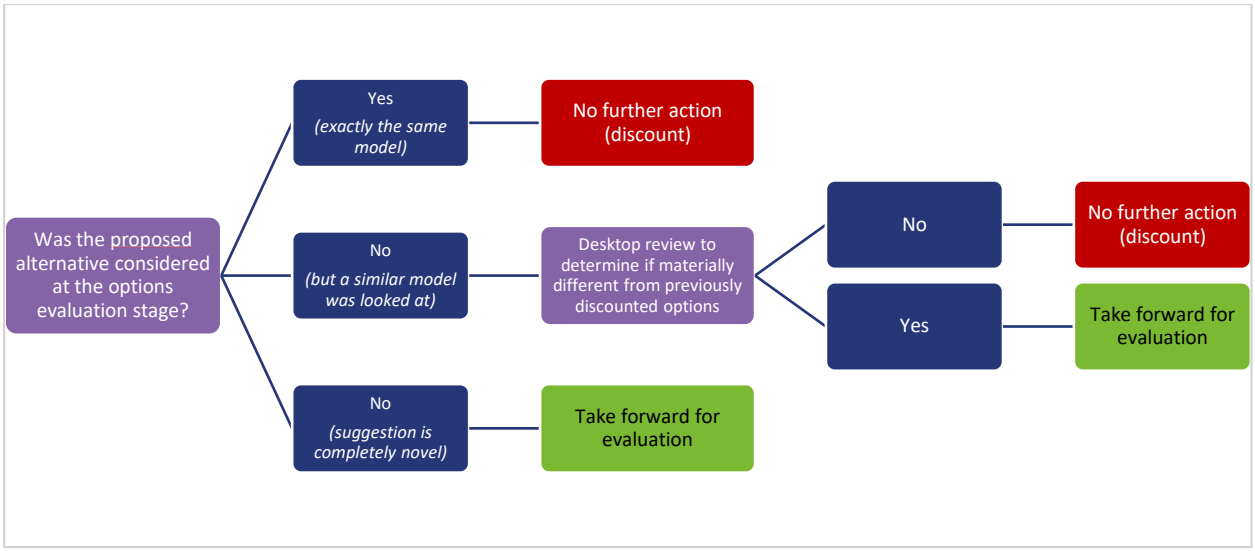


Figure 4.2 Desktop review of alternative suggestions (Step 1)

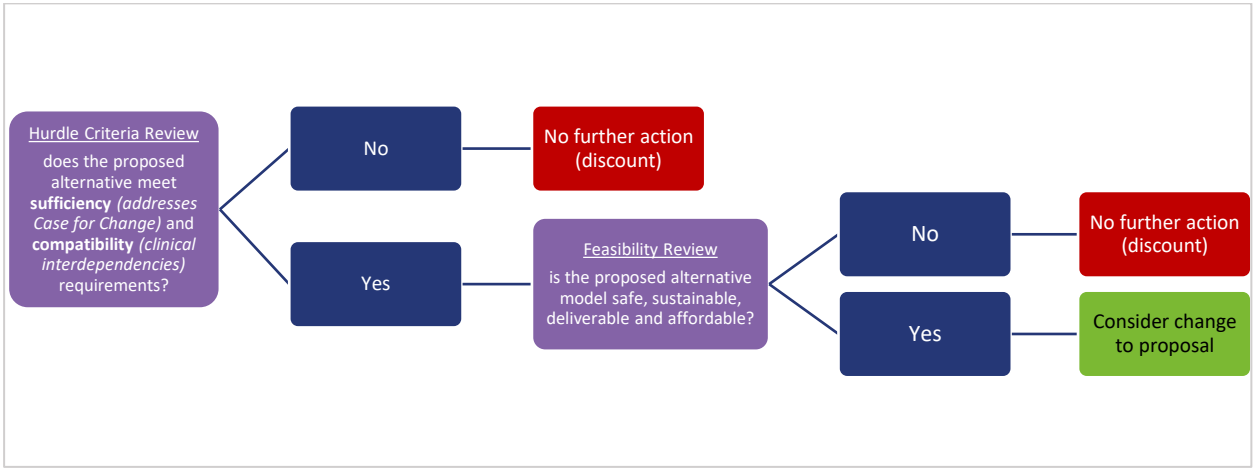


Figure 4.3 Evaluation of alternative suggestions (Step 2)

The vast majority of the alternative suggestions made through the public consultation were either variations of a 'do nothing' position or of options that had been considered during the pre-consultation phase. These included, for example:

- maintaining the status quo by addressing staffing and funding issues in another way
- consolidating some of the proposed services but keeping paediatrics and Trauma Unit at both sites
- keeping services as they are but staffing them in a different way (e.g., providing on-call rotas on alternate days or alternative emergency activity between the sites).

Bringing services together at Scunthorpe instead of Grimsby or building a new hospital in the middle for all services to be brought together in were also proposed as alternative solutions. Both of these options were fully evaluated during the pre-Consultation options appraisal and ruled out at that stage. NHS England's requirements that any proposed change meets strict capital affordability criteria limits the possible options available to the system and ruled both of these options out at pre-Consultation stage.

Step one of the review process, therefore, ruled out most of the alternative suggestions put forward by consultees.

A small number of the alternative suggestions put forward were evaluated in more detail and as a result some amendments to the original proposal have been made and are reflected within the recommended way forward in this business case. This iterative process of review and response underpins the recommendations made within this Decision-Making Business Case (DMBC) for each service area.

A detailed record of all the alternative suggestions that were reviewed and how they were evaluated is provided in the supporting You Said, We Did document (see appendix 10.14).

4.2 Summary of Responses – You Said, We Did

A wide range of issues and concerns were raised through consultation. These are set out in detail in the Consultation Feedback report and the responses categorised and logged within the You Said, We Did document.[36]

The table below summarises – at a very high level – the key areas that were raised and how these have been considered and responded to. These have been logged in detail in the supporting You Said, We Did document, which should be read alongside this summary.

[36] see appendix 10.14 see ICB Board Page for final document

4.2.1 You Said, We Did

Theme	Key issues raised	Reassure	Mitigate	Change	Explanation
Travel and access	Relatives and loved ones unable to visit due to cost/lack of transport.		x		Transport action plan agreed through multi-agency group to support those in greatest need.
	Difficulties for some getting home upon discharge due to lack of transport.		x		Transport action plan agreed through multi-agency group to support those in greatest need.
	Inter-hospital transfers meaning delays accessing specialist patient care.	x			Right-sized inter-hospital transfer service will be in place prior to implementation of new pathways.
	Unpleasant transfer experiences for patients/families (e.g., children with autism/ADHD, people with dementia, and people for whom English is a second language).	x	x		Mitigations and protocols will be co-designed with potentially impacted groups to mitigate impact of transfer experience as far as possible.
Ambulance impacts	Increased journey times negatively impacting on ambulance service performance, leading to treatment delays and poorer patient outcomes.	x			Independent analysis of ambulance journey times and impacts concluded the proposed change of Trauma pathways would have no material impact on ambulance performance.
Capacity and infrastructure at Diana Princess of Wales Hospital, Grimsby (DPoW)	Insufficient beds/staff/wards at DPoW to manage additional patients.	x			Detailed capacity and demand modelling has been undertaken to ensure the right number of beds is planned for each site, based on the changes proposed. Ward configuration changes will be made in advance of implementing the change to pathways.
	Additional ambulance traffic impacting on handover times and Emergency Department performance.	x	x		Additional trauma conveyances are modest (around 3 per week to DPoW) and would not be significant enough to materially impact ED performance. Direct admission pathways to

					specialist wards will enable transferred patients to bypass ED.
Staffing issues	Attracting staff to work in Grimsby could be more challenging due to its 'isolated' location.	x	x		Cross-site rotas (for medical staff and some specialist nursing staff) are already in place and will continue. Cross-site working is a key element to ensuring staff maintain competencies and skills. The new Group operating model supports greater integration.
	'Unfair' impact on Scunthorpe-based staff of additional travel and/or reduced career progression opportunities.	x	x		
Impact on the future of Scunthorpe General Hospital (SGH)	Proposals could impact on the skills/capabilities of clinical teams in Scunthorpe and the longer-term viability of SGH.	x	x		Cross-site rotas (for medical staff and some specialist nursing staff) are already in place and will continue. Cross-site working is a key element to ensuring staff maintain competencies and skills. The new Group operating model supports greater integration.
	SGH could become less attractive to potential recruits.	x	x		
	Other services could be withdrawn from SGH in future.	x			The proposed consolidation of specialist services will make services at both hospitals more sustainable, helping to ensure long term viability for both sites. The proposed way forward supports continuation of consolidated services at SGH, including Hyper Acute Stroke (HASU) and Urology.

Table 4.1 You Said, We Did Summary - General Feedback

Theme	Key issues raised	Reassure	Mitigate	Change	Explanation
Trauma Unit	The system's ability to respond to major incidents (e.g., an industrial accident) could be compromised by a reduction in Trauma Units.	x			Emergency Departments (EDs) will continue to operate at SGH and DPoW and respond to major incidents in line with existing protocols – new ED buildings provide better capacity to respond to major incidents (e.g., decontamination facilities). The proposals have been reviewed by the Local Resilience Forum (LRF) and EPRR teams.
	Potential impact of increased activity on Emergency Departments in Doncaster.	x			Re-modelled activity data identifies only 44 additional trauma patients per year (fewer than one per week) will be taken to Doncaster. Repatriation pathways will be reviewed as part of implementation.
Specialist Medical Inpatients	Cardiology is needed at both sites due to high levels of cardiovascular disease (CVD) in both populations.	x			The proposed changes would mean quicker access to specialist care (7-day services) and improved outcomes for people with CVD in our communities.
	Specialty services e.g., emergency cardiac/respiratory care should be consolidated at 'super-specialty units' in Hull.	x		x	It is possible that benefits could be derived from further consolidation of specialist services, but these would need to be evaluated fully within the context of the new Group operating model. No further changes (beyond what is set out in this DMBC) are proposed at this time.
Emergency Surgery	Safety of out-of-hours transfers where life-or-limb emergency surgery is required (e.g., burst appendix/ruptured spleen).	x		x	The revised proposal within the DMBC makes provision for life-or-limb emergency surgery to be provided in Scunthorpe if required. This would involve the surgeon travelling rather than the patient. Anaesthetic cover will continue to be in place in SGH providing cover for ED and critical care.
	Specific concerns relating to gynaecology patients requiring emergency surgery due to interdependencies with obstetric services.			x	The revised proposal recommends no change to gynaecology at this time due to current clinical rotas and strong interdependencies with obstetric services.

Inpatient Paediatrics	Emotional impacts for children and young people being treated further away from home in an unfamiliar environment.			x	Revised proposal to focus on implementing community-first paediatrics model to reduce reliance on hospital-based provision.
	Risks involved in transferring very unwell children between two hospital sites (those needing long-term ventilation, for example).			x	Revised proposal to retain inpatient provision on both sites and maximise Same Day Emergency Care (SDEC) for paediatrics.
	Requirement for a specialist paediatric transfer team with a higher level of training and expertise.			x	Revised proposal to retain inpatient provision on both sites, therefore transfer team not required.
	Increased distance to tertiary services at Sheffield (moving children in the 'wrong direction').			x	Tertiary transfers will continue as is, provided by specialist team (EMBRACE).
	Impact on children and young people with eating disorders or other mental health conditions of being moved out of area (as a result of disruption to local partnerships and ways of working).			x	Revised proposal to focus on implementing community-first paediatrics model to reduce reliance on hospital-based provision.
	Interdependencies with obstetric and neonatal provision.			x	Future model for Paediatric inpatient care to be considered as part of system-wide review of maternity, neonatal and paediatric services.

Table 4.2 You Said, We Did Summary - Specific Proposals

4.3 Proposed way forward

The recommendations within this Decision-Making Business Case (DMBC) seek to respond to the key issues raised through the consultation in relation to the proposal for change as set out briefly above. The next chapter of this DMBC sets out the recommended way forward for each specialty impacted by the proposal for change, considering the views and evidence provided during public consultation alongside other material information, including relevant changes to policy, regulations or clinical standards and updated activity and workforce modelling.

In some areas, the DMBC recommends changes to/alternative approaches to the proposed changes as set out in the consultation document, in other areas, the DMBC recommends implementing the proposed changes as originally set out but with mitigations to address the key concerns raised during the public consultation. The recommended changes to the proposal reflect the outcomes of detailed implementation planning, updated activity and workforce modelling and consideration of other evidence provide during public consultation.

Case studies have been developed for each specialty, supported by a detailed implementation plan which sets out the proposed timeline with key milestones and Go/No Go criteria as well as plans for enabling changes and mitigating actions that have been identified as necessary to support the proposed change. The recommendations are summarised briefly in the table below with further detail provided in the next chapter.

4.3.1 Summary of amended proposal

Service	Recommendation	Rationale / key benefits	Impact *(patients/day)*
Implement as proposed			
Trauma Unit			
Trauma Unit	Bring together into a single Trauma Unit at Grimsby (DPoW)	• Improved quality of specialist care – specialist teams available 24/7 • Improved outcomes for patients • Delivery of key clinical standards	<1
Some Medical Specialties			
Cardiology	Bring specialist inpatient care together at Grimsby (DPoW)	• Deliver 7-day services, improved quality of specialist care • Improved outcomes for patients • Delivery of key clinical standards	2
Respiratory	Bring specialist inpatient care together at Grimsby (DPoW)	• Deliver 7-day services, improved quality of specialist care • Improved outcomes for patients • Delivery of key clinical standards	
Gastroenterology	Bring specialist inpatient care together at Grimsby (DPoW)	• Deliver 7-day services, improved quality of specialist care • Improved outcomes for patients • Delivery of key clinical standards	
Amend proposal based on feedback			
Emergency Surgery			
Trauma and Orthopaedics	Bring acute trauma and orthopaedics together at Grimsby (DPoW)	• Improved efficiency and productivity • Improved quality of specialist care – develops specialist expertise in trauma care at DPoW	1

	(NOTE: including all fractured hip operations)	• Improved outcomes for patients being cared for by specialist trauma workforce with the right equipment and more opportunities to train and develop skills. • +65yrs fractured hip (NOF) patients cared for by medical (not surgical) teams to provide holistic care and address co-morbidities – pathways developed to repatriate to Scunthorpe and/or directly home with intensive rehab support immediately post-op for rehab and recovery close to/at home.	
General Surgery	Bring acute general surgery together at Grimsby (DPoW) Bring complex planned care together at Scunthorpe (SGH)	• Improved efficiency and productivity • Improved quality of specialist care • Improved outcomes for patients • Changes to elective pathways are required to deliver the proposed change to acute pathways and ensure efficient use of staffing and theatre capacity.	2.5
Urology	Bring emergency *and* planned care inpatients together at Scunthorpe (SGH)	• Improved efficiency and productivity • Improved quality of specialist care • Improved outcomes for patients • Small workforce to cover elective and acute activity – co-locating acute and elective inpatient care improves productivity. • Equipment already in place in Scunthorpe General Hospital.	1 *(DPoW to SGH – existing pathway)*
ENT	Bring emergency and planned care inpatients together at Grimsby (DPoW)	• Improved efficiency and productivity • Improved quality of specialist care • Improved outcomes for patients • Small workforce to cover elective and acute activity – co-locating acute and elective inpatient care improves productivity.	<1
Ophthalmology	Bring all surgical emergencies together at specialist Eye Hospital (Hull Royal Infirmary)	• Improved efficiency and productivity • Improved quality of specialist care • Improved outcomes for patients • Reduced on-call rotas for very limited number of inpatients (c.12 per year).	0

Gynaecology	Retain current service on both sites – review future model as part of maternity and neonatal review	• Strong interdependencies with obstetric services • No workforce benefits to inpatient consolidation if continuing to staff obstetric-led maternity services on both sites due to current rotas and cross-cover between obstetrics and gynaecology.	0
Inpatient Paediatric Services			
Paediatrics	Retain some inpatient beds on both sites but work towards reduced reliance on inpatient beds in favour of a community-based model, supported by full implementation of Hospital at Home. Increase utilisation of Paediatric Same Day Emergency Care (SDEC) and PAU to reduce length of stay and need for inpatient beds over time.	• Strong interdependencies with neonatal services. • Limited workforce benefits to implementing proposal in isolation (due to maternity and neonatal provision on both sites). • Further work to be undertaken with partners to review pathways for critically ill children and/or those with long-term complex needs (in particular those on long-term ventilation) to develop long-term sustainable solution. • Revised approach seeks to reduce the impact on children by reducing the need for hospital stays and keep children at home as much as possible.	0
			TOTAL IMPACT **c.7 patients/day** *(SGH to DPOW)*[37]

Table 4.3 Summary of amended proposal

[37] The model would also see some patients transferred from Grimsby (DPoW) to Scunthorpe, including c. 1.5 acute urology patients each day. These pathways are already in place and therefore these transfers do not appear in the impact modelling as they are part of the current operating model.

4.3.1 Mitigations

In addition to changes made to the original proposal, a range of mitigations have been identified to support implementation of the revised proposal. These are detailed in sections 6.3 and 7.2.3 and summarised briefly in the diagram below.

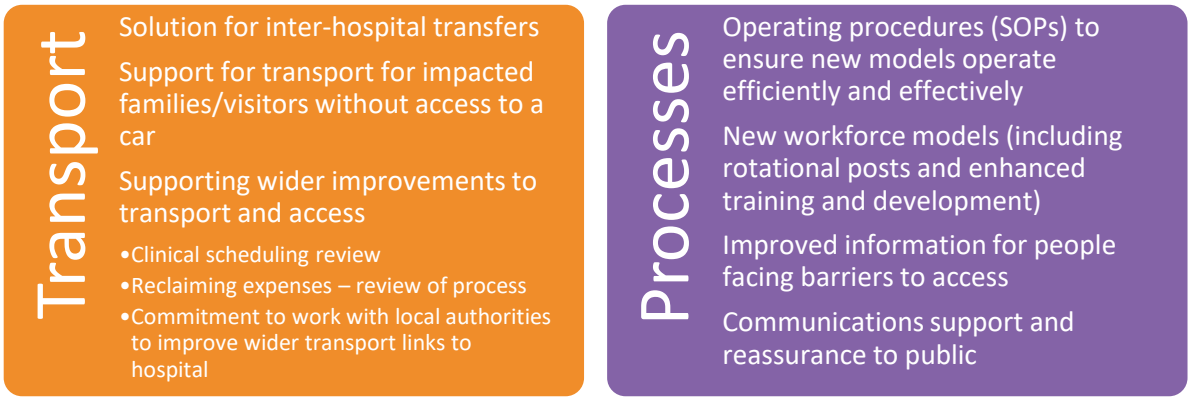


Figure 4.4 Summary of mitigations

The extensive feedback gathered through consultation has been independently analysed and reported on and carefully considered by clinical and managerial leaders across the Integrated Care Board (ICB) and partner organisations.

Potential alternative suggestions have been reviewed against the original criteria, including patient safety, clinical effectiveness and capital affordability.

Feedback on the clinical model and proposed location has also been responded to in detail, with amendments proposed to the clinical model and location of some elements of the original proposal for change.

A range of mitigating actions have been developed to ensure the proposal can be implemented effectively and minimise any negative impacts on local communities.

Summary Box 4.2

5. Case Studies

Fully considering the views and evidence provided during the public consultation alongside other material information – such as changes to policy, regulations or clinical standards and updated activity and workforce modelling – a revised proposal is recommended, as set out in the table below.

Service area	Original Proposal	Revised proposal
Trauma Unit	Consolidate to DPoW	Consolidate to DPoW
Emergency surgery	Consolidate to DPoW	Consolidate to one site (mixed approach)
– *Trauma and Orthopaedics*		– Consolidate to DPoW
– *Acute General Surgery*		– Consolidate to DPoW
– *Urology*		– Consolidate to SGH
– *ENT*		– Consolidate to DPoW
– *Ophthalmology*		– Consolidate to HRI
– *Gynaecology*		Retain on both sites – align to obstetrics review
Some medical specialities	Consolidate to DPoW	Consolidate to DPoW
– *Cardiology*		
– *Respiratory*		
– *Gastroenterology*		
Paediatric overnight (inpatient) care	Consolidate to DPoW	Retain inpatient beds on both sites but work towards a reduction in beds through implementation of community-based paediatrics model

Table 5.1 Summary of revised proposal

Benefits

- Improved quality of specialist care, fewer delays, better clinical outcomes.
- Shorter waiting times, reduced length of stay and improved flow.
- Improved recruitment, retention and training opportunities for staff.

Impact

- Around 7 patients per day transferred from SGH to DPoW for specialist inpatient care.

Mitigations

- Transport – to support those impacted most by the proposed change.
- Processes and procedures – to ensure effective operating of the model.

Summary Box 5.1

5.1 Trauma Unit

5.1.1 Original proposal

The proposal put forward for consultation recommended bringing together Trauma services – for people with injuries requiring specialist care (typically brought by ambulance) and who might need an operation or observation by a trauma team – at Diana Princess of Wales Hospital, Grimsby. The proposed change would result in having one consolidated Trauma Unit for northern Lincolnshire. Within the proposed model of care, both hospitals would continue to provide 24/7 Emergency Departments.

> Bringing trauma services together would provide access to more specialty skills 24/7 and allow for faster assessment and treatment, reducing the pressure on both Emergency Departments and reducing the wait to be seen.

The proposal for change is summarised below and explained in more detail in the Pre-Consultation Business Case (PCBC).[38]

Service	Current situation	Proposed change	What would be different
Trauma	Major Trauma Centre (adults) at Hull Royal Infirmary and Trauma Units located in both Grimsby and Scunthorpe Hospitals.	Trauma Unit level care would be provided at one hospital, with Hull Royal Infirmary (HRI) remaining as the regional Major Trauma Centre (MTC). Patients would be taken by ambulance directly to one of these hospitals based on their clinical needs.	Bringing trauma services together would provide access to more specialty skills 24/7 and allow for faster assessment and treatment, reducing the pressure on the Emergency Department and reducing the wait to be seen. It is estimated this change may impact **c.1.7 patients per day.** This could be mitigated and potentially reduced though improved ambulance transfer protocol and advice and guidance for crews prior to conveyance.

Table 5.2 Summary of proposed change (Trauma Unit)

5.1.2 Consultation Feedback

Consultees raised concerns about the impact of the proposed changes on ambulance providers and their ability to get patients to an Emergency Department quickly and also the impact of the potential increase in demand at Diana Princess of Wales Hospital, Grimsby (DPoW) on ambulance handover times and subsequent performance. Other consultees raised concerns about the state of the road network across northern Lincolnshire and whether the change to the clinical model might impact upon journey times to hospital in an emergency and adversely affect patient outcomes.

[38] Humber and North Yorkshire Health and Care Partnership (2023), *Humber Acute Services Review - Pre-Consultation Business Case (PCBC)* Pre-Consultation Business Case (pp.151-153).

In addition to the general feedback on the model as a whole, there were some specific concerns raised in relation to the proposals to consolidate to a single Trauma Unit for northern Lincolnshire. Some consultees raised questions about whether the change might impact upon the system's ability to respond to major incidents (e.g., an industrial accident), which was thought to be more likely in the northern Lincolnshire area due to the large number of significant heavy industries operating in the region.

Some queries were also raised by Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust regarding the potential impact of additional activity on their already stretched Emergency Department at Doncaster Royal Infirmary (DRI) as a result of the proposed change. [39] In addition, the trust raised concerns that more patients would self-present at Doncaster rather than Scunthorpe due to the perceived reduction in services and to avoid potential transfer to Grimsby.

5.1.3 Refreshed activity modelling and impacts

In addition to reviewing and considering the consultation feedback, further work was undertaken to refresh the activity modelling and ambulance impact modelling to enable decision-making in relation to the proposal for change.

5.1.3.1 Trauma conveyances and ambulance impacts

The number of Trauma conveyances in each year from the baseline year (2019/20) to the most recent full year of data (2022/23) was gathered to provide a more accurate assessment of the anticipated impact of the proposed change on ambulance providers and neighbouring trusts.

Trauma conveyances (demand)					
Ambulance provider	**Receiving Hospital**	**2019/20**	**2020/21**	**2021/22**	**2022/23**
EMAS	DPoW	1030	390	338	253
YAS		0	0	0	0
EMAS	SGH	644	247	216	168
YAS		21	0	20	23

Table 5.3 Trauma conveyances - anticipated demand [40]

As the table demonstrates, the numbers of Trauma Unit cases and anticipated demand for trauma conveyances is significantly lower than was anticipated when the proposal was put forward for consultation (based upon figures from the baseline year 2019/20).

Based on the updated trauma demand, independent ambulance impact modelling was undertaken by the expert organisation ORH (Operational Research in Health). ORH modelled where patients would be taken (based upon a 10-minute threshold to remain within the existing EMAS boundaries). In addition, based on feedback raised during consultation, consideration has been made for individuals who make their own way to the Scunthorpe Emergency Department but require specialist Trauma Unit care and would therefore require emergency ambulance transport.

The outputs of the modelling show that using the 10-minute threshold for EMAS to stay within their existing boundaries significantly reduces the impact on neighbouring providers such that they will see an increase of fewer than one additional patient per week.

[39] see *Public Consultation Feedback Report* Appendix III: Written Submissions see ICB Board Page for final report
[40] Reflects changes to definitions/measurement criteria. These have consistent from 2020/21 onwards.

	Patients diverted from Scunthorpe Hospital to nearest Trauma Unit *(with 10 min threshold)* per year				**TOTAL**
	DPoW	**Hull**	**Lincoln**	**Doncaster**	
Nearest Trauma Unit - EMAS	105	18	24	21	**168**
Nearest Trauma Unit - YAS	0	0	0	23	**23**
Potential walk-ins[41]	70	0	0	0	**70**
Total	**175**	**18**	**24**	**44**	**261**

Table 5.4 Trauma Unit patients diverted from Scunthorpe

ORH concluded that no additional resource would be required to manage the diverted trauma conveyances and maintain current response times for EMAS or YAS.

5.1.3.2 Emergency Department impacts

The impact of making the proposed change to Trauma Unit status on the Emergency Department (ED) in Scunthorpe General Hospital (SGH) was also reviewed in response to concerns and challenges raised during the consultation. In particular, consultees were concerned that the reduction in the number of Trauma Units on the south bank of the Humber would impact the region's ability to respond to a major incident, e.g., an industrial accident.

Engagement with emergency services, including East Midlands Ambulance Service (EMAS) and the NHS Humber Health Partnership's lead for Emergency Preparedness, Resilience and Response (EPRR) and the Humber Local Resilience Forum (LRF), confirmed that the proposed change would not impact negatively upon the system's ability to respond to a major incident. Ambulance providers and first responders would continue to operate according to Trauma protocols to triage and convey patients to the most appropriate facility based on clinical need. The Emergency Department in Scunthorpe Hospital would still be able to see and treat the vast majority of ambulance conveyed patients and would continue to form part of any emergency response. Furthermore, the new Emergency Department buildings in both Scunthorpe and Grimsby provide the region with significantly improved capacity to respond to major incidents. For example, improved and enhanced decontamination suites and increased numbers of resuscitation bays at the Scunthorpe and Grimsby sites.

5.1.4 Conclusion and recommendations

Feedback and suggestions raised during public consultation have been reviewed and responded to in relation to the proposals for consolidation of Trauma Units in northern Lincolnshire.[42] Appropriate mitigations can be put in place to address the key concerns raised.

> The recommendation is to proceed with the proposed change to consolidate Trauma Unit activity to a single site at Diana Princess of Wales Hospital, Grimsby (DPoW).

[41] potential walk-ins to Scunthorpe Hospital who require Trauma Unit level care and would need to be transferred to Diana Princess of Wales Hospital, Grimsby. The potential requirement has been calculated based on an audit of trauma calls, deducting ambulance-conveyed patients.
[42] See section 4.2 for more details.

Rationale:

- Consolidating to a single designated Trauma Unit for northern Lincolnshire will enable the creation of a specialist centre with improved training and skills development for trauma teams and ensure patients receive timely care from a dedicated specialist team 24/7.
- Pooling resources together on one site will enable trauma coordination to increase to 7-day service, improving delivery of trauma care over a weekend.
- Consolidating all trauma cases to one site will improve patient flow through the Emergency Department in Scunthorpe General Hospital (SGH) by removing the disruption caused by trauma calls.
- Bringing acute trauma care together on one site will support aligned changes to Trauma and Orthopaedic surgery (see section 5.2.4 below), which are a key enabler to making improvements in elective performance.

5.1.4.1 Benefits

Bringing patients who require a specialist Trauma Unit together onto a single site at Diana Princess of Wales Hospital, Grimsby (DPoW) will enable specialist Trauma teams to enhance their skills by seeing more patients and developing expertise in Trauma care. Patients will benefit from being treated in a specialist centre and repatriation pathways will be in place to ensure they can be discharged home or stepped down to their local hospital as quickly as possible after their trauma.

5.1.4.2 Impacts

The impact of the change on local ambulance services is minimal and can be implemented swiftly by amending existing trauma protocols that ambulance teams already use on a daily basis to determine the optimal site to convey trauma patients to. Additionally, the impact on neighbouring providers can be mitigated by utilising the 10-minute threshold to remain within the EMAS boundary, ensuring most patients are transferred to another site within the Group.

5.1.4.3 Mitigations

Responding to concerns raised by neighbouring providers, the implementation of the proposed change will be supported by a communications campaign to provide reassurance to the local population, reaffirming that the Emergency Department in Scunthorpe remains to mitigate the risk of people avoiding seeking help or going to neighbouring providers.

5.2 Emergency Surgery

5.2.1 Original proposal

The proposal put forward for consultation recommended bringing together Emergency surgery and acute surgical inpatient services – for people who need an operation in the middle of the night or who need to stay in hospital overnight and be looked after by teams with surgical expertise – at Diana Princess of Wales Hospital, Grimsby. The proposed change would mean that all patients who need surgery out of hours or need to be looked after overnight on a surgical ward would transfer from SGH to DPoW. Within the proposed model of care, both hospitals would continue to provide 24/7 Emergency Departments and day case surgery for some emergency patients.

> Bringing together emergency surgery and inpatient surgical services with 24/7 teams including surgeons, theatre teams and nursing staff together at one hospital would increase productivity and efficiency of surgical services, reduce out of hours on-call requirements, and support the future sustainability of the workforce.

The proposal for change is summarised below and explained in more detail in the Pre-Consultation Business Case (PCBC).[43]

Service	Current situation	Proposed change	What would be different
Surgery	Emergency Surgery is currently provided from both Grimsby and Scunthorpe Hospitals (and Hull Royal Infirmary). Workforce challenges impact on surgical teams across the Humber.	24/7 emergency surgery and acute surgical admissions (more than 24 hours) **would be consolidated at Grimsby Hospital.** Emergency surgery that is appropriate to be dealt with as a day case would also be provided at Scunthorpe Hospital.	Bringing emergency surgery with 24/7 teams including surgeons, theatre teams and nursing staff together at one hospital will reduce out of hours on-call and **support the future sustainability of our workforce**. Modelling suggests this could impact **c.6.7 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 is expected to reduce as surgical pathways and protocols change in line with the model of care.

Table 5.5 Summary of proposed change (Acute and Emergency Surgery)

5.2.2 Consultation Feedback

In addition to the general feedback on the model as a whole, there were some specific concerns raised in relation to the proposals to consolidate emergency surgery and acute surgical inpatient care at Diana Princess of Wales Hospital, Grimsby. Some staff and other stakeholders raised questions, for example,

[43] Humber and North Yorkshire Health and Care Partnership (2023), *Humber Acute Services Review - Pre-Consultation Business Case (PCBC)* Pre-Consultation Business Case (pp.151-153).

about how patients would be kept safe if they required life-or-limb emergency surgery out of hours (e.g., burst appendix/ruptured spleen) and questioned what would happen if there was no ambulance available for transfer or if there was insufficient bed or theatre capacity at Diana Princess of Wales Hospital.

Additionally, some asked questions about how the proposal would impact gynaecology patients requiring emergency surgery and how the proposed change would work given the interdependencies between gynaecology and obstetrics and shared medical staffing across these specialities. These issues and concerns have been reflected in the revised proposals set out below.

5.2.3 Refreshed activity modelling and impacts

In addition to reviewing and considering the consultation feedback, further work was undertaken to refresh the activity modelling in relation to the proposed change. Detailed case studies were also developed for each of the surgical specialties, to provide more detailed understanding of how changes could be implemented. In preparing these speciality-specific case studies, the detailed consultation feedback was considered alongside theatre capacity modelling, bed modelling and workforce modelling to find the optimum approach for each service, reflecting proposed alternatives and other feedback gathered during consultation.

