HUMBER ACUTE SERVICES PROGRAMME UPDATE

(NOVEMBER 2021)

Purpose

1. The purpose of this report is to provide members of the Committee with a further update on the progress of the Humber Acute Services Programme, specifically in relation to:

    - Engagement undertaken and outcomes to date
    - Programme 2 (Core Hospital Services) and Programme 3 (Building Better Places)
    - An overview of future plans, timelines and next steps

2. It also sets out some of the current legislative requirements in relation to health scrutiny and provides an opportunity for members to ask questions, seek more information and provide feedback on their future engagement with the programme.

Background

3. The Humber Acute Services (HAS) Programme is designing hospital services for the future across the Humber region to deliver better and more accessible health and care for the population. The programme involves the two acute trusts in the Humber – Northern Lincolnshire and Goole NHS Foundation Trust (NLaG) and Hull University Teaching Hospitals NHS Trust (HUTH) – and the four Clinical Commissioning Groups (CCGs).

4. The Programme sets out a vision that: everyone across the Humber will have access to the best possible healthcare and opportunities to help them live healthy, happy lives. All partners across the health and care system in the Humber have an important role to play in the short, medium and longer-term to deliver this vision, which is much wider than the acute hospital sector alone.

5. The Humber Acute Services Programme is comprised of three distinct but inter-related programmes:

    - Interim Clinical Plan (Programme One) – stabilising services within priority areas over the next couple of years to ensure they remain safe and effective, seeking to improve access and outcomes for patients.

    - Core Hospital Services (Programme Two) – long-term strategy and design of future core hospital services, as part of broader plans to work more collaboratively with partners in primary, community and social care.

    - Building Better Places (Programme Three) – working with a wide range of partners in support of major capital investment to develop our hospital estate and deliver significant benefits to the local economy and population.

6. This paper is one of a series of updates on the progress of the Humber Acute Services Programme provided to the Health Overview and Scrutiny Committees in each of the local authority areas across the Humber. Links to previous updates are provided in the background papers for further reading.

7. An update on Programme One (the Interim Clinical Plan) was circulated to Health Overview and Scrutiny Committee members in September / October 2021, which is available here.

Why hospital services need to change

8. Our health and care system across the Humber needs to change. It is not always meeting the needs of everyone in the region and, as currently designed, is not set to do this in the future:

    - We're not providing the standards we should be in all our services
    - We don't have enough staff to continue to do everything everywhere
    - Some of our buildings and equipment are falling apart and are not fit for the future

9. These and other challenges we face were detailed in the programme's Case for Change (November 2019) and are set out in more detail below.

<u>We're not providing the standards we should be in all our services</u>

10. Our waiting lists are growing. When the case for change was published in 2019, both Trusts were in the bottom quartile for performance against the referral to treatment time (RTT) standard. The impact of the pandemic has led to significant growth in waiting times and the overall waiting list size. People are not being seen as quickly as they could be if services were organised differently. For example, our operating theatres and other facilities sometimes get taken up with emergency cases, which means some people who need a planned operation have to wait even longer.

11. Many NHS services have specific clinical standards that should be met. These can include caring for a specific number of patients or doing a set number of procedures or operations to ensure staff maintain the necessary level of skill and competency. Some of our services are struggling to meet these standards. For example, some of our neonatal services do not see the number of babies that the national guidelines recommend for staff to keep their skills up to date and maintain the necessary expertise to adequately care for such vulnerable babies. National guidelines recommend that every year a Level 2 neonatal care unit should admit at least 25 babies with birth weights of less than 1500g. Over the last 3 years, data shows that on average the Level 2 units at Grimsby and Scunthorpe, treated 26 and 19 babies[1], respectively. Similarly, activity levels for the neonatal intensive care unit (NICU) at Hull Royal Infirmary (HRI) are lower than the recommended level, with a 3-year average of 72 births of very low birthweight babies, where the recommended level for a NICU is 100 per year.

12. In addition, many of our services need trained staff to cover rotas 24/7, 365 days a year and we don't have enough staff to do this for all our services, all the time. This means that some staff are often on the rota more than we would like them to be. We know from staff engagement that maintaining a healthy work/life balance is very important to our staff. This also increases our reliance on agency and locum staff to cover shortages, which leaves

[1] Based on data from the Yorkshire and Humber Neonatal Operational Delivery Network (ODN) as follows: 2018/19 – HRI (75), Grimsby (23) and Scunthorpe (14); 2019/20 – HRI (75), Grimsby (28) and Scunthorpe (23); and 2020/21 – HRI (67), Grimsby (26) and Scunthorpe (19)

services more vulnerable and at risk of failing should existing members of staff become ill and unable to work, or if they move to another job.

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

13. Some services may be just about managing to deliver services now. However, with over 30% of our staff eligible to retire within the next five to 10 years, it is imperative that we plan for workforce changes now[2]. Failing to plan for these predicable changes to our workforce will lead to the need to implement urgent service changes due to patient safety issues in future years.

14. In some services, there are shortages of staff with specific skills that are needed to deliver services and provide the best care to our patients. Some of these shortages can be on a national or international scale, which makes it extraordinarily difficult to recruit staff with the right skills – which adds further difficulties on how 24/7 rotas are covered. Therefore, we need to change how we offer care and treatment across the Humber to maximise the number of patients existing staff can see and treat. For example, there is a national and international shortage of oncologists. UK-wide there was an estimated shortfall of oncologists in 2019 of 19% or 207 consultant oncologists[3]. The impact of these shortages in our region has placed significant and ongoing pressure on oncology services, resulting in some temporary changes to where some patients access some aspects of oncology services.

15. In addition, many staff want to work in hospitals that run research and teaching programmes. Not all our hospitals across the Humber currently offer such opportunities. Therefore, if we change what we do and how we do it, including investing in more research facilities and working with our universities, we will provide the best opportunity to be able to attract and retain more staff. Working collaboratively with our universities could also open up and/or create new jobs and opportunities, which in turn could help us to recruit more staff in the longer term.

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

16. Our hospital buildings across the Humber need £105 million additional investment just to keep them running. We have some fantastic new buildings on some of our sites, but these are the exception rather than the rule. As an example, 82% of Scunthorpe General Hospital's critical infrastructure is at risk of failing within five years and we have already had to close parts of that hospital to patients because the buildings were not safe. If we don't do something now, the situation will only deteriorate and lead to the closure of other parts of the hospital. This programme of change offers an opportunity to build new and better facilities that will benefit the whole region.

17. We also know that we don't have enough operating theatres to do the number of operations we need to – which has a significant impact on waiting lists and waiting times. This problem has been exacerbated by the COVID-19 pandemic, including existing theatres

[2] 32.8% of NLaG workforce are 50yrs+ and 29.6% of HUTH workforce are 50yrs+. Some professions are eligible for retirement at 55 years.

[3] 'Clinical oncology UK workforce census report' (2019), The Royal College of Radiologists, https://www.rcr.ac.uk/system/files/publication/field_publication_files/clinical-oncology-uk-workforce-census-2019-report.pdf

becoming less efficient as a result of additional time needed between operations to undertake deep cleans, and we need to perform more operations to cover the backlog of operations that have built up (see below table for a snapshot).

	Total waiting list size		Patients waiting >1 year	
	(pre-Covid)	(post-Covid)	(pre-Covid)	(post-Covid)
Hull University Teaching Hospitals NHS Trust	54,000	58,000	0	9000
Northern Lincolnshire and Goole NHS Foundation Trust	28,000	31,000	9	700

18. We use lots of different digital systems across the different hospital sites that are not based on the latest technological developments and do not work together. As such, we need investment in our equipment and digital systems so we can offer care in different, more effective and efficient ways that will also have a positive impact on addressing the waiting times and the length of stay in hospital.

19. The Case for Change (November 2019) describes in detail the reasons why we need to do things differently. Since this was published, the reasons for change have not diminished. Indeed, a number of our challenges have grown as a direct consequence of the COVID-19 pandemic.

20. Without significant investment in our healthcare estate, we cannot deliver the necessary clinical changes to ensure services are fit-for purpose, sustainable and meet the needs of our communities in the future. However, it is very clear that without delivering substantial clinical changes, we cannot attract the level of capital investment needed to significantly improve our healthcare estate and infrastructure.

21. Despite the hugely successful vaccination programme, the health and care system across the Humber is continuing to work hard to support patients who are waiting for treatment, and the increases in waiting lists, waiting times and intensifying pressure across the entire health and care system remain. As such, we cannot continue to provide services in the same ways we have done in the past and we need to increase the amount of collaboration between all health and care organisations across the Humber, sharing (wherever possible) the limited resources available to deliver the timely, safe care our patients require.

22. As a system, we are working on changes to all our health and care services. Partners from primary, community and hospital services are working together to design new ways of supporting patients in their own homes or as close to them as possible. Part of our overall strategy is to ensure that hospitals are only used for the things that can only be provided in a hospital setting and where we can help people to access advice, tests or treatment at home, at a GP surgery, on the high street or another easy to access location in the community we will. The complexity of the heath and care system means that we cannot change everything at once, but we will continue to work with partners to ensure all our plans are aligned and deliver the change we need for our population.

Our engagement with patients, the public and staff

23. Ongoing dialogue with patients, staff, the public and other stakeholders has been a key feature of the Humber Acute Services programme since its inception – starting with a conversation about the issues and challenges facing the acute hospital sector across the Humber undertaken between March and September 2018 (see issues paper feedback report). A full summary of our engagement work to date is presented at Appendix 1.

24. Throughout 2021, in spite of the challenges posed by the pandemic and ongoing restrictions we have undertaken extensive engagement with patients, the public, staff and other stakeholders. This engagement has been across a number of areas to support the development of proposals for service change across core hospital services.

25. In particular, we have:

- Asked staff, patients, the public and their representatives *What Matters to You?* to help ensure that future services reflect the views of a broad range of stakeholders and are designed to meet the needs of those who will use them.
- Surveyed women, birthing people and their families about their *Birthing Choices* to find out where they would choose to give birth and why.
- Spoken to people who have used our Emergency Departments about their experiences and whether they would consider using alternatives to A&E.
- Made a particular effort to engage with and listen to the views of those facing additional barriers to accessing care or opportunities to improve their overall health and wellbeing.

What Matters To You?

26. Nearly 4000 people took part in this engagement exercise (between February and May 2021) either by filling in a questionnaire or taking part in a focus group. Some of the main feedback we received included:

- The majority of respondents (82%) had accessed one or more type of hospital service within the last two years and 83% of those were **satisfied** or **very satisfied** with their care.
- The most common areas of positive feedback were in relation to:
    - workforce – praising kind, compassionate and caring staff;
    - waiting times – praising efficient and well-run services; and,
    - clinical standards – commenting on how safe and well looked after respondents felt, often in relation to concerns they had around Covid.
- The most common areas where respondents felt improvements could be made were in relation to:
    - clinical outcomes – in particular, improving communication with patients and between different parts of the health and care system; and,
    - travel and access – in particular, improving access to car parking facilities.

- A summary of what mattered most to people when thinking about future hospital services is presented below:

27. While showing the overall position of what stakeholders told us through that engagement work, we have also established there are different priorities when we consider different demographic information and different stakeholder group, as presented below:

28. While this snapshot shows a high degree of consistency between different age groups / demographics and different stakeholders in terms of matters that are most important, it also highlights some differences in the identified priority areas. The full feedback report (published in May 2021) is available here, with a summary version of also available here.

29. We have continued to engage with different cohorts of patients, the public and other stakeholders to gather more views and perspectives on what matters most to our communities. We are continuing to ask *What Matters to You* within all our engagement activities and will continue to listen to feedback.

30. The findings from the *What Matters to You* engagement will help us to decide which clinical models best meet the needs, priorities and preferences of our different stakeholders by shaping the evaluation framework we use.

What Matters To You – our staff and teams

31. We delivered an awareness raising campaign and targeted engagement for our staff across the Humber, including a specific *What Matters To You* on-line staff survey that ran throughout July 2021. In this, we asked our staff what was most important to them when thinking about their day-to-day roles, their teams and their future career aspirations within the NHS or health and care.

32. This generated nearly 600 responses, which identified the following themes:

- Making a difference to patients' lives and maintaining a healthy work/life balance are really important to staff.
- Solving the workforce issues is the most important issue that the Humber Acute Services Programme must get right.
- Improved communication – in particular ensuring staff are involved in any changes before they take place – is also important to staff.

33. Following the survey, we also held two, targeted staff focus groups in September 2021. The outcomes of the focus groups are included in the overall staff survey feedback report, which is available here.

34. We are continuing to engage with staff across both Trusts, as well as clinicians and teams in partner organisations through a range of mechanisms. These include, clinical workshops, Question and Answer sessions, briefing sessions on different aspects of the programme, an online portal to allow the opportunity for staff to ask questions and fortnightly newsletters for staff at both hospital trusts and partner health and care organisations across the Humber.

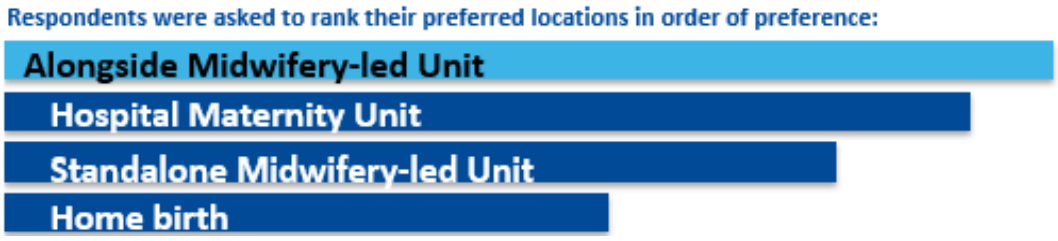
35. Over 700 staff have also been involved in clinical design workshops since November 2020, and we will continually involve and engage staff as the programme progresses. We will also use the feedback from staff to help refine and evaluate potential clinical models.

Your Birthing Choices

36. The *Your Birthing Choices* engagement was undertaken to understand what is important to women and birthing people, partners and support people when choosing where to give birth. This included identifying the main concerns around the different birthing options (i.e. births at home, in a hospital or other midwife-led settings) and what measures could be put in place to alleviate those concerns.

37. Feedback was gathered through a combination of targeted focus groups and an online questionnaire. Focus groups were set up to hear from people with lived experience of neonatal services, young families, women from Black, Asian and Minority Ethnic (BAME) backgrounds, dads, birthing partners and co-parents. The online survey generated over 1100 responses, with over 750 responses from people with a Humber postcode. Some of the main feedback received from respondents living within the Humber included:

    - **74.3% would not choose** to give birth at **home** due to **concerns around safety** should any complications arise during labour.
    - **56.7% would not choose** to give birth in a **standalone midwifery-led** unit due to **concerns around safety** should complications arise during labour resulting in the need to be transferred to a hospital, many feel the delay in receiving specialist care is a **risk** not worth taking.
    - **43.3%** of respondents **would choose** to give birth at a **standalone midwifery-led** unit as they feel it is **a more homely environment** and have **confidence in the care provided by midwives**.
    - **86.0% would choose** to give birth at an **alongside midwifery-led unit** as it feels a **much safer option** as additional support is close by if needed.



38. A detailed feedback report from the *Your Birthing Choices* engagement is currently being finalised and will be published in the near future. The feedback received will help to shape the clinical models we put forward for maternity and neonatal services and will help us to consider the different ways we might be able to provide choice for women and birthing people across our region.

    A&E survey

39. During July to August 2020, an engagement exercise was undertaken across the Humber, Coast and Vale Health and Care Partnership area to understand the reasons why people attend A&E/Emergency Departments (ED) in our region.

40. In total, 2008 people responded to the survey and shared their experiences of Urgent and Emergency Care and views on alternatives to A&E.

41. A summary of the key findings from those who had used one of the three Emergency Departments (EDs) within the Humber (Hull Royal Infirmary, Scunthorpe General Hospital and Diana Princess of Wales Hospital, Grimsby) is set in feedback report – available here. Some headlines include:

    - Most people attending the ED had been advised to attend by another healthcare professional – most commonly NHS 111.

- Where the individual (the patient) believes it is appropriate to their condition, most people would use an alternative service if they could be seen/ treated more quickly by a healthcare professional.
- Of the alternative services available, there was less awareness of Urgent Treatment Centres (UTCs), particularly amongst those attending ED in Grimsby or Scunthorpe. (This is possibly because the UTCs are co-located on the ED site and therefore respondents may not be aware they have been seen and treated through the UTC provision.)

42. These findings (and follow up engagement) are helping to shape our options for Urgent and Emergency Care and ensure we are putting in place alternatives to A&E that will work for our population and meet their needs and expectations. The report is available here and a Humber-specific summary will be included in the Pre-Consultation Business Case evidence pack.

Ongoing Engagement and Next Steps

43. As we refine potential clinical models, we are continuing to listen to what our stakeholders tell us about their experiences of healthcare services across the Humber and what matters most to them. Details of our current live surveys are available on the Humber, Coast and Vale Health and Care Partnership's Engagement Hub. Examples of our ongoing engagement include the following:

- In August 2021 we reopened our ***What Matters to You?*** survey to capture more views on the needs, priorities, and preferences of our different stakeholders, which will help us shape the evaluation framework we use to assess which clinical models meet these needs, priorities and preferences. The survey is available here.
- In October we launched some further engagement, targeted at ***children and young people***, their parents, carers and families to help shape clinical models for paediatric services and to ensure we fully understand any impacts of potential changes on our younger patients. Details of how to take part are available here.
- We are also continuing to work with voluntary and community sector and local authority partners to gather experiences and insights from ***individuals and communities with protected characteristics*** and others who might be less able or willing to engage with statutory services. This engagement will support our options evaluation as well as informing the Equalities Impact Assessment.

44. In addition, we are starting to develop our plans for consulting with the public on potential clinical models in Spring 2022 and would welcome the opportunity to engage with members and seek views from relevant Health Overview and Scrutiny Committees in early 2022, whilst consultation plans are still at a formative stage.

Responding to our challenges now – the Interim Clinical Plan (Programme One)

45. The challenges within our health and care services, set out above, are significant. Whilst we work to develop plans for the longer term, we are also putting in place a number of changes now that are helping to address the challenges in the short term.

46. We need to do both to ensure we can continue to provide good quality care for our population now and into the future.

47. Our short-term programme of change is referred to as the Interim Clinical Plan (or Programme One). The Interim Clinical Plan is focused on specific services that are considered the most fragile or vulnerable across one or both of Northern Lincolnshire and Goole NHS Foundation Trust and Hull University Teaching Hospitals NHS Trust. This programme is about pooling resources, skills and expertise to provide more resilient services that patients across the Humber can access equitably. It is also about providing better career opportunities for current and future staff.

48. An update on the progress of this work was shared with members in September / October 2021, (and is available here). This update provides an overview of progress specialty-by-specialty together with the next steps and anticipated timelines. This included those specialties where urgent temporary changes had been implemented to continue to deliver services safely. It also provides details of the establishment of the Humber Neurology Service that launched in October 2021 –the first specialty to run as a joint Humber-wide service across both hospital trusts – which is also outlined below:

Humber Neurology Service

49. Neurology is a branch of medicine dealing with diagnosis and treatment of a range of disorders and diseases relating to the nervous system (including the brain and spinal cord).

50. In developing a single Neurology Service across the Humber, service teams across Hull University Teaching Hospitals NHS Trust (HUTH) and Northern Lincolnshire and Goole NHS Foundation Trust (NLaG) have been working together to implement the following shared clinical vision and principles:

    - **Patients** will be **treated by the most appropriate clinician** in the **most appropriate setting**.
    - **Clinicians** will be able to **work from any location**, with **access to all relevant clinical records** and will be **able to request diagnostics and other tests at any site**.
    - The service will be **provided and managed as a single service** with a single team; and all **staff will work as a single team** with **consistent policies, procedures, pathways and support** (irrespective of the employing Trust).
    - **All referrals** will be managed through a **single point of access**, with **a single waiting list** and **consistent pathways in place** at both sites.

51. By working together across the Humber, we will be able to provide a more resilient, patient-focused and equitable Neurology service for all patients across the Humber. Patients will be triaged more quickly and directed to the right specialist clinician straight away; rather than the existing two-step process (for patients on the south bank) that involves an initial general neurology assessment and referral (if required) to the relevant specialist Neurologist. While specialist clinics and services will continue to be located at HUTH (as the Specialist Tertiary Neurosciences Centre), the new triaged approach will shorten waiting times for individual patients (particularly on the south bank) and create additional capacity across the service, by streamlining how patients are assessed and directed to the right service. This approach

will help reduce waiting lists overall and ensure patients get to the right specialist more quickly.

52. Patients will also be supported by the Specialist Nurse at their nearest site, rather than having their care automatically transferred to HUTH if they see a HUTH consultant. This will be a significant improvement to patient care, as travel can be extremely difficult and challenging with some neurological conditions.

53. The development of a single service model is supported and has been informed by patient feedback previously gathered[4], where patients shared their views on the services provided.

54. How the Neurology service has and will continue to respond to patient feedback is set out in the Neurology *How Your Voice is Making a Difference* feedback report, available here.

55. A number of the developments outlined above have not been done before and require detailed technological changes and testing to ensure the new system works as intended, in order to put this type of work into practice across Neurology and other service areas.

56. The developments represent a minor change to the patient pathway in terms of where and how some patients will receive care – for example, being able to go straight to test rather than having to wait for a first outpatient appointment before being referred for a test or to the relevant sub-specialist. Such changes respond to the patient feedback previously gathered and it is anticipated these will significantly improve waiting times, the overall care patients receive and their general experience of the service.

57. Commissioners and GPs have worked with the service teams and are fully engaged in the development of the approach. Primary care colleagues are supportive of establishing and developing a single Humber-wide service. Impact assessments have been conducted and commissioners have been engaged in reviewing contracting and oversight arrangements for the new services. Required documentation to support the change will be published appropriately through relevant commissioners (CCGs).

58. Mobilising in October 2021, the Humber Neurology Service is anticipated to continue to go through a period of transition and development, likely to run until March 2022. During this time the single service will continue to be consolidated and embedded, alongside an ongoing assessment of the longer-term resource requirements (compared to planned assumptions) to ensure the long-term sustainability and delivery of a combined, single service.

Other Interim Clinical Plan Services

59. The September / October 2021 update on the Interim Clinical Plan provides a comprehensive update, including the following key highlights and improvements:

- Outline vision drafted for **Ophthalmology** the service with an agreement in principle for **Post-Operative Cataract Assessments to be moved into Primary Care**.

[4] Humber Acute Services - Focus Group Feedback Report (April 2019) – available here

- Service vision drafted for **Cardiology** and building on successes such as pilot of the **Clinical Health Network model** which has **reduced waiting times**, **reducing need for hospital attendance** and **cleared the patient backlog**. More details of the **Clinical Health Network model** are presented at Appendix 2.
- **Joint Clinical Leads** working across both Trusts appointed for **Neurology, Cardiology, Dermatology, Haematology** and **Oncology**.

60. In order to support the pooling of resources, skills and expertise, the Interim Clinical Plan is establishing single clinical leadership across each specialty. Putting in place dedicated leadership will help, by:

    - Creating a more resilient workforce through joint recruitment that is able to respond to changes in demand for services.
    - Establishing Humber-wide clinical leadership that helps build a sustainable workforce with pooled resource that supports staff to meet the demands of each service and provides better access to training and development.
    - Developing a 'one team, one service' approach and providing access to a wider range of colleagues for support, mentoring, sharing knowledge and expertise.
    - Providing more opportunities for innovation and looking at doing things differently.
    - Enhancing career development by providing more training opportunities within a single workforce.

61. The ultimate aim of these changes to leadership and management is to ensure that by working together the two trusts can provide services that patients across the Humber region can access equitably. All specialties within the scope of the Interim Clinical Plan are developing service strategies for the short to medium term, which will set out how they can make best use of resources to deliver safe and effective care to patients across the region.

62. The Humber Neurology Service model will be used as a pilot to test and adapt the approach, and will then be used to inform, replicate and develop arrangements across other specialties.

63. In the immediate term we are also working with partners across the Humber, Coast and Vale Health and Care Partnership (Integrated Care System/ICS) on a number of other programmes to make improvements in the here and now. Some examples of other programmes and improvement activities are set out in Appendix 3.

64. Whilst many of these interventions are making things better for patients today and helping to address some of the impacts of the Covid-19 pandemic, short-term changes on their own will not be sufficient to address all the challenges facing our hospital services. In particular, long-term plans for clinical services that are fit-for-purpose and meet the needs of our communities in the future are required if we are to be successful in securing the capital investment needed to improve our healthcare estate, equipment and technology.

Programme two (Core Hospital Services)

65. The Humber Acute Services programme provides a huge opportunity to improve services by doing things differently. To improve the ways we provide care, which our patients tell us are often fragmented, have high levels of duplication and, sometimes, poor communication

between organisations. We have an ambition to deliver more care closer to or at home, but this will only work if we change our existing models of care.

66. The work across Programme Two is clinically led and involves detailed options development and appraisal to help identify clinically viable models for core hospital services:

    - Urgent and Emergency Care
    - Maternity, Neonatal Care and Paediatrics
    - Planned Care and Diagnostics

67. The complexity of the heath and care system means that we cannot change everything at once, but we will continue to work with partners to ensure all our plans are aligned and work together to deliver the changes we need for our population.

Progress on the development of clinical models

68. We started identifying potential models of care by generating a really long list of possible outline ideas that were discussed at a series of public involvement workshops in October 2019. Feedback from these workshops (report available here) was incorporated to refine the outline ideas into potential models of care.

69. After an initial hiatus following the onset of the pandemic, work has continued over the last 12 months to develop and refine potential clinical models. We have been working to define the impact of each of the potential clinical models from a patient, staffing and a range of other perspectives utilising a wide range of data and intelligence.

70. Identification of clinical interdependencies have enabled us to remove some clinical models from consideration. Clinical interdependencies have been identified through discussion and engagement with a range of clinicians through our Clinical Design Group. An example of how clinical interdependencies might be applied is – providing doctor-led maternity services (Obstetric Lead Unit (OLU)) without also providing care for sick or premature babies (neonatal care) staffed by paediatricians on the same site was not considered a viable clinical model.

71. Whilst causing some delays or disruption to the Programme, the pandemic has highlighted and reinforced some of what we already knew about our healthcare system – specifically that planned care and unscheduled care (Urgent and Emergency Care) are too interdependent and pressures in urgent and emergency care (often brought about by sudden and sustained increases in demand for services) have a significant impact on the overall care we provide to patients and the performance of our hospitals against waiting times and other key standards. As such, planned care in the future needs to be provided in a way that protects those services from winter pressures and any future pandemics. The planned care clinical models we are currently modelling focus on looking for ways to deliver dedicated facilities for planned care that protects them from urgent care pressures in the future.

72. As we continue to define the impact of each of the potential clinical models from a patient, staffing and a range of other perspectives, potential trade-offs may emerge and need to be considered. For example, centralisation of a service onto a single site may lead to improvements in staffing, such as reductions in number of on-call rotas required or meeting

standards on patient numbers and staff competencies, however, this may have a detrimental impact in other areas, such as patient or staff travel – particularly for members of our communities who are least well-off and/or already find it difficult to access care.

73. We are currently evaluating potential clinical models in order to include in our Pre-Consultation Business Case (PBCB). The PCBC will be subject to independent assurance processes in the first quarter of 2022, including NHS England and Improvement and the Clinical Senate. Subject to the independent assurance, we are then aiming to take forward deliverable clinical models for public consultation, starting in Spring 2022.

Programme three (Building Better Places)

74. The Building Better Places programme is about securing the investment we need to redevelop and rebuild our healthcare buildings. Our current healthcare estate is one of our biggest challenges – with many of our buildings being old, unfit for purpose, not very ecologically friendly and in need of immediate investment.

75. We are seeking approval to develop a large-scale capital investment plan for our hospital estate across the Humber that will support better clinical care but also make a significant contribution to the wider economic regeneration of the region.

76. This work is closely aligned to Programme two (Core Hospital Services) and there continues to be widespread enthusiasm and support for our collective plans to develop an approach to investment that will maximise the impact and benefit to local residents in the form of new and rewarding careers, improved local infrastructure, investment in innovation and improved environment.

77. Through the Building Better Places programme we are seeking to design and build healthcare facilities for the future that are more flexible, more integrated and better equipped for the provision of 21st century healthcare. While our communities have grown and changed around us, the way in which we offer acute healthcare services has stayed largely the same and is no longer delivering what they need.

78. In response to the government's invitation for expressions of interest from NHS trusts wanting to be considered for inclusion in the next wave of the New Hospitals Programme, in September 2021 the Humber, Coast and Vale Health and Care Partnership submitted an expression of interest – in the region of £720m – for the development of healthcare infrastructure across the Humber.

Interdependencies

79. We have emphasised above that we cannot continue to provide existing hospital services in the same ways we have done in the past and we need to increase the amount of collaboration between all health and care organisations across the Humber. Wherever possible, this will include sharing the limited resources available to deliver the timely, safe care our patients need.

80. The Humber Acute Services Programme is not seeking to address all the challenges currently facing services across the Humber, Coast and Vale Health and Care Partnership. As previously highlighted, some examples of other programmes across the Partnership are presented in Appendix 3.

81. Equally, due to the complex arrangements for all health and care services, it is not practicable or feasible to try to change all our services, all at the same time. However, that complexity cannot be a reason for not aiming to improve services where we can.

82. Programme two and Programme three are mutually interdependent and one cannot be delivered without the other. Significant changes across our health and care system are needed to successfully deliver both programmes.

    - **Without significant investment in our healthcare estate, we cannot deliver the necessary clinical changes to ensure services are fit-for purpose, sustainable and meet the needs of our communities in the future; and,**
    - **Without delivering substantial clinical changes, we cannot attract the level of capital investment needed to not only significantly improve our healthcare estate and infrastructure, but also to be truly transformative to the wider economic regeneration of the region.**

83. Nonetheless, developing potential clinical models (Programme 2) in tandem with developing a Strategic Outline Case (SOC) for capital funding (Programme 3) is complex, challenging and ground-breaking. Although supported by regional and national teams, this approach moves away from the traditional approach of two separate processes for major service change and capital investment.

84. No decisions have been made in relation to Programme 2 and there are a number of potential clinical models still being worked through, which will be evaluated by the end of 2021 for inclusion within the Pre-Consultation Business Case. While the expression of interest submitted to government set out highly ambitious plans for our healthcare infrastructure, it is important that 'form must follow function'. As such, decisions around the final configuration of buildings cannot and **will not be made** until the public consultation on clinical models has been completed in 2022 and decisions have been made about the clinical model in the light of information gathered through the public consultation. This will ensure our communities and other key stakeholders help to shape the final proposals.

Local authority – health scrutiny arrangements

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

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

87. In consulting with the appropriate local authorities, NHS bodies must provide, publish and keep up to date the proposed date by which a decision as to whether or not to proceed with

the proposed service reconfiguration is intended to be taken; and the date by which HOSCs must provide any formal response on such proposals.

Joint health overview and scrutiny committees

88. The Regulations also make provision for the establishment of mandatory joint health overview and scrutiny committees (JHOSC) where NHS bodies plan to consult more than one local authority in relation to any specific proposed substantial service reconfiguration.

89. Where the need for a mandatory JHOSC has been identified, the identified local authorities must appoint a JHOSC for the purposes of that consultation and it is only the established JHOSC that may:

    a) Make formal comments on the proposal(s) under consideration – i.e. submit a formal consultation response.

    b) Require the provision of information about the proposal(s) under consideration; or

    c) Require a member or employee of the relevant NHS body to attend before it to answer questions in connection with the consultation and the proposal(s) under consideration.

Health and Care Bill 2021

90. Members are likely to be aware that the Health and Care Bill 2021-22 (the Bill) proposes some wide-ranging NHS reforms aiming to make it less bureaucratic, more accountable, more integrated, and incorporating lessons learned from the COVID-19 pandemic.

91. The proposals include establishing existing Integrated Care Systems (ICSs) on a statutory footing, formally merging NHS England and NHS Improvement, and making changes to procurement and competition rules relating to health services.

92. The Bill also proposes new powers for the Secretary of State for Health and Social Care to intervene in (or call-in) any proposed health service reconfiguration (at any stage). While it is understood the role of local Health Overview and Scrutiny Committees (HOSCs) and the requirement to involve them in reconfigurations will remain, the status of the current Local Authority referral power and how that will relate to the Secretary of State intervention proposals is less clear.

93. Future scrutiny arrangements and requirements are particularly pertinent to the Humber Acute Services Programme at this time, as substantial service reconfiguration proposals are planned to be consulted on in Spring 2022. Such consultation is likely to be undertaken under a new legislative framework, as the projected timeline is expected to allow Integrated Care Systems to become statutory bodies from April 2022. Nonetheless, the exact impact of any new legislation on future health scrutiny arrangements is not yet known, and it will be important to maintain oversight of the emerging landscape over the coming weeks to ensure appropriate planning and implementation of any necessary arrangements, specifically in relation to the Humber Acute Services Programme.

Next steps

94. Work is progressing to further refine and evaluate potential clinical models for hospital services in the future. It is anticipated that this evaluation work will be completed by the end of 2021 to feed into the Pre-Consultation Business Case (PCBC). This will be developed

alongside the outline Strategic Outline Case (SOC) for capital investment purposes in early 2022.

95. During the first quarter of 2022, there will be an assurance process in relation to the PCBC involving NHS England and Improvement and the Clinical Senate; and in April 2022 Integrated Care Systems are set to become statutory bodies (subject to the conclusion of the parliamentary process).

96. We are aiming to start formal consultation on deliverable clinical models with the public and other stakeholders, after the decision on the PCBC and authority to proceed. This is anticipated to be May 2022, subject to the timing of decisions in relation to the capital programme. It is important to highlight that, subject to Parliamentary processes in relation to the Health and Social Care Bill 2021, the decision to proceed to public consultation will most likely sit with the new Integrated Care Board that will come into being from 1 April 2022. It is anticipated that Clinical Commissioning Groups (CCGs) will cease to exist from this date.

97. Notwithstanding any unexpected delays in the process, we are continuing to develop our public consultation plans and would welcome the opportunity to discuss the draft plan with relevant health overview and scrutiny committees in early 2022.

Conclusion

98. In summary, **our local health system across the Humber needs to change**. It is not always meeting the needs of everyone in the region and, without changes to the way services are organised, this will likely worsen in the future.

99. This paper provides members of the Committee with an update on the progress of the Humber Acute Services Programme, specifically in relation to:

- Engagement undertaken and outcomes to date
- Programme 2 (Core Hospital Services) and Programme 3 (Building Better Places)
- An overview of future plans, timelines and next steps

100. This paper also sets out some of the current legislative requirements in relation to health scrutiny and provides an opportunity for members to ask questions, seek more information and provide feedback on their future engagement with the programme.

101. **Programme two and Programme three are mutually interdependent** and one cannot be delivered without the other. Significant changes across our health and care system are needed to successfully deliver both programmes. That is:

- Without significant investment in our healthcare estate, we cannot deliver the necessary clinical changes to ensure services are fit-for purpose, sustainable and meet the needs of our communities in the future; and,

- Without delivering substantial clinical changes, we cannot attract the level of capital investment needed to not only significantly improve our healthcare estate and infrastructure, but also to be truly transformative to the wider economic regeneration of the region.

102. Our expression of interest submitted to government set out highly ambitious plans for our healthcare infrastructure. However, 'form must follow function' and therefore **decisions around the final configuration of buildings <u>will not be made</u> until the public consultation on clinical models has been completed in 2022**. This will ensure our communities and other key stakeholders have the opportunity to help shape the final proposals.

103. Over the next six to eight weeks, **we aim to finish evaluating a range of clinical models and looking more closely at their potential impact**.

104. We are **working collaboratively to put forward potential options on what hospital care might look like in the future** (in five to ten years) and **aiming to consult the public (and other key stakeholders) on these options in Spring 2022.**

Recommendations

105. Members are specifically asked to:

- Consider and note the details presented in this report and appendices, including the reasons for change, the work undertaken to date and the next steps.
- Note the intention to complete a Pre-Consultation Business Case in early 2022, with the aim of formally consulting on potential clinical models with the public and other stakeholders in Spring 2022.
- Note the current legislative framework governing statutory consultation with local authorities in relation to NHS reconfiguration proposals, recognising existing health scrutiny arrangements and provisions may change as the current Health and Care Bill (2021) is enacted and becomes law.
- Identify any specific aspects where further and/or more detailed information may be required.
- Provide feedback on how they would like to be engaged over the next phase of the programme; and,
- Determine any other specific future scrutiny activity at this time.

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Background Papers and further reading

Hospital Services for the Future: Humber Acute Services Review - Issues Paper (October 2018), available here
Humber Acute Services Review: Case for Change (November 2019), available here.
Humber Acute Services Review – Interim Clinical Plan (October 2020), available here.
The Yorkshire and Humber Clinical Senate report (November 2020), available here.
The Interim Clinical Plan Update (September 2021), available here).

Engagement reports

Hospital Services for the Future: Public Engagement Feedback Report (Issues Paper) (October 2018), available here
Hospital Services for the Future: Humber Acute Services Review – Focus Group Feedback Report (April 2019), available here.
Hospital Services for the Future: Humber Acute Services Review – Patient Workshop Feedback Report (October 2019), available here.
Hospital Services for the Future: Humber Acute Services Review – Targeted engagement (February 2020), available here.
Accident & Emergency Public / Patient feedback report (October 2020) available here
What Matters To You (May 2021) full feedback report and the summary report
What Matters To You – response to patient and public engagement in Neurology (September 2021) available here
What Matters To You – Our Staff and Teams (October 2021) available here.

Appendix 1

Humber Acute Services Programme

Engagement Timeline Overview

Timeframe	Engagement	Purpose/Scope	Responses	Link to Report
March to October 2018	Issues Paper	To start a conversation with patients, public and other stakeholders about the issues and challenges facing the acute hospital sector across the Humber we published the Humber Acute Services Review - Issues Paper and invited responses through a short survey.	393 responses	Public Engagement - Issues Feedback Report
November 2018	Established a Citizen's Panel	To ensure the voices of local populations are heard, to help inform the development and approaches for our broader engagement work and patient-facing information.	Citizen's Panel	N/A
Oct 2018 to April 2019	Focus Groups – five specialties	Deliberative workshops to support the development of change plans and to gather wider feedback to support the review, focusing on five specialties (8 events in total across the Humber region): • Cardiology • Complex rehabilitation • Critical care • Neurology • Stroke	119 participants	Humber Acute Services Review – Focus Group Feedback Report
Jan to Oct 2019 (note: report published Feb 2020)	Targeted Engagement	Targeted Engagement commissioned by the Review from a local Voluntary and Community Sector organisation – Humber and Wolds Rural Action. The scope was to engage with a wide range of individuals from diverse communities and/or with protected characteristics under the Equalities Act and gather views on the potential impact of any changes to services.	192 people (with protected characteristics)	Targeted Engagement Report

Appendix 1

Humber Acute Services Programme

Engagement Timeline Overview

Timeframe	Engagement	Purpose/Scope	Responses	Link to Report
Oct to Nov 2019	Focus Groups – core hospital services	Workshops and focus groups undertaken to gather patient and public feedback on long-list of models for core hospital services: • Urgent and emergency care • Maternity and paediatrics • Planned Care (8 events in total across the Humber region)	77 participants	Patient Workshop Feedback Report
November 2019	Citizen's Panel	Feedback on Case for Change	Citizen's Panel	Citizen's Panel Feedback on Case for Change
November 2019	Citizen's Panel	Feedback on Long List Clinical Models	Citizen's Panel	Citizen's Panel Feedback on Long List Clinical Models
March 2020	Citizen's Panel	Feedback on Access and Experience	Citizen's Panel	Citizen's Panel Feedback on Access and Experience
July to Aug 2020	A&E Survey (HCV-wide)	Online survey undertaken to understand behaviours, attitudes and barriers to using alternatives to A&E across the region.	2008 responses (931 – Humber hospitals)	A&E survey (2020) - HCV-wide
Feb to May 2021	What Matters to You	Engagement exercise undertaken to gather the views and perspectives of a range of stakeholders to enable decision-making within the programme to reflect the priorities and preferences of local people. The engagement took the form of an online survey and a series of focus groups. (6 workshops were held in total – all undertaken virtually due to Covid restrictions)	3946 people (3883 survey responses + 63 focus group participants)	What Matters To You – Feedback Report

Appendix 1

Humber Acute Services Programme

Engagement Timeline Overview

Timeframe	Engagement	Purpose/Scope	Responses	Link to Report
July 2021	What Matters to You – Our Staff and Teams	Targeted engagement exercise to gather the views and perspectives of staff to further inform decision-making within the programme. The engagement took the form of an online survey and two focus groups (undertaken virtually due to Covid restrictions)	563 staff responses	What Matters to You – Our Staff and Teams Feedback Report
June to July 2021	Your Birthing Choices	Targeted engagement exercise to understand what is important to women, birthing people, partners and co-parents when choosing where to give birth to help inform the development of maternity and neonatal services. The engagement took the form of an online survey, alongside a series of focus groups (held virtually due to Covid restrictions). The engagement was undertaken across Humber, Coast and Vale and responses analysed to provide specific feedback from people across the Humber.	1133 survey responses (753 responses from people within the Humber).	Feedback report in development.
October to November 2021	Children and Young People's Engagement	Targeted engagement exercise to hear from children and young people to better understand what works well, what doesn't and what could change to improve the patient experience.	Children and young people.	Survey due to close on 22 November.
October to November 2021	What Matters to You – Parents and Carers	Targeted engagement exercise to hear from parents/ carers of children and young people who have experience of accessing paediatric services in one of our hospitals, to better understand what works well, what doesn't and what could change to improve the patient experience.	Parents/ carers of children and young people	Survey due to close on 22 November.

Appendix 1

Humber Acute Services Programme

Engagement Timeline Overview

Timeframe	Engagement	Purpose/Scope	Responses	Link to Report
August to November 2021	What Matters to You – Revisited	Engagement exercise undertaken to gather more views and perspectives to enable decision-making within the programme to reflect the priorities and preferences of local people. This engagement is based around an online survey with options available for offline participation.	Patients and the public	Survey due to close on 15 November.
October to December 2021	A&E engagement	Collaboration with Healthwatch to undertake 'Enter and View' visits and gather insight from people attending A&E about their experiences. Gather further insight into behaviours and why people choose A&E and the barriers to using alternative provision.	People using A&E services	Interim results due early December
October to December 2021	Healthwatch engagement (planned care)	Collaboration with Healthwatch to undertake survey of current patients (particularly those on waiting lists) regarding their opinions and experiences of planned hospital care (as part of a wider engagement exercise on the impact of Covid-19 across the region).	Patients and the public	Interim results due mid-December (work continuing through to January 2021)

Appendix 2

Humber Acute Services Programme

The Connected Health Network Model

Introduction

Northern Lincolnshire and Goole NHS Foundation Trust and Meridian Health Group have piloted an innovative model for delivering outpatient services, working across traditional boundaries and putting the patient at the centre of the care delivery model.

The Connected Health Network (CHN) model represents a transformative break from the traditional model of patients being referred by primary care into secondary care, by health and care professionals working across organisational boundaries, with GPs working in partnership with specialists to provide ongoing care and support to patients when they need it. The CHN can be considered as an extension of the GP practice rather than the traditional model which sees GPs referring patients to secondary care, subsequent waiting lists for patients and then patients eventually discharged by the specialist to the care of their GP until specialist advice is once more required and the cycle repeats for the patient.

In order to reduce cardiology outpatient waiting times and provide cardiology patients with integrated care, this pilot scheme involved senior clinicians from NLaG worked with colleagues at Meridