Humber and North Yorkshire
Health and Care Partnership

# Humber Acute Services Programme

# Briefing

## July 2022

# The Humber Acute Services Programme aims to deliver new models of care and infrastructure investment across a challenged health and care system

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## Challenges

- Delivery of Constitutional Standards
- Complex population health needs
- Unwarranted variation in pathways of care
- Tactical plans
- Ageing and failing infrastructure: buildings/digital
- Do not deliver College/National Guidance/standards
- Recruitment and retention issues

**Programme 2: Core Service Change**

- Urgent and Emergency Care
- Maternity/Paediatrics and Neonatal Care
- Planned Care concepts

**Programme 3: Strategic Capital**

- SGH £350m
- HRI £250m
- DPoW £120m

£720m

## Opportunities

- Improved access/outcomes and reduced waiting times
- Standardised service models
- Increased use of technology
- Increased collaboration – cross organisation/sector
- Build local skills and contribute to local economy
- Optimise training opportunities and new skills
- Fulfil our role as Anchor Organisations and in Levelling Up

# A significant proportion of the work that is required has been completed – the programme is at a critical point

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We are here

Case for Change — Nov 2019

Clinical Senate Review (#1) — Nov 2020

Clinical Senate Review (#2) — March 2022

Pre-Consultation Business Case — March 2022

Decision-Making Business Case — March 2023

**Engagement/Surveys**

**Continued Engagement**

Case for Change

Prog design and early engagement

Models of Care Design

Evaluation

Travel and Access

Workforce

Enablers – OOH and Digital

Assurance Reviews

Capital Pre SOC

Options for Consultation

Clinical Senate

Briefings – Internal/External

NHSE/I Gateway — August 2022

ICB Approval — Sept/Oct 2022

End Nov 22 – Mid Mar 23 — **Consultation**

Capital SOC

*all dates are tentative and subject to change

# We have identified a wide range of issues and challenges across our Humber hospitals, which mean we need to look at doing things differently.

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- ***We're not providing the standards we should be in all our services***
  - Pressures in urgent and emergency care impact upon planned care
  - Clinical standards and Royal College guidelines around staffing and activity levels (e.g. how many patients go through a service each year) are increasingly challenging to meet
  - Temporary staff are often required to fill gaps in rotas
- ***We don't have enough staff to continue to do everything everywhere***
  - shortages of staff with specific skills in some services
  - 25% vacancy rate within Paediatric training grade doctors (across Northern Lincs)
  - vacancy rates in our Emergency Department teams range from 6% up to 28%
  - We are looking at new roles and different workforce models (e.g. rotational posts, joint services across the Humber to provide career development and support recruitment and retention)
- ***Some of our buildings and equipment are not fit for the future***
  - Current buildings not designed for modern methods of care
  - Critical Infrastructure Risks = £59m, Backlog Maintenance issues = £105m
  - Seeking £720m through New Hospitals Programme
  - This would radically improve the infrastructure and bring a wide range of additional benefits e.g. the creation of new, high-quality jobs, support R&D and innovation and help to grow the local economy.

# Overview of engagement

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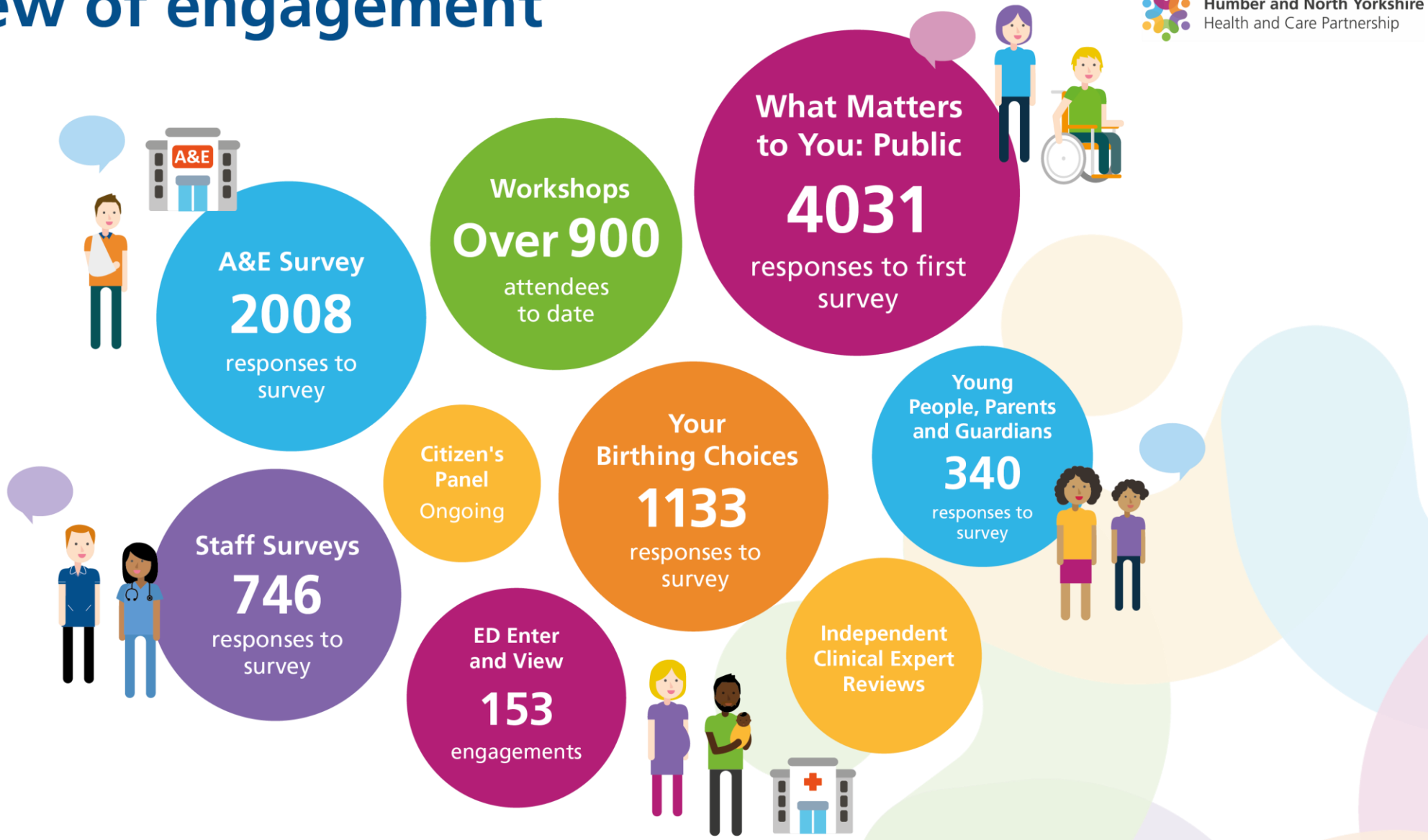

# We have listened to patients, service-users, staff and other stakeholders to influence the design and evaluation of potential models of care

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Surveys

**8370** responses

Workshops and focus groups

c.**1000** engagements

## What Matters to You?

- I am seen and treated quickly
- I am kept safe and well looked after
- There are enough staff
- Things go well for me
- Everyone can access care
- I know services will be there
- I am able to get there
- Buildings/equip
- Value for Money

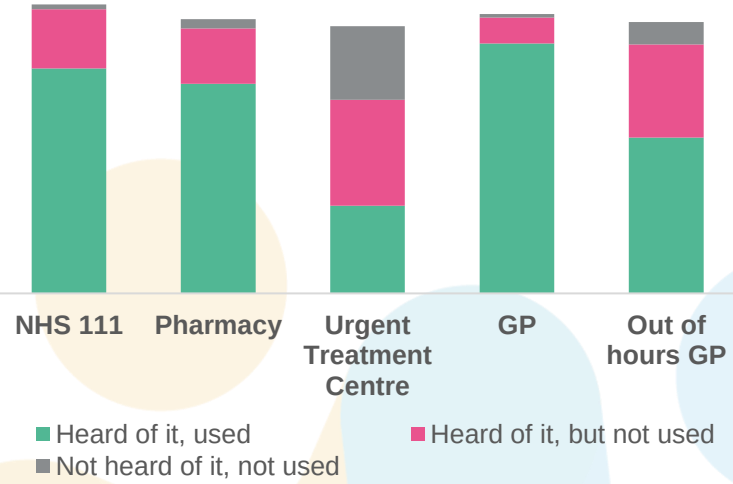
## Your Birthing Choices

- I am kept safe and well looked after
- I am seen and treated as quickly as possible
- There are enough staff
- Things go well for me
- Everyone can access care
- I know services will be there
- I am able to get there
- Buildings/equip
- VfM

## Alongside Midwifery-led Unit

- Hospital Maternity Unit
- Standalone Midwifery-led Unit
- Home birth

## Urgent and Emergency Care




## Children and Young People

- I feel cared for and safe
- I don't have to wait too long
- There are enough Drs & nurses
- The building is nice
- Things are fair
- It's easy to get to

"Can't see the trees…"

"Would like toys to play with while waiting."

# Summary of key issues and challenges raised through engagement with stakeholders throughout our programme

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Woman and birthing people have told us that **safety** is their number one priority

*They also identified that the facilities available (e.g. for partners to stay) and support services are also important*

Clinical engagement has also highlighted the need to consider safety within potential models for maternity services

"If things go wrong you have to make a journey to get help. I could not risk being away from emergency equipment when two lives are at stake."

"Hospitals make me anxious, and I feel there is more chance of intervention"

"But if you've got midwifery-led unit and you get a lady deliver a very sick neonate, what do you do with that neonate if you've got no neonatal staff there?"

**Travel** and accessibility are key concerns for all our stakeholders

*Ensuring people can access care and considering the travel impact of any options for patients, staff and carers are really important factors.*

"Grimsby and Scunthorpe are quite far in distance ... [for] families that can't afford travel it would be a big impact."

"A lot of people use public transport. They (will) have to pay more to go and visit their relatives."

**The impact of displacement on neighbouring health economies needs to be understood**

"For me it's the geographical location and the impact it has on the other EDs in the region..."

Surveys

**8370 responses**

**Workshops and focus groups**

**c.1000 engagements**

**Having the right workforce is important to staff and patients alike**

"Good staffing levels to ensure a good work/life balance, (not having to constantly cover staff shortages)."

"Get more staff as it is evident that wards are undermanned which comes at a price to the patient who are just a number."

# We are following a multi-faceted evaluation approach to provide an assessment of the potential models of care

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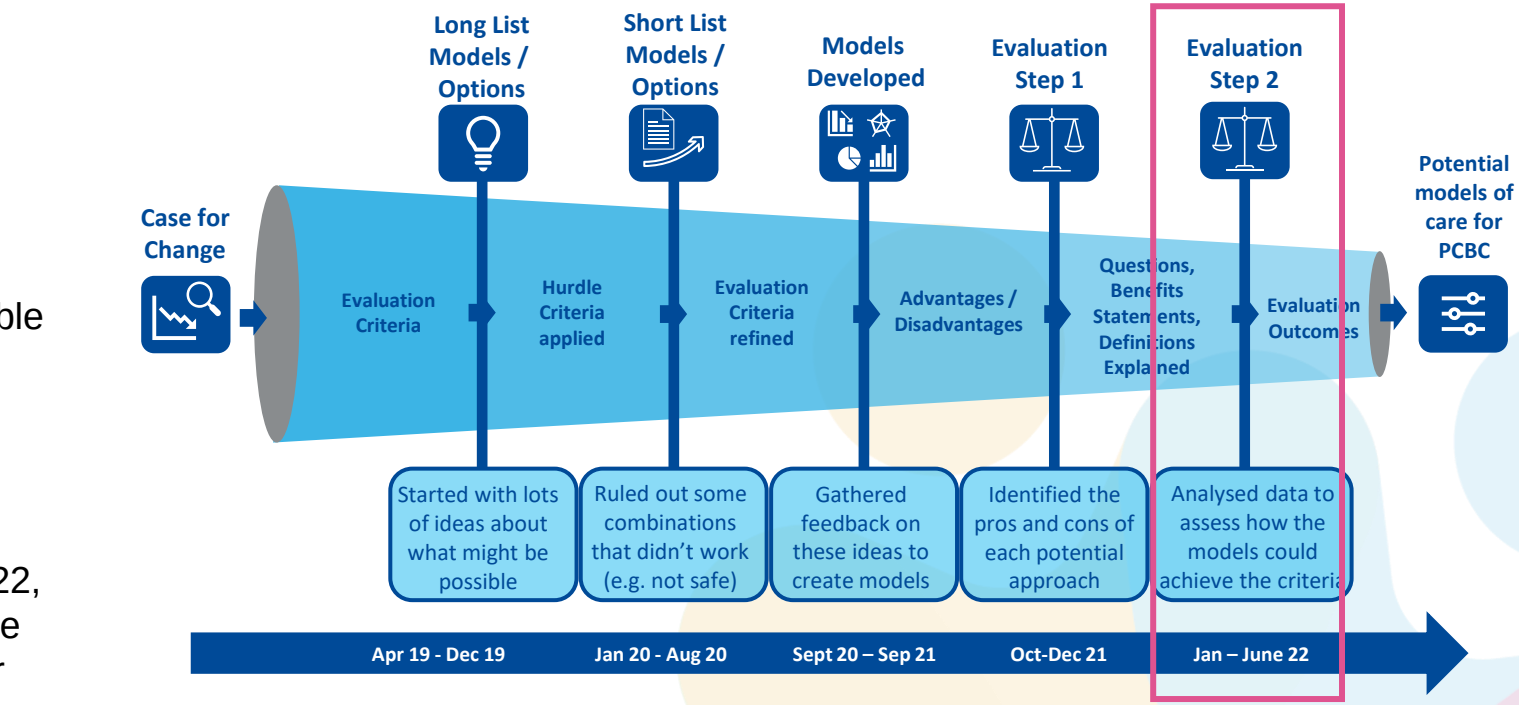
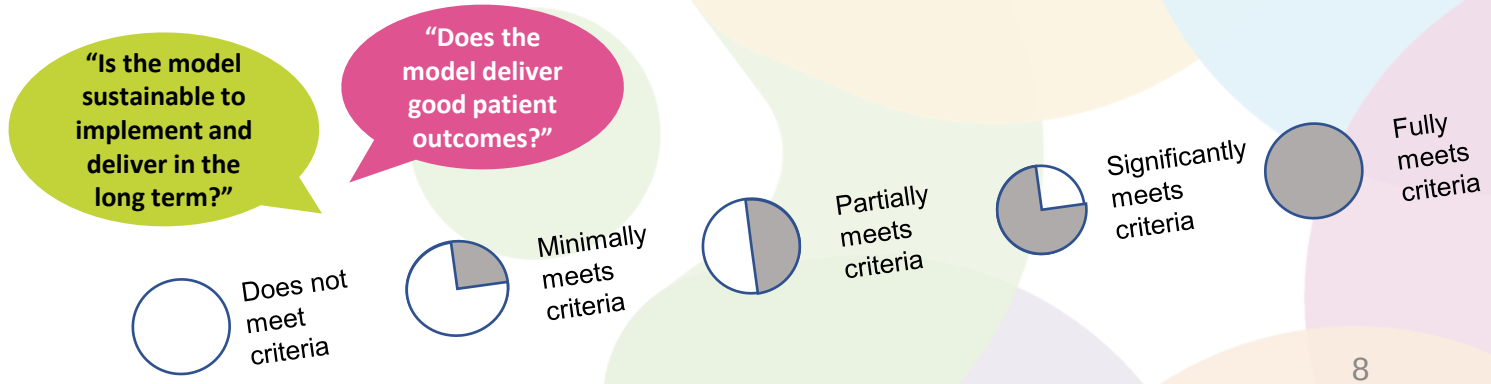
- The evaluation process we are following is iterative, adopting ***a multi-step, multi-faceted approach***, to narrow down the possible solutions to those that are most able to address the issues identified within our Case for Change and provide the best possible solutions for our population.
- To ensure a robust and consistent process, all possible combinations of the potential future models of care were evaluated (unless there was a clear rationale already identified to rule them out). This included reviewing some previously discounted ideas.
- Multiple workshops took place throughout March 2022, following a balanced room approach, involving a wide range of stakeholders, including clinical teams, other professionals, partners, patient representatives and other lay members.
- In total **130 people** took part in the workshops.




Evaluation workshops

**130** participants

# Evaluation of potential models of care and finalisation of Pre-Consultation Business Case

*(estimated completion July 2022)*

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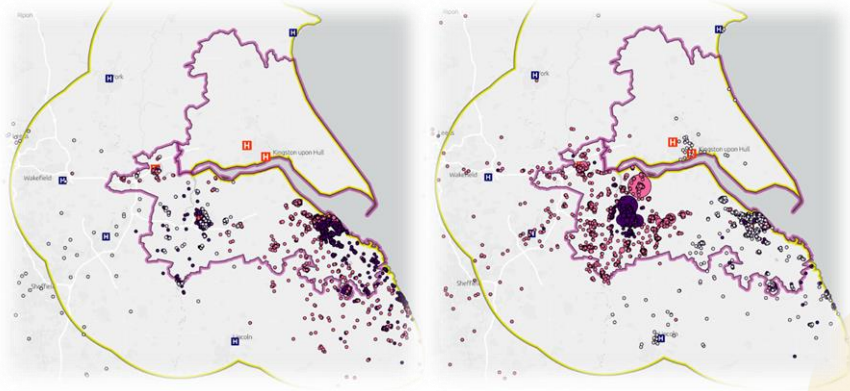
## Ockenden Review

- Key issue = safety
- Review the models (and variations) against recommendations from Ockenden Report (part 2) to determine viability and workforce implications.
- Re-run workforce modelling/assumptions to confirm maternity models.

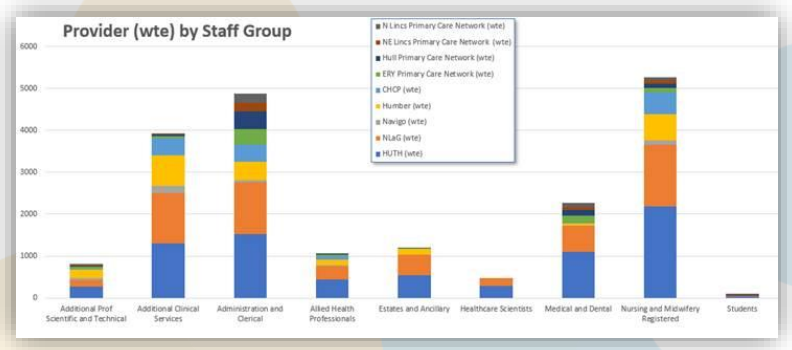
## Travel Mapping

- Utilise travel impact (GIS) data and mapping to confirm travel impact for staff, patients and carers / family against each of the models / variations.



## Workforce Modelling

- Review workforce modelling and staffing requirements for each model
- Alignment with out of hospital workforce planning and recruitment (link to ICS/Place work)




## Displacement impact mapping

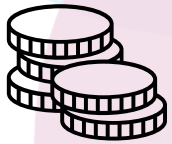
- Model impact of UEC displacement on neighbouring trusts based on admission ratio / Length of Stay / bed occupancy scenarios for 5 patients per day and 10 patients per day to determine impact on neighbouring health economies.

## Economic impact assessment

- Conduct high level (macro) economic analysis of impact of each model / variation to support evaluation.

## Financial analysis

- Undertake a full financial assessment of the shortlisted models of care to inform pre-consultation business case



# Clinical Senate Review (April – May 2022)

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"I congratulate the programme on the excellent and comprehensive work that has been progressed since our last visit in developing the significant range of options to address the challenges being faced. It is evident that those involved in this process have worked very hard to get to this point and we hope this report helps to make the decisions that are needed a little easier."

**Prof Chris Welsh**
**Chair Clinical Senate**

## Points to Note

- Panel considered recommending we discount options that have a **significant displacement impact** but concluded it was not their role – our work was comprehensive in this area and should support our ongoing discussions
- Recommended information on **impact of models** is placed up front in Consultation document
- The panel supported the approach to evaluation and reducing options – panel recognised detailed travel analysis already completed and stressed need to finalise pre consultation
- The panel advised that the PCBC to DMBC will need to consider **detailed rota planning** for UEC
- Panel discussed the **issues of a standalone MLU** and highlighted numbers that opened and closed – panel have identified that should a standalone MLU be in the options that the clinical model must ensure appropriate risk assessment
- Panel raised the issue of running obstetric-led maternity services and the **issues of staffing** – and cited feedback in recent CQC/Regulatory reports along with proposed guidance changes and **Ockenden 2**

# We have worked with “Out of Hospital Programme” Leaders to map dependencies and support their work programmes through our work

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## Out of Hospital

- Engagement in Clinical Models Design – workshops/focus groups
- Specific engagement with working groups – e.g. UECN
- System wide workforce mapping and links to ICS Workplans
- Shared data analysis
- Digital programme mapping and links to ICS Digital Strategy and Programmes
- Dependency mapping – CDC
- Consideration of estates through Strategic Estates Group

## Hospital

Emergency Department

Acute Assessment Unit

Paediatric Assessment Unit

Maternity and Obstetrics

Neonatal

Medical Specialities

Surgical Specialties

## Joint Working

Frailty
End of Life
UTC/UCS
Urgent Community Response (2hrs)
Hear and treat/see and treat
Long Covid
Virtual Wards
Long term conditions
Community Diagnostic Hubs
Connected Health Network (CHN) (including PIFU)*

*Rheumatology, Cardiology, Diabetes, ENT, Urology
Orthopaedics, Respiratory, Skin, Gastroenterology, Dementia, MSK, Pain, Gynae

**Children’s**
Integrated Health and Care
Community Hub
Community Care (The Ill Child)
Palliative and End of Life Care
Neurodiversity Service

**Clinical enablers**
Intelligent booking scheduler
Clinical messaging tool
Any-to-any booking

## ‘Out of Hospital’

Enhanced health in care homes
Anticipatory Care
Social Prescribing
Smoking cessation
Weight Management
Falls Prevention
Clinical Assessment Service
7 day crisis response
Mental Health

**Key**
Already in place or can be undertaken now
In development but not yet active
Opportunities for working together in the future

**PIFU = Patient Initiated Follow Up**

# Timeline and Next Steps

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**Only after the responses to the consultation have been considered will a decision will be made about how to progress.**





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