5.2.3.1 Activity modelling

Refreshing the activity modelling to the revised baseline (2022/23) shows there has been a marginal decrease in demand for inpatient surgical services – driven largely by improvements in acute assessment processes and conversion of some procedures from inpatient to day case. Through the case study engagement, it was clear that there is further scope to convert more cases from inpatient to day case and provide more hot clinics – where the patient goes home and is listed the following day for an urgent procedure – for people requiring emergency surgery. Prudent estimates of shift from inpatient to elective have been assumed, however, there is potential for further improvements once the new model of care is implemented and embedded.

	2019-20 (baseline)		2022-23 (baseline)	
	DPoW	SGH	DPoW	SGH
Trauma Inpatients (>24 hrs)	460	611	433	639
Acute Surgery Inpatients (>24 hrs)	2,570	2,444	2,030	1,801

Table 5.6 Trauma and surgery activity data

5.2.3.2 Theatre capacity

Across Diana Princess of Wales Hospital, Grimsby (DPoW) and Scunthorpe General hospital (SGH), there is a total of 13 theatres plus two dedicated obstetric theatres. There are eight surgical specialties providing both acute (emergency) and elective surgery across either 1, 2 or 3 Northern Lincolnshire and Goole hospital sites. Each specialty has fixed access (job planned) to theatre suites and access to a general CEPOD (emergency) theatre list to undertake any emergency or urgent treatment.

	Theatres			Total Sessions		
	Elective	Acute	Maternity	Elective	Acute	Maternity
DPoW	6.25	1.75	1	62.5	17.5	14

SGH	3.25	1.75	1	32.5	17.5	14
TOTAL	**9.5**	**3.5**	**2**	**95**	**35**	**28**

Table 5.7 Theatre capacity – Scunthorpe and Grimsby

Currently each of the acute sites (Scunthorpe and Grimsby) uses one theatre (14 sessions per week) to cover acute surgical activity (CEPOD) and 0.75 theatres (9 sessions per week) to cover trauma activity. To implement the proposed changes to acute surgery across all specialties – without any changes to elective (planned) care pathways – would require additional theatre space to be provided on the Diana Princess of Wales Hospital, Grimsby (DPoW) site and leave theatres on the Scunthorpe General Hospital (SGH) site underutilised.

The proposed way forward – and amended proposal for surgical specialties – has been developed to ensure the available theatre capacity across both sites is maximised and to reduce the need for additional investment in buildings and equipment.

Furthermore, the proposed way forward will deliver a more efficient operating model across the surgical specialties, which will enable the Group to make further improvements to theatre productivity. Putting in place consolidated rotas and separating planned and unplanned care for the larger surgical specialties will enable the Group to maximise theatre utilisation to 7-days per week, increase the number of sessions per day and tackle the problem of long elective waiting list, helping more people to be seen and treated more quickly.

5.2.3.3 Bed impact

Bed modelling was undertaken on the original proposal and the amended proposal based on the feedback gathered during consultation, taking into account demand and capacity analysis and updated activity data. The number of inpatient non-elective surgical beds at Diana Princess of Wales Hospital, Grimsby (DPoW) would need to increase to accommodate the additional activity associated with the proposed changes, but the non-elective surgical beds at Scunthorpe General Hospital (SGH) would be reduced in parallel.

There is a net reduction in non-elective surgical beds associated with the model as a whole, which will be delivered through continued improvements on day case rates and reduced length of stay. There is further scope to convert more cases from inpatient to day case and provide more hot clinics for people requiring emergency surgery once the new model of care is implemented and embedded, building a platform for further gains in efficiency and productivity.

Requirements for critical care beds were also reviewed to ensure sufficient capacity would be available on both sites to support the anticipated levels of activity from both surgical specialties and complex medical specialties where changes are proposed. These requirements are detailed below (see section 5.3.7).

5.2.3.4 Capital requirements

Based upon the detailed bed modelling and updated demand and capacity analysis, the proposed changes to emergency surgery and acute surgical inpatient services (as set out below) can be without additional capital investment in theatres or wards. The changes to the proposed configuration have been designed to ensure the existing infrastructure can accommodate the anticipated level of demand for the consolidated services on each site.

There is, however, a requirement to invest in the critical care infrastructure at Diana Princess of Wales Hospital, Grimsby (DPoW) to support the model of care. These requirements are detailed below (see section 5.3.7.3).

5.2.3.5 Anaesthetic rotas and emergency surgery lists

One of the anticipated benefits of bringing all emergency surgery together at one site – Diana Princess of Wales Hospital, Grimsby (DPoW) – was the ability to completely remove the CEPOD list from Scunthorpe General Hospital (SGH) and reduce duplication in the on-call cover required to staff both lists on the two hospital sites. Undertaking detailed implementation planning, however, has demonstrated that there is limited benefit from removing the CEPOD list completely, due to the current staffing model for anaesthetic cover across both sites. Anaesthetic cover for the CEPOD emergency theatre is provided by the on-call anaesthetics team who also provide cover for critical care (ITU), resus and cardiac arrests and therefore would need to be retained to provide cover for the Emergency Department within Scunthorpe General Hospital (SGH), which is continuing to operate in the proposed model.

Whilst the proposal to bring together emergency surgery on one site has a limited benefit in relation to the anaesthetic workforce, it still has significant benefits in relation to the wider surgical workforce and will enable significant reduction in duplication of on-call rotas across both sites. Furthermore, retaining access to a CEPOD list – for limited circumstances – will enable life-or-limb surgery to be performed in Scunthorpe where necessary by moving the surgeon rather than the patient. This model responds to some of the concerns raised during public consultation and is in line with the approach in place currently for ENT services, which are consolidated at Diana Princess of Wales (DPoW), and Urology services, which are consolidated at Scunthorpe General Hospital (SGH). This approach works well for the very small number of cases where surgery is required out of hours, whilst still enabling the on-call team to look after the inpatient cohort on an ongoing basis by concentrating them in one location.

5.2.3.6 Inpatient care and length of stay

Detailed implementation planning also considered the impact of the proposed change on inpatient services and length of stay, with a view to reducing length of stay wherever possible and supporting emergency/acute patients to be treated and discharged as quickly as possible.

	Emergency (Acute)			Elective (Planned)		
	NLaG	Peer	National	NLaG	Peer	National
Orthopaedics	2.2	2.9	2.8	9.9	14.5	14.3
General Surgery	6.5	7.2	3.1	2.1	2.1	3.4
Urology	7.4	6.0	6.0	2.0	1.8	1.8
Gynaecology	4.6	3.7	4.1	1.3	1.6	1.6
ENT	4.7	4.2	5.2	1.1	1.3	1.6
Ophthalmology	7.8	8.9	6.7	1.9	2.8	1.2

Table 5.8 Length of Stay - surgical specialties

The average length of stay for emergency patients in Urology and Gynaecology are higher than peer and national averages. Longer lengths of stay are sometimes a result of lack of early access to a CEPOD list, as theatre slots are often prioritised for acute general surgical patients. The amended proposal will support a reduction in length of stay for patients in these specialties by consolidating Urology onto a different

site from Acute General Surgery and improving access to specialists in all specialties by consolidating services onto one site.

5.2.3.7 Workforce and staffing requirements

Detailed workforce modelling and rota planned was undertaken against the refreshed activity data and revised proposal for change.

In order to deliver key workforce standards and meet the anticipated levels of demand in the future, significant investment is required in both medical and nurse staffing to continue to provide safe services. The proposed changes will deliver improved productivity and better utilisation of both medical and nurse staffing against a do-nothing position. Bed reductions and reorganisation of inpatient care to a more efficient model will deliver further savings in relation to the nursing establishment over the do-nothing (forecast) position.

5.2.3.8 Summary

The proposed way forward for emergency and acute surgery, following consultation and review of other data and evidence, includes a range of changes to the original proposal. These amendments to the original proposal will maximise the benefits of bringing services together on one site and enable effective implementation of the proposed change and reflect the alternative ideas, concerns and challenges raised by stakeholders through the consultation.

> The proposed way forward will deliver improvements to the quality and safety of emergency (non-elective) surgical services across northern Lincolnshire and, importantly, set the foundations for the Group to deliver improved productivity within planned care (elective) services to reduce waiting lists and help to ensure patients are seen and treated more quickly.

The proposed way forward is set out below for each of the key surgical specialties impacted by the proposed change.

5.2.4 Trauma and Orthopaedics

Trauma and orthopaedics (T&O) provides acute trauma services on both Diana Princess of Wales (DPoW) and Scunthorpe General Hospital (SGH) sites. Elective (planned) orthopaedic activity takes place at DPoW and Goole only. The teams provide three tiers of on-call rotas across both SGH and DPoW.

The Trauma service is supported by two whole time equivalent (WTE) Trauma Coordinators on the acute sites to coordinate and manage the trauma demand through the available theatre capacity.

The current configuration of the service increases the likelihood of cancellations of elective procedures. Lack of equipment, overrun of lists and the impact of undertaking urgent cases lead to cancellation of planned procedures. The utilisation of elective theatre sessions in orthopaedics is lower than other specialties due to the acute service pressures and the inability to backfill during peak periods of leave.

The service is delivered across three hospital sites, which dilutes the skills and expertise in Trauma and Orthopaedics between upper and lower limb activity and also dilute further with the sub-specialisms of hand, food, knee, hip and shoulder specialist. Ensuring there is adequate cover for each of these sub-specialisms across trauma and elective activity is challenging across three sites and has resulted in delays for treatment and some trauma patients, particularly on the Goole and Scunthorpe sites where the consultants rotate daily between the two sites.

As a result of the pressures within the service, waiting lists for planned (elective) procedures and outpatients are significantly challenged.

	78+ weeks	52-77 weeks	40-51 weeks	18-39 weeks
Trauma and Orthopaedics (number of people waiting)	2	235	310	1297

Table 5.9 Waiting lists - Trauma and Orthopaedics

The RTT waiting times in Orthopaedics hold the most risk of all of the surgical specialties due to the volume awaiting treatment from 40+ weeks (545 patients). In addition, there is further risk associated with patients awaiting their first outpatient's appointment. The lack of clinic capacity available to see these patients affects the RTT waiting time should the patient require a surgical intervention following review, increasing the risk to delivery already held on the RTT waiting lists.

The proposal put forward for consultation would see emergency (acute) trauma surgery and inpatient trauma care consolidated to Diana Princess of Wales (DPoW). This would bring a number of benefits and support the proposed consolidation of the Trauma Unit to develop a dedicated, specialist trauma centre. Developing a dedicated trauma centre would enable the trauma coordinator role to be increased to 7-days with existing resource (no additional investment), improving the effectiveness of trauma care at weekends.

Taking on board feedback gathered through the consultation and reflecting on revised activity data and detailed implementation planning, a minor amendment is proposed to the change to further consolidate acute (emergency) trauma care to include all patients with a fractured neck of femur (broken hip), rather than just those aged under 65 years. This is to ensure all patients can benefit from access to improved specialist care irrespective of age and underlying comorbidities.

The total number of patients this change is expected to impact is around 190 per year (or 3-4 per week), as set out in the table below. These patients, who are often frail and/or have a range of comorbidities or underlying health conditions, can spend longer in hospital than other trauma patients and often wait longer for surgery due to the need to ensure their other health conditions are optimised ahead of any procedure. Outcomes for these patients can be improved if they are operated on quickly and returned home or to a Care of the Elderly medical ward to receive intensive rehabilitation and reablement to support early discharge back home.

	2019-20 (baseline)		**2022-23 (baseline)**	
	DPoW	**SGH**	**DPoW**	**SGH**
<17 years	0	1	0	1
18-65 years	25	16	31	21
>65 years	259	223	257	190
Total	**284**	**240**	**288**	**212**
Average per day	0.8	0.7	0.8	0.6

Table 5.10 Fractured Neck of Femur patients by age cohort

Under the proposed approach, ambulance diversionary pathways will be agreed in advance of implementation to ensure patients with a fractured neck of femur are routed directly to DPoW to receive care by the specialist trauma team. Ambulance services have the equipment and expertise to immobilise and transfer with appropriate pain relief. This will help to ensure they are operated on more quickly and in line with national clinical standards, which are not being met consistently at the current time due to workforce pressures within the service. Post-operatively, they will be cared for on a medical ward by

orthogeriatricians rather than a surgical ward as is currently the case. Where patients reside in the North Lincolnshire area, they will be repatriated to a medical ward in Scunthorpe General Hospital (SGH) as soon as practically possible after their surgery to receive their rehabilitation and follow-up care. This will help to ensure those patients are close to home to receive support from family and loved ones and within their own local authority area with stronger links to social care and other services to ensure a speedy discharge from hospital.

By developing a centre of excellence for acute trauma and orthopaedic (T&O) surgery and having dedicated emergency lists for T&O patients and improved pathways, patients will be seen, treated and operated on more quickly and have better outcomes. Specialist teams will be able to develop and improve their ways of working will support faster recovery. Intensive rehabilitation and therapy input will ensure patients are mobilised on day 1 post-op and discharged on day 3, not day 7 as is more commonly the case in the current model of care.

Concentrating emergency (acute) surgeries onto the DPoW site would enable elective lists to run at full capacity, supporting significant improvements to the productivity and efficiency of elective care, laying the foundations for a significantly improved RTT position.

Refreshed activity modelling demonstrates the total impact of this change (including both fractured NOFs and other T&O patients requiring emergency surgery or inpatient care) would be around 1-2 patients per day, or around 12 per week, who would be treated at DPoW rather than SGH.

	2019-20 (baseline)		2022-23 (baseline)		2028-29 (proposed)	
	DPoW	**SGH**	**DPoW**	**SGH**	**DPoW**	**SGH**
Trauma and Orthopaedics inpatient admissions (>24 hours)	460	611	433	639	954	0

Table 5.11 Trauma activity impacts

For the vast majority of patients, for example, those who attend the Emergency Department with a simple fracture, care will continue to be provided locally at both hospitals. Fracture clinics will continue to be provided locally at both hospitals, providing care for the vast majority of patients in the locality. There will continue to be middle grade medical cover from Trauma and Orthopaedics specialists within the Acute Assessment Unit in Scunthorpe General Hospital (SGH) to assess and care for as many patients as possible within the local service.

The revised proposal is therefore to consolidate acute (emergency) trauma and orthopaedic surgery (including day cases) and surgical inpatient care to Diana Princess of Wales Hospital, Grimsby (DPoW) and develop a specialist trauma centre for acute trauma care.

Rationale:

- Consolidating acute trauma surgery and inpatient care onto one site will make best use of the existing clinical workforce, improve efficiency in emergency theatres and help to reduce length of stay by ensuring access to specialist clinical input more quickly.
- The proposed approach will deliver a range of benefits including:
    - Creation of specialist trauma centre.
    - Trauma activity would not impact the elective workload which would reduce the number of cancellations across all elective activity.
    - Increase in training opportunities and workforce development.

- Increase in quality of care for patients with input from sub-specialisms readily available.
- Trauma coordination increased to 7-day service (from existing establishment), improving delivery of trauma care over a weekend.
- Reduction in medical staffing on call models.

- Consolidating acute care on one site and concentrating complex elective care on another will enable greater sub-specialisation and improve training and skills development for trauma teams and help to reduce the impact of equipment constraints on productivity and efficiency.

5.2.5 General Surgery

The General Surgery, Colorectal and Upper GI team provide both elective and acute services across both acute hospital sites – Scunthorpe General Hospital (SGH) and Diana Princess of Wales Hospital, Grimsby (DPoW). General Surgery has the largest volume of acute patients of all the surgical specialties (with the exception of Trauma) with 77% of its workload presenting to the Emergency Department. When combined with Colorectal and Upper GI, the acute (emergency) workload across the three specialties is still significant, accounting for 38.5% of all patient admissions.

Colorectal is the largest cancer specialty across Northern Lincolnshire and Goole NHS Trust (NLaG) and has seen a 19% increase in referrals from 2021/22 to 2022/23. There have been increases in urgent and routine referrals across all three specialties.

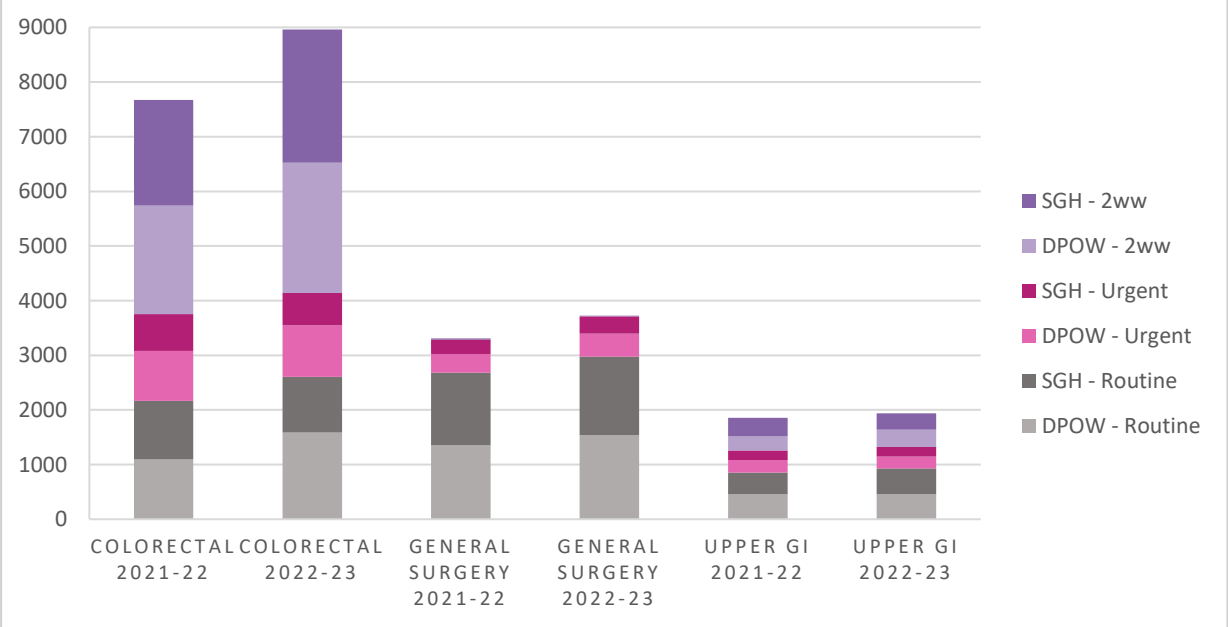


Table 5.12 Referal demand (Colorectal, General Surgery and Upper GI)

The proposal put forward for consultation would see emergency (acute) General Surgery and acute surgical inpatient care for colorectal, general surgery and upper GI specialisms consolidated to Diana Princess of Wales (DPoW). This would bring a number of benefits including reduction in waiting times, improved training and opportunities for sub-specialisation and improved patient outcomes.

To implement this proposed change to acute (emergency) pathways for General Surgery, Colorectal and Upper GI patients and maximise the use of available theatre capacity, workforce and beds, requires some elective inpatient care within these specialties to be consolidated to Scunthorpe General Hospital (SGH).

Further detailed work needs to be undertaken as changes are implemented to develop appropriate pathways to determine which patients would require a more complex procedure and would benefit from being treated at a dedicated specialist elective centre in Scunthorpe and which could continue to be treated locally in Grimsby (DPoW).

The table below shows the elective inpatient activity for all three specialties in the revised baseline year. If all elective inpatient care within these specialties was to be consolidated at Scunthorpe (SGH), this would result in around 1.4 patients per day who are currently treated at Diana Princess of Wales Hospital, Grimsby (DPoW), being treated at Scunthorpe instead. However, it is not anticipated that all elective activity would need to be transferred so the actual impact will be less and will be quantified as part of detailed implementation planning, aligned to detailed pathway reviews.

		2022-23 (baseline)	
		DPoW	**SGH**
Elective inpatient admissions (>24 hours)	Colorectal	283	268
	General Surgery	162	152
	Upper GI	70	38
	TOTAL	**515**	**458**

Table 5.13 Elective activity - Colorectal, General Surgery and Upper GI

Splitting acute (emergency) and elective (planned) General Surgery will deliver a number of other significant benefits, including a reduction in cancellation rates for elective inpatient procedures, improved efficiency and productivity of elective theatres, and improved outcomes for patients through the creation of a specialist cancer hub for Colorectal patients (the largest cancer specialty). This move would help to improve cancer waiting times and quality outcomes for patients with colorectal cancers by removing the impact of urgent cases on elective procedures and ensuring patients can be seen and treated as quickly as possible.

The revised proposal is therefore to consolidate acute (emergency) General Surgery, Colorectal and Upper GI services to Diana Princess of Wales Hospital, Grimsby (DPoW) and, to enable this change, consolidate some complex inpatient elective (planned) surgery at Scunthorpe General Hospital (SGH), creating a specialist cancer hub for Colorectal patients in Scunthorpe.

Rationale:

- Consolidating acute general surgery and inpatient care onto one site will make best use of the existing clinical workforce, improve efficiency in theatres and help to reduce length of stay by ensuring access to specialist clinical input more quickly.
- The proposed approach will deliver a range of benefits including:
    - Reduction in elective cancellations due to lack of bed capacity or theatre space.
    - Creation of specialist cancer centre for colorectal patients (in Scunthorpe) leading to improved quality of care.
    - Ability to manage the growth in demand for cancer services, which can be managed more fluidly on the elective site with diagnostic and workforce capacity unaffected by acute activity.
    - Reduction in waiting list size due to efficiencies gained by running a dedicated elective (cold) site.
    - Increase in training opportunities and workforce development.

  - Reduction in consultant out of hours cover requirements.
- Consolidating acute care on one site and concentrating complex elective care on another will enable greater sub-specialisation and improve training and skills development for surgical teams.

5.2.6 Urology

Emergency (acute) Urology services have been consolidated at Scunthorpe General Hospital (SGH) since 2018. This change was made on a temporary basis when the services became unsafe due to extreme staffing shortages. The temporary change has been reviewed at key stages, which have determined it was not possible to return to the previous model with the current available staffing, and the future configuration of the service was incorporated within the Humber Acute Services (HAS) programme proposal for change.

Urology has also seen a 9% increase in cancer referrals since 2021 and, despite the introduction of one stop cancer clinics, meeting cancer targets continues to be a challenge. Most of the activity undertaken by the specialty is elective, with acute (emergency) surgery accounting for a much smaller element of the workload. Separating out acute and elective inpatient care, whilst it delivers key benefits in respect of efficiency and productivity in general terms, for urology this would come at the cost of additional workforce required to staff clinical rotas to cover inpatients at both sites, with acute patients on one site and elective patients on another.

In response to feedback gathered through the consultation and detailed implementation planning undertaken during and following consultation, an alternative way forward is proposed for Urology. The proposed way forward is to bring Urology services together at Scunthorpe General Hospital (SGH) rather than Diana Princess of Wales Hospital (DPoW) as proposed in the Pre-Consultation Business Case (PCBC).

This approach would retain the current benefits of having the specialist workforce together in one place, providing peer support and sub-specialist input into patient care plans. Elective activity and cancer pathways for urology patients would be protected from cancellation and the impacts of winter pressures by being provided away from the majority of acute (emergency) surgery. Furthermore, it could also improve the length of stay of acute patients who would have priority on the limited CEPOD list available at SGH and not be delayed by the impact of general surgery or trauma and orthopaedics cases, which would all be consolidated at DPoW.

Because this model is an extension of the status quo, the activity modelling does not identify any impact on patients being displaced to a different site. Reviewing current activity, however, it is possible to identify that approximately 265 patients per year – or fewer than one a day – travel from outside of the immediate catchment area of Scunthorpe General Hospital (SGH) to access urology inpatient care at SGH at present and therefore the expectation is that this level of transfers would continue under the proposed model.

Local Authority area	**SGH Urology Admissions** (2022-23)
North Lincolnshire	250
East Riding of Yorkshire	26
North East Lincolnshire	202
Kingston Upon Hull	1
West Lindsey	28
East Lindsey	62

Lincoln	0
Other	17
Total	**586**

Table 5.14 Urology admissions by local authority area

Out of hours emergency activity is limited to two types of procedure for Urology patients – paediatric torsions and patients requiring an insertion or change of stent due to an obstruction. In the past 12 months, a total of six patients (3 torsion cases and 3 stent cases) have presented to either Grimsby or Scunthorpe hospitals. In these circumstances, out of hours medical staff will travel to the site the patient has presented at to undertake these procedures. This approach would continue in the proposed model.

The revised proposal is to consolidate acute (emergency) urology admissions as well as inpatient elective activity at Scunthorpe General Hospital (SGH), rather than DPoW as proposed.

Rationale:

- Consolidating acute surgical inpatients onto one site will make best use of the existing clinical workforce, improve efficiency in emergency theatres and help to reduce length of stay by ensuring access to specialist clinical input more quickly.
- Co-locating acute with inpatient elective care will also improve training and sub-specialisation.
- Consolidating the service to SGH will support quicker access to CEPOD lists (due to the movement of other surgical specialties to DPoW) and lead to reduced length of stay.
- Theatre capacity in DPoW is limited. This approach makes best use of existing theatres across both sites to maximise benefit.

5.2.7 ENT

Emergency (acute) Ear, Nose and Throat (ENT) services have been consolidated at Diana Princess of Wales Hospital, Grimsby (DPoW) since 2018. This change was made on a temporary basis when the services became unsafe due to extreme staffing shortages. The temporary change has been reviewed at key stages, which have determined it was not possible to return to the previous model with the current available staffing, and the future configuration of the service was incorporated within the Humber Acute Services (HAS) programme proposal for change.

The model proposed within the Pre-Consultation Business Case (PCBC) would represent a continuation of the status quo for ENT services with acute inpatient activity continuing to be provided from one site – Diana Princess of Wales Hospital (DPoW). Due to the relatively small size of the service and limited workforce, elective (planned) activity is also now predominantly provided from the DPoW site. The proposed way forward would see this continue. It would deliver the benefits of having the specialist workforce together in one place, providing peer support and sub-specialist input into patient care plans. In addition, a consolidated service would make best use of the existing workforce and reduce the need to rely on expensive agency cover for gaps in rotas required to cover multiple sites.

Because this model is an extension of the status quo, the activity modelling does not identify any impact on patients being displaced to a different site. Reviewing current activity, however, it is possible to identify that approximately 115 patients per year – or around two per week – would travel from outside of the immediate catchment area of Diana Princess of Wales Hospital (DPoW) to access ENT inpatient care at DPoW under this proposed model.

Like urology, out of hours emergency activity in ENT is limited. In the past 12 months, a total of eight patients have presented to either Grimsby (six patients) or Scunthorpe (two patients) hospitals requiring ENT surgery out of hours. In these circumstances, out of hours medical staff will travel to the site the patient has presented at to undertake these procedures. This approach would continue in the proposed model.

Local Authority area	**DPoW ENT Admissions** (2022-23)
North Lincolnshire	88
East Riding of Yorkshire	2
North East Lincolnshire	134
Kingston Upon Hull	0
West Lindsey	25
East Lindsey	33
Lincoln	0
Other	12
Total	**294**

Table 5.15 Urology admissions by local authority area

The proposal is therefore to progress with the proposed consolidation of acute (emergency) ENT admissions at DPoW in addition to inpatient elective activity.

Rationale:

- Consolidating acute surgical inpatients onto one site will make best use of the existing clinical workforce, improve efficiency in emergency theatres and help to reduce length of stay by ensuring access to specialist clinical input more quickly.
- Co-locating acute with inpatient elective care will also improve training and sub-specialisation.

5.2.8 Ophthalmology

A range of Ophthalmology services are provided across all three NLaG sites. The proposed model of care for Emergency Surgery that was put forward for public consultation, would impact only on the surgical elements of ophthalmology currently provided across Scunthorpe and Grimsby.

In Scunthorpe and Grimsby around 3,000 medical emergencies are seen each year in emergency eyecare clinics, with supervision from the consultant on-call. The proposal would not impact upon this element of ophthalmology care, which would continue to be provided on both sites, with the majority of patients being seen and treated within the Emergency Department or through the emergency eyecare clinics.

Surgical emergencies, however, are extremely low in volume across both sites, with around 1 patient a month presenting across the two northern Lincolnshire sites. In comparison, Hull University Teaching Hospitals (HUTH) manage approximately 30-40 emergency surgical patients per month, with a dedicated vitreo-retinal rota to manage retinal detachment demand.

Emergency Theatre activity (2022/23)						
	08:00-18:00		18:00- 21:00		21:00-8:00	
Ophthalmology theatre activity (emergency/unplanned)	DPoW	SGH	DPoW	SGH	DPoW	SGH
	1	2	0	0	0	1

Table 5.16 Ophthalmology theatre activity (2022/23)

Given the extremely low volume of surgical emergencies within Ophthalmology at both northern Lincolnshire sites, the proposal is to treat these patients at the specialist eye hospital in Hull where they can have their operation performed by the specialist team based there and be cared for within this specialist service. This will provide additional benefits to the patients of consolidation to a regional centre of excellence, whilst ensuring the vast majority of patients requiring medical input from ophthalmology can continue to be seen and treated in the Emergency Departments and local eye clinics at both Scunthorpe and Grimsby.

The proposal is to consolidate acute (emergency) Ophthalmology surgical admissions for the whole of northern Lincolnshire to the specialist eye hospital in Hull.

Rationale:

- Consolidating acute surgical inpatients onto one site will make best use of the existing clinical workforce, improve efficiency in emergency theatres and help to reduce length of stay by ensuring access to specialist clinical input more quickly.
- Consolidating the care of northern Lincolnshire patients (c.12 per year) to Hull will help to improve clinical outcomes for those patients by providing access to specialist teams and equipment.

5.2.9 Gynaecology

The Gynaecology service provides both acute and elective services at both Scunthorpe General Hospital (SGH) and Diana Princess of Wales Hospital, Grimsby (DPoW). These services are provided by clinical teams who also provide cover for Obstetric-led maternity services provided at both sites. The Gynaecology medical workforce supports both Obstetric and Gynaecology elective work. As part of the on-call rota, the team also supports any acute Gynaecology that presents at either Emergency Department (ED).

The team typically treats around one to two out of hours surgical emergencies per week (across both sites), however, most patients require minimal theatre time and are generally discharged within 24 hours.

Emergency Theatre activity (2022/23)						
	08:00-18:00		18:00- 21:00		21:00-8:00	
Gynaecology theatre activity	DPoW	SGH	DPoW	SGH	DPoW	SGH
	85	125	26	37	14	0

Table 5.17 Gynaecology theatre activity (2022/23)

Within the gynaecology service there are around 8 or 9 inpatient admissions per week at each site, which has remained broadly similar in the refreshed modelling.

	2019-20 (baseline)		2022-23 (baseline)	
	DPoW	SGH	DPoW	SGH
Gynaecology inpatient admissions (>24 hours)	462	450	465	462

Table 5.18 Gynaecology inpatient activity

The interdependencies between Obstetrics and Gynaecology services pose challenges to implementing the model as proposed through consultation. Bringing emergency Gynaecology services together at Diana Princess of Wales Hospital, Grimsby (DPoW) would require an increase in medical and nurse staffing at DPoW to support the increase in acute work being undertaken there. However, this increase in staffing at the DPoW site could not be off-set by reductions in on-call medical rotas and associated staffing at the Scunthorpe site, as in other specialties, because the same clinicians would still be required to provide cover to the Obstetric services on the Scunthorpe site.

Additional theatre capacity would also be required at DPoW to accommodate an additional 3 to 4 emergency cases per week.

The revised proposal is therefore to retain acute (emergency) gynaecology admissions on both sites (DPoW and SGH) due to the interdependencies with Obstetric services and to review the service model as part of the forthcoming system-wide maternity and neonatal review.

Rationale for proposed change (to retain on both sites):

- Interdependencies with Obstetric services (shared medical staffing) would require increased workforce to consolidate due to requirement to maintain full cover at SGH.
- Quicker access to CEPOD lists will support reduced length of stay.
- Theatre capacity in DPoW is limited. This approach makes best use of existing theatres across both sites to maximise benefit.

5.2.10 Conclusion and recommendations

In response to feedback and suggestions raised during public consultation, updated activity modelling and planning for implementation, a revised proposal for changes to Emergency Surgery has been developed, as detailed above.

The recommendation is to:

- Consolidate all emergency (acute) Trauma and Orthopaedics to DPoW
- Consolidate emergency (acute) General Surgery/Colorectal/Upper GI to DPoW and consolidate some complex planned (elective) General Surgery/Colorectal/Upper GI to SGH
- Consolidate emergency (acute) and planned (elective) Urology to SGH
- Consolidate emergency (acute) and planned (elective) ENT to DPoW
- Consolidate emergency (acute) surgical Ophthalmology to Hull
- Retain emergency (acute) Gynaecology on both sites and review the future service model aligned to the system-wide maternity and neonatal review.

5.2.10.1 Benefits

Bringing patients who require specialist trauma care or acute (emergency) surgery together in one place will enable specialist surgical teams to enhance their skills by seeing more patients and developing expertise and sub-specialist skills. Consolidation will generate efficiencies and drive productivity gains in use of theatres and patients will benefit from being treated in a specialist centre.

5.2.10.2 Impacts

The proposed changes will improve the quality of care for all patients, however, will require the transfer of some patients between the two hospital sites – Scunthorpe General Hospital (SGH) and Diana Princess of Wales Hospital, Grimsby (DPoW). The revised proposal recognises concerns raised during consultation and seeks to maximise the theatre and bed capacity and specialist workforce between the two sites – rather than consolidating all acute surgery to one site.

The total anticipated impact of the proposed way forward for emergency surgery and acute surgical inpatient services is that up to 5 patients per day (including Trauma patients also referenced in section 5.1 above) being transferred from Scunthorpe to Grimsby for their care.

5.2.10.3 Mitigations

The key concerns raised in relation to emergency surgery proposals specifically related to safe pathways for out of hours patients and managing the interdependencies between gynaecology and obstetric services. The proposed way forward responds to both of these with changes to the model (as set out above).

Processes to ensure smooth operating of the proposed model will be put in place, including repatriation pathways to ensure patients who are transferred for their surgical procedure can be discharged home or stepped down to their local hospital as quickly as possible.

Proposed mitigations to wider concerns raised in relation to transport and access are set out in section 7.2 below.

5.3 Some Medical Specialties

5.3.1 Original proposal

The proposal put forward for consultation recommended bringing together some specialist medical inpatient services – for people who need a longer stay in hospital (more than 3 days) and to be looked after by a specialist team for their heart, lung or stomach condition – at Diana Princess of Wales Hospital, Grimsby. The proposed change would mean that patients who need to be under the care of a specialist and/or need to stay in hospital for longer than 3 days would transfer from SGH to DPoW. Within the proposed model of care, both hospitals would continue to provide 24/7 Emergency Departments, Assessment and Short Stay and General Medical/Care of the Elderly inpatient wards. This would mean the majority of patients requiring medical care would remain in Scunthorpe with in-reach provided by specialists.

> Bringing together specialist medical care would enable services to meet key clinical standards by providing swifter access to specialists 7 days a week, which would improve the quality of care, reduce length of stay and support patients to go home more quickly.

The proposal for change is summarised below and explained in more detail in the Pre-Consultation Business Case (PCBC).[44]

Service	Current situation	Proposed change	What would be different
Specialty Medicine	**Speciality inpatient services** currently provided from both Grimsby and Scunthorpe Hospitals. Current services provide senior review for patients approx. 3-4 days a week only, leading to longer length of stay. Current services **do not meet clinical standards**.	**Inpatient gastroenterology, cardiology and respiratory** services for patients who need: • a higher level of speciality care, or • to stay in hospital for more than 72 hours would be provided at Diana Princess of Wales Hospital, Grimsby (DPoW). 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.	We would be able to provide **dedicated 7-day per week care from specialists** in gastroenterology, cardiology and respiratory medicine, improving the quality of patient experience, reducing length 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 **c.2.9 per day**. This could be mitigated and potentially reduced through the provision of specialist in-reach, enabling more patients to be cared for by a General Medical Physician or Geriatrician on site.

Table 5.19 Summary of proposed change (Specialty Medicine)

[44] Humber and North Yorkshire Health and Care Partnership (2023), *Humber Acute Services Review - Pre-Consultation Business Case (PCBC)* Pre-Consultation Business Case (pp.154-155).

5.3.2 Consultation Feedback

There were relatively few specific issues raised regarding the proposals to specialist medicine, however, most of the general feedback on the model as a whole applies to this element of the proposal. Some concerns were raised regarding consolidating specialist cardiology services due to concerns about the high levels of cardiovascular disease (CVD) in both populations and therefore a potential need for specialist care to be provided in both localities. It was also suggested through the consultation that specialty services e.g., emergency cardiac/respiratory care should be consolidated at 'super-specialty units' in Hull and that the proposed consolidation does not go far enough.

5.3.3 Refreshed activity modelling and impacts

In addition to reviewing and considering the consultation feedback, further work was undertaken to refresh the activity modelling in relation to the proposed change. Detailed case studies were also developed for each of the medical specialties, to provide a much more detailed understanding of how changes could be implemented. In preparing these speciality-specific case studies, the detailed consultation feedback was considered alongside bed modelling and workforce modelling to find the optimum approach for each service, reflecting proposed alternatives and other feedback gathered during consultation.

5.3.3.1 Activity modelling

Refreshing the activity modelling to the revised baseline (2022/23) shows there has been a decrease in demand for specialist medical inpatient services – driven largely by improvements in the integrated acute assessment model leading to reduced level of specialty admissions and a greater proportion of patients being treated within a same day emergency care or short stay pathway.

	2019-20 (baseline)		2022-23 (baseline)	
	DPoW	SGH	DPoW	SGH
Specialist Medical Inpatients (>72 hrs)	1,610	1,087	1,137	690

Table 5.20 Medical specialties activity data

5.3.3.2 Bed impact

Bed modelling was undertaken on the original proposal and the amended proposal based on the feedback gathered during consultation, taking into account demand and capacity analysis and updated activity data.

Whilst both sites currently have named wards for Cardiology, Respiratory and Gastroenterology, a significant proportion of beds in these wards are occupied by general medical and/or care of the elderly patients or other medical outliers. This makes it more difficult to provide the right clinical input to all those patients and reduces the efficiency of services and staffing rotas. The proposed model would consolidate those patients who need a higher level of specialist care and/or require a longer inpatient stay to right-sized specialist wards at Diana Princess of Wales Hospital, Grimsby (DPoW). This will enable the number of general medical and care of the elderly beds to be expanded on both sites to accommodate anticipated patient volumes, including the required pre- and post-surgical care for patients with fractured hips. This will support more integrated models of care for the frail patient cohort.

The model will also drive reductions to length of stay for both specialist and general medical patients, which will enable a modest net reduction in the total bed base. This will also be supported by

improvements to frailty pathways and other out of hospital interventions to drive reductions in attendances and admissions for patients living with frailty (see section 7.1.1).

Requirements for critical care beds were also reviewed to ensure sufficient capacity would be available on both sites – these requirements are detailed below (see section 5.3.7).

5.3.3.3 Capital requirements

Based upon the detailed bed modelling and updated demand and capacity analysis, the proposed change to specialist medical care can be delivered with relatively limited capital investment.

Minor changes to the ward layout on the existing medicine floor (C-floor) at Diana Princess of Wales Hospital, Grimsby (DPoW), will enable sufficient additional capacity to accommodate the anticipated level of demand for the consolidated services. Investment is required to improve the flow between ED, short stay and medicine specialties and ensure the benefits of the proposed clinical change can be fully realised. Investment will support internal reconfiguration and upgrades to the medicine wards on the C-floor at DPoW.

Outline plans for the necessary refurbishment have been drawn up and costed and the anticipated investment that would be required is c. £600,000.

Capital requirements (C-Floor)	**£**	**Capital funding**	**£**
Equipment	0	HASR	609,067
Building	609,067	BLM/CIR	0
TOTAL	**609,067**	**TOTAL**	**609,067**

Table 5.21 Capital requirements (medicine – C floor)

5.3.3.4 Summary

Feedback and suggestions raised during public consultation have been reviewed and responded to in relation to the proposals for consolidation of complex medical inpatient care.[45] Appropriate mitigations can be put in place to address the key concerns raised.

> The recommendation is to proceed with the original proposal to consolidate specialist medical care (for patients requiring higher level of specialist care and/or an inpatient stay of >72 hours) at Diana Princess of Wales Hospital, Grimsby (DPoW).

The proposed way forward is set out below for each of the medical specialties impacted by the proposed change.

5.3.4 Cardiology

Due to workforce and equipment constraints, the Cardiology service across northern Lincolnshire remains challenged and is not meeting a range of key clinical standards. As a result, patients at both Grimsby and Scunthorpe hospitals wait longer than they should to receive input from a specialist cardiologist.

[45] See details in You Said, We Did (see section 4.2)

Key clinical standards that are not currently being met within this service are detailed in the table below.

Achieving	*Partially achieving*	*Not achieving*	
Cardiology – GIRFT Programme National Specialty Report, 2021			**DPoW**	**SGH**
All hospitals receiving acute medical admissions must have a consultant cardiologist on-call 24/7 who is able to return to the hospital as required. There should be a consultant job planned specifically to review newly admitted and acutely unwell inpatients 7/7 and a consultant job planned (note this may be the same consultant) to deliver 7/7 review of other inpatients, ensuring continuity of care.				
All NHS consultant cardiologists should, by default, participate in an on-call rota for general and/or specialist cardiology.				
Clinical Standards - NICE Quality Standards - Acute Coronary syndromes in adults (2020), NICE Guideline - Acute Heart Failure (2021)			**DPoW**	**SGH**
NSTEMI: 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				
NSTEMI: Adults with NSTEMI or unstable angina who are clinically unstable have coronary angiography (with follow-on PCI if indicated) as soon as possible, but within 24 hours of becoming clinically unstable.				
Acute Heart Failure: Adults admitted to hospital with acute heart failure have input within 24 hours of admission from a dedicated specialist heart failure team				

Table 5.22 Clinical Standards Gaps – Cardiology

The inability to meet the above standards is driven, in large part, by the way in which the clinical workforce is organised and the requirement to provide cover for inpatient care across two acute sites. Currently, the service operates on a 5-day basis, meaning patients who arrive at hospital on a Friday or over the weekend wait until Monday to be seen by a specialist cardiologist, potentially delaying the start of definitive treatment and increasing their length of stay.

To achieve 7-day consultant-led care within the existing service model would require a significant uplift in medical staffing. To achieve the same benefits of 7-day consultant-led care within the proposed consolidation, would still require an uplift in medical staffing, however, at a lower level than the forecast (do nothing) position due to the staff being utilised more effectively.

	Baseline *(current)*	**Forecast (do nothing)** *(delivering all standards)*	**Proposed consolidation** *(delivering all standards)*
Medical – Consultants	9.6	13.4	10.6
Medical – M/G	3.6	5.0	7.3
TOTAL	**13.1**	**18.4**	**17.9**

Table 5.23 Summary of cardiology workforce modelling

The proposed consolidation will also drive reductions in the total nursing establishment required across the medical specialties by utilising the workforce more effectively, helping to resolve challenges associated with high levels of vacancies and reduce agency spend.

Under the proposed model, patients who need specialist cardiology input would be identified at source – either through agreed ambulance diversionary pathways or by teams within the Emergency Department – and transferred directly to the specialist ward at Diana Princess of Wales Hospital, Grimsby (DPoW). This would ensure much swifter diagnosis and definitive treatment under specialist supervision, enabling patients to go home much sooner.

The proposed change would not impact upon existing pathways for the most seriously ill cardiac patients, who would continue to be taken by ambulance services directly to Castle Hill Hospital to receive specialist treatment at the dedicated Cardiology centre. The ongoing development and implementation of the Same Day Emergency Care (SDEC) and Integrated Acute Assessment Unit (IAAU) model at both Scunthorpe (SGH) and Grimsby (DPoW) will ensure that the majority of patients who attend either Emergency Department can be seen and treated quickly with access to in-reach cardiology expertise through the IAAU. This means that patients with less complex cardiac conditions will be able to be cared for locally within a short stay or general medical ward.

The recommendation is to proceed with the original proposal to consolidate specialist cardiology admissions (for patients requiring higher level of specialist care and/or an inpatient stay of >72 hours) at Diana Princess of Wales Hospital, Grimsby (DPoW).

Rationale:

- Bringing together specialist cardiology inpatient care onto one site will make best use of the existing clinical workforce to improve access to specialist expertise, enabling patients to be seen, treated and discharged home more quickly.
- Reducing the time to be seen by a specialist will drive reductions in length of stay for cardiology patients, improving both their experience of care and their outcomes.
- Consolidating specialist care will improve training and development opportunities for staff, improving outcomes for patients.

5.3.5 Respiratory

Respiratory services face a number of key challenges to providing high quality care across Grimsby and Scunthorpe Hospitals. The way in which services are currently organised, coupled with a variety of workforce constraints, means they are not able to meet a range of key clinical standards.

In September 2017 (updated February 2022), NHS England has published their "Seven Day Services" Clinical Standards:

Achieving	*Partially achieving*	*Not achieving*	
Seven Day Services Clinical Standards			**DPoW**	**SGH**
Hospital inpatients must have timely 24-hour access, seven days a week, to key consultant-directed interventions that meet the relevant specialty guidelines, either on-site or through formally agreed networked arrangements with clear written protocols.				
All patients with high dependency needs should be seen and reviewed by a consultant TWICE DAILY (including all acutely ill patients directly transferred and others who deteriorate). Once a clear pathway of care has been established, patients should be reviewed by a consultant at least ONCE EVERY 24 HOURS, seven days a week, unless it has been determined that this would not affect the patient's care pathway.				
All those involved in the delivery of acute care must participate in the review of patient outcomes to drive care quality improvement. The duties, working hours and supervision of trainees in all healthcare professions must be consistent with the delivery of high-quality, safe patient care, seven days a week.				

Table 5.24 Respiratory - 7-days standards

The service is not fully delivering 7-day consultant-led care due to workforce pressures and the way in which current services are organised. As a result, patients often wait longer than necessary for specialist

input, leading to longer lengths of stay and potential delays to treatment. Length of stay for patients in both Grimsby and Scunthorpe was significantly longer than in similar trusts in 2019/20. The gap has narrowed, however, this is as a result of the peer benchmark increasing rather than any reductions in length of stay within local services.

Respiratory inpatient LoS (average days)	**2019/20**	**2022/23**
DPoW Non-Elective	7.3	10.5
SGH Non-Elective	10.4	9.0
Peer benchmark	**4.7**	**9.4**

Table 5.25 Respiratory Length of Stay

Moving to a full 7-day service will support reductions in length of stay, ensuring patients are seen and treated more quickly and able to return home sooner. This will also be supported by further development of Virtual Wards (see section 7.1.1.4), enabling earlier discharge with additional monitoring and support.

Achieving	*Partially achieving*	*Not achieving*	
British Thoracic Society / Intensive Care Society (2021) Respiratory Support Units (RSU)			**DPoW**	**SGH**
Complex respiratory care should be co-located and delivered in an RSU environment				
There should be 24/7 cover available from the same pool of consultants who deliver daytime work				
A senior decision maker should be available to assess patients within 30 minutes of admission and deterioration				

Table 5.26 Royal College Clinical Standards - Respiratory

Consolidating specialist respiratory patients onto one ward at Diana Princess of Wales Hospital, Grimsby (DPoW) will enable the development of a co-located Respiratory Support Unit (RSU). A Respiratory Support Unit (RSU) is an area of enhanced care that enables a higher level of monitoring and respiratory intervention than would be expected for a routine ward environment. Patients suitable for management in an RSU are those individuals who need more monitoring and/or intervention than can typically be provided in a ward, but do not currently require critical care. While RSUs have emerged due to the need to provide high quality acute non-invasive ventilation (NIV), there is a wider patient group likely to benefit.

The development of co-located RSU will support patients who currently are cared for within a Critical Care bed, due to the lack of appropriate alternatives. Level 2 and 3 critical care beds are very expensive to run due to the high staffing requirements, enabling some patients to be stepped down to RSU will free up capacity within Critical Care in DPoW for the anticipated increase in demand associated with the proposed change. This will avoid the need for additional investment in expensive critical care beds.

There are significant vacancy challenges within the medical workforce in Respiratory services. As a result, the service is heavily reliant on locums, accounting for 2.3% of the total NLaG locum spend in 2022/23. Focusing resource on a specialist site will help to attract future workforce and improve the training support for the junior doctors.

To achieve 7-day consultant-led care within the existing service model would require a significant uplift in medical staffing. To achieve the same benefits of 7-day consultant-led care within the proposed consolidation, would still require an uplift in medical staffing, however, at a lower level than the forecast (do nothing) position due to the staff being utilised more effectively.

	Baseline *(current)*	**Forecast (do nothing)** *(delivering all standards)*	**Proposed consolidation** *(delivering all standards)*
Medical – Consultants	9.9	13.9	12.0
Medical – M/G	3.3	4.7	5.3
TOTAL	**13.3**	**18.6**	**17.3**

Table 5.27 Summary of cardiology workforce modelling

The proposed consolidation will also drive reductions in the total nursing establishment required across the medical specialties by utilising the workforce more effectively, helping to resolve challenges associated with high levels of vacancies and reduce agency spend.

The proposed consolidation will be supported by the development of ambulance diversionary pathways, where necessary, to help reduce the number of secondary transfers by getting patients to the right place first time. The creation of a dedicated respiratory ward with co-located RSU and avoiding accommodating medical outliers on the ward, will improve efficiency and effectiveness of the service and improve training and development opportunities for junior doctors and nurse specialists.

The ongoing development and implementation of the Same Day Emergency Care (SDEC) and Integrated Acute Assessment Unit (IAAU) model at both Scunthorpe (SGH) and Grimsby (DPoW) will ensure that the majority of patients who attend either Emergency Department can be seen and treated quickly with access to in-reach respiratory expertise through the IAAU and Short Stay. This means that patients with less complex respiratory conditions will be able to be cared for locally within a short stay or general medical ward.

Critical Care (levels 2 or 3) capacity will be retained on the Scunthorpe site, which will provide care for those respiratory patients who are not stable enough to transfer and/or require a higher level of care within a Critical Care environment.

The recommendation is to proceed with the original proposal to consolidate specialist respiratory admissions (for patients requiring higher level of specialist care and/or an inpatient stay of >72 hours) at Diana Princess of Wales Hospital, Grimsby (DPoW).

Rationale:

- Bringing together specialist respiratory inpatient care onto one site will make best use of the existing clinical workforce to improve access to specialist expertise, enabling patients to be seen, treated and discharged home more quickly.
- Reducing the time to be seen by a specialist will drive reductions in length of stay for respiratory patients, improving both their experience of care and their outcomes.
- Consolidating specialist care will improve training and development opportunities for staff, improving outcomes for patients.

5.3.6 Gastroenterology

The Gastroenterology service has historically operated as two separate services on the Scunthorpe and Grimsby sites with limited collaboration between the teams. The service continues to face a number of challenges driven by workforce constraints.

Gastroenterology patients experience longer lengths of stay (LoS), when compared with peer averages. For example, the average length of stay at Diana Princess of Wales Hospital, Grimsby (DPoW) for a Gastro patient is 12.8 days, compared with a peer benchmark of 6.3 days.

Gastroenterology inpatient LoS (average days)	2019/20	2022/23
DPoW Non-Elective	15.4	12.8
SGH Non-Elective	9.4	4.9*
Peer benchmark	**6.1**	**6.3**

Table 5.28 Gastroenterology Length of Stay** **change in activity recording

This longer length of stay is driven by lack of availability of senior clinicians and the physical location of patients, who are often spread across different wards leading to inefficiencies and communication challenges.

Implementing the proposed change to bring all Gastroenterology patients together at DPoW would enable the development of a specialist Gastroenterology service in one location, bringing together skills and expertise and improving the training and skills development opportunities for staff working within the service. The proposed consolidation will enable patients to be admitted to the right place, first time with quicker access to the right specialty care.

The proposal is to co-locate Gastroenterology patients on the Surgery floor, given the alignment and interdependencies with Upper GI and General Surgery. Co-locating these specialties will enable shared care for these patients without need to be transferred to or from other wards and support the longer-term development of an integrated digestive diseases specialist ward.

To achieve 7-day consultant-led care within the existing service model would require a significant uplift in medical staffing. To achieve the same benefits of 7-day consultant-led care within the proposed consolidation, would still require an uplift in medical staffing, however, at a lower level than the forecast (do nothing) position due to the staff being utilised more effectively.

	Baseline *(current)*	**Forecast (do nothing)** *(delivering all standards)*	**Proposed consolidation** *(delivering all standards)*
Medical – Consultants	7.5	10.5	9.7
Medical – M/G	4.1	5.7	5.0
TOTAL	**11.6**	**16.3**	**14.7**

Table 5.29 Summary of gastroenterology workforce modelling

The ongoing development and implementation of the Same Day Emergency Care (SDEC) and Integrated Acute Assessment Unit (IAAU) model at both Scunthorpe (SGH) and Grimsby (DPoW) will ensure that the majority of patients who attend either Emergency Department can be seen and treated quickly with access to in-reach gastroenterology expertise through the IAAU and Short Stay. This means that patients with less complex conditions will be able to be cared for locally within a short stay or general medical ward.

The recommendation is to proceed with the original proposal to consolidate specialist gastroenterology admissions (for patients requiring higher level of specialist care and/or an inpatient stay of >72 hours) at Diana Princess of Wales Hospital, Grimsby (DPoW).

Rationale:

- Bringing together specialist gastroenterology inpatient care onto one site will make best use of the existing clinical workforce to improve access to specialist expertise, enabling patients to be seen, treated and discharged home more quickly.
- Reducing the time to be seen by a specialist will drive reductions in length of stay for respiratory patients, improving both their experience of care and their outcomes.
- Consolidating specialist care will improve training and development opportunities for staff.
- Co-locating the Gastroenterology service with surgical specialties will enable more joined-up care for patients with digestive diseases.

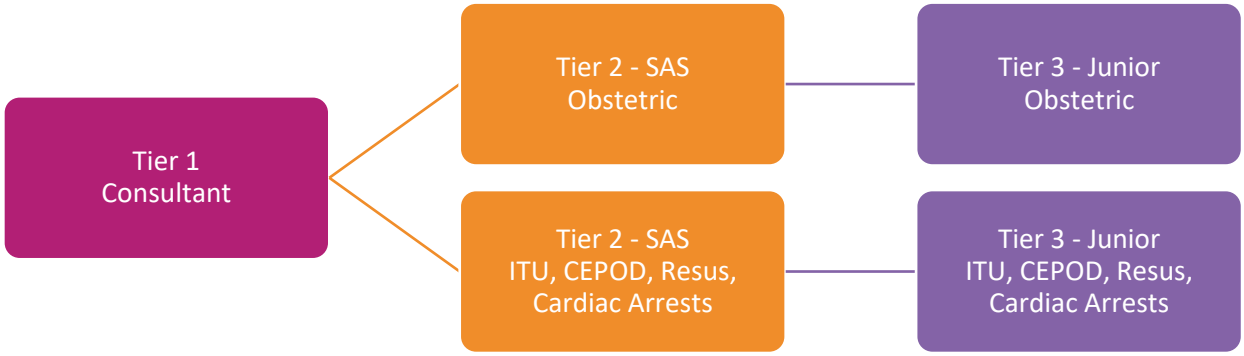
5.3.7 Critical Care and Anaesthetics

Critical Care and Anaesthetic requirements at both Diana Princess of Wales, Grimsby (DPoW) and Scunthorpe General Hospital (SGH) were reviewed against both the original and revised proposals. Anaesthetic cover and sufficient critical care capacity are vital to ensure both the medical and surgical services impacted by the proposed changes can operate safely and effectively.

5.3.7.1 Workforce and on-call cover

As detailed in section 5.2.3.5, current ways of working provide anaesthetic on-call cover to a range of services including Critical Care (ITU), emergency surgery (CEPOD), and attend Resus and Cardiac Arrest calls throughout the hospital.

Across both acute hospital sites (DPoW and SGH) there are 3 tiers of on-call anaesthetic staff in place as outlined in the diagram below:



Anaesthetic cover both in hours and out of hours will continue to be required on both sites to support the proposed model of care.

5.3.7.2 Bed modelling

Bed modelling for Critical Care requirements was undertaken on the proposed way forward to ensure sufficient Critical Care capacity within the DPoW site, given the higher level of acuity of some of the patients transferring for more specialist care. Audits of current activity demonstrated that some patients are currently being cared for in a critical care environment when they could be cared for in a lower intensity setting, which would enable some critical care capacity to be released.

The proposed changes to respiratory services will see the addition of four Respiratory Support Unit (RSU) specialist beds, co-located on the respiratory ward. This will enable patients who are currently cared for within HDU or ITU to be stepped down into an RSU bed, freeing up further capacity within Critical Care.

A modest increase over time (from 13 to 14 beds) would still be required to support the increased demand on the DPoW site.

5.3.7.3 Capital requirements

Critical Care at DPoW is currently running from a temporary location, with care split across two different areas (High Dependency Unit and Critical Care Unit). The service is not able to operate to full capacity due to the state of repair of the temporary building – one bed completely out of use following damage to the roof. The proposed way forward would see investment in a new, purpose-built critical care unit, which would have sufficient capacity to support an increase in acutely ill patients at the Diana Princess of Wales site. The investment would deliver a range of wider benefits through the opportunity to create a co-located critical care service which will be fit for purpose and meet the required standards. The anticipated cost of building the new Critical Care Unit is £8.6 million (excluding BLM/CIR).

Outline plans for delivering the necessary improvements to critical care infrastructure at the Diana Princess of Wales Hospital, Grimsby (DPoW) have been drawn up and costed and the anticipated investment that would be required is c.£8.6million (excluding BLM/CIR).

Capital requirements (Critical Care)	**£**	**Capital funding**	**£**
Equipment	339,840	**HASR**	**8,634,743**
Building	9,260,225	BLM/CIR	965,322
TOTAL	**9,600,065**	TOTAL	9,600,065

Table 5.30 Capital requirements (critical care)

5.3.8 Conclusion and recommendations

Having undertaken a review of the feedback and suggestions raised during public consultation, updated activity modelling and planning for implementation.

> The recommendation is to proceed with the proposed change to consolidate specialist medical inpatient care (for patients requiring higher level of specialist care and/or an inpatient stay of >72 hours) at Diana Princess of Wales Hospital, Grimsby (DPoW).

5.3.8.1 Benefits

Bringing patients who require specialist medical inpatient care together in one place will enable specialist teams to enhance their skills by seeing more complex patients and developing enhanced expertise. The ability to implement 7-day consultant-led care across the medical specialist services will improve the quality of care patients receive and reduce their length of stay in hospital by getting them to the right specialist care sooner. The proposed workforce model will support recruitment and retention through less onerous on-call rotas and present a more attractive offer for current and future clinical staff.

5.3.8.2 Impacts

The proposed changes will improve the quality of care for all patients, however, will require the transfer of around 2 patients per day between the two hospital sites – Scunthorpe General Hospital (SGH) and Diana Princess of Wales Hospital, Grimsby (DPoW).

5.3.8.3 Mitigations

Ambulance diversionary pathways will be put in place to reduce the need for secondary transfers wherever possible, getting patients to the right place first time. Transfer protocols between sites will also be agreed prior to implementation to ensure patients go directly to the right specialist ward, ensuring no impact on DPoW's Emergency Department.

Proposed mitigations to wider concerns raised in relation to transport and access are set out in section 7.2 below.

5.4 Paediatrics

5.4.1 Original proposal

The proposal put forward for consultation recommended bringing together paediatric overnight (inpatient) care – for children and young people who need to stay in hospital for more than 24 hours – at Diana Princess of Wales Hospital, Grimsby. Within the proposed model of care, a Paediatric (children's) Assessment Unit would continue to operate at both hospitals and care for children with acute care needs for up to 24 hours.

The proposal for change is summarised below and explained in more detail in the Pre-Consultation Business Case (PCBC).[46]

Service	Current situation	Proposed change	What would be different
Paediatrics	Paediatric inpatient services currently provided at both Grimsby and Scunthorpe Hospitals.	**Inpatient services for children and young people** who need to stay in hospital **more than 24 hours** would be provided at one hospital. Paediatric Assessment Units would continue to be provided at both DPoW and Scunthorpe, providing 24/7 assessment and care for up to 24 hours. Children who require admission post-24 hours would be transferred 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. The modelling estimates that this may impact **c.2.6 patients per day.** This could be mitigated and potentially reduced through the implementation of the Hospital at Home model of care for paediatric cases which has been seen to reduce the need for admission and support earlier discharge, reducing length of stay.

Table 5.31 Summary of proposed change (paediatrics)

5.4.2 Consultation Feedback

In addition to general feedback on the proposal as a whole, many consultees highlighted concerns and/or questions regarding the proposed changes to paediatric inpatient services. In particular, concerns were raised by families and carers of children with special educational needs and disabilities (SEND) and professionals working in education, children's social care and mental health about how the proposed model of care would work in practice. These stakeholders asked questions about how continuity of care could be provided for children and young people with multiple or complex needs if they were transferred to a hospital site outside of their usual locality, highlighting the challenges associated with out of area provision for social services, mental health providers and other organisations based in North Lincolnshire.

The children and young people who engaged both during and before the consultation, gave clear feedback that their preference, wherever possible, is to be at home and/or in a familiar environment.

[46] Humber and North Yorkshire Health and Care Partnership (2023), *Humber Acute Services Review - Pre-Consultation Business Case (PCBC)* Pre-Consultation Business Case (pp.155-156).

Hospital environments were said to be particularly stressful and unhelpful for neurodiverse children and young people and best avoided wherever possible.

Some of the challenges highlighted – for example, those related to travel and access for families and loved ones – were not unique, however, were said to have a higher impact when looking at paediatric care specifically. In particular, the impact on parents and siblings if a child has an inpatient admission at a hospital that is not easy for them to get to. Throughout the consultation, feedback was gathered from families who have significant experience of hospital-based, inpatient care in Scunthorpe, Sheffield and elsewhere, highlighting the importance of familiarity and easy access so they can remain with their child whilst in hospital as much as possible whilst also managing responsibilities at home such as work and caring for other children. Additionally, specific concerns were raised by clinical stakeholders regarding the feasibility of transferring critically ill children and the mitigations that would be required to do this safely with appropriately trained and equipped specialist staff.

5.4.3 Refreshed activity modelling and impacts

In addition to reviewing and considering the consultation feedback about the proposed changes to paediatric services, further work was undertaken to refresh the activity modelling, workforce modelling and capital requirements to implement the proposed change.

5.4.3.1 Activity modelling

Refreshing the activity modelling to the revised baseline (2022/23) shows there has been an increase in demand for paediatric services across both sites. This increase in demand is evident across Emergency Department attendances, Paediatric Assessment Unit (PAU) attendances and inpatient admissions.

	2019-20 (baseline)		2022-23 (baseline)	
	DPoW	SGH	DPoW	SGH
Emergency Department (0-16yr attendances)	13,693	12,989	15,802	15,893
Paediatric Assessment Unit	2,685	2,341	3,555	2,730
Ward attenders	*not recorded*	*not recorded*	1,296	626
Inpatient admissions (>24 hrs)	951	898	1,010	904

Table 5.32 Paediatric activity data

Whilst demand for services has increased, rates of admissions and of conversion from Paediatric Assessment Unit (PAU) into inpatient admissions have fallen slightly since 2019/20. Further analysis of activity shows that around 78% of children attending a PAU are discharged within 8 hours. Levels of acuity of children presenting to the Emergency Department are increasing and demand for paediatric services has continued to rise following the COVID-19 pandemic.

5.4.3.2 Bed impact

Based on anticipated future demand, additional capacity will be required across both Paediatric Assessment Units. To implement the proposed change would require an increase in ward capacity at Diana Princess of Wales Hospital, Grimsby (DPoW) from 12 to 24 beds. This would require additional capital investment and additional staffing (detailed below). Furthermore, two High Observation (HOBS)

beds would need to be retained at Scunthorpe within the PAU to enable children to be stabilised prior to safe transfer to the inpatient ward in DPoW.

	Current		**Proposed model** *(consolidation to DPoW)*	
	DPoW	SGH	DPoW	SGH
Paediatric Assessment Unit (beds/chairs)	8	8	14	11
Inpatient beds	12 (10 general + 2 HoBs)	12 (10 general + 2 HoBs)	24 (20 general + 4 HoBs)	2 HoBs

Table 5.33 Bed modelling paediatrics

Included within the inpatient bed modelling is a 2.9-day average length of stay (LoS) and an 85% occupancy (currently 65%) for inpatient admissions, noting both sites are currently achieving a better LoS ratio in comparison to both peer and national benchmarks.

Inpatient (>24 hours) average Length of Stay (LoS)	**2019/20**	**2021/22**	**2022/23**
Diana Princess of Wales (non-elective)	2.9	3.1	3.2
Scunthorpe General Hospital (non-elective)	2.9	2.8	3.4
HAS Model (assumption)	**2.9**	**2.9**	**2.9**

Table 5.34 Average Length of Stay (paediatrics)

5.4.3.3 Capital requirements

In order to accommodate the additional activity within the inpatient ward at Diana Princess of Wales Hospital, Grimsby (DPoW), an expansion to the existing Rainforest ward would be required. Outline plans for the necessary expansion have been drawn up and costed and the anticipated investment that would be required to enable the original proposal to progress is c. £2.9 million (excluding BLM/CIR).

Capital requirements (Paediatrics)	**£**	**Capital funding**	**£**
Equipment	0	HASR	2,940,668
Building	3,624,697	BLM/CIR	684,029
TOTAL	**3,624,697**	**TOTAL**	**3,624,697**

Table 5.35 Capital requirements (paediatrics)

5.4.3.4 Transfers

A further consideration in looking to implement the proposed changes to paediatrics is the requirement for the safe transfer of paediatric patients. This issue was raised by stakeholders during the consultation and in the clinical workshops held with paediatric teams.

Since launching the public consultation on the proposed new model of care, new paediatric intensive care intra-hospital transfer standards have begun to be developed, which set out the additional workforce that would be required to facilitate such transfers between sites. Whilst these standards are not yet applicable to current services, there would be a requirement in any future change to meet them.

	Description	Workforce requirements
Level 0	Ward level transfer	YAS/EMAS + parents/guardians +/- nurse only
Level 1	Basic critical care (HDU)	Paediatric team: Doctor/advanced nurse practitioner + nurse
Level 2	Intermediate critical care	Anaesthetic team: Doctor + nurse/ODP
Level 3	Advanced critical care	Hybrid Paediatric + anaesthetic team (Embrace)

Table 5.36 Intra-Hospital Transfer Standards

Level 3 critical care transfers are undertaken by the regional service Embrace, which will continue to provide this specialist care for the most critically ill patients who require transfer to a tertiary centre. Lower-level transfers, however, would require additional staffing to be made available by the Trust to support the safe transfer of Level 1 and 2 children.

Based on the refreshed activity modelling, it is anticipated that approximately 921 children per annum would need to be transferred from Scunthorpe to Grimsby for inpatient care under the proposed model. Analysis of current activity and levels of acuity suggests that approximately 220 of those children would require high observation or high dependency care and a higher level of supported transfer team. Some of those children would require stabilisation prior to transfer, therefore it would also be necessary to retain high observation skill and capacity within the Paediatric Assessment Unit in SGH.

The remaining level 0 transfers could be undertaken by existing ambulance or inter-hospital transfer providers but would still require paediatric nursing support for the transfer. Workforce modelling shows the requirement to be 5.1 WTE additional staff – made up of 2.80 WTE Band 6 registered nurses and 2.21 WTE middle-grade doctors. Input would also be required from anaesthetics/ODPs for level 2 transfers.

5.4.3.5 Workforce and staffing requirements

Revised workforce modelling was undertaken to assess the impact of implementing the proposed change on medical and nurse staffing levels in paediatrics. Within the current staffing models, paediatricians continue to provide some level of cross-cover for neonatal units, general paediatrics and the Paediatric Assessment Unit at Scunthorpe General Hospital (SGH) and Diana Princess of Wales Hospital, Grimsby (DPoW). To reach full compliance with the updated national standards produced by the British Association of Perinatal Medicine (BAPM) would require significant investment in the workforce across both sites (as detailed in the table below).

Implementing the proposed change to inpatient paediatric care while continuing to provide Level 2 neonatal care and a 24/7 Paediatric Assessment Unit on the Scunthorpe site would require an even larger uplift in workforce due to a number of factors, including:

- requirement to retain some capacity for stabilisation of critically ill children within SGH.
- requirement to provide 24/7 cover for the Paediatric Assessment Unit (PAU).
- requirement to provide cover to the Level 2 neonatal unit.
- requirement to meet required medical and nurse staffing ratios for safe care on the Grimsby ward given the increase in capacity from a 12 bedded ward to a 24 bedded ward.
- requirement to staff the transport team to support level 0, 1 and 2 transfers.

A summary of the workforce modelling outputs is set out below. Additional investment will be required to deliver the revised BAPM workforce standards in both the ‘do nothing’ scenario and the proposed consolidation. However, given the additional requirements to support the transport team and continue

to provide cover to the 24/7 Paediatric Assessment Unit and Level 2 Neonatal Unit on the Scunthorpe site, a further investment would be required of both nursing and medical staff (16.8 WTE) to deliver the proposed consolidated model in isolation from any changes to neonatal provision.

	Baseline *(current)*	**Forecast (do nothing)** *(delivering all standards)*	**Proposed consolidation** *(delivering all standards)*
Medical	70.4	88.0	95.0
Nursing	62.6	85.7	90.4
Transport Team	0	0	5.10
TOTAL	**133.0**	**173.7**	**190.5**

Table 5.37 Summary of paediatric workforce modelling

5.4.4 Hospital at Home

Alongside the proposed consolidation of inpatient paediatric care at Diana Princess of Wales Hospital (DPoW), the Hospital at Home model described in the Pre-Consultation Business Case (PCBC) has continued to be developed, with the service starting to be rolled out in the North Lincolnshire locality.[47]

'Hospital at Home' harnesses 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.

5.4.5 Conclusion and recommendations

The proposed way forward has been arrived at following conscientious consideration of consultation feedback alongside a thorough review of the refreshed activity data, bed modelling, financial analysis, workforce modelling and consideration of changes to clinical guidance for safe paediatric transfers.

The recommendation is to retain inpatient beds on both sites but seek to reduce reliance on inpatient care over time by developing a community-first approach to paediatric provision, enabling more children and young people to be treated and recover at home where they feel safe.

This will be achieved through:

- renewed focus on the rollout of Hospital at Home service
- increased use of remote monitoring
- development of paediatric SDEC model
- reductions in length of stay and admissions
- working with partners to review the provision of paediatric critical care to develop a safe and sustainable model for the region.

[47] Further detail is set out in section 7.1.2.1

Rationale

- There are limited workforce benefits to implementing the proposal in isolation due to the interdependencies between paediatric and neonatal services and staffing models across both sites.
- Implementing the original proposal to inpatient paediatric care while continuing to provide Level 2 neonatal care and a 24/7 Paediatric Assessment Unit on the Scunthorpe site would require an uplift in medical and nursing workforce, resulting in an additional cost pressure to the system.
- Given current and predicted future levels of demand, implementing the proposed change would require an expansion of the ward at DPoW, costing approximately £2.9 million.
- There are opportunities to improve the front-end of the pathway so that more children and young people can be seen, treated and discharged from the Emergency Department and/or Paediatric Assessment Unit (PAU).
- Further work is required to review pathways for critically ill children and/or those with long-term complex needs (in particular those on long-term ventilation) to develop long-term sustainable solution.

The proposed way forward, therefore, does not require the additional capital investment (c.£2.9 million) for expansion of paediatric inpatient beds at Diana Princess of Wales Hospital, Grimsby (DPoW). The revised proposal seeks to reduce the impact on children by reducing the need for hospital stays and helping to keep children at home wherever possible.

5.5 Summary

5.5.1 Original proposal

The Public Consultation sought views on the ICB's proposal to change the way some more complex medical, urgent and emergency care and paediatric (children's) services are delivered at hospitals in Scunthorpe and Grimsby (Scunthorpe General Hospital and Diana Princess of Wales Hospital, Grimsby).

The aim of the proposed change was to improve services for those with the most urgent and complex needs, keeping them safe and of high quality in the long term.

The proposed services would be brought together at one hospital – Diana Princess of Wales Hospital, Grimsby:

- **Trauma Unit** – for people with injuries requiring specialist care (typically brought by ambulance) and who might need an operation or observation by a trauma team.
- **Emergency surgery (overnight)** – for people who need an operation in the middle of the night or who need to stay in hospital overnight and be looked after by teams with surgical expertise.
- **Some medical specialities (inpatient)** – for people who need a longer stay in hospital (more than 3 days) and to be looked after by a specialist team for their heart, lung or stomach condition.
- **Paediatric overnight (inpatient) care** – for children and young people who need to stay in hospital for more than 24 hours.

5.5.2 Revised proposal

Fully considering the views and evidence provided during the public consultation alongside other material information – such as changes to policy, regulations or clinical standards and updated activity and workforce modelling – a revised proposal is recommended, as set out in the table below.

Service area	Original Proposal	Revised proposal
Trauma Unit	Consolidate to DPoW	Consolidate to DPoW
Emergency surgery	Consolidate to DPoW	Consolidate to one site (mixed approach)
– *Trauma and Orthopaedics*		– Consolidate to DPoW
– *Acute General Surgery*		– Consolidate to DPoW
– *Urology*		– Consolidate to SGH
– *ENT*		– Consolidate to DPoW
– *Ophthalmology*		– Consolidate to HRI
– *Gynaecology*		Retain on both sites – align to obstetrics review
Some medical specialities	Consolidate to DPoW	Consolidate to DPoW
– *Cardiology*		
– *Respiratory*		
– *Gastroenterology*		

Paediatric overnight (inpatient) care	Consolidate to DPoW	Retain inpatient beds on both sites but work towards a reduction in beds through implementation of community-based paediatrics model

Table 5.38 Summary of revised proposal

5.5.3 Benefits

Bringing specialist services together in one place will enable specialist teams to enhance their skills by seeing more patients and developing expertise and sub-specialist skills. The ability to implement 7-day consultant-led care across the specialist services will improve the quality of care patients receive and reduce their length of stay in hospital by getting them to the right specialist care sooner. Consolidation will generate efficiencies and drive productivity gains in use of theatres and patients will benefit from being treated in a specialist centre. The proposed model will also support recruitment and retention, presenting a more attractive offer for current and future clinical staff.

The proposed way forward will deliver a number of benefits and, crucially, creates the conditions for services to make more significant improvements in efficiency and productivity of elective care.

Key benefits include:

- Supporting the delivery of 7-day services and key clinical standards.
- Enabling more patients to be seen by a specialist with appropriate skills and expertise earlier in their pathway, reducing the length of time they need to stay in hospital and improving outcomes.
- Maximising the use of available theatre capacity by splitting elective (planned) and urgent (unplanned) activity wherever possible and splitting key specialties between the two main sites.
- Providing dedicated elective theatre time and staffing and protects elective lists from cancellation due to the impact of urgent activity and winter pressures on theatres, beds and other key resources.
- Supporting a reduction in length of stay for surgical patients by streamlining processes and improving efficiency by consolidating specialist teams and key equipment in one place.
- Supporting recruitment and retention by developing specialist centres and less onerous on-call rotas that will be more attractive to clinical staff.
- Developing centres of expertise, consolidating skills and knowledge and providing enhanced opportunities for learning and skills development.

5.5.4 Impacts

The total anticipated impact of the proposed way forward (across all specialties) is that around 7 patients per day will be transferred from Scunthorpe to Grimsby for their care. The expected levels of activity for the services proposed to change over the course of a year are set out in the table below.

	2022-23 (revised baseline)		**2028-29 (proposed model)**		**Total patients displaced**		
	DPoW	**SGH**	**DPoW**	**SGH**	**SGH to DPoW**	**DPoW to SGH**	**SGH/DPoW to HRI**
Trauma Inpatients (>24 hrs)	433	639	954	0	639	0	88

Specialist Medical Inpatients (>72hrs)	1,137	690	1,610	0	678	0	22
Acute Surgery Inpatients (>24 hrs) – excl. Urology	1,969	1,276	3,044	0	1,241	0	19
Acute Surgery Inpatients (>24 hrs) – Urology	61	525	0	560	0	*264**[48]	10
Acute Surgery Inpatients (>24 hrs) – Gynaecology	465	462	447	444	0	0	0
Paediatric Inpatient admissions (>24 hrs)	1,010	904	1,029	921	0	0	0
TOTAL	**5,075**	**4,496**	**7,084**	**1,925**	**2,558**	**264**	**139**

Table 5.39 Summary of activity impacts (all service areas)

5.5.5 Mitigations

Mitigations will be put in place to address key concerns to ensure the proposed model of care is effective and efficient.

Detailed pathway design will continue in preparation for implementation, involving key partners, in particular, ambulance service providers YAS and EMAS. This will ensure internal and external processes are in place to get the right patients to the right place for their care.

Communications support will also be provided to give reassurance to public and provide targeted and accessible information for those most likely to face barriers and/or be impacted by the change.

Staff engagement and communications will continue throughout to ensure staff are kept informed regarding timescales and impacts of the changes as they are implemented. This will include formal staff consultation, as required.

A range of transport mitigations have been developed and these are set out more fully in section 7.2.

5.5.6 Financial Impact

5.5.6.1 Workforce and staffing requirements

Detailed workforce modelling and rota planning was undertaken against the refreshed activity data and revised proposal for change to determine the required workforce to deliver the proposed model of care.

In order to deliver key workforce standards and meet the anticipated levels of demand in the future, significant investment is required in both medical and nurse staffing. Additional medical staffing is required across many of the services in scope for change to meet national standards and guidelines, in particular, with respect of providing seven-day services.

The proposed changes will deliver improved productivity and better utilisation of both medical and nurse staffing against a do-nothing position. By consolidated specialist inpatient wards onto one site, consultant on-call rotas can be consolidated reducing the size of the investment required to reach seven-

[48] *NOTE: this represents a continuation of existing pathways (not an impact of the proposed change), but has been modelled from the postcode data of existing patients who are transferred from North East Lincolnshire and East Lindsey areas to SGH for acute urology inpatient care.

day cover. Junior and middle grade doctors will continue to provide in and out of hours cover on both sites and consultant in-reach models have been designed across the different specialties.

Improvements in length of stay and reduction in admissions through improved frailty pathways and other enabling developments will result in some bed reductions. Together with the reorganisation of inpatient care to a more efficient model, this will deliver savings in the nursing establishment over the do-nothing (forecast) position.

The overall impact on the future workforce requirements is summarised in the table below.

WTE	**Baseline** *(current)*	**Forecast** *(do-nothing)*	**Proposed**	**Proposed vs Forecast**
Medical – consultants	160.3	178.1	171.6	6.5
Medical – M/G	135.7	142.3	155.7	(13.4)
Medical – Juniors	112.5	118.5	117.7	0.8
Nursing	1,467.0	1,546.2	1,487.2	59.0
TOTAL	**1,875.4**	**1,985.1**	**1,932.2**	**52.8**

Table 5.40 Summary of workforce impacts

The workforce requirements represent a moderate increase in WTE of senior medical and other advanced practitioners against the current baseline position, but a reduction against what would be required to cope with future demand if no changes were made to the model of care. The investment in senior medical staffing and advanced practitioners supports earlier access to senior decision-makers for patients, which will enable delivery of reductions in length of stay and improve flow through urgent and emergency care pathways. These increases will be offset by reductions in staffing required for inpatient beds and future savings elsewhere in the group and wider system. The proposed way forward provides a platform for future change and productivity gains and accelerates delivery of future service change, which will mitigate any increase in WTE workforce in the short term.

5.5.6.2 Revenue impact

The workforce model detailed above drives revenue savings against a do-nothing position, through improved productivity and better utilisation of both medical and nurse staffing.

Improvements in length of stay and reduction in admissions through improved frailty pathways and other enabling developments will result in bed reductions. Together with the reorganisation of inpatient care to a more efficient model, this will deliver savings in the nursing establishment over the do-nothing (forecast) position.

The main drivers for savings are:

- Increased Day Case rates – a shift from inpatient to day case surgery will lead to reductions in required number of bed days for inpatient non-elective surgical patients.
- Admission avoidance – improvements to integrated frailty pathways, better joint working with out of hospital and community providers will drive a reduction in medical inpatients through admissions avoidance (+5% over BAU - discounted for optimism bias*).
- Reduction in length of stay (medicine) – length of stay reductions across the medical specialties will drive a reduction in the required number of bed days.
- More effective model of care for high dependency patients – development of Respiratory HOBS on the Grimsby site aligned to consolidated respiratory service will enable conversation of some critical care activity to respiratory HOBs.

The additional investment required to fund the growth in senior medical and other advanced practitioners against the current baseline position, would be funded through growth funding, which is assumed at 1% in the financial model. [49]

The overall impact of on the future revenue requirements to deliver the model is set out in the table below. The proposed change represents a **net saving of £4.09 million** against a do-nothing position.

£	Baseline (£k) *(current)*	Forecast (£k) *(do-nothing)*	Proposed (£k)	Proposed vs Forecast (£k)
Medical – consultants	24,092	26,787	25,768	1,019
Medical – M/G	12,593	13,256	14,570	(1,314)
Medical – Juniors	7,966	8,129	8,086	42
Nursing	67,065	70,516	66,164	4,352
TOTAL	111,717	118,687	114,588	**4,099**

Table 5.41 Summary of revenue impacts

The proposed way forward will improve productivity and efficiency across all impacted services, supporting with delivery of reduced length of stay and helping more patients to be seen and treated more quickly. By consolidating emergency and acute surgical cases on one site, other sites within the group will be able to focus on planned (elective) surgery unaffected by surges in demand for emergency theatres. Improved day case rates and reduced length of stay will also generate potential additional capacity for undertaking more planned cases and generating additional income through the Elective Recovery Fund (ERF).[50] The proposed way forward provides a platform to accelerate delivery of future service change, which will support wider system efforts to increase productivity and reduce acute sector spend overall.

5.5.6.3 Capital requirements

The infrastructure changes required to implement the proposed changes are set out in more detail in section 7.3.2.

The total level of capital investment required to deliver the proposed change is set out in the tables below.

Capital requirements	Critical Care (£)	C-Floor (£)	Paediatrics (£) (NOT REQUIRED)
Equipment	339,840	0	0
Building	9,260,225	609,067	3,624,697
TOTAL	**9,600,065**	**609,067**	**3,624,697**
BLM/CIR	-965,322	0	-684,029
Total excluding BLM/CIR	**8,634,743**	**609,067**	**3,624,697**

Table 5.42 Capital requirements (breakdown of costs)

[49] The financial model assumes funding growth of 1% per annum (c.£3.6 million per year).
[50] NOTE: additional elective activity has not been included in the modelling and therefore potential additional ERF has not been included within the financial summary in this business case.

Capital requirements	Critical Care (£)	C-Floor (£)	Total (£)
Equipment	339,840	0	339,840
Building	9,260,225	609,067	9,869,292
TOTAL	**9,600,065**	**609,067**	**10,209,132**
BLM/CIR	-965,322	0	-965,322
Total excluding BLM/CIR	**8,634,743**	**609,067**	**9,243,810**

Table 5.43 Capital requirements (total for delivery of proposed way forward)

The total anticipated **capital investment required to deliver the proposed changes is £9.2 million (less BLM/CIR)**. The capital requirements will be funded through the Trust's internal capital programme and phased over a two-year period. Replacement of Critical Care provision at Diana Princess of Wales Hospital, Grimsby has been included within the Trust's capital plan for a number of years due to longstanding issues with the current accommodation for this service. The proposed investments do not put any other priority investments within the Trust at risk and therefore the investment is affordable within existing plans.

6. Integrated Impact Assessment

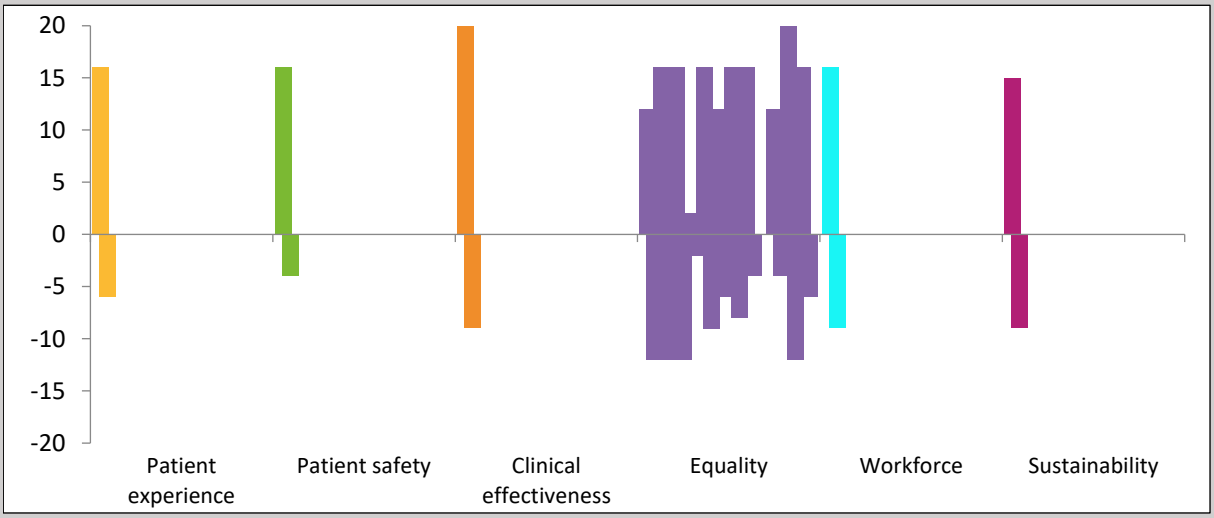
The proposed service change will deliver a number of **key benefits**:

- **Patient experience** – less time spent in hospital, quicker access to specialist care, reduced waiting times for treatment.
- **Patient safety** – improved quality of specialist care, fewer delays, better clinical outcomes.
- **Clinical effectiveness** – improved flow and effectiveness of clinical pathways and ability to meet national clinical standards to provide 7-day consultant-led care.
- **Equalities** – reduction in underlying health inequalities by improving quality of specialist care and clinical outcomes for those most at risk.
- **Workforce** – improved recruitment, retention and training opportunities for staff.
- **Sustainability** – more sustainable model of care and maximisation of existing buildings.

The proposed service change (without mitigations) could have a **negative impact on**:

- **Patient experience** – increased stress and anxiety associated with transfers and due to increased difficulty for loved ones to visit.
- **Patient safety** – possible delays to treatment if transport or specialist beds are unavailable.
- **Clinical effectiveness** – difficulty for mental health and social care providers to provide in-reach and/or continuity of care to out of area patients.
- **Equalities** – Negative impacts associated with transfer/travelling are likely to have a bigger impact on:
  - People living in more deprived communities
  - Older people
  - Disabled people and people with autism and/or learning disabilities
  - Carers
  - People for whom English is not their first language.
- **Workforce** – impact on staff required to travel cross-site, including impact of uncertainty associated with change process.
- **Sustainability** – impact on environment of increased journeys associated with patient transfers and longer/additional patient journeys.

The graph below summarises the positive and negative impacts of the proposed change.



Summary Box 6.1

6.1 Background and context

The Integrated Impact Assessment (IIA) provides a robust mechanism to consider and document how proposed changes could impact different people and different groups of people, both positively and negatively.

The IIA provides an assessment of impact against six different areas:

- Patient experience
- Patient safety
- Clinical effectiveness
- Equalities
- Workforce
- Sustainability

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.[51] To ensure decision-makers comply with their duties under the Equality Act, the Impact Assessment (IIA) provides 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 and sets out proposed mitigations to these anticipated impacts. The proposed mitigations have been fully incorporated into implementation plans for the proposed service change.[52]

The Integrated Impact Assessment also looks more broadly at people who face 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.[53] The Core 20 PLUS 5 approach[54] has been adopted throughout the planning process to ensure reducing healthcare inequalities is at the heart of proposals for the future shape of hospital services across the Humber.

The aim of each of the pathway changes described within this business case is to contribute to improve clinical outcomes through provision of better and more sustainable specialist care, faster access to senior decision-makers and specialist input and shorter lengths of stay in hospital. The proposed changes will deliver positive benefits to the Core20 population (people living in the most deprived communities) and other health inclusion groups, through more effective services and improved clinical outcomes. The provision of specialist input at an earlier stage in the patient's journey will provide better care for patients with complex conditions and multiple comorbidities and therefore have a beneficial impact on the Core20 PLUS population.

The proposals will also have a negative impact upon the Core20 PLUS population, due to the impact of additional travel on patients, families and loved ones, which are likely to disproportionately impact those from most deprived backgrounds and/or those who face existing barriers to access. Mitigation plans have been designed to target support to those most impacted to ensure patients get home as quickly as possible and loved ones can visit them wherever possible.

[51] The Equality Act (2010) Equality Act 2010
[52] More detail is included within the Integrated Impact Assessment (see section 0)
[53] Health and Care Act (2022) Health and Care Act 2022 (see sections 14Z35, 14Z42)
[54] NHS England (2023) Core20PLUS5 – an approach to reducing healthcare inequalities Core20PLUS5 (adults)

6.1.1 Outline of approach

In preparing the Pre-Consultation Business Case (PCBC), a comprehensive Integrated Impact Assessment (IIA) was undertaken of the proposal and made available to stakeholders during the consultation process.[55] The impact assessment was developed collaboratively by the programme team, clinical leads and the Citizen's Panel, supported by extensive engagement. It was also reviewed by external bodies, including NHS England as part of the Gateway assurance process.

Following consultation, the Integrated Impact Assessment was reviewed and refreshed, incorporating new evidence and insight during the consultation process. This included reviewing verbatim comments from targeted engagement and questionnaire responses from specific equalities groups to ensure any and all evidence provided was taken into account.

In addition, the refreshed activity modelling and recommended changes to the proposal were reflected in the updated IIA to provide a more accurate account of the anticipated impact of the proposed service change and enable planning to focus on effective mitigations for the proposed way forward.

The Integrated Impact Assessment (IIA) was reviewed by a cross-organisational group comprising equalities, diversity and inclusion (EDI) leads, governance and commissioning leads, clinical leads and public health experts to ensure all areas were carefully considered. The IIA review group included colleagues from North and North East Lincolnshire Councils, NHS Humber and North Yorkshire Integrated Care Board (ICB), Northern Lincolnshire and Goole NHS Foundation Trust and local Primary Care Networks in North and North East Lincolnshire. The detailed IIA is included as a supporting document.[56]

6.2 Summary of key findings

6.2.1 Positive impacts

The proposed service change will deliver a number of key benefits across all streams of the assessment. These are set out in detail in the IIA, but can be summarised against the following key themes:

Theme	Summary of positive impacts
Patient experience	Less time spent in hospital, quicker access to specialist care, reduced waiting times for treatment.
Patient safety	Improved quality of specialist care, fewer delays, better clinical outcomes.
Clinical effectiveness	Improved flow and effectiveness of clinical pathways. Ability to meet national clinical standards to provide 7-day consultant-led care.
Equalities	Support reduction in underlying health inequalities by improving quality of specialist care and clinical outcomes for those most at risk.
Workforce	Improved recruitment and retention and training opportunities for staff. Better ways of working for teams – making the best use of workforce.
Sustainability	More sustainable model of care. Maximisation of existing buildings and some improved facilities (critical care).

Table 6.1 IIA - summary of positive impacts

[55] Humber and North Yorkshire Health and Care Partnership (2023), *Humber Acute Services Review – Integrated Impact Assessment (IIA)* Integrated Impact Assessment
[56] See appendix 0 for details of Integrated Impact Assessment

6.2.2 Negative impacts

During the consultation, a number of potential negative impacts of the proposed service change were identified. These have been reviewed in light of the updated activity modelling and recommended changes to the proposal. The negative impacts are set out in detail in the IIA, but can be summarised against the following key themes:

Theme	Summary of negative impacts
Patient experience	Increased stress and anxiety associated with transfer (including the experience of travelling). Increased stress and anxiety due to increased difficulty for loved ones to visit.
Patient safety	Possible delays to treatment if transport or specialist beds are unavailable.
Clinical effectiveness	Difficulty for mental health and social care providers to provide in-reach and/or continuity of care to out of area patients.
Equalities	Negative impacts associated with transfer/travelling are likely to have a bigger impact on: • People living in more deprived communities • Older people • Disabled people and people with autism and/or learning disabilities • Carers • People for whom English is not their first language
Workforce	Impact on staff required to travel cross-site, including impact of uncertainty associated with change process.
Sustainability	Impact on environment of increased journeys associated with patient transfers and longer/additional patient journeys.

Table 6.2 IIA - summary of negative impacts

6.2.3 Equalities considerations

Over the course of the consultation concerns were identified in relation to equalities impacts, most of which centred on travel and access, focusing on the ease with which patients are able to travel to access care. Several groups were highlighted as being particularly vulnerable to these impacts, including:

- People and families on lower incomes and/or without access to private transport.
- People living in rural isolation.
- Older people.
- People with disabilities.
- People living with dementia.
- People living with mental health issues.
- Carers.
- People living in particular geographies (like Scunthorpe and surrounding areas, and north Lincolnshire)
- Single parents, especially those with no support network.
- Parents, especially single parents, with other children to care for.
- Patients with longer term conditions requiring repeat appointments.
- People (especially children and young people) with additional/complex needs like autism and their families.

In refreshing the Integrated Impact Assessment, further analysis of the activity impact data was carried out to provide a better understanding of who would be impacted by the proposed changes to service configuration to inform decision-making and help to plan appropriate mitigations.

6.2.3.1 Age

An analysis of the anticipated impacts by age of patient was undertaken to identify whether the proposed changes would have a disproportionate impact on older adults, including the frail and elderly population.

Older people make up a higher proportion of people in hospital compared with the population as a whole because ill-health and likelihood of a hospital admission increases with age. However, as shown in the diagram below, the proposed changes are more likely to impact on younger cohorts of patients rather than older ones, when compared with the hospital population as a whole. This is due to the pathways and mitigations put in place within the model of care to ensure, wherever possible, frail and/or elderly patients are looked after in a General Medical/Care of the Elderly ward in their local hospital or are supported to stay at home wherever possible through improved frailty pathways.

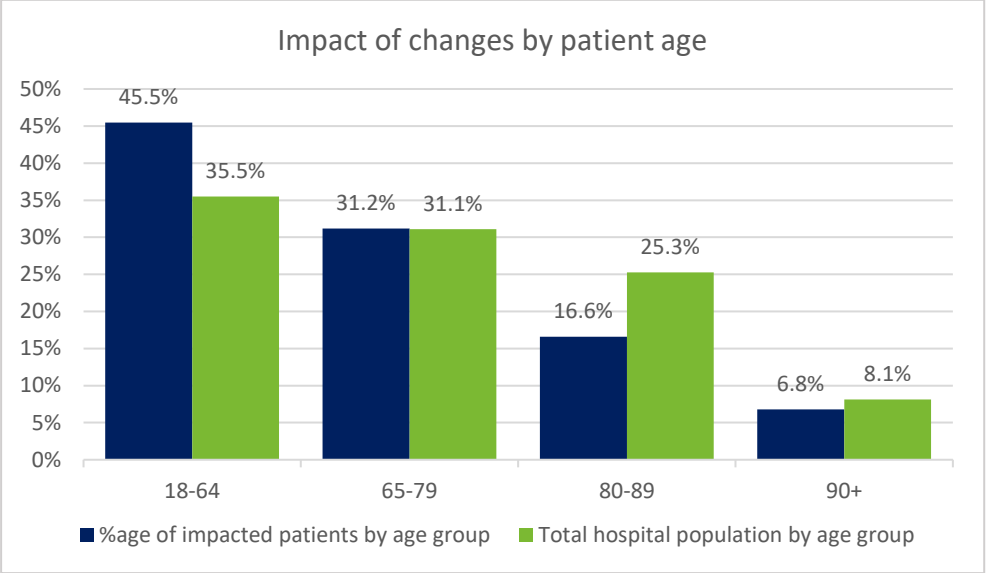


Figure 6.1 Summary of impact by patient age

6.2.3.2 Locality

Building on the work undertaken in developing the Pre-Consultation Business Case (PCBC), postcode analysis of the refreshed activity data was undertaken to assess the areas that are most likely to be impacted by the proposed change.

Whilst the overall number of patients impacted has reduced, the geographical spread is broadly similar to the original proposal.

Local Authority	%age of impacted patients (PCBC modelling)	%age of impacted patients (DMBC modelling)
North Lincolnshire	74.84%	71.04%
East Riding of Yorkshire	8.24%	9.96%
West Lindsey	7.59%	6.80%
North East Lincolnshire	5.59%	6.16%

Table 6.3 Summary of impact by locality

The majority of patients impacted by the change live in and around Scunthorpe (within the North Lincolnshire local authority area). A smaller number of patients in the East Riding of Yorkshire local authority area, mainly living in and around Goole, are also likely to be impacted by the change.

In response to concerns raised through consultation, work has been undertaken to minimise the impact on patients living in and around Goole and seeking to put in place pathways to avoid admission to Diana Princess of Wales Hospital, Grimsby wherever possible given the specific challenges for the Goole population to travel to Grimsby. Where patients are picked up by ambulance in or near Goole and require Trauma Unit level care, they will be taken to their nearest hospital site, which is likely to be either Doncaster Royal Infirmary (DRI) or Hull Royal Infirmary (HRI) and not Diana Princess of Wales Hospital, Grimsby (DPoW). In addition, the new Group operating model provides opportunities to improve and streamline pathways for Goole patients who attend Scunthorpe's Emergency Department to facilitate transfer to Hull Royal Infirmary (or Castle Hill Hospital) if more appropriate for their ongoing care, reflecting patient choice.

6.3 Summary of key mitigations

The detailed impact assessment sets out proposed mitigations against all of the identified negative impacts. Where significant negative impacts were identified that could not be mitigated, or where the mitigations that would be required significantly outweigh the benefits of making the service change, these elements of the proposal have been amended in response to the consultation feedback. These changes are summarised in section 4.3.

The mitigations that will be put in place to support the proposed changes fall into two main categories:

- Processes and operating procedures
- Travel and transport solutions

6.3.1 Processes and operating procedures

Many of the potential negative impacts and/or risks that were highlighted during consultation can be avoided or mitigated by ensuring appropriate protocols and operating procedures are in place ahead of the service changes being implemented.

These include, for example, putting in place appropriate operating procedures and pathways to ensure the efficient management of patients between and within hospital sites. The processes and procedures that will be implemented to enable the proposed change include:

- Operating procedures to ensure new models of care operate efficiently and effectively:
    - Pathways for direct admissions to specialist wards at DPoW to avoid any impact on the smooth running of the Emergency Department.
    - Ambulance transfer conditions and diversionary protocols to get patients directly to the right location for definitive care and avoid the need for secondary transfers.
    - Agreed repatriation and discharge protocols for transferred and/or out of area patients to ensure they can return home as quickly as possible and to minimise the impact on other providers.
- Staffing models to ensure effective operation of the new models of care:
    - Rotational posts and effective cross-site working to enable skills development.
    - In-reach models for specialist medicine and surgical specialties in Scunthorpe to provide safe care for patients in Assessment, Short Stay and General Medical wards.

- Improved information for people facing barriers to access:
    - Translation services and support for patients and families who need to be transferred and may require additional information and reassurance.
    - Proactive support and information to signpost families and loved ones to existing support (e.g., for transport).
- Communications support for the change
    - Provide reassurance to the local population, reaffirming that the Emergency Department in Scunthorpe remains to mitigate the risk of people avoiding seeking help or going to neighbouring providers.

These mitigations have been included within the implementation plans for the proposed changes and will be worked up in detail by operational teams in preparation for go live of the new service model.[57] Wherever necessary, protocols will be developed in collaboration with key partners to ensure buy-in from all providers for the changes to ways of working. This includes, for example, developing clear transfer conditions and protocols with ambulance providers to ensure relevant patients are taken directly to Diana Princess of Wales Hospital, Grimsby (DPoW) to avoid unnecessary secondary transfers, and working with partners in social care and mental health to ensure processes are in place for assessment and in-reach for out of area patients to ensure there are no additional discharge delays as a result of the service changes.

6.3.2 Travel and transport solutions

The other main source of negative impacts is related to transport between the two hospital sites and the wider impacts on patients, staff and visitors of additional travel distance. Many of these impacts can be mitigated by ensuring effective and efficient transport solutions are in place for the increase in inter-hospital transfers that will be required within the model. Where required, transport solutions will be in place in preparation for go live of the new service model. In addition, a cross-sector transport working group has developed proposed mitigations to support those seeking to visit loved ones in hospital further from home. The proposed Transport Action Plan is set out in more detail in section 7.2.3 and is included within the implementation plan.

6.4 Monitoring and review

It will be important to review the effectiveness of proposed mitigations following implementation of the proposal and adapt or adjust accordingly. The detailed Integrated Impact Assessment (IIA) sets out proposed metrics for monitoring the positive impact and anticipated benefits of the change as well as the measures used to monitor the effectiveness of proposed mitigations for the anticipated negative impacts.

The measures for monitoring and review include a mixture of quantitative performance metrics and qualitative evidence gathered over time (as set out in the table below).

Theme	Indicator
Performance	• Length of stay • A&E performance (4-hour wait) • RTT performance • On the day cancellation rates

[57] For further details see section 8.2

	• Number of patients with No Criteria to Reside (NCTR)
Workforce	• Staff turnover. • Agency and locum spend. • Staff surveys and exit interviews.
Patient safety	• Clinical incidents and SIs. • Clinical governance reports.
Patient Experience	• Patient feedback – including Friends and Family Test and national inpatient surveys. • PALS and Complaints.
External providers and partners	• Contract monitoring reports. • Liaison with key partners.

Table 6.4 Summary of metrics for monitoring benefits and mitigations

Named leads have been identified within the Integrated Impact Assessment (IIA) to review performance at regular intervals during and following implementation of the proposed changes to ensure the benefits are being delivered and mitigations are effective for those who require them.

The proposed change will bring a number of benefits by making services more effective and efficient, bringing together specialist skills and expertise to develop staff, improve experience and outcomes for patients and reduce the amount of time people spend in hospital.

Whilst the overall number of people impacted is small (and less than XX% of total hospital activity), the increased travel times for relatives and loved ones and the experience of being transferred in an emergency will have a negative impact on some people and communities. The travel and related impacts are likely to be felt most by those communities who already face barriers to accessing care, e.g., people from deprived communities or health inclusion groups.

A range of mitigating actions have been developed to ensure the proposal can be implemented effectively and minimise any negative impacts on local communities. Transport support has been targeted to those most in need, through the use of an established community transport provider. As changes are implemented, ongoing review will be undertaken, with a particular focus on those from the most deprived backgrounds to ensure they are getting the support they need to access care and benefit from the improvements this proposed change will deliver.

Summary Box 6.2

7. Enablers and Dependencies

Out of hospital enablers

- **Frailty** – developing and embedding a community-based approach to frailty is essential to the core delivery of improved in-hospital services and will have the greatest impact in reducing demand on urgent and emergency care services in hospitals, through:
    - Anticipatory care (includes Enhanced healthcare in Care Homes)
    - Urgent community response
    - Acute frailty model (front door)
    - Virtual ward
    - Discharge
- **Hospital at Home** – more integrated pathways for children and young people in and out of hospital will help to ensure paediatric services are sustainable in the long-term, ensuring children only go to hospital and spend time there when it is absolutely necessary.

Transport

- **Ambulance impacts** – the impact on local ambulance providers of the proposed service change is minimal:
    - c.**3 patients per week** are expected to be diverted to a different Trauma Unit
    - c.**1 patient per day** is expected to require blue-light transfer between hospital sites
    - Given the reduced scale of change, the proposed change can be delivered without any significant impact on the performance of emergency ambulance provision.
- **Inter-hospital transfers** – anticipated demand for (non-emergency) inter-hospital transfers:
    - **c.5 patients per day** expected to transfer between hospital sites as a result of the service change.
    - A re-tendering process will be undertaken to secure an integrated transport solution to deliver a more effective and efficient service by bringing a number of existing contracts under one umbrella with more robust oversight.
- **Visitor and patients travel** (non-statutory transport) – there is an anticipated increase in visitor journeys to DPoW from North Lincolnshire and surrounding areas:
    - **c.22 additional visitor journeys per day from the North Lincolnshire area as a result of the service change.**
    - **around four journeys each day** would be reliant on family, friends, community or public transport to reach Diana Princess of Wales Hospital, Grimsby (DPoW).
    - To mitigate the impact on those families most impacted, additional funding will be provided to enhance the existing community transport provision, supported by a number of wider actions taken by partners to improve transport across the region.

Buildings and Infrastructure

- The total anticipated **capital investment required to deliver the proposed changes is £9.2 million**, which will be funded through the Trust's internal capital programme and phased over a two-year period.

Summary Box 7.1

7.1 Out of Hospital

The Pre-Consultation Business Case (PCBC) which underpinned the proposal for change also set out a series of enabling developments involving a range of system partners to support the proposed new model of care within the hospital.[58] These aligned out of hospital pathways are key enablers for ensuring successful implementation of the proposed change due to the 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.

As the proposals for change have been reviewed in response to feedback gathered during consultation, the out of hospital enablers have similarly been reviewed and, where appropriate, assumptions around delivery included within implementation plans.

Whilst all of the out of hospital enabling developments described within the PCBC are important in improving the overall effectiveness of health and care services across the Humber, there are two key programmes that are essential to the delivery of the proposals within this Decision-Making Business Case (DMBC). These vital enablers are the frailty and community ill child programmes.

Developing and embedding a community-based approach to frailty is essential to the core delivery of improved in-hospital services and will have the greatest impact in reducing demand on urgent and emergency care services in hospitals. Implementation of the proposed service change is most reliant on delivery of the planned improvements to the way in which Frailty services work across the region.

Similarly, rolling out and embedding Hospital at Home and developing the wider community ill child programme is vital to successfully delivering the proposed way forward for paediatrics set out in this DMBC.

7.1.1 Frailty

Improving care and outcomes for frail older people is both a national and a local priority. Nationally, 10% of people over 65 years of age and 1 in 2 (50%) over 85 are frail[59] and within the Humber and North Yorkshire population around 21 of every 1000 people are moderately frail and 8 out of every 1000 are severely frail.[60]

Place	Population	Mild	Moderate	Severe	All Frailty	% mod/severe
East Riding of Yorkshire	312,946	6,132	6,495	2,852	15,479	2.97%
Hull	311,995	5,712	7,109	2,062	14,883	2.94%
North East Lincolnshire	173,224	6,797	3,992	2,097	12,886	3.52%
North Lincolnshire	184,346	8,628	3,981	1,278	13,887	2.85%
Humber total	**982,511**	**27,269**	**21,577**	**8,289**	**57,135**	**3.04%**

Table 7.1 Frailty in Humber population[61]

[58] Humber and North Yorkshire Health and Care Partnership (2023), *Humber Acute Services Review - Pre-Consultation Business Case (PCBC)* Pre-Consultation Business Case (pp. 118-143).
[59] AgeUK (2024) *Understanding Frailty* What is frailty? | Age UK
[60] Humber and North Yorkshire Health and Care Partnership (2023), *Reimagining Health & Care – An Integrated Strategy* ICS Strategy – Reimagining Health & Care
[61] Source: eFI RAIDR data 27th Feb 2024

People who are frail are disproportionately represented amongst medical patients within acute hospitals – currently around 30% of people occupying medical beds are frail[62] – and are at risk of having a longer length of stay than medically necessary, which can have a significantly detrimental impact on their health and wellbeing.

Across Northern Lincolnshire there are a number of services and interventions in place to support people with frailty to improve outcomes and reduce unnecessary attendances and admissions to hospital. However, the services and routes into them vary between different places and the interface between primary and community care services and the hospital is not always as effective as it could be.

In developing the implementation plans for the proposed service change, these enabling services and pathways have been reviewed in partnership with colleagues across the health and care system and revised plans and approach agreed through the Humber Out of Hospital programme board.

There is a recognition amongst partners that existing services could achieve significantly better results through better integration and improved ways of working, learning from what is working well in other places. For example, within the Humber, a nationally recognised best-practice approach to Anticipatory Care for frail people is already being delivered through the Jean Bishop Integrated Care Centre (ICC) in Hull. Elements of this approach are replicated within local services in other parts of the Humber; however, the Out of Hospital programme board have identified opportunities to significantly improve outcomes by ensuring local services in all four places deliver all aspects of the best-practice approach developed in Hull. To do this a Centre of Excellence has been established to scale up the benefits of integrated community-based frailty across the whole system. The Centre of Excellence has overseen the formalisation of 10 refined principles aligned to guidance from British Geriatrics Society, NHS Elect System Wide Frailty Network and the GIRFT report on Geriatric Medicine and established a platform for information sharing and to support the development of the Humber & North Yorkshire Community Frailty Centre of Excellence.

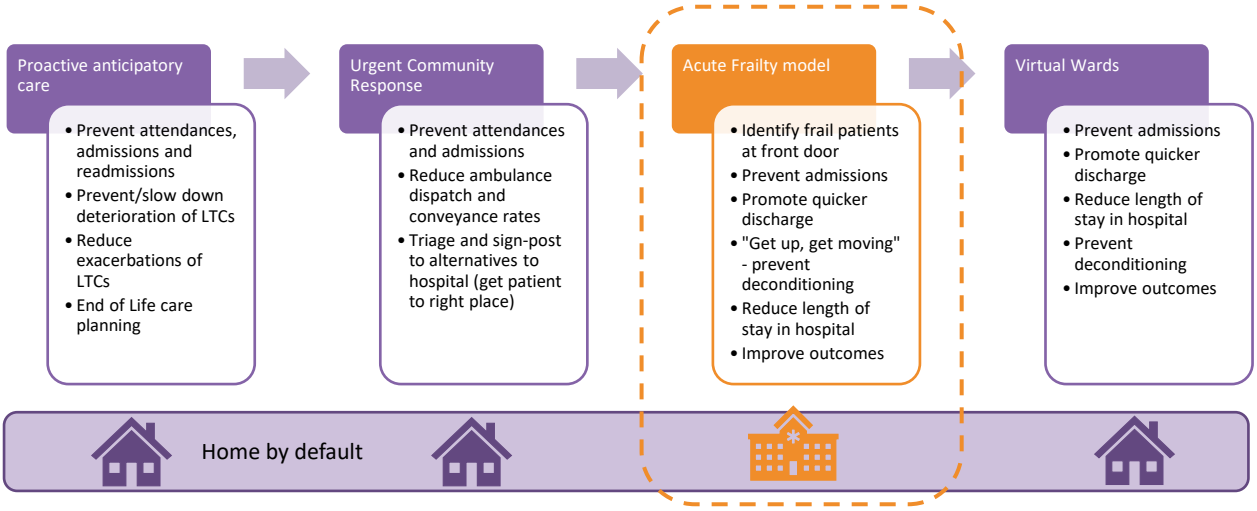
Working together through the Humber Out of Hospital programme board, partners have developed an integrated frailty programme to coordinate actions to improve outcomes for frailty across the system and deliver the reductions in attendances and admissions to hospital, which will support delivery of the proposed changes to hospital care. Structured governance arrangements are in place with well-established Frailty Oversight Groups in place for both North and South bank of the Humber. The key purpose of these groups is to support collaborative working, agree priorities, align acute and community models of care and provide clear lines of accountability for delivery.

Through successful collaboration, supported by strong clinical leadership, improved digital maturity, structured programmes of professional development and implementation of outward-facing acute care, partners are confident that a reduction in hospital admissions for people aged 65 and over of 3.2% (or 8 patients per week) can be delivered over the next 5 years. The admission reductions are a prudent assessment, based on partial delivery only of the 8% reduction that clinical review of activity data suggests is possible. These reductions in emergency attendances and admissions will primarily be achieved through improvements to existing services and interventions rather than through new initiatives.

Coordinated through the Frailty Oversight Group (FOG), interventions at each stage of a frail person's pathway will be maximised to reduce the likelihood of them having to go to hospital and reduce the time they spend in hospital if they do need to go.

[62] Hopper, Adrian (2021) *Geriatric Medicine: GIFRT Programme National Specialty Report* GIRFT Report

The diagram below sets out the key interventions within the frailty pathway which are the focus of the integrated frailty programme and identifies key actions for improvement.



Priority actions			
Proactive anticipatory care	**Urgent Community Response**	**Acute Frailty model (incl. discharge)**	**Virtual wards**
Ensure consistent identification of patients with frailty	Embed community-based specialist advice and guidance model	Comprehensive assessment at front door aligned to proactive care models	Improve interface between acute team and Virtual Ward
Expand existing services to include non-medical input – fully holistic assessment		Provision of specialist advice and guidance to community/primary care	Enable step-up from GP/community (to avoid hospital attendance/admission)

Table 7.2 Summary of priority actions (frailty)

7.1.1.1 Anticipatory Care

The progression of frailty can be slowed and through proactive anticipatory care the frequency of emergency trips to hospital can be reduced. Locally there is ongoing work to consistently identify the frail cohort and to deliver personalised, joined-up care and support planning for this group. This approach empowers and enables people to play an active part in their care and tailors support to their individual needs and preferences. This model is being progressed through the development of Integrated Neighbourhood Teams including primary care and community teams, mental health, secondary care and voluntary sectors.

The overall aim of anticipatory care is to delay the onset of health deterioration, maintain independent living and reduce avoidable exacerbations and hospital admissions.

Whilst Places have differing baselines and infrastructure, there is an exemplar model in Hull with opportunities for shared learning being optimised. Within North Lincolnshire anticipatory care is provided through the SAFE (Specialist Assessment of Frail Elderly) team, which is GP-led and receives referrals from GP practices based on clinical assessment. In North East Lincolnshire Primary Care Network (PCN) Frailty teams use the electronic Frailty Index (eFI) and clinical validation to proactively identify patients for Frailty assessment. There is access to specialist Comprehensive Geriatric Assessment (CGA) where appropriate, prioritising multi-professional resource.

Work is ongoing to ensure consistent identification of patients with frailty is in place in all localities and the benefits of the Integrated Care Centre (ICC) approach to holistic assessment are maximised in the different models and approaches to anticipatory care provided on the south bank of the Humber.

7.1.1.2 Urgent Community Response

Up to 20% of emergency admissions can be avoided with the right care in the right place.[63] This means people living with frailty will get the help they need without needing admission to hospital when it is not necessary.

All four places across the Humber have established a single point of access (SPA) providing a first point of contact for people and professionals needing to access community services. Currently there is some variation in approach across the Humber. North East Lincolnshire have an integrated single point of access taking all referrals and calls into the service from health professionals, patients and families.

Through the SPA, a 2-hour Urgent Community Response Service (2UCR) is available and is already helping to reduce avoidable hospital admissions. The 2UCR service supports adults who, if not seen within 2 hours, are likely to need to attend an Emergency Department and potentially have an unplanned admission to hospital.

North Lincolnshire benefits from a well-established Single Point of Access for people with urgent care needs which delivers a clinical triage and direction into community-based services where clinically appropriate. This approach enables the SPA to accept primary care and Category 3 & 5 ambulance calls, avoiding admission through the use of alternative community options. Work continues as part of our integration agenda to further embed social care input into this function.

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 service is structured slightly differently in each locality and there are opportunities to improve outcomes across the region by sharing learning between places. Hull and East Riding have a community-based specialist advice and guidance model and partners across Northern Lincolnshire are working together to develop a similar approach, which will help to drive further reductions in ambulance conveyance and emergency hospital attendances.

7.1.1.3 Acute Frailty Model

Evidence shows that poor or late recognition of frailty or associated syndromes increases the likelihood of having a longer length of stay in hospital and experiencing poor long-term health outcomes. If patients are identified and assessed promptly (ideally within 30 minutes of arrival) the risk of deconditioning will be minimised.

Work is ongoing to embed routine identification and assessment of frail patients at the front door of the hospital by appropriately trained professionals in all Emergency Departments within the Group (Scunthorpe, Grimsby and Hull). Working with partners to ensure prompt and reliable provision of care by other parts of the integrated health and social care system are in place to facilitate timely access to alternatives to hospital admission for example Virtual Wards, community rehabilitation and proactive early discharge. Through the Frailty Oversight Group, joint working will ensure pathways are better aligned and more responsive with a home by default approach embedded across all aspects of care for those identified as having frailty.

[63] Department of Health and Social Care (2024) *NHS Urgent and Emergency Care* Media Fact Sheet

Successful initiatives such as “Get Up, Get Moving” will be scaled up and embedded across all hospital sites to tackle the problem of deconditioning in frail patients. Work will also be undertaken across Care Groups to ensure services are aligned to a community-based approach to frailty by providing specialist advice and guidance to community and primary care helping to avoid the need for frail patients to come to hospital and enable swifter discharge for those who do need to attend.

7.1.1.4 Virtual Wards

Where it is safe and appropriate to do so Virtual Wards will provide acute clinical care at home (including for care home residents) with treatment and monitoring. Virtual Wards are currently established across the Humber for both frail and respiratory patients, with plans in place to expand the offer over time to include a wider range of pathways.

Virtual wards allow patients to get the care they need at home (including within care homes) safely and conveniently, rather than being in hospital. Patients can be admitted to a Virtual Ward to shorten LoS in a hospital bed enabling early transfer home before they are medically fit for discharge, alternatively patients can be admitted directly from home as an alternative pathway to being admitted to a hospital bed in the first place. Virtual wards are particularly beneficial for frail patients and specific cohorts of patients for whom being out of their normal environment can be particularly disruptive (e.g. people with dementia).

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.

Virtual Wards are in place within the Humber and already providing some support to reduce the length of stay of frail patients. These existing assets, however, are not being used as effectively as they could be so work will be prioritised in the coming months to improve the effectiveness of virtual wards and help to deliver reductions in Emergency Department (ED) attendances and admissions for the frail population. In particular focus will be on improving the interface between the acute team and the Virtual Ward and enabling step-up into the Virtual Ward from GP/community to avoid hospital attendance or admission.

Within North Lincolnshire, the community response has been further strengthened by the implementation and expansion of virtual ward and outpatient antibiotic therapy to reduce the need for admission or support early discharge with care provided at home. The outpatient antibiotic service can manage 10 patients at any time, delivering intravenous anti-biotics in the home and community clinics. This enables patients to be discharged soon after the initial doses of antibiotics which would have previously required a longer hospital stay to complete the course. North Lincolnshire currently has 14 Virtual Ward beds, where people can be cared for in their own home, under the care of a consultant with remote monitoring and nursing and therapy support through the door. This capacity is set to increase to 16 beds over the summer as additional technology is mobilised.

7.1.1.5 Integrated Discharge

The integrated approach to discharge planning in North Lincolnshire, delivered by the Integrated Discharge Team maximises the proportion of people able to be discharged back to their usual residence keeping the number of complex discharge delays low. The ‘describe not prescribe’ workstream continues to drive forward a reduction in the over prescribing of care on discharge, utilising a Discharge to Assess model to ensure long term needs can be assessed in the individual’s own environment.

The Home First model is supported by the current joint ICB/Local Authority re-commissioning of the Care at Home framework with the aim of increasing care at home capacity and delivery of a transformed, outcome-based model which aims to maintain or reduce need for care through a strengths-based approach.

To support the implementation of Home First, intermediate tier bed capacity has been increased to support timely discharge for those with rehabilitation needs. Working in conjunction with North Lincolnshire Council and Northern Lincolnshire and Goole NHS Trust (NLaG), capacity has been increased through the use of designated care home beds with dedicated therapy input to support rehabilitation and reablement. Data demonstrates an average length of stay of 17 days, with most people then discharged home to their usual residence. In addition to this, capacity in the Community Home First Teams has been increased and work is continuing to integrate both health and social care teams to maximise capacity. This will support the timely discharge of people from hospital, reducing the proportion of beds occupied by those with no criteria to reside.

7.1.1.6 Impacts

Delivery of these improvements will support an incremental reduction in Emergency Department attendances and admissions, which have been modelled into the demand and capacity assumptions in this business case. Based on a clinical evaluation of conditions suitable for treatment out of hospital, it was identified that approximately 8% of admissions for people aged 65[64] and over could be treated in an out of hospital setting (or 1,053 cases based on refreshed activity modelling). Prudent estimates of delivery have been used to assume around 40% of cases that could be treated in out of hospital setting by year 5 are delivered in an appropriate out of hospital pathway. This would equate to around 8 fewer admissions per week by year 5.

Emergency Admissions (65+) avoided through out of hospital pathway improvements			
Year		Total annual volume	Average per week
2022/23	*10% of yearly total delivered*	105	2
2023/24	*20% of yearly total delivered*	211	4
2024/25	*30% of yearly total delivered*	316	6
2025/26	*40% of yearly total delivered*	421	8
Total Baseline at 100% - Yearly Total		**1,053**	

Table 7.3 Summary of admission avoidance - frailty programme

7.1.2 Community Ill Child

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 the region. This has an impact on their health and wellbeing and can put increased demand on healthcare services.[65]

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.

[64] Consistent recording of frailty is not yet in place across all localities therefore age was used as a proxy to model the impacts of interventions on attendances and admissions.
[65] Humber and North Yorkshire Health and Care Partnership (2023), *Humber Acute Services Review - Pre-Consultation Business Case (PCBC)* Pre-Consultation Business Case (pp.30-42).

The proposed approach for paediatrics, in response to feedback and evidence gathered during consultation, is to focus on developing and embedding a community-based approach to paediatrics that builds on early successes with the Community Ill Child programme and goes further, faster to support more children and families at home, reducing the reliance on inpatient care in the long-term.

7.1.2.1 Hospital at Home

'Hospital at Home' is an acute hospital service but provided within the child's own home. It provides a short term acute personalised care in a child's home that is similar to that provided in a hospital setting. It is a seven-day service provided 8am to 8pm Monday to Friday and 8am to 6pm on weekends and bank holidays. The service is nurse-led and under the remit of the Consultant Paediatrician of the week/con call for the Paediatric Assessment Unit (PAU) and Children's Ward. Referrals are accepted from the Emergency Department, PAU, inpatient ward and also from Primary Care – to avoid a child coming to hospital at all.

On initial contact, families are given information about the Hospital at Home service, contact details, when and how to escalate if they are concerned, and details of the 'Healthier together' website. At each contact, the plan of care is agreed and updated with the family. When conducting a home visit, a holistic approach is taken and all opportunities are utilised for health education, advice and guidance, health promotion and encouraging self-care (improving health literacy). These interventions have a longer-term impact in supporting and upskilling the child's family, helping to build confidence. If the child deteriorates in their home setting, care is escalated to the PAU to ensure children are kept safe.

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.

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 are higher during the winter months and the service supports 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.

The service is now well-established in North East Lincolnshire and currently being rolled out in North Lincolnshire. There are opportunities to improve the service, including through increased use of remote monitoring and telemedicine and improved linkages with primary care and community services. Focusing on improvements to out of hospital and embedding a home first approach to paediatric care will help to ensure more children can be seen and treated in their own home instead of attending an Emergency Department or being admitted to hospital.

7.2 Transport

Through the consultation, many respondents expressed concerns about the increased distance and journey times to reach Diana Princess of Wales Hospital, Grimsby (DPoW). Travel, transport and access issues were by far the most commonly raised concerns through the consultation process. Key concerns raised included:

- The potential impact of the proposed changes on ambulance services.
- The potential impact on patients and visitors of travelling to Grimsby, particularly from Scunthorpe and areas to the west and north (e.g., Isle of Axholme and Goole).

Ensuring the right transport solutions are in place is vital to the success of the proposed service change. Whilst the amendments to the proposed way forward and updated activity modelling have minimised the impact of the proposed change, there is still a requirement to put in place transport solutions as part of the implementation of the change.

Transport impacts and proposed solutions fall into three broad categories and therefore impacts have been reviewed and, where required, solutions developed through three separate working groups.

Category	Group	Scope
Statutory (Emergency)	YAS/EMAS Strategic Planning Meeting	• Emergency ambulance attendances in the community • Emergency (inter-hospital) transfers requested through 999 ambulance services
Statutory (non-emergency)	Ambulance Transport Task and Finish Group	• Inter-hospital transfers between NLaG sites DPoW, SGH and Goole (primary objective) • Inter-hospital transfers with HUTH sites (primary objective) • Patient Transport Service (PTS) for discharge transport from our hospitals (secondary objective)
Non-statutory	Non-statutory transport group	• Non-Statutory patient and visitor transport (e.g., taxi, voluntary sector, public transport)

Table 7.4 Transport Task and Finish Groups

The plans developed through each group have been incorporated into the implementation plan and are summarised briefly below.

7.2.1 Emergency ambulance

In developing the proposal for consultation, the impact on ambulance services was considered. Detailed modelling undertaken by ORH (Operational Research in Health Ltd) assessed the impacts of the proposal on the operations of the main ambulance provider – East Midlands Ambulance Service NHS Trust (EMAS).

During the consultation period, ORH were commissioned to re-run the impact assessment using more up to date data on trauma conveyances – for both EMAS and Yorkshire Ambulance Service NHS Trust (YAS) – and activity assumptions to estimate the additional demand for inter-hospital transfers. Based on this updated modelling, the impact on ambulance services reduced significantly.

Following consultation and the changes made to the proposed way forward, there is a further reduction in the requirement for inter-hospital transfers and resultant demand on EMAS services. The impact of this reduction on EMAS performance has not been re-modelled by ORH.

The impact of the proposed change on emergency ambulance services is comprised of:

- Additional travel time for trauma conveyances due to longer travel distances
- Emergency inter-hospital transfers for patients who need to be transferred by blue-light

The number of Trauma conveyances in each year from the baseline year (2019/20) to the most recent full year of data (2022/23) was gathered to provide a more accurate assessment of the anticipated impact of the proposed change on both EMAS and Yorkshire Ambulance Service NHS Trust (YAS).

Trauma conveyances (demand)					
Ambulance provider	**Receiving Hospital**	**2019/20**	**2020/21***	**2021/22**	**2022/23**
EMAS	DPoW	1030	390	338	253
YAS		0	0	0	0
EMAS	SGH	644	247	216	168
YAS		21	0	20	23
**Covid impact*					

Table 7.5 Trauma conveyances - anticipated demand

Based on the updated trauma demand, ORH modelled the impact on ambulance services and modelled where patients would be taken (based upon a 10-minute threshold to remain within the existing EMAS boundaries). In addition, based on feedback raised during consultation, consideration has been made for individuals who make their own way to the Scunthorpe Emergency Department but require specialist Trauma Unit care and would therefore require emergency ambulance transport. A prudent estimate of anticipated demand has been made based on an audit of local data on trauma calls.

	Patients diverted from Scunthorpe Hospital to nearest Trauma Unit *(with 10 min threshold)* per year				**TOTAL**
	DPoW	**Hull**	**Lincoln**	**Doncaster**	
Nearest Trauma Unit - EMAS	105	18	24	21	**168**
Nearest Trauma Unit - YAS	0	0	0	23	**23**
Potential walk-ins[66]	70	0	0	0	**70**
Total	**175**	**18**	**24**	**44**	**261**

Table 7.6 Trauma Unit patients diverted from Scunthorpe

ORH concluded that no additional resource would be required to manage the diverted patients and maintain current response times for EMAS or YAS, given the relatively limited number of patients who would need to be diverted and handover times at the respective Emergency Departments (EDs).

In addition to ambulance-conveyed trauma, a proportion of patients transferring to Diana Princess of Wales Hospital, Grimsby for specialist care is likely to require emergency (blue-light) transfer. Based on historical data, this is assumed to account for around 20% of total inter-hospital transfers.

[66] potential walk-ins to Scunthorpe Hospital who require Trauma Unit level care and would need to be transferred to Diana Princess of Wales Hospital, Grimsby. The potential requirement has been calculated based on an audit of trauma calls, deducting ambulance-conveyed patients.

At the time the ORH modelling was undertaken the anticipated volume of secondary transfers was:

- 3,886 per annum
- 777 of which would require blue-light transfer by EMAS (2.1 per day)

Based on this level of activity, ORH anticipated the impact on ambulance performance to be minimal – requiring around 50 additional dual-crewed ambulance hours (less than a third of an additional ambulance) to maintain response times across the region.[67]

Following changes to the proposal in response to consultation feedback, the anticipated volume of secondary transfers is now around:

- 2,335 per annum
- 467 of which would require blue-light transfer by EMAS (1.28 per day)

Given this further reduction to anticipated demand, the additional blue light transfers resulting from the proposed service change would have only a marginal impact on overall response times for EMAS across the region. It is anticipated, therefore, that this impact can be managed within existing system resources.

The impact on local ambulance providers of the proposed service change is minimal:

- around **3 patients per week** are expected to be diverted to a different Trauma Unit
- around **1 patients per day** is expected to require blue-light transfer between hospital sites

Given the reduced scale of change, the proposed change can be delivered without any significant impact on the performance of emergency ambulance provision.

Summary box 7.2

7.2.2 Non-emergency ambulance transport

As a result of the proposed service change, it is anticipated that around 1,868 additional patient transfers per annum (or around 5 per day) will be required between Scunthorpe General Hospital (SGH) and Diana Princess of Wales Hospital in Grimsby (DPoW).[68] This is in addition to existing inter-hospital transfers that take place between NLaG sites – SGH, DPoW and Goole (c.1,400 per annum) and with HUTH sites – Hull Royal Infirmary (HRI) and Castle Hill Hospital (CHH) (c.120 per annum).

The anticipated future demand for inter-hospital transfers is summarised in the table below.

Transfer	Approx Total per Year	Split Emergency/non-emergency (based on 20%/80% where applicable)		Per Day Approx Average Non-Emergency Transfers
		Emergency	Non-Emergency	
***Specialist Medical inpatients** (cardio/resp/gastro)	678	136	542	1.5
***Emergency surgery admissions**	1,241	248	993	2.7
ENT *(existing/continuation)*	520	104	416	1.1
Urology *(existing/continuation)*	364	73	291	0.8

[67] Lincolnshire, North Lincolnshire and North East Lincolnshire
[68] Total anticipated secondary transfers is 2,881, of which 20% (576) would be via EMAS blue-light ambulance and the remaining 80% (2,305) would require a separate commissioned solution.

Stroke repatriation *(existing/continuation)*	730	0	730	2.0
TOTALS	**3,533**	**561**	**2,972**	**8.1**
** impact of proposed service change*				

Table 7.7 Anticipated inter-hospital transfers

To ensure the new model of care works effectively and efficiently, a transport solution for these additional transfers is required.

A Task and Finish Group was established to review current transport services and scope future opportunities and solutions for timely inter-hospital transport. To deliver the best value for money and most effective solution, the Task and Finish Group reviewed existing ambulance transport contracts for:

- Inter-hospital transfers between NLaG sites DPoW, SGH and Goole (primary objective)
- Inter-hospital transfers with HUTH sites (primary objective)
- Patient Transport Service (PTS) for discharge transport from our hospitals (secondary objective)

Patient Transport Services (PTS) for discharge was considered as part of the review because there are potential economies of scale to be achieved by considering both transport elements together and current transport providers (contracted to provide inter-hospital transfers) are being used to support PTS discharge journeys when they are not engaged in inter-hospital transfer journeys. Patient Transport Services for routine, outpatients and elective activity were not considered within the scope of the Task and Finish Group and would not be affected by the proposed service change.

Inter-hospital transfers and PTS for discharge transport are currently delivered through a number of providers across different contracts, held by a mix of Acute Providers and the Integrated Care Board (previously Clinical Commissioning Groups).[69] There are multiple constraints and challenges with the existing arrangements which impact upon service delivery, efficiency and patient experience.

Within the Implementation Plan for the proposed service change, provision has been made to re-tender these transport services to ensure a more effective and efficient service is in place to manage the anticipated level of demand. The proposed way forward is to develop a detailed specification to tender for a single specialist transport provider to cover inter-hospital transfers for NLaG and HUTH, with the potential to extend this to include PTS for discharges to deliver further efficiencies. This will be supported by a review of existing patient transport coordinator roles to develop a joined-up approach across the Group to make the service more sustainable and resilient. Development of a more integrated transport hub across the Group will also help to respond to concerns raised through the consultation that the change might negatively impact upon effective discharge from hospital and help to ensure people get home as quickly as possible after an inpatient admission.

Given the level of inefficiency and duplication within existing contracts and findings from initial soft market testing, the future solution is expected to be affordable within the cost envelope of current provision and could deliver further efficiencies if extended to include PTS services for discharge (currently commissioned by the ICB for North Lincolnshire and North East Lincolnshire places). Bringing the existing contracts together and putting in place more robust performance monitoring and coordination will ensure the service change can be delivered without any transport-related delays for

[69] The responsibility for ensuring the patient is transported (governance and funding) is different for the different elements in scope. Inter-hospital transfers are the responsibility of the acute hospital Trust whilst the PTS for discharge transport is the responsibility of the ICB that covers the patient's registered GP location.

patients. It will also bring additional benefits of improving the experience for patients who are already required to transfer between sites as services are currently configured.

Anticipated demand for (non-emergency) inter-hospital transfers:

- around **5 patients per day** expected to transfer between hospital sites as a result of the service change.
- around **8 patients per day** expected to transfer between hospital sites in total (including existing pathways).

To deliver the proposed service change, a re-tendering process will be undertaken to secure an integrated transport solution to deliver a more effective and efficient service by bringing a number of existing contracts under one umbrella with more robust oversight.

7.2.3 Non-statutory transport

The above solutions will ensure that all patients who need to be transferred to access specialist care as a result of the proposed service changes are transferred in a timely manner. In addition, consideration has been given to the wider impacts of the proposed service changes on patients' families and loved ones, particularly those affected by socio-economic deprivation, without access to a car or van, and living in rural areas with poor access to public transport.

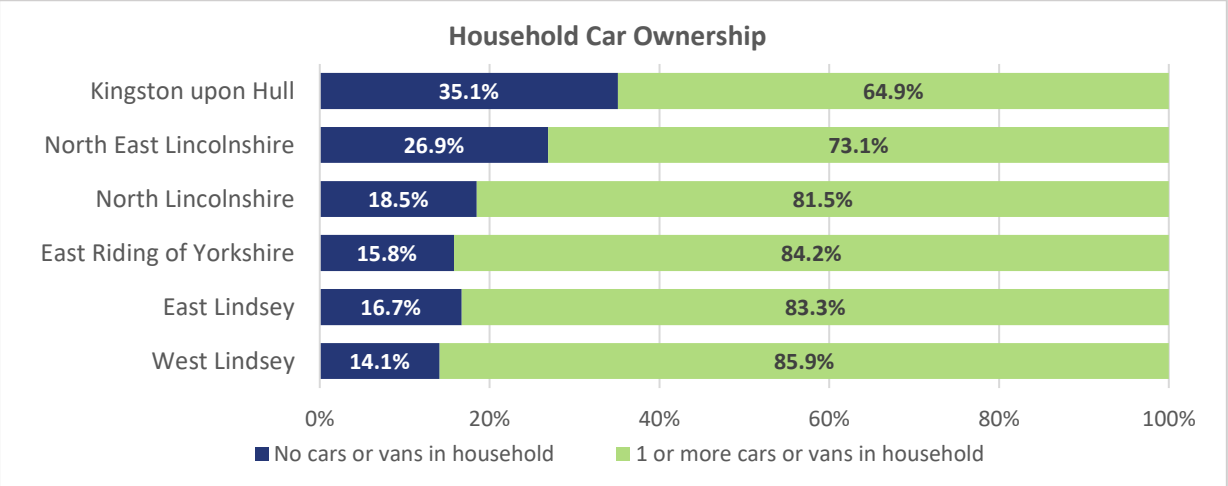


Figure 7.1 Car ownership rates by local authority[70]

The impact of the amended proposal following consideration of consultation feedback is expected to result in around 7 patients per day being transferred from Scunthorpe to Grimsby. Based on the anticipated length of stay, this would generate approximately 22 additional visitor journeys per day (assuming every patient has one visitor every day).[71] When considering rates of car ownership in the relevant areas, it is reasonable to expect that around four of these visitor journeys each day would be reliant on family, friends, community or public transport to reach Diana Princess of Wales Hospital, Grimsby (DPoW).

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

[71] 2.34 medical patients per day with an average length of stay of 5 days and 5.15 surgical patients per day with an average length of stay of 2 days – (5*2.34) + (2*5.15) = 22

Whilst there is no statutory requirement on the acute hospital Trust or the Integrated Care Board (ICB) to provide transport services for relatives and loved ones to visit patients in hospital, work was undertaken during and following the consultation to review existing transport provision and develop potential solutions that could support those families who might struggle to visit loved ones as a result of the proposed service change and help to mitigate against any negative impacts on the patient and their wider support network of being further away from home.

7.2.3.1 Transport working group

A multi-agency group was established to explore potential mitigations to support people who might be impacted by the proposed changes to hospital services and make recommendations for inclusion within this Decision-Making Business Case (DMBC). The multi-agency group included representation from:

- HUTH / NLaG
- Integrated Care Board (ICB)
- Local Authority transport planners
- Patient representatives
- Voluntary and community transport providers
- Public transport providers

The remit of the group was to:

- Review suggestions for improvements to existing travel arrangements identified during public consultation and make recommendations.
- Identify the potential implications of the proposed changes in relation to Access, Travel, Parking, and Public Transport, taking account of the timing and potential impact of the sequencing of the movement of services.
- Collaboratively scope future opportunities and solutions for travel / transport (non-PTS or emergency transport) for patients, carers, families and staff impacted from the HAS proposed model of care and service change.

The working group considered the feedback that was provided through the consultation, with particular regard for the issues raised regarding travel, transport and access. Through the consultation it was very clear that there are many wider transport issues across the region that are not directly related to the proposed service change. Furthermore, many people raised concerns they have with the status quo and difficulties they find getting to and from hospital, both their nearest hospital and those further afield.

Whilst the remit of the working group was to look at potential mitigations for the patients and families impacted by the proposed service change, they also made a number of recommendations that would help to address some of the wider issues and challenges faced by local residents in accessing the different hospital sites across the Humber.

7.2.3.2 Reviewing the transport action plan

The working group also reviewed the Transport Action Plan that was developed in the pre-Consultation phase in light of the refreshed impact assessment of the revised proposal.[72] The group reviewed the proposed areas of focus and identified some actions that could potentially mitigate the impact of the proposed service change.

[72] Humber and North Yorkshire Health and Care Partnership (2023), *Humber Acute Services Review - Pre-Consultation Business Case (PCBC)* Pre-Consultation Business Case (pp.212-215).

The table below summarises the key actions and themes within the pre-Consultation transport action plan and identifies which could potentially support with mitigating the impact of the proposed change and which would contribute to addressing some of the wider issues raised through consultation.

Theme	Action	Mitigate impact of change	Address wider issues
Understand holistic needs *Provide more responsive services that flex around patient needs*	**Patient Letters** - review of current practice to improve information provided in appointment letters based on patient feedback		X
	Reimbursement scheme - review of current practice to make it easier for eligible patients to reclaim travel costs		X
Design out unnecessary travel *Reduce the need for patients to travel to hospital, bringing more care closer to home*	**Clinical scheduling and accessibility** - review of current practice to ensure patients are offered an appointment close to home wherever possible (or remote/virtual appointment where clinically appropriate) and to reduce the need for multiple appointments		X
	Hospital at Home and virtual wards - implementation of alternatives to hospital-based care to reduce the need for travel	X	X
	Community Diagnostics Centres - implementation of alternatives to hospital-based care to reduce the need for travel		X
Make transport easier *Simply the transport offer to make it easier for people to get the help they need*	**Explore potential expansion of staff shuttle bus to patients/visitors** - undertake a Cost-Benefit Analysis of potential expansion and explore alternative options for accessible transport for patients/visitors	X	X
	Work with local authorities to review public transport routes - provide information and support to Local Authorities to improve the local public transport offer and connectivity with hospital sites	X	X

Table 7.8 Review of pre-Consultation Transport Action Plan

The group focused its efforts on reviewing potential options that could help to “Make transport easier” for patients, families and loved ones, in particular, looking at potential solutions that could help to mitigate the impact of the proposed service change on those facing existing barriers or health inequalities due to poverty and lack of access to affordable transport options.

7.2.3.3 Mitigating the impact on patients, families and loved ones

The group undertook an options appraisal to identify the most cost-effective and beneficial way to improve access to Diana Princess of Wales Hospital, Grimsby (DPoW) for families and loved ones in North Lincolnshire and surrounding areas who might otherwise struggle to get there.

The options considered included:

- expanding the staff shuttle buses currently operating between SGH and DPoW,
- use of private taxi hire,
- expanding the existing community transport service offered by the voluntary sector,
- use of North Lincolnshire Council's Just Go bus service.
- use of the existing public transport network (with or without enhancement).

The options were costed and reviewed by the group and a preferred option put forward for inclusion in this business case.

The preferred option put forward by the multi-agency group is to fund an expansion to the existing voluntary car service, which is currently provided by Humber and Wolds Rural Action (HWRA). Humber and Wolds Rural Action has received a grant from North Lincolnshire Council since 2008 to support the delivery of the Voluntary Car Scheme to residents of the local authority. This service is provided by volunteer drivers, recruited from the local area, who undergo a DBS check and undertake an induction. The scheme currently has 28 North Lincolnshire based drivers with 2 currently undergoing the recruitment process.

Drivers receive re-imbursement at 45 pence per mile for the journey they undertake, this pays for petrol and general wear and tear to their vehicle and is within the HMRC limit. Passengers receive a registration pack and complete a form which identifies specific mobility and health issues that we need to be aware of to provide an appropriate service. The form also includes emergency contact details. The majority of journeys are to meet hospital and health provider appointment needs.

The service is well-established and in a good position to grow, however, it is operating with a current shortfall in funding due to the expansion of the service over the years to meet demand.

The proposed expansion would enable the service to operate with extended hours, including provision of on-call cover and enabling the service to work more flexibly and accommodate shorter notice periods given the unplanned nature of the services proposed to move. The cost of funding this extension for one year is set out in the table below.

HWRA service expansion – costings	
Staffing/on call	£8,395
Shortfall in service funds	£18,500
Total Running Costs for 12 months	**£26,895**

Table 7.9 HWRA community transport costs

Funding the HWRA community transport service is the most viable option of those reviewed – staffing is in place, and it offers an efficient and convenient service at a low cost. This option will require the Humber and North Yorkshire Integrated Care Board (ICB) to work with North Lincolnshire Council to determine the optimal contracting and procurement route to provide the funding required to extend community transport provision in the North Lincolnshire area.

The recommendation of the transport group is to provide the additional funding required to enable Humber and Wolds Rural Action to extend its community transport service to provide an accessible transport option for families and loved ones – including those in rural or isolated areas – to enable them to more easily visit loved ones who have been impacted by the proposed service change.

Based on the anticipated level of demand, the shuttle bus option was prohibitively expensive (costing between £338,000 and £825,000 per annum, depending on the frequency and size of bus). In addition, it was not considered a suitable option for families living in rural or isolated areas who would need to use an alternative service to travel to Scunthorpe General Hospital (SGH). Similarly, the use of private taxis exclusively was an expensive option compared with others that were evaluated. North Lincolnshire Council's Just Go bus service is not continuing in its current form beyond 2024 and therefore was not a viable option. The public transport option was considered by the group to be part of the future solution but given the timescales involved to make necessary changes and improvements it was considered to be part of the longer-term solution and insufficient in itself to mitigate the negative impacts of the proposed change.

7.2.3.4 Wider transport actions and next steps

The group also identified a range of other key actions that would provide wider benefits beyond just those people impacted by the service change and help to address the wider accessibility issues that were raised through consultation.

In addition to the proposed service expansion, the following additional actions were agreed to be taken forward alongside implementation of the proposed change to deliver wider improvements for local residents:

Issue	Action	Lead agency	Timescale for completion
Reimbursement scheme	Reviewing existing arrangements for those eligible to reclaim expenses to help make it simpler	Humber and North Yorkshire ICB	October 2024
Clinical scheduling	Review existing arrangements for scheduling of outpatient clinics and other planned care services to reduce the need for patients to travel long distances (or to travel to hospital at all).	NHS Humber Health Partnership	March 2025
Public transport review	Review existing public transport routes and links to/between hospital sites and explore where changes could be made to support future service models.	Local Authorities	Summer 2025

Table 7.10 Summary of key transport actions

The actions being taken forward include looking at how patients who are eligible for help with their transport costs are able to access this support. The current system was said to be too difficult to navigate and too slow to repay expenses. The process is already under review and feedback gathered through the consultation will support in developing a more effective process for this in the future.

Additionally, as providers, the NHS Humber Health Partnership has agreed to take forward a review of clinical scheduling, with two key aims:

- reduce the frequency of patients being asked to travel long distances for outpatient appointments.
- ensure patients are offered an appointment at the closest hospital available to them or over the phone/virtually, if clinically appropriate.

Whilst some services cannot be offered everywhere, the aim of the review will be to ensure that wherever possible patients are offered the option of an appointment at their closest clinic (or virtual if appropriate), which will also support a reduction in 'did not attend' (DNA) rates and improve patient experience.

Earlier this year, councils in Greater Lincolnshire approved a devolution deal which means existing money and power can move from central government to decision-makers in Greater Lincolnshire.

This devolution deal promises to deliver £24 million per annum for 30 years to invest in infrastructure and skills development and access for the Combined Authority to a multi-year transport budget with greater flexibility to spend the money on local priorities. The changes are set to put in place a single Local Transport Authority, which can develop public transport improvements that connect people with homes, work, leisure and learning.

The multi-agency group also agreed that further work should be taken forward by Council officers, with support and input from the local NHS bodies and public transport providers, to review the public transport offer in the context of the recent devolution agreement and potential scope to improve public transportation links pan-Lincolnshire.

Anticipated increase in visitor journeys:

- approximately **22 additional visitor journeys per day** from the North Lincolnshire area as a result of the service change.
- around **four journeys each day** would be reliant on family, friends, community or public transport to reach Diana Princess of Wales Hospital, Grimsby (DPoW).

To mitigate the impact on those families most impacted by the additional travel – including those with no access to a car or van at home – additional funding will be provided to enhance the existing community transport provision, supported by a number of wider actions taken by partners to improve transport across the region.

7.2.4 Sustainability and net zero targets

The Health and Care Act 2022 placed new duties on NHS England, and all trusts, foundation trusts, and integrated care boards to contribute towards statutory emissions and environmental targets. The NHS Humber Health Partnership continues to make significant progress against these carbon reduction goals and is developing more sustainable ways of working across all its sites. Recent investments include, for example, Hull University Teaching Hospitals NHS Trust (HUTH)'s £4.5 million 'Field of Dreams', consisting of 11,000 solar panels generates electricity for the Castle Hill Hospital site, supporting delivery of the Trust's ZeroThirty ambitions.

The proposed changes set out in this business case will result in a moderate increase in inter-site travel, for staff, patients and visitors. This is, however, set against reductions in Length of Stay (LoS), which will

help to reduce the overall number of visitor journeys by reducing the length of time patients spend in hospital. Furthermore, a number of the enabling changes – virtual wards, Hospital and Home, enhanced frailty services, Community Diagnostic Centres – work together to reduce the need for patients to travel to hospital at all. The net impact of the proposed changes on hospital journeys is therefore minimal.

In implementing the changes, a number of mitigations will be put in place to ensure any travel-related impacts are minimised and, wherever possible, offset by improvements in other aspects of the Group's net Zero delivery. For example, carbon reduction targets and use of greener fleet will be considered within the criteria for inter-hospital transport procurement and the Group and ICB will work with transport providers to reduce the carbon impact of their fleet over time.

7.3 Buildings and digital infrastructure

7.3.1 Digital

Despite investment over recent years, the digital infrastructure within the Humber's hospitals continues to pose significant challenges.[73] The proposed new models of care were developed alongside wider digital strategies and the HNY Partnership's digital investment portfolio to ensure the benefits of current and planned future digital investments are maximised.

Following consultation, the service change proposals have been reviewed and the digital requirements for each proposed service move accounted for within implementation plans. There are no significant additional digital investments required to enable the proposed service changes to be made – beyond business-as-usual investments to maintain effective working of core digital infrastructure.

The proposed service moves will be enabled by improved cross-site working across the new NHS Humber Health Partnership Group. As the Group works towards a joint Electronic Patient Record (EPR) system and greater digital integration (both internally and with wider partners), this will support continued improvements in efficiency and effectiveness of teams working across all sites within the Group. The proposed service changes will help to build a platform for greater integration with other providers outside of hospital, enabled by improved digital integration.

7.3.2 Estates

Many of the hospital buildings across the Humber are outdated, inefficient and do not make it easy for teams to provide the best possible care to patients. There is limited access to the investment needed to improve or replace them. The ageing condition of the estate limits the changes that can be made within the capital affordability envelope.

The capital investment requirements to deliver the proposed model of change were reviewed by NHS England through the Gateway assurance process prior to consultation. The Gateway process provided assurance that the proposed service change met the NHS England financially affordability criteria and could be delivered from within existing financial resource. [74]

[73] These are set out in more detail within the PCBC: Humber and North Yorkshire Health and Care Partnership (2023), *Humber Acute Services Review - Pre-Consultation Business Case (PCBC)* Pre-Consultation Business Case (pp.193-197)

[74] Details of the assumptions used to develop the capital investment plans are set out in more detail in the PCBC: Humber and North Yorkshire Health and Care Partnership (2023), *Humber Acute Services Review - Pre-Consultation Business Case (PCBC)* Pre-Consultation Business Case (pp.163-164 and pp.198-200)

Following consultation, the service change proposals have been reviewed and the estates investment requirements for each proposed service move accounted for within implementation plans. The revised proposal seeks to make best use of existing estate and further limit the capital investment required to deliver the proposed change.

Amendments to the original proposal have reduced the capital requirements from £16 million (excluding BLM/CIR) as set out in the Pre-Consultation Business Case (PCBC) to £9.2 million (excluding BLM/CIR).

These reductions have been achieved through:

- Removal of required investment in expansion of the inpatient paediatric ward at Diana Princess of Wales Hospital, Grimsby – linked to alternative approach proposed for paediatrics (£2.9 million).
- Reduction of investment required to implement proposed changes to specialist medical and acute surgery services by maximising the use of existing ward locations to minimise the additional investment needed (£3.8 million).

To deliver the proposed service changes, investment is required to refurbish, expand and/or rebuild key clinical areas at Diana Princess of Wales Hospital, Grimsby (DPoW) to accommodate additional patients for the consolidated services.

Additional investment is required to deliver:

- an increase in non-elective inpatient beds
- an increase in critical care capacity

The total number of non-elective inpatient beds at DPoW will increase under the proposed model of care. The majority of this increase can be managed within the existing physical capacity of the site, by maximising the use of existing ward space and amending staffing models accordingly. Some investment, however, is required to improve the flow between ED, short stay and medicine specialties and ensure the benefits of the proposed clinical change can be fully realised. Investment will support internal reconfiguration and upgrades to the medicine wards on the C-floor at DPoW. The anticipated cost of this work is £600k.

Critical Care at DPoW is currently running from a temporary location, with care split across two different areas (High Dependency Unit and Critical Care Unit). The service is not able to operate to full capacity due to the state of repair of the temporary building – one bed completely out of use following damage to the roof. The proposed way forward would see investment in a new, purpose-built critical care unit, which would have sufficient capacity to support an increase in acutely ill patients at the Diana Princess of Wales site. The investment would deliver a range of wider benefits through the opportunity to create a co-located critical care service which will be fit for purpose and meet the required standards. The anticipated cost of building the new Critical Care Unit is £8.6 million (excluding BLM/CIR).

Capital requirements	**Critical Care (£)**	**C-Floor (£)**	**Total (£)**
Equipment	339,840	0	339,840
Building	9,260,225	609,067	9,869,292
TOTAL	**9,600,065**	**609,067**	**10,209,132**

BLM/CIR	-965,322	0	-965,322
Total excluding BLM/CIR	**8,634,743**	**609,067**	**9,243,810**

Table 7.11 Capital requirements (total)

The total anticipated **capital investment required to deliver the proposed changes is £9.2 million**, which will be funded through the Trust's internal capital programme and phased over a two-year period.

The proposed way forward 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.

In responding to feedback and finalising the proposed way forward, a detailed review of required enablers was undertaken to provide confidence in the proposals and ability to deliver.

Out of Hospital

Reductions in hospital attendances and admissions for the frail population across the Humber will be delivered through improved integration between existing services and providers and overseen by the multiagency Frailty Oversight Group (FOG). All partners are committed to delivering the plans set out above.

Transport

Effective and efficient transport solutions are vital to the success of the proposed way forward. The necessary procurement processes have been included within the implementation plan to ensure solutions are in place to support Go Live of the new service models.

Buildings

The total anticipated capital investment required to deliver the proposed changes is £9.2 million, which will be funded through the Trust's internal capital programme.

Summary Box 7.3

8. Implementation Plan

Implementation of the proposed way forward will be led and managed by the NHS Humber Health Partnership, ensuring buy-in from relevant Care Groups and all key partners (including, ambulance providers, primary care, community services, neighbouring providers, VCSE sector, staff, patients and communities).

Implementation will be phased over a two-year period, with Year 1 focused on implementing the key enabling projects and developing detailed pathways and processes to ensure safe and effective changes. Once key enabling changes are in place, implementation of the proposed service moves will be phased over Year 2 – with changes to medical specialty inpatients being undertaken first, followed by changes to surgical specialties.

	Year 1				Year 2				Year 3	
	2024/25		2025/26				2026/27			
	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Enablers										
Medical Specialties										
Trauma Unit										
Emergency Surgery										

Summary Box 8.1

8.1 Implementation Framework

Planning for implementation has been undertaken in parallel with public consultation, recognising that definitive implementation plans cannot be developed until after the outcome of the decision-making process is confirmed and it is clear which, if any, should be taken forward.

Clinical involvement through case study workshops helped to define the interdependencies between different service moves and identify key enabling actions that need to be in place prior to confirmation of a Go Live date for each proposed service move.

8.1.1 Governance

To ensure success, implementation will be clinically led and will involve a wide range of clinical professionals from different backgrounds and organisations. Accountability for delivery will sit with the Group (NLaG and HUTH), working closely with partners and overseen by the Integrated Care Board (ICB).

Given the breadth and scope of the proposed changes, a large number of the newly established Gare Groups will be involved, either directly or indirectly, in implementation of the proposed changes. To ensure this is undertaken smoothly and all interdependencies are mapped and understood, implementation will be overseen by an Implementation Group including representatives from each of the Care Groups involved. The Implementation Group will help to coordinate actions between different Care Groups and ensure teams are working in a coordinated way to implement the proposed changes.

The following Care Groups will be involved in implementing the proposed changes. There are multiple interdependencies between different service changes and workstreams and these will be coordinated via the Implementation Group, ensuring relevant support services and corporate functions are involved at each stage of implementation.

As a minimum, the following Care Groups will be involved in the Implementation Group:

- Cardiovascular
- Specialist Medicine
- Digestive Diseases
- Acute and Emergency Medicine
- Theatres, Anaesthetics and Critical Care
- Specialist Surgery
- Head and Neck
- Family Services
- Community, Frailty and Therapy

The Implementation Group will also coordinate engagement with external partners, including with Primary and Community providers, via the Out of Hospital programme, and ambulance providers. Task and Finish groups will be established as required to undertake specific elements of work and will report into the Implementation Group.

8.1.2 Delivery

Programme management support will be vital to the successful delivery of the proposed changes, which will include access to resource from key corporate services including Estates, Digital, Information, Human Resources, Communications and Finance.

The PMO will 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.

Key workstreams to be undertaken are set out in the table below. These will be adapted and amended as required, to ensure implementation is agile and responds to learning and constant review.

Workstream	**Key areas of focus**
Clinical Governance	SOPs and policies (develop and embed)
	Alignment of pathways with other providers
Workforce	Staff engagement and consultation (if required)
	Rosters and work planning
	Recruitment (if required)
Infrastructure	Estates planning
	Facilities management
Logistics	Equipment and supplies

	Digital/IT
	Support services (e.g., diagnostics, theatres, clinical admin)
Transport	Ambulance (emergency 999) protocols
	Inter-hospital transfers solution
	Mitigating non-statutory transport plan
Corporate support	Communications
	Procurement and Legal

Table 8.1 Summary of implementation workstreams

8.2 Implementation Plan

8.2.1 Overview

A detailed plan for implementation has been developed for the proposed way forward recommended within this DMBC. The plan has been developed with input from clinical and operational teams with responsibility for each specialty impacted. In addition, the plan incorporates key mitigation measures identified through the consultation and Integrated Impact Assessment (IIA) review process.

The implementation will be phased over a two-year period, with year one focused on planning and putting in place the key enablers to facilitate successful transition to the new model of care. Key actions for year one include:

Theme	Key actions
Productivity	• Optimisation of SDEC, frailty pathways and length of stay.
Clinical pathways	• Clinical design, review and sign-off of diversionary and transfer pathways (internal and with partners, e.g., ambulance providers). • Detailed review of surgical activity and theatre utilisation mapping. • Embedding Paediatric community-first model.
Transport	• Procurement of right-sized inter-hospital transfer (IHT) solution. • Implementation of non-statutory transport action plan.
Buildings / infrastructure	• C-floor enabling works (refurbishment/upgrades). • Design, planning and procurement for critical care unit re-build (construction in Yr2).
Communications and engagement	• Staff consultation (as required) – undertaken as a rolling programme of consultation for any potentially impacted staff, linked to each service change. • Communications (internal and external) – undertaken as a rolling programme linked to each key service change.

Table 8.2 Year 1 enabling actions

These actions will enable the proposed changes to medical specialties to be implemented at the beginning of year two and the surgical pathway changes towards the end of year two. Construction of the new critical care unit will take place during year two. The addition of RSU beds within the respiratory ward will enable the medical specialties to proceed with consolidation prior to the completion of the new critical care unit by adding additional capacity for high dependency patients. The new purpose-built unit will support further improvements when it comes on stream.

HR teams within the Group will provide support for any staff consultation that becomes necessary in relation to implementing the proposed change. Impacted services and staff will be identified early and teams will work with any staff impacted well before the launch of formal consultations processes. Ahead of an agreed go live date, a staff consultation process will be carried out with members of staff where roles are significantly impacted the proposed changes. Wider communications support will be ongoing to ensure the public know and understand the proposed changes and any impact they might have – including providing reassurance that Scunthorpe's Emergency Department remains open.

Throughout the implementation process there will be continual review and plans will be amended accordingly. Clinical governance and alignment with partners – in particular ambulance services, primary care and other out of hospital providers – will be vital and will form a key workstream within the implementation group.

8.2.2 Implementation timeline

A timeline for implementation has been produced identifying the high-level actions and interdependencies between projects – as set out in the table below:

Ref	Service	24/25		25/26				26/27			
		Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
	Trauma Unit										
1	Trauma Unit consolidation to DPoW *(align with T&O)*										
	Medical Speciality Inpatients										
2	Cardiology inpatients consolidation to DPoW										
3	Gastroenterology inpatients consolidation to DPoW										
4	Respiratory inpatients consolidation to DPoW										
	Emergency Surgery inpatients										
5	Trauma & Orthopaedics (T&O) consolidation to DPoW										
6	Acute General Surgery consolidation to DPoW										
7	Urology consolidation to SGH *(continuation)*										
8	ENT consolidation to DPoW (continuation)										
9	Ophthalmology surgical emergencies consolidation to HRI										
	Paediatrics										
10	Embed Hospital @ Home in North Lincolnshire										
11	Develop Paediatric SDEC model										
12	Review paediatric critical care model										
	Enablers										
a	Optimise SDEC and frailty pathways										
b	Optimise Length of Stay *(within existing pathways)*										
c	Activity review - mapping theatre utilisation										
d	Detailed clinical pathways (internally and with partners, e.g. EMAS)										
e	Staff consultation (rolling programme, as required)	*Planning*									
f	Transport (IHTs/PTS) - procurement of new/enhanced service	*Planning*	*Procurement*		*Implementation*				*Review*		
g	Transport (non-statutory) - contract/support to community transport	*Planning*	*Procurement/grant support*		*Implementation*				*Review*		
h	Capital: DPoW Critical Care co-located unit (ITU and HDU to relocate)		*Design*		*Tender & Mob*	*Construction*					
i	Capital: DPoW C-Floor enabling works	*Design*	*Tender*	*Works*							
j	Communications to support changes (rolling programme, as required)			*Planning*							

Figure 8.1 High-level implementation timeline

Implementation will be phased over a two-year period, with Year 1 focused on implementing the key enabling projects and developing detailed pathways and processes to ensure safe and effective changes. Once key enabling changes are in place, implementation of the proposed service moves will be phased over Year 2 – with changes to medical specialty inpatients being undertaken first, followed by changes to surgical specialties.

Summary Box 8.2

9. Conclusions and Recommendation

Fully considering the views and evidence provided during the public consultation alongside other material information – such as changes to policy, regulations or clinical standards and updated activity and workforce modelling – a revised proposal is recommended, as set out in the table below.

Service area	Original Proposal	Revised proposal
Trauma Unit	Consolidate to DPoW	Consolidate to DPoW
Emergency surgery	Consolidate to DPoW	Consolidate to one site (mixed approach)
– *Trauma and Orthopaedics*		– Consolidate to DPoW
– *Acute General Surgery*		– Consolidate to DPoW
– *Urology*		– Consolidate to SGH
– *ENT*		– Consolidate to DPoW
– *Ophthalmology*		– Consolidate to HRI
– *Gynaecology*		Retain on both sites – align to obstetrics review
Some medical specialities	Consolidate to DPoW	Consolidate to DPoW
– *Cardiology*		
– *Respiratory*		
– *Gastroenterology*		
Paediatric overnight (inpatient) care	Consolidate to DPoW	Retain inpatient beds on both sites but work towards a reduction in beds through implementation of community-based paediatrics model

Table 9.1 Summary of revised proposal

Benefits

- Improved quality of specialist care, fewer delays, better clinical outcomes.
- Shorter waiting times, reduced length of stay and improved flow.
- Improved recruitment, retention and training opportunities for staff.

Impact

- Around 7 patients per day transferred from SGH to DPoW for specialist inpatient care.

Mitigations

- Transport – to support those impacted most by the proposed change.
- Processes and procedures – to ensure effective operating of the model.

Summary Box 9.1

9.1 Recommendation

The Public Consultation sought views on the ICB's proposal to change the way some more complex medical, urgent and emergency care and paediatric (children's) services are delivered at hospitals in Scunthorpe and Grimsby (Scunthorpe General Hospital and Diana Princess of Wales Hospital, Grimsby).

The aim of the proposed change was to improve services for those with the most urgent and complex needs, keeping them safe and of high quality in the long term.

9.1.1 Revised proposal

Fully considering the views and evidence provided during the public consultation alongside other material information – such as changes to policy, regulations or clinical standards and updated activity and workforce modelling – a revised proposal is recommended, as set out in the table below.

Service area	Original Proposal	Revised proposal
Trauma Unit	Consolidate to DPoW	Consolidate to DPoW
Emergency surgery	Consolidate to DPoW	Consolidate to one site (mixed approach)
– *Trauma and Orthopaedics*		– Consolidate to DPoW
– *Acute General Surgery*		– Consolidate to DPoW
– *Urology*		– Consolidate to SGH
– *ENT*		– Consolidate to DPoW
– *Ophthalmology*		– Consolidate to HRI
– *Gynaecology*		Retain on both sites – align to obstetrics review
Some medical specialities	Consolidate to DPoW	Consolidate to DPoW
– *Cardiology*		
– *Respiratory*		
– *Gastroenterology*		
Paediatric overnight (inpatient) care	Consolidate to DPoW	Retain inpatient beds on both sites but work towards a reduction in beds through implementation of community-based paediatrics model

Table 9.2 Summary of revised proposal

9.1.2 Benefits

Bringing specialist services together in one place will enable specialist teams to enhance their skills by seeing more patients and developing expertise and sub-specialist skills. The ability to implement 7-day consultant-led care across the specialist services will improve the quality of care patients receive and reduce their length of stay in hospital by getting them to the right specialist care sooner. Consolidation will generate efficiencies and drive productivity gains in use of theatres and patients will benefit from being treated in a specialist centre. The proposed model will also support recruitment and retention, presenting a more attractive offer for current and future clinical staff.

9.1.3 Impacts

The total anticipated impact of the proposed way forward (across all specialties) is that around 7 patients per day will be transferred from Scunthorpe to Grimsby for their care. The impacts of the proposed change are set out in more detail in the Integrated Impact Assessment IIA (see section 6.2).

9.1.4 Mitigations

A range of mitigations have been included within the Implementation Plan to address key concerns raised through consultation and to ensure the proposed model of care operates effectively and efficiently. These are set out in more detail in section 6.3.

9.1.5 Assurance and tests for service change

When considering substantial service change, NHS England follows a set of key tests to ensure effective planning and implementation. These tests help guide decision-making in the best interests of patients.[75]

In developing this Decision-Making Business Case (DMBC), a review against the four key tests – plus the additional "beds test" – has been undertaken to ensure the proposed way forward meets the requirements set out by NHS England. A self-assessment against these tests is provided in the table below.

By undertaking a robust consultation process and responding to issues raised, the proposed way forward demonstrates an ongoing commitment to strong public and patient engagement and consistency with future need for patient choice. Concerns and issues raised by consultees have been recorded, considered and responded to within the proposals set out in this DMBC.

A clear clinical evidence base has been used in both the design and review of proposed changes. This included a review of clinical interdependencies, using the South East Clinical Senate guide to Clinical Co-dependencies of Acute Hospital Services, to ensure the proposed way forward meets clinical adjacency requirements to safely deliver urgent and emergency care.[76]

Clinical leadership and ongoing involvement of key clinical stakeholders will ensure the proposals will deliver improved clinical outcomes. Clinical decision-makers have been – and will continue to be – involved in reviewing and approving the recommendations within this DMBC.

The proposal will deliver a net reduction in the inpatient bed base across northern Lincolnshire. This will be achieved through a combination of interventions, including:

- Improvements to integrated frailty care to reduce Emergency Department attendances and inpatient admissions for the frail population.

[75] See NHS England (2018) *Planning, Assuring, and Delivering Service Change for Patients* Service Change Guidance for more detailed guidance.

[76] This guide was used to develop the original model but has subsequently been updated and re-issued. To ensure the proposed model of care still provided the appropriate on-site services to meet the requirements set out in the guidance, a review was undertaken to identify any changes to the updated guidance that might impact upon the model. The review demonstrated that there were no material changes to the guidance that impacted upon the services in scope for change and therefore the proposed way forward will ensure that Scunthorpe General Hospital and Diana Princess of Wales Hospital (DPoW) will continue to provide the necessary on-site services to safely operate an Emergency Department. See South East Clinical Senate (2024) *The Clinical Co-Dependencies of Acute Hospital Services* Clinical Co-Dependencies Matrix

- Reductions in length of stay (LoS) driven by improved service models (e.g., move to 7-day consultant-led care and consolidated bed base for specialist medicine).

Prudent estimates of the potential impacts have been used in calculating required bed capacity to ensure all system partners have confidence in delivery of these plans.

Tests for service change		Evidence of meeting them
☑	Strong public and patient engagement	• Extensive engagement of patients, the public, staff and other stakeholders in consultation (c.4,000 responses + c.2,500 people involved in events). • Ongoing involvement of public representatives and Overview and Scrutiny Committees (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. • Revised proposal responds to issues and challenges raised by clinical teams through consultation.
☑	Support for proposals from clinical commissioners	• Integrated Care Board (clinical and managerial) involvement in conscientious consideration of feedback and design of proposed way forward.
☑	Alternative provision in place to enable bed reductions	• Strong collaborative working will ensure 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.

Table 9.3 Summary of compliance with tests for service change

The NHS Humber and North Yorkshire Integrated Care Board (ICB) is recommended to:

- Endorse the proposed way forward for service change (as set out in this DMBC), which has been developed following their review of the consultation feedback and takes account of key issues and concerns raised by consultees.
- Work with key partners to deliver the proposed Transport Action Plan, including increasing support to the existing community transport provider to help mitigate the potential impacts of the proposed change.

Summary Box 9.2

10. Appendices

A. How we have listened

10.1 List of Consultation Events/Activities

Event/Activity	Date	Approximate number of participants
Public Exhibition Events		
Goole (included 3 break-out discussion sessions)	12th October 2023	88 (13 attended break-out discussion sessions)
Grimsby (included 2 break-out discussion sessions)	16th October 2023	12 (8 attended break-out discussion sessions)
Scunthorpe (1) (included 4 break-out discussion sessions)	20th October 2023	98 (27 attended break-out discussion sessions)
Scunthorpe (2)	4th December 2023	36
Gainsborough	7th December 2023	5
Scunthorpe (3)	9th December 2023	135
Pop-up Engagement Roadshows		
Crowle Community Hub	11th December 2023	20
Immingham Civic Centre Hub	20th November 2023	50
Brigg Garden Centre	21st November 2023	30
Scunthorpe Christmas Market	25th November 2023	200
ASDA Scunthorpe	28th November 2023	180
Louth Library	29th November 2023	12
Additional Engagement		
Patient engagement at Goole Outpatient Department and canteen	8th November 2023	15+
Patient engagement at Scunthorpe Hospital Outpatient Department and canteen	6th November 2023	80
Patient engagement at Scunthorpe Hospital Outpatient Department and canteen	9th November 2023	40
Online deliberative event	6th December 2023	4
Promotional Warm Up Events		
Goole Leisure Centre	10th October 2023	50
Grimsby Freeman Street Market	10th October 2023	45
The Pods at Scunthorpe	17th October 2023	50

Activity	Core audience/demographic/meeting type	Approx. no. of participants	Date	Location
Drama-based workshop Playing ON sessions (young people and vulnerable adults)	Adults with experience of homelessness/substance misuse	9	15/11/23	Scunthorpe
	Adults with learning difficulties (Starlight Arts)	26	16/11/23	Scunthorpe
	Children aged 7-11	2	25/10/23	Scunthorpe
	Young people aged 8-14	8	15/11/23	Scunthorpe
	Parents of children attending 8-14 years Playing ON session	3	15/11/23	Scunthorpe
Targeted focus group discussions and in-depth conversations	Armed forces veterans (mainly men aged 55+)	11	13/12/23	Scunthorpe
	Autism support worker specialising in neurodivergence and LGBTQ+	1	20/12/23	Online (Microsoft Teams)
	Carers Voice Northern Lincs	5	17/11/23	Scunthorpe
	Parent-carers of children with SEND and/or complex health and care needs (including current carers, ex-carers, and professionals from Carer Support)	15		Brigg
	Experts by experience (carers, ex-carers, people with learning disabilities)	12	08/11/23	Ashby
	Male group	40	24/11/23	Islamic Centre
	Members of the Learning Disability Partnership and carers	4	04/12/23	Scunthorpe
	Members of the LGBTQ+ community	2	19/12/23	Grimsby
	Men in Sheds (men experiencing social isolation due to, e.g., substance misuse, homelessness, disability, health issues, mental ill-health)	12	23/11/23	Epworth
	Mindful Sisters Coffee Morning (Black, Asian and Minority Ethnic women)	7	11/12/23	Scunthorpe
	Moorlands Community Centre Luncheon Club (mix of people from various equalities groups)	17	18/12/23	Goole
	Mothers of children with Special Educational Need and Disability (SEND)	3	17/11/23	Scunthorpe
	North Lincolnshire parent/carers of children with SEND and/or other complex health and care needs	3	17/11/23	Scunthorpe
	Parent/carer at a drop-in public exhibition	80		Scunthorpe
	People living in a deprived area of Scunthorpe	30	6/12/23	Ashby Hub, Scunthorpe
	People living in areas of deprivation, including several mothers of children with SEND and/or health issues	8	19/10/23	Scunthorpe

	People living in a highly deprived area of Barton	15	14/12/23	Viking Community Centre, Barton
	People living in a highly deprived area of Grimsby at a drop-in exhibition	20	20/11/23	Centre 4, Grimsby
	Representatives of local Voluntary, Community or Social Enterprise (VCSE) organisations	5	08/12/23	Online
	Sikh Gurdwara	5	24/11/23	Scunthorpe
	Scotter Textile Group members	12	27/11/23	Scotter
	Winterton Disabled Club (older people living in a rural area, predominantly with physical disabilities)	25	29/11/23	Winterton
	Winterton Seniors Forum (aged 65+)	23	09/11/23	Winterton
NHS staff discussions	Allied Health Professionals and support teams in Radiology in Northern Lincolnshire and Goole (NLaG)	18	17/11/23	NLaG
	Clinical Admin Forum	63	19/10/23	NLaG
	Digital and information workstream meeting	11	02/10/23	Online
	Goole Hospital staff	10+	08/11/23	Goole Hospital
	ICB Roadshow with staff in Scunthorpe	30	04/10/23	Scunthorpe
	ICB Roadshow with staff in Willerby	20	05/10/23	Willerby
	ICB Roadshow with staff in York	15	09/10/23	York
	Joint Medical Advisory Committee (MAC) and Hospital Consultant Committee (HCC) meeting	17	13/11/23	Online
	Joint MAC and HCC meeting for consultants	17	09/10/23	Online
	Joint Liaison and Negotiating Committee (NLaG)	15	20/11/23	Online
	Joint Negotiating Consultative Committee	30	20/11/23	Online
	NLaG Children's Safeguarding team	3	17/10/23	Online
	NLaG theatre nursing and support teams	32	13/11/23	Online
	Staff evening Q&A session (NLAG and HUTH)	1	11/12/23	Online
	Staff morning Q&A session (NLAG and HUTH)	12	27/11/23	Online
	Trust-wide anaesthetic briefing (anaesthetic consultants, specialty and specialist doctors, NLaG theatre managers)	50		Online
	Trust-wide theatres briefing (NLaG)	40		Online
	Urology business meeting (Urology consultants, specialty and specialist doctors, clinical nurse specialists, Urology business team)	35		Online

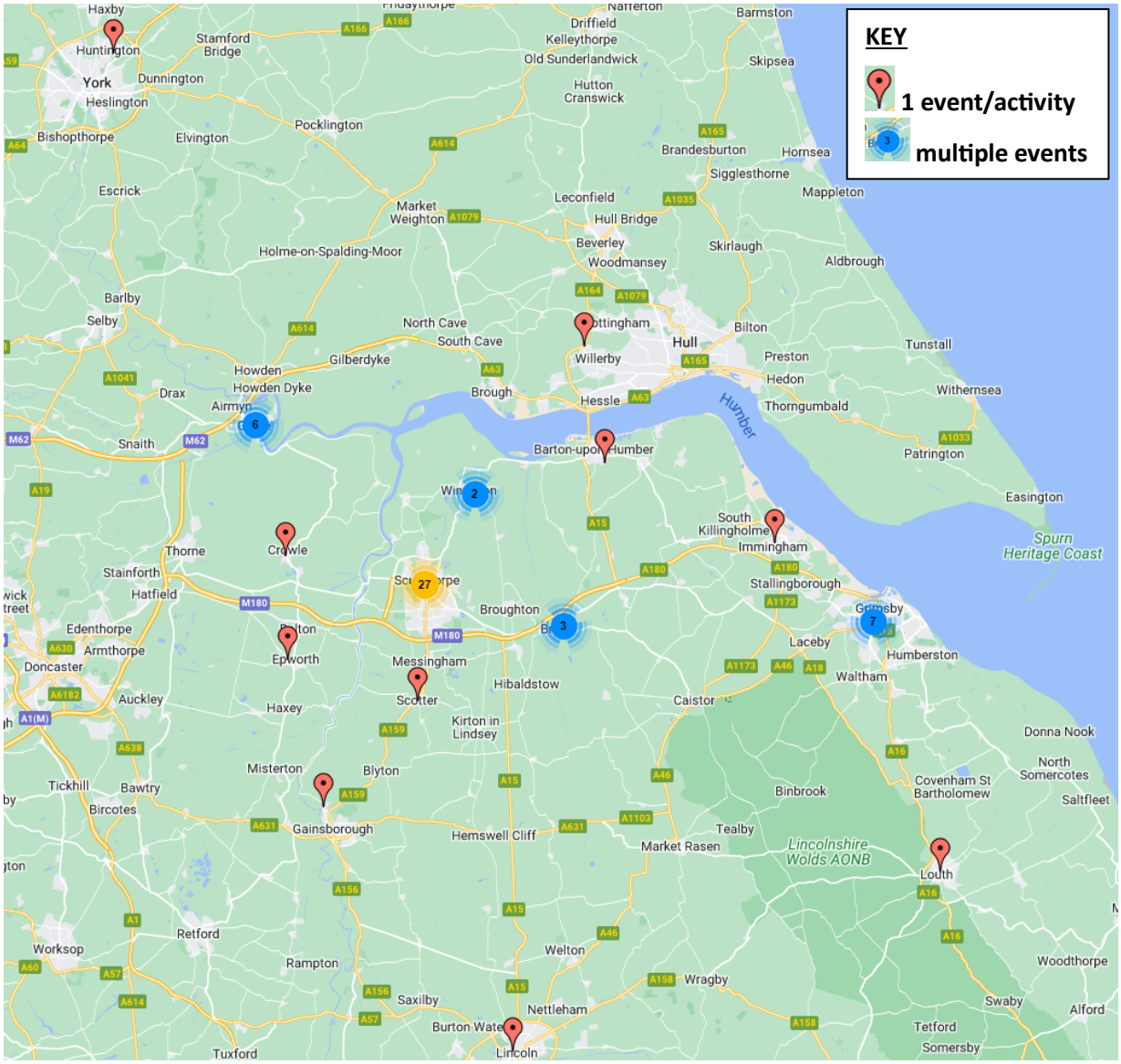
Discussions with external clinical stakeholders	Yorkshire & Humber Paediatric Critical Care Operational Delivery Network Executive Group	50	17/10/23	Online
	North Yorkshire and Humber Major Trauma Operational Delivery Network	30	07/12/23	Online
	South Yorkshire Major Trauma Strategic Board Operational Delivery Network	40	26/09/23	Online
	Critical Care Operational Delivery Network	50		Online
	Operational Manager representatives from the East Midlands Ambulance Service and the Yorkshire Ambulance Service	12	16/11/23	Online
	Meeting with representatives from Lincolnshire ICB and United Lincolnshire Hospitals NHS Trust (ULHT)	10	19/10/23	Online
	Primary and Secondary Care Interface Group	30	02/11/23	Online
	Mental health practitioners and service providers (Paediatric Mental Health Act/CAMHS/Community Eating Disorders)	11	20/11/23	Online
	Clinical leads for trainees and deanery doctors	5	17/10/23	Online
	Meeting with representatives from Doncaster and Bassetlaw Teaching Hospitals Trust (DBTHT) and South Yorkshire ICB	10	28/09/23	Online
	Embrace Transport (for infants/children who require care in another hospital in the region or further afield)	6	25/10/23	Online
	Meeting with representatives from Navigo and RDaSH (mental health providers) to discuss impacts of the proposed paediatric changes	7	19/10/23	Online
	Humber Clinical and Professional Leaders' Board meeting (covered in its own section as it comprises both internal and external stakeholders)	12	11/10/23	Online
Discussions with political and statutory stakeholders and partner organisations	North Lincolnshire Council Conservative group	12	27/11/23	Scunthorpe
	North Lincolnshire Council Labour group	18	13/11/23	Scunthorpe
	Humber Acute Services & Safeguarding Children	5	17/10/23	Online
	NEL Health and Care Partnership Leadership Group x2	18	12/10/23 and 09/11/23	Online
	NL Place Partnership meeting x2	12	19/10/23 and 16/11/23	Online
	Humber and North Yorkshire Inclusion Assembly	25	23/11/23	Online
	Integrated Children's Trust	20	13/12/23	Online

	North Lincolnshire Health and Wellbeing Board	21	02/10/23	Scunthorpe
	Joint Health Overview and Scrutiny Committee	15	17/10/23	Scunthorpe
	North Lincolnshire Overview and Scrutiny Committee	15	03/10/23	Scunthorpe
	North East Lincolnshire Overview and Scrutiny Committee	24	04/10/23	Grimsby
	Lincolnshire County Council Overview and Scrutiny Committee	20	08/11/23	Online
	East Riding of Yorkshire Council workshop	10	28/11/23	Beverley

Table 10.1 List of consultation events and activities

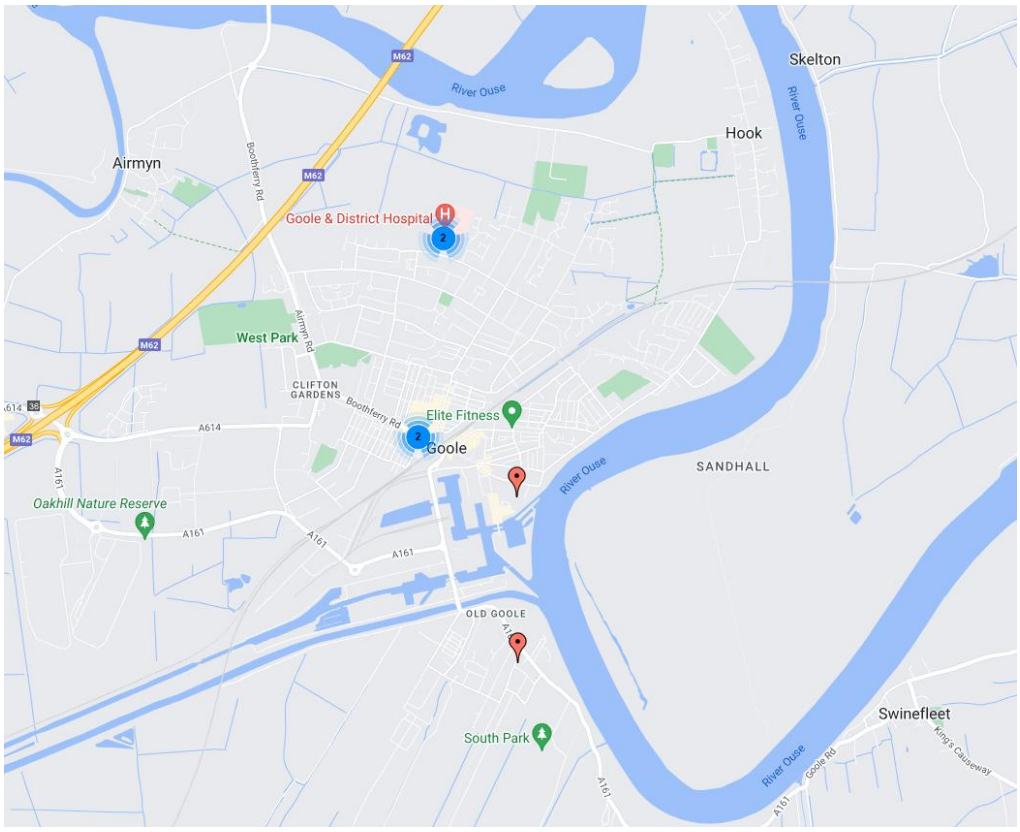
10.2 Maps of Consultation Activities

10.2.1 Overview of all engagement activities



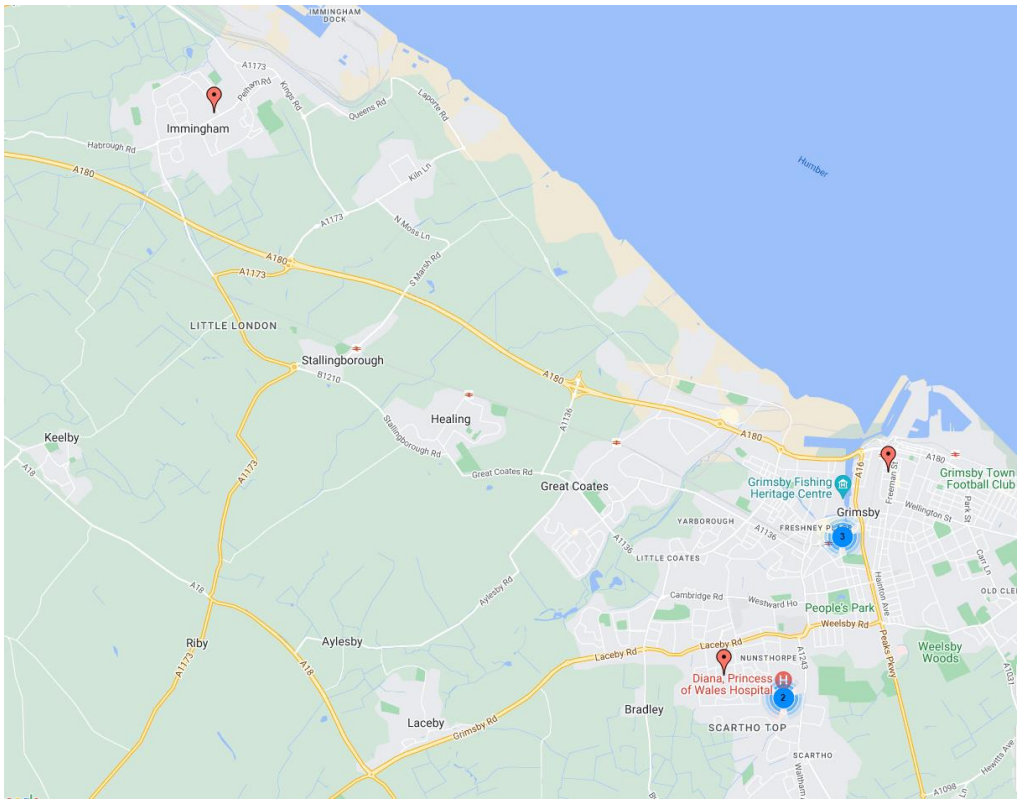
Picture 10.1 Humber and North Yorkshire - map of engagement venues

10.2.2 Goole



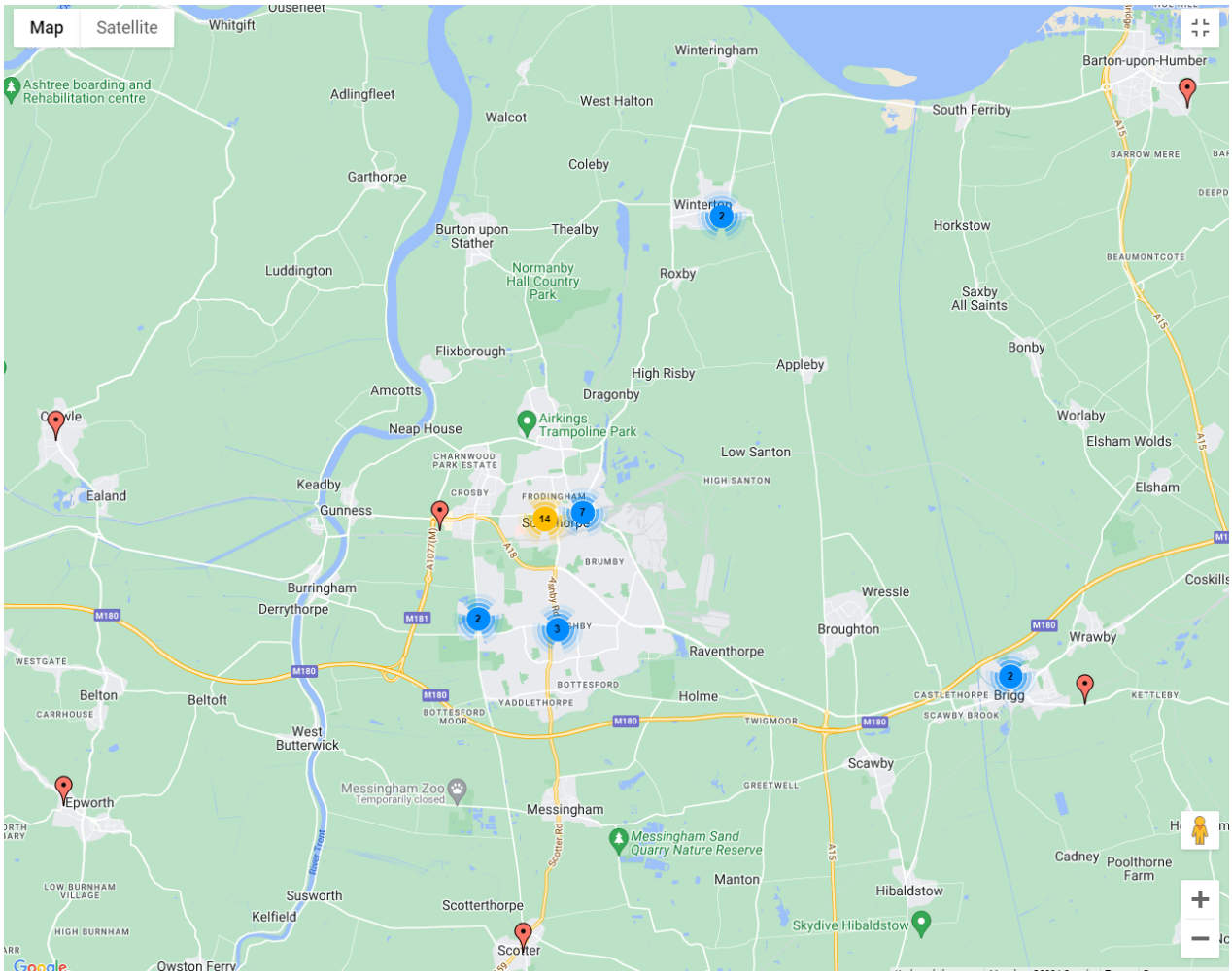
Picture 10.2 Goole - map of engagement venues

10.2.3 North East Lincolnshire



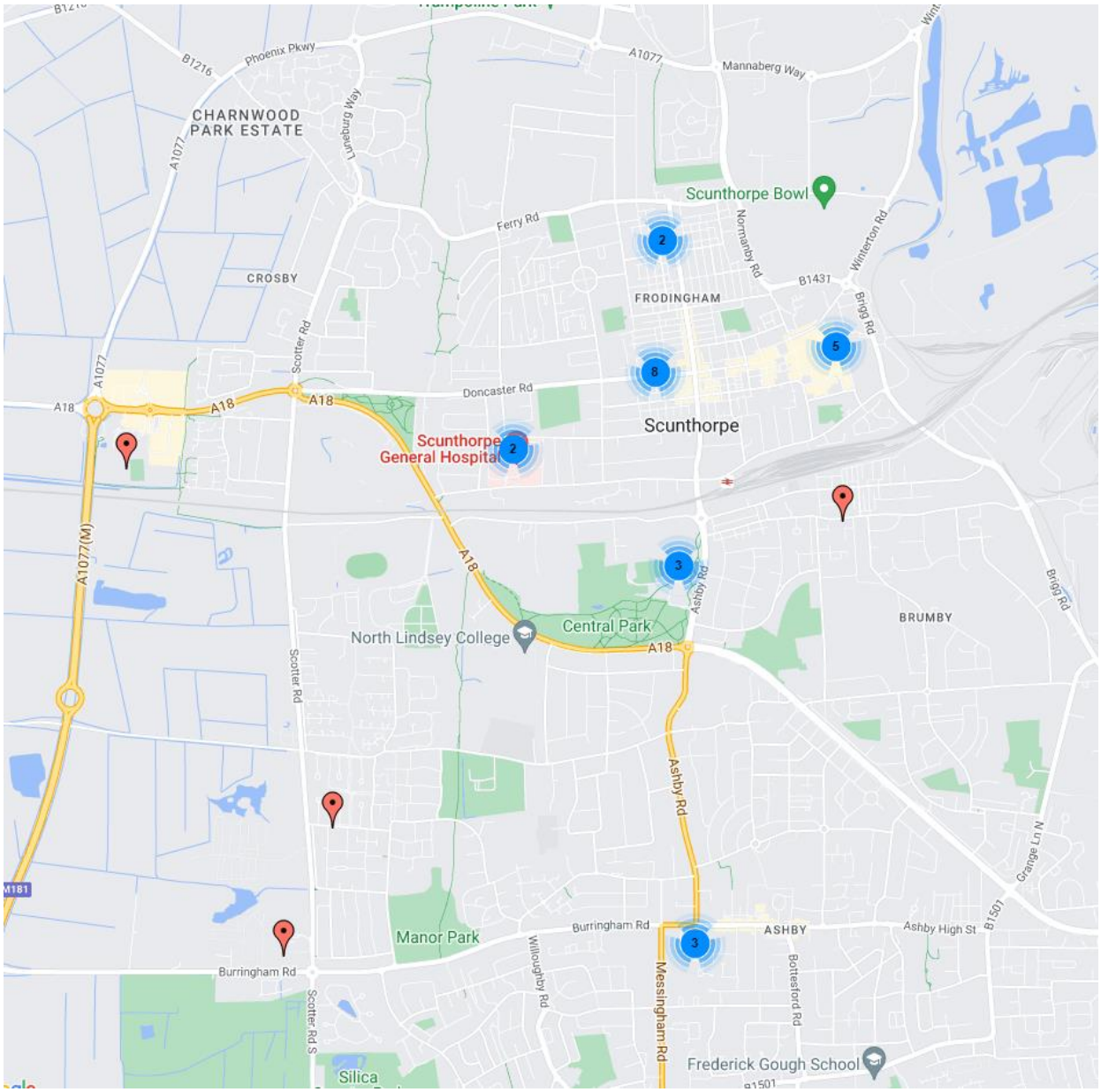
Picture 10.3 North East Lincolnshire - map of engagement venues

10.2.4 North Lincolnshire



Picture 10.4 North Lincolnshire - map of engagement venues

10.2.5 Scunthorpe



Picture 10.5 Central Scunthorpe - map of engagement venues

10.3 List of Promotion and Distribution

Category	Organisation/Stakeholder Type	Number of organisations	
		Email	Leaflets
Formal Consultees	Acute Hospital Trusts	8	3
	Ambulance Trusts	2	
	Community Services Providers	4	3
	Emergency Services	2	
	Neighbouring ICBs	2	
	Local Authorities *(Including HOSC and HWBB Chairs)*	10	
	Mental Health Trusts	4	
	MPs	13	
VCSE Partners	BAME	1	
	Children and Young People	10	1
	Deprivation	4	7
	Disabled	3	1
	Drug and Alcohol Dependency	3	
	Elderly	4	
	Homeless	3	1
	LGBTQ+	3	
	Long-Term Health Conditions	13	
	Mental Health	4	4
	Other (e.g. Healthwatch, HEY Smile, VANL)	6	9
	Parents and Carers	9	3
Public Sectors Partners	Children's Centres		16
	Family Hubs		3
	Job Centres		4
	Libraries		18
Industry / Business	e.g., Steelworks, Ports, Refineries	45	
NHS Partners	GP Practice		47
	Communications Network (for onward cascade)	7	
Patient representatives (e.g., PPG chairs)	e.g., Citizen's Panel, PPG Representatives	115	
Total organisations contacted		**275**	**120**
Grand Total organisations contacted			**395**

Table 10.2 Email and digital promotion (organisations)

10.4 Record of Document Distribution

Organisation	Documents sent	Quantity (Approx)	Date
NEL Carers Centre	Consultation Document	50	28/09/2023
Winterton Disability Group	Consultation Document	50	17/10/2023
Public (request)	Consultation Document	1	18/10/2023
Louth Town Council	Consultation Document	1	18/10/2023
Louth Town Council	Printed questionnaire	10	18/10/2023
Public (request)	Consultation Document	1	18/10/2023
Public (request)	Consultation Document	1	18/10/2023
Public (request)	Consultation Document	1	18/10/2023
Public (request)	Consultation Document	1	18/10/2023
Cloverleaf Advocacy	Easy Read documents and questionnaires	22	18/10/2023
Northern Lincolnshire and Goole Trust	Summary documents	1000	07/11/2023
North Lincolnshire Council	Summary documents	100	07/11/2023
North Lincolnshire Council	Consultation Document	25	07/11/2023
North Lincolnshire Council	Printed questionnaire	25	07/11/2023
North Lincolnshire Council	Multi-language leaflet	10	07/11/2023
Public (request)	Consultation Document	2	13/11/2023
Public (request)	Consultation Document	2	05/12/2023
Linkage College	Easy Read documents and questionnaires	80	05/12/2023
Public (request)	Consultation Document	2	05/12/2023
Public (request)	summary documents and questionnaires	4	14/12/2023
Public (request)	Easy Read documents and questionnaires	20	14/12/2023
North Lincolnshire Council	Consultation Document	140	15/12/2023
Ropewalk Cafe	Posters, Summary Documents	20	14/12/2023
Tesco, Barton	Posters, Summary Documents	10	14/12/2023
Central Surgery	Posters, Summary Documents, Business cards	30	14/12/2023
Job Centre, Barton	Posters, Summary Documents, Business cards	30	14/12/2023
Boots Pharmacy, Barton	Posters, Business Cards	30	14/12/2023
Baysgarth Leisure Centre	Posters, Summary Documents, Business cards	30	14/12/2023
Baysgarth Library	Posters, Summary Documents, Business cards	30	14/12/2023
Experts by Experience	Easy Read documents and questionnaires	20	08/11/2023
Mindful Sisterhood	Consultation Document	25	11/12/2023
The Arc	Consultation Document	20	17/10/2023
Men in Sheds	Consultation Document	20	23/11/2023
Veterans Hub	Consultation Document	30	13/12/2023
Starlight Arts	Easy Read documents and questionnaires	30	11/12/2023
The Forge	Consultation Document	20	15/11/2023
North Lincolnshire Council	Summary Documents	200	15/12/2023
Immingham Over 60s Group	Summary documents	100	20/11/2023
Louth library	Posters, Summary Documents, Business cards	30	29/11/2023

Centre4	Posters, Summary Documents, Business cards	30	22/11/2023
Wetherspoons – The Blue Bell, Oswald Road, Scunthorpe	Posters, Summary Documents	11	27/11/2023
Premier shop, Doncaster Road, Scunthorpe	Posters, Summary Documents	11	27/11/2023
HELP charity shop, Dunstall Street, Scunthorpe	Posters, Summary Documents	11	27/11/2023
Market Asia, Clarke Street, Scunthorpe	Posters, Summary Documents	11	27/11/2023
Weldricks Pharmacy, Ironstone Centre	Posters	1	27/11/2023
Shah's Uniforms, West Street, Scunthorpe	Posters, Summary Documents	11	27/11/2023
West Street Children's Centre, West Street, Scunthorpe	Posters, Summary Documents	12	27/11/2023
Crosby Community Association, Frodingham Road, Scunthorpe	Posters, Summary Documents	12	27/11/2023
Sainsburys, Doncaster Road, Scunthorpe	Posters	1	27/11/2023
HA Stores and Post Office, Henderson Avenue, Scunthorpe	Posters	1	27/11/2023

Table 10.3 Document Distribution

10.5 List of Media Coverage

Date	Media outlet	Headline and summary content
13 July	Health Services Journal (HSJ)	**Plans to downgrade A&E services revealed**
2 August	BBC Look North	**Humber Acute Services Review plans**
2 August	ITV Calendar	**Humber Acute Services Review plans**
14 August	Grimsby Live	**The full changes proposed at Scunthorpe and Grimsby hospitals and the reasons why** Subject to approval by NHS England, the plans will go to public consultation around the end of September.
16 August	Grimsby Live	**Petition created to oppose possible Scunthorpe General Hospital changes** Trauma and emergency out of hours surgery could move from Scunthorpe to Grimsby - but the changes will be subject to a public consultation if they do progress any further.
16 August	BBC Radio Humberside	**Scunthorpe Hospital proposals – petition launched**
CONSULTATION LAUNCH		
25 September	ITV1 Yorkshire East	**ITV1 Yorkshire East - Mon, 25 Sep 2023 22:41:58 BST - ITV News Calendar** ITV News Calendar, ITV1 Yorkshire East - 25/09/2023 22:41:58 A public consultation's started on potential changes to hospitals in Northern Lincolnshire, including a proposal to move the trauma unit in Scunthorpe to Grimsby.
25 September	BBC 1 North (Yorks & Lincs) Look North (East Yorkshire	**BBC 1 North (Yorks & Lincs) - Mon, 25 Sep 2023 22:32:00 BST - Look North (East Yorkshire and...** Look North (East Yorkshire and..., BBC 1 North (Yorks & Lincs) - 25/09/2023 22:32:00 Hospital patients could see services moving out of Scunthorpe to Grimsby - including overnight emergency surgery
25 September	BBC 1 North (Yorks & Lincs) Look North (East Yorkshire	**BBC 1 North (Yorks & Lincs) - Mon, 25 Sep 2023 18:39:23 BST - Look North (East Yorkshire and...** Look North (East Yorkshire and..., BBC 1 North (Yorks & Lincs) - 25/09/2023 18:39:23 Hospital patients could see services moving out of Scunthorpe to Grimsby - including overnight emergency surgery.
25 September	BBC Radio Humberside	**BBC Radio Humberside - Mon, 25 Sep 2023 14:00:24 BST** BBC Radio Humberside - 25/09/2023 14:00:24 There is concern from people living in northern
26 September	BBC News	**Scunthorpe hospital set to lose trauma unit under NHS plan (Web)** BBC News - 26/09/2023 Scunthorpe General Hospital could lose some of its services, including its trauma unit, under new NHS proposals.
26 September	BBC 1 North (Yorks & Lincs) Look North (East Yorkshire	**BBC 1 North (Yorks & Lincs) - Tue, 26 Sep 2023 18:55:28 BST - Look North (East Yorkshire and...** Look North (East Yorkshire and..., BBC 1 North (Yorks & Lincs) - 26/09/2023

		18:55:28 Report on the plans to downgrade the services offered at Scunthorpe hospital.
26 September	Grimsby Telegraph	**NHS wants views on plans to move hospital services** Grimsby Telegraph - 26/09/2023 p6 News. Ivan Morris Poxton. PEOPLE can now have their say on potential changes to hospitals in northern Lincolnshire, which include a proposal to move a trauma unit from Scunthorpe General Hospital to Grimsby.
26 September	Viking Radio	**NHS propose moving some services from Scunthorpe to Grimsby hospital** A trauma unit, overnight emergency surgery, paediatric overnight care, and other selected medical specialities are all areas that could move from Scunthorpe General Hospital to Diana Princess of Wales Hospital in Grimsby.
27 September	Nursing Standard	**Hospital could lose vital services due to nurse shortages** Consultation wants your views on proposal to move emergency surgery from Scunthorpe General Hospital to another site amid concerns that care has become 'unsafe and unsustainable'
27 September	Planet Radio	**NHS propose moving some services from Scunthorpe to Grimsby hospital (Web)** Planet Radio - 27/09/2023 The NHS wants your views on proposals to move specialist care services.
02 October	Grimsby Live	**Conservatives and Labour unite to oppose Scunthorpe General Hospital changes (Web)** Grimsby Live - 02/10/2023 Labour and Conservative councillors in Scunthorpe plan to oppose proposed changes to services at Scunthorpe General Hospital, including the loss of its trauma unit.
02 October	Viking FM	**Viking FM - Mon, 2 Oct 2023 12:02:24 BST** Viking FM - 02/10/2023 12:02:24 Labour and Conservative councillors in Scunthorpe plan to oppose proposed changes to the general hospital there.
02 October	Radio Lincs FM	**Radio Lincs FM - Mon, 2 Oct 2023 12:01:42 BST** Radio Lincs FM - 02/10/2023 12:01:42 Both Labour and Conservative councillors in Scunthorpe plan to oppose changes to the general hospital there.
10 October	Yorkshire Post	**Planned loss of hospital services 'death by a thousand cuts'** Yorkshire Post - 10/10/2023 p9 News. Harriet Sutton COUNCILLORS have voted unanimously to oppose the proposed removal of some services from Scunthorpe General Hospital to Grimsby - and threatened a judicial review if it happens.
11 October	Local Government Lawyer	**Local authority threatens judicial review over proposed transfer of hospital services (Web)** Local Government Lawyer - 11/10/2023 North Lincolnshire Council has threatened judicial review proceedings over proposals to move some services out of Scunthorpe General Hospital, if local people's views are not given the weight they deserve when deciding on the future of health services in the area".

12 October	Planet Radio	**Council not going to lie down over hospital changes, says leader (Web)** Planet Radio - 12/10/2023 A public consultation on proposed changes to services in Scunthorpe and Grimsby is running until 5 January.
12 October	Goole Times	**Make your voice heard on hospital plans** Goole Times - 12/10/2023 p9 News. People in our area are being invited to attend a public consultation about plans to change some hospital services in our area.
12 October	Scunthorpe Telegraph	**Council threatens judicial review if hospital service changes go ahead** Scunthorpe Telegraph - 12/10/2023 p5 News. Ivan Morris Poxton. NORTH Lincolnshire Council members have voted unanimously to oppose the proposed removal of some services from Scunthorpe General Hospital to Grimsby, and threatened a judicial review if it happens anyway.
13 October	BBC News	**Scunthorpe hospital changes to be shared at drop-in sessions (Web)** BBC News - 13/10/2023 Under the plans, a trauma unit and out-of-hours emergency overnight surgery would be moved to Diana, Princess of Wales Hospital in Grimsby.
13 October	Grimsby Telegraph	**Trade union condemns controversial proposals to move some hospital services from Scunthorpe to Grimsby (Web)** Grimsby Telegraph - 13/10/2023 A trade union has condemned the controversial proposals to move some crucial services out of Scunthorpe General Hospital to Grimsby's Diana, Princess of Wales Hospital, stating that the plans require "proper consultation".
13 October	Grimsby Telegraph	**Goole drop-in consultation today on proposed changes to Scunthorpe General Hospital services (Web)** Grimsby Telegraph - 13/10/2023 A drop-in consultation session is being held today in Goole for proposed changes to services at Scunthorpe General Hospital.
13 October	Lincolnshire Today	**North Lincolnshire councillors join forces to object to NHS shifting services to Grimsby (Web)** Lincolnshire Today - 13/10/2023 North Lincolnshire Council councillors have voted unanimously to object to what it calls a 'major downgrading' of Scunthorpe General Hospital as the NHS considers shifting a raft of services to Grimsby.
16 October	BBC 1 Yorkshire and North Midlands	**BBC 1 Yorkshire and North Midlands - Mon, 16 Oct 2023 06:27:15 BST - Breakfast** Breakfast, BBC 1 Yorkshire and North Midlands - 16/10/2023 06:27:15 More consultations are being held this week to help decide the future of Scunthorpe Hospital
17 October	Grimsby Telegraph	**Scunthorpe MP wants residents' views to 'fight their corner' on proposed hospital changes (Web)** Grimsby Telegraph - 17/10/2023 The third in a series of drop-in consultation events on the hospital proposals is taking placing at The Pods on Friday
19 October	Grimsby Telegraph	**Councillors voice worries proposed Scunthorpe hospital service changes will lead to more in future (Web)** Grimsby Telegraph - 19/10/2023 Members of five different councils

		met to discuss the possible move of some services from Scunthorpe General Hospital.
19 October	Scunthorpe Telegraph	**Trade union condemns proposal to move some hospital services** Scunthorpe Telegraph - 19/10/2023 p2 News. Lauren Davidson. A TRADE union has condemned the controversial proposals to move some crucial services out of Scunthorpe General Hospital to Grimsby's Diana, Princess of Wales Hospital, stating that the plans require "proper consultation".
20 October	Yorkshire Post	**Fears over future of hospital services after proposed changes** Yorkshire Post - 20/10/2023 p9 News. Ivan Morris Poxton. COUNCILLORS across Humberside have voiced concerns that proposed changes to Scunthorpe General Hospital services will lead to even more in the future.
26 October	Scunthorpe Telegraph	**MP wants residents' views to 'fight their corner' on proposed changes to hospital** Scunthorpe Telegraph - 26/10/2023 p4 News. Ivan Morris Poxton. SCUNTHORPE'S MP has launched a survey to gather "as much ammunition as possible" to fight for residents' views on proposed changes to the town's hospital
22 December	Grimsby Telegraph	**Time running out on Scunthorpe hospital consultation, as NHS acknowledges transport concerns (Web)** The public have until January 5 to have their say on plan to move some services to Grimsby
23 December	Planet Radio	**Health bosses say proposals to move some services from Scunthorpe to Grimsby hospital will only affect some patients (Web)** Northern Lincolnshire residents have until January 5 to make their views known on proposed changes to Scunthorpe General Hospital services.
27 December	Grimsby Telegraph	**Last chance to have your say on proposed hospital changes** p4 News. Ivan Morris Poxton. NORTHERN Lincolnshire residents have until January 5 to make their views known on proposed changes to Scunthorpe General Hospital services.
27 December	Yorkshire Post	**January 5 deadline for comments on proposed changes to services at hospital** p4 News. RESIDENTS in northern
28 December	Scunthorpe Telegraph	**Last chance to have your say on proposed hospital changes** p2 News. Ivan Morris Poxton. NORTHERN Lincolnshire residents have until January 5 to make their views known on proposed changes to Scunthorpe General Hospital services

Table 10.4 List of media coverage

10.6 Direct mail

10.6.1 Multilingual Leaflet

A multilingual leaflet – featuring information about the Consultation in English and the five most commonly used languages across the region – was distributed to households in areas where there are lower rates of English language proficiency (identified as areas where more than 5% of the population cannot speak English or cannot speak English well).[77]

Leaflets were delivered by Royal Mail delivery door2door service. Due to limitations in the targeting available, the leaflets were also distributed to a large number of neighbouring areas, to ensure the target households were reached.

The leaflet was delivered to all residential addresses in the following postcode areas:

Area	Postcode area	Number of addresses
Goole	DN14 6	5,640
Scunthorpe	DN15 6	2,240
Scunthorpe	DN15 7	3,938
TOTAL		**11,818**

Table 10.5 Multilingual leaflet drop

10.6.2 Digital exclusion – targeted leaflet drop

To supplement social media marketing that was used towards the end of the Consultation window, a second targeted leaflet drop took place. This leaflet drop was targeted to households in North and North East Lincolnshire most impacted by digital exclusion – to ensure people without access to the internet and social media had an opportunity to hear about and take part in the consultation.

This leaflet drop was undertaken by Leaflet distribution company DLM marketing.

In total 9,571 summary leaflets[78] were distributed in the following postcode areas:

Area	Postcode area	Number of addresses
Scunthorpe	DN16 1	5,343
Scunthorpe	DN16 3	2,154
Grimsby	DN32 7	2,074
TOTAL		**9,571**

Table 10.6 Summary leaflet drop – digital exclusion

[77] Public Consultation Multilingual Leaflet
[78] Public Consultation Summary Leaflet

10.7 QR Code monitoring

Item	**Number of unique clicks** (to 5 Jan 2024)
Paper questionnaire	12
Summary leaflet	81
Long Consultation Document	24
Easy Read summary consultation document	6
Pull-up banners	5
Explainer video / Animation	6
Posters	29
Business cards	1
Multi-lingual leaflet	9

Table 10.7 QR Code monitoring

10.8 Case Study – Clinical Engagement Timeline

Date	Area / Specialty	Engagement Approach
Tuesday 5th September	Surgery overview	Clinical lead engagement
Wednesday 6th September	Trauma and Orthopaedics	Clinical lead engagement
Thursday 7th September	Trauma and Orthopaedics	Clinical lead engagement
Friday 8th September	Urology	Clinical lead engagement
	Theatre Modelling	Clinical lead engagement
Monday 11th September	Trauma and Orthopaedics	Clinical lead engagement
Thursday 14th September	Trauma and Orthopaedics	Consultant engagement meeting
Friday 15th September	Urology	Workshop
	Gynaecology	Clinical lead engagement
Wednesday 20th September	General Surgery	Clinical lead engagement
Friday 22nd September	Gynaecology	Consultant engagement meeting
Tuesday 26th September	Ophthalmology	Clinical lead engagement
Friday 29th September	General Surgery	Consultant engagement meeting
	Paediatrics	Workshop
Monday 2nd October	Surgery and theatres	Clinical lead engagement
Wednesday 4th October	Diagnostics	Clinical lead engagement
Thursday 5th October	Critical Care	Clinical lead engagement
	Emergency Surgery	Workshop
Friday 6th October	Urology	Case Study Review
Monday 9th October	ED/Acute Care/Trauma	Workshop
Wednesday 11th October	Paediatrics	Workshop
Friday 13th October	Cardiology	Workshop
Friday 20th October	Paediatrics	Workshop
	Anaesthetics and Crit Care	Consultant Briefing
	Trauma and Orthopaedics	Case Study Review
Thursday 26th October	Gastroenterology	Workshop
	Cardiology	Workshop

Tuesday 31st October	Respiratory	Workshop
Wednesday 1st November	Paediatrics	Workshop
Friday 3rd November	ED/Acute Care/Trauma	Workshop
	Urology	Case Study Review
Wednesday 8th November	Goole Theatre Team	Briefing
Thursday 9th November	Gastroenterology	Workshop
Monday 13th November	Ophthalmology	Case Study Review
Wednesday 15th November	General Surgery	Case Study Review
Monday 20th November	Surgical Board	Case Study Review
Tuesday 21st November	Respiratory	Workshop
Monday 27th November	Radiology	Briefing

Table 10.8 Clinical Engagement Timeline

10.9 DMBC Engagement Timeline

Date	Meeting	Audience/Stakeholders Involved
4th January	IIA Equality	EDI leads (NLaG)
	YAS/EMAS Strategic Planning	Ambulance services
	Primary/Secondary Care Interface meeting (Southbank)	Primary Care
	Finance DMBC Check Point meet	NLaG – finance teams
10th January	Capital Group	NLaG/HUTH teams
	Out of Hospital (OOH) Programme Board	ICB, primary care, community services and other providers
11th January	Medicine Case Studies	NLaG Staff
	Staff Changes & Engagement Plans	NLaG staff
	Lincolnshire Programme Discussions	Neighbouring systems
	IIA Equality	EDI leads (NLaG)
12th January	North Yorkshire and Humber Adult Critical Care Operational Delivery Network (ODN) Strategic Board	NLaG/HUTH, neighbouring providers, regional clinical leads
15th January	Impact Assessment on Pharmacy Services	NLaG Staff
	Non-Statutory Transport Group (subgroup meeting)	NLaG/HUTH, Local Authorities, ICB
19th January	Finance DMBC Check Point meet	NLaG – finance teams
22nd January	Joint MAC & HCC	NLaG/HUTH clinical teams
23rd January	South Yorkshire Major Trauma Operational Delivery Network (ODN) Strategic Board	NLaG/HUTH, neighbouring providers, regional clinical leads
	Consultation – Presentation of interim findings	NLaG, ICB, independent reviewers (ORS)
	IIA Review	NLaG, ICB
24th January	Staffing and Engagement Planning	NLaG staff – clinical and operational teams
25th January	Review of plans on a page – surgery	NLaG clinical teams
	Doncaster Programme Discussions	Neighbouring providers
31st January	Non-Statutory Transport Group	NLaG/HUTH, Local Authorities, ICB, patient representatives, lay people, voluntary sector representatives
1st February	IIA Review	NLaG/HUTH, ICB
2nd February	Finance Check Point meet	NLaG staff
6th February	Digital & Information Workstream	NLaG/HUTH
12th February	Joint MAC & HCC meeting	NLaG/HUTH clinical teams
16th February	Finance Check Point meet	NLaG staff

19th February	Review of plans on a page – medicine	NLaG staff – clinical and operational teams
21st February	Capital Group	NLaG staff
22nd February	YAS/EMAS Strategic Planning	Ambulance services
27th February	Review of plans on a page – medicine	NLaG staff – clinical and operational teams
29th February	IIA Workshop	NLaG/HUTH, ICB, Local Authorities, Primary Care, Public Health, EDI leads
	Frailty	ICB
1st March	Finance Check Point meet	NLaG staff
7th March	ICB Informal review of feedback and consideration	ICB clinical and managerial leads
11th March	Joint MAC & HCC	NLaG/HUTH
13th March	Capital Group	NLaG staff
18th March	Review of plans on a page – medicine	NLaG staff – clinical and operational teams
20th March	tCI QA meeting – Reporting and Analysis	ICB, external assessors
	Evaluation of Alternative Suggestions	NLaG/HUTH, ICB
	Non-Statutory Transport Group (subgroup meeting)	NLaG/HUTH, Local Authorities, ICB
21st March	Out of Hospital (OOH) Programme Board	ICB, primary care, community services and other providers
	YAS/EMAS Strategic Planning	Ambulance services
27th March	Review of Bed modelling and nurse staffing impacts	NLaG clinical teams
28th March	Frailty and out of hospital (OOH)	NLaG, ICB, Primary Care
2nd April	Review of out of Hospital enabling plans	ICB, NLaG
8th April	Critical Care Bed Modelling	NLaG/HUTH
10th April	Paediatrics – case study review	NLaG staff
	ICB consideration of feedback	ICB clinical and managerial leads
11th April	Non-Statutory Transport Group (subgroup meeting)	NLaG/HUTH, Local Authorities, ICB
15th April	Doncaster Programme Discussions	Neighbouring providers
18th April	NLaG Council of Governors (CoG) Business meeting	Public governors
19th April	YAS/EMAS Catch up	Ambulance services
	Paeds Critical Care	NLaG staff
22nd April	Doncaster Programme Discussions	Neighbouring providers
23rd April	Non-Statutory Transport Group	NLaG/HUTH, Local Authorities, ICB, patient representatives, lay people, voluntary sector representatives

26th April	Finance DMBC Check Point meet	NLaG staff
3rd May	Finance DMBC Check Point meet	NLaG staff
10th May	Finance DMBC Check Point meet	NLaG staff
16th May	Primary/Secondary Care Interface Group	ICB, Primary Care, NLaG
29th May	Finance review - DMBC finalisation	NLaG staff
3rd June	Beds and Finance Review	NLaG/HUTH
4th June	ICB consideration of feedback	ICB clinical and managerial leads
6th June	Paediatric Critical Care Operational Delivery Network (ODN) engagement	NLaG/HUTH, neighbouring providers, regional clinical leads
7th June	Finance DMBC check point meet	NLaG staff
12th June	ICB consideration of feedback	ICB Board
12th June	Non-Statutory Transport Group	NLaG/HUTH, Local Authorities, ICB, patient representatives, lay people, voluntary sector representatives
19th June	Specialised Commissioning	Specialised Commissioning – NHS England

Table 10.9 DMBC Engagement Timeline

B. Modelling Outputs

10.10 Activity and displacement

10.10.1 Proposed option and impacts

Source: HASR ED APC UEC Modelling -2022-23 (DMBC) V2.0 - *adjusted to reflect revised proposal for Urology/Gynaecology*	*Bucket 1*		DPoW as the Acute site							
DPoW Acute/SGH LEH DMC model v2.0	**Baseline (2022/23)**		***Proposed (inc. 5 year growth, service changes and Transformation)***			**Number of patients forecasted to be impacted or a Transfer Condition red = displaced from their original hospital blue = nearest alternative hospital to access based on post code or transfer condition**				
	DPoW	**SGH***	**Acute DPoW**	**LEH SGH***		**DPoW**	**SGH**	**HRI**	**DRI**	**LCH**
Emergency Department (adults & children)* **	76,458	76,103	40,092	37,403		0	0	0	0	0
Urgent Care Service (adults & children)	0	0	38,169	41,135		0	0	0	0	0
Inpatient admissions:										
Specialist Medical Inpatients >72 hrs	1,137	690	1,610	0		670	-678	22	0	0
Acute Surgery Inpatients >24hrs (excluding Urology)	1,969	1,276	3,044	0		1,225	-1,241	19	0	0
Urology	61	525	0	560		-45	45	10	0	0
Fractured Neck of Femur >72hrs	249	264	279	255		24	-24	0	0	0
Trauma Inpatients >24hrs	433	639	954	0		562	-639	88	0	0
Other (incl. Oncology/Gynae)	505	451	480	412		14	-14	2	0	0
Total Admissions >24 hrs (surgery) >72 hrs (medicine)	**10,141**	**9,561**	**12,430**	**5,014**		**2,495**	**-2,596**	**259**	0	0
					Total Displaced		-2,596			
							7.11	*per day*		

** SGH includes GDH*

Table 10.10 Activity modelling outputs - proposed model (services consolidated at DPoW)

Key:	
DPoW	Diana Princess of Wales Hospital
SGH	Scunthorpe General Hospital
HRI	Hull Royal Infirmary
DRI	Doncaster Royal Infirmary
LCH	Lincoln County Hospital

The total number of patients expected to be displaced in the revised model – who would need to transfer to DPoW for an inpatient ward admission – is **2,596 per annum or 7 per day**.

This is compared with an anticipated **5,059 per annum or 14 per day**, at pre-consultation stage.

10.10.2 Impact by local authority area

ICB	Local Authority	Trauma	Emergency Surgery Admissions >24hrs	Specialist Medical Inpatients >72 hrs	Total
Humber and North Yorkshire	North Lincolnshire	464	834	540	1838
	East Riding of Yorkshire	73	111	74	258
	North East Lincolnshire	24	122	13	159
	Kingston upon Hull	1	5	1	7
	Selby	1	5	3	9
	York	0	1	0	1
	Richmondshire	0	0	0	0
	Ryedale	0	0	0	0
Lincolnshire	West Lindsey	45	87	44	176
	East Lindsey	5	38	6	49
	Lincoln	0	2	0	2
	South Holland	0	0	0	0
	Boston	0	0	0	0
	South Kesteven	0	0	0	0
	North Kesteven	0	0	0	0
South Yorkshire and Bassetlaw	Doncaster	4	10	3	17
	Bassetlaw	3	3	0	6
	Rotherham	1	0	0	1
	Barnsley	1	0	0	1
	Sheffield	0	1	0	1
West Yorkshire	Wakefield	1	1	0	2
	Leeds	1	1	0	2
	Bradford	0	0	0	0
Other		2	4	1	7
	NULL	13	24	17	54
	TOTAL	**639**	**1,247**	**702**	**2,588**

Table 10.11 Impact by local authority area

10.11 Bed Modelling

*Assessment in current reflect overnight admissions. Assessment in Forecast and HAS model reflect <12hrs	Forecast (with growth but no service change) 2022/23 baseline		Proposed HAS Model (2022/23 baseline)	
Specialty	**DPoW**	**SGH & GDH**	**DPoW**	**SGH & GDH**
Assessment*				
Short stay (12-72hrs)	25	31	25	30
Cardiology (>72hrs)	14	7	26	
Gastroenterology (>72hrs)	10	0	15	
Respiratory (>72hrs)	13	13	24	
Resp (support hobs)			4	
GIM (>72hrs) (amalagamating previous CoE)	29	26	23	23
	94	86	80	63
Acute surgery (>24hrs)	35	32	36	6
Trauma (>24hrs)	9	15	22	
#NOFs (>72 hrs)	8	11	21	0
Gynaecology	3	3	3	3
Stroke		21		21
Medicine (GDH)		10		14
Oncology/Haem			1	
Sub total Non-Elective beds	**240**	**255**	**280**	**160**
Critical Care	17	8	14	6
Paediatrics (>24hrs)	12	12	12	12
Obstetrics/Maternity				
Neonatal cots				
Elective	0	0	0	0
		15		15
	22	25	22	25
Total by site	**291**	**315**	**328**	**218**
Total by Trust	**606**		**546**	

HASR variance to current G&A bedstock by Trust	30	-30	
HASR variance to current G&A bedstock by Site		37	-67
HASR variance to Forecast (do-nothing) position		-60	
HASR variance to Forecast (do-nothing) by Site		37	-97

Table 10.12 Summary of Bed Modelling Outputs

10.12 Workforce and Finance Modelling

10.12.1 Summary of workforce modelling outputs

WTE	Baseline (WTE Budget)	Forecast (WTE) *Do-nothing position*	Proposed (WTE)	Forecast vs Baseline (WTE Budget)	Proposed vs Baseline (WTE Budget)	Proposed vs Forecast (WTE)
Medical - Consultants	160.3	178.1	171.6	-17.8	-11.4	6.5
Medical - Middle Grades	135.7	142.3	155.7	-6.7	-20.1	-13.4
Medical - Juniors	112.5	118.5	117.7	-6.0	-5.2	0.8
Nursing	1,467.0	1,546.2	1,487.2	-79.1	-20.2	59.0
Total	**1,875.4**	**1,985.1**	**1,932.2**	**-109.7**	**-56.8**	**52.8**

Table 10.13 Summary of workforce modelling outputs

10.12.2 Summary of financial modelling

£	Baseline (£k)	Forecast (£k) *Do-nothing position*	Proposed (£k)	Forecast vs Baseline (£k)	Proposed vs Baseline (£k)	Proposed vs Forecast (£k)
Medical - Consultants	24,092	26,787	25,768	-2,695	-1,676	1,019
Medical - Middle Grades	12,593	13,256	14,570	-662	-1,976	-1,314
Medical - Juniors	7,966	8,129	8,086	-162	-120	42
Nursing	67,065	70,516	66,164	-3,451	901	4,352
Total	**111,717**	**118,687**	**114,588**	**-6,970**	**-2,871**	**4,099**

Table 10.14 Summary of financial modelling outputs

10.12.3 Assumptions and drivers for savings

Revenue savings associated with the model are largely driven by reductions in the need for inpatient beds and associated staffing due to improvements in efficiency and productivity associated with the proposed model of care. Some of these savings are off set against increased investment in clinical and

advanced practitioner workforce to enable faster decision-making and improved flow. The proposed change represents a **net saving of £4.09 million** against a do-nothing position.

The main drivers for revenue savings are summarised in the table below.

	Activity change	Beds impact	Savings (£000s)	Narrative/explanation
Surgical beds	(1,677)	(25)	(1,782)	Shift from inpatient to day case surgery *(applied to General Surgery and Urology only)* will lead to reductions in required number of bed days for inpatient non-elective surgical patients.
Admission avoidance*	(1,959)	(17)	(1,083)	Improvements to integrated frailty pathways, better joint working with out of hospital and community providers will drive a reduction in medical inpatients through admissions avoidance (+5% over BAU - discounted for optimism bias*).
Reduction in Length of Stay (Medicine)	(642)	(13)	(828)	Length of stay reductions across the medical specialties will drive a reduction in the required number of bed days.
Critical Care Conversion to Respiratory HOBS	0	(5)	(659)	Development of Respiratory HOBS on the Grimsby site aligned to consolidated respiratory service will enable conversation of some critical care activity to respiratory HOBs.
TOTAL	**(4,278)**	**(60)**	**(4,351)**	

Table 10.15 Summary of drivers for savings

C. Supporting Documents and Further Information

10.13 Integrated Impact Assessment

Supporting document is provided with Board pack.

This document provides a detailed record of the positive and negative impacts that the proposal is anticipated to have. It also sets out the proposed approach to measuring impact, proposed mitigations, and responsibility for monitoring progress.

The Integrated Impact Assessment (IIA) provides a robust mechanism to consider and document how proposed changes could impact different people and different groups of people, both positively and negatively.

10.14 You Said, We Did

Supporting document provided with Board pack.

This document provides a detailed record of the issues and concerns raised through the consultation and sets out the considered response as feedback has been reviewed and discussed by teams within the Integrated Care Board (ICB) and Humber Health Partnership (HHP).

It also sets out all the alternative proposals that were put forward by consultees and documents how these were reviewed and assessed by teams within the Integrated Care Board (ICB) and Humber Health Partnership (HHP).

10.15 List of Acronyms

A&E	Accident and Emergency
BAPM	British Association of Perinatal Medicine
BAME	Black, Asian and Minority Ethnic
BAU	Business as Usual
CAMHS	Children and Adolescent Mental Health Service
CAS	Clinical Advisory Service
CIR	Critical Infrastructure Risk
DMBC	Decision Making Business Case
DPOW	Diana Princess of Wales Hospital, Grimsby
ED	Emergency Department
eFI	Electronic Frailty Index
EMAS	East Midlands Ambulance Service
ENT	Ear Nose and Throat
EQIA	Equality Impact Assessment
GDH	Goole District Hospital
GIRFT	Getting it Right First Time
GP	General Practitioner
HAS	Humber Acute Services
HDU	High Dependency Unit
HHP	NHS Humber Health Partnership
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
HUTH	Hull University Teaching Hospitals NHS Trust
HWRA	Humber and Wolds Rural Action
ICB	Integrated Care Board
ICS	Integrated Care System
IIA	Integrated Impact Assessment
IMD	Index of Multiple Deprivation
JHOSC	Joint Health Overview and Scrutiny Committee
LA	Local Authority
LoS	Length of Stay
LSOA	Lower Super Output Area
MDT	Multi-Disciplinary Team
MTC	Major Trauma Centre
NHSE	NHS England
NLaG	Northern Lincolnshire and Goole NHS Foundation Trust
ODN	Operational Delivery Network
ONS	Office for National Statistics
OOA	Out of Area

OP	Outpatients
ORH	Operational Research in Health
OSC	Overview and Scrutiny Committee
PAU	Paediatric Assessment Unit
PCBC	Pre-Consultation Business Case
PCN	Primary Care Network
PIFU	Patient Initiated Follow Up
PKB	Patient Knows Best
PMO	Programme Management Office
RTT	Referral to Treatment
SAS	Speciality and Specialist
SDEC	Same Day Emergency Care
SGH	Scunthorpe General Hospital
TU	Trauma Unit
UEC	Urgent and Emergency Care
UCR	Urgent Community Response
UCS	Urgent Care Service
UTC	Urgent Treatment Centre
VCSE	Voluntary Community and Social Enterprise
WTE	Whole Time Equivalent
YAS	Yorkshire Ambulance Service

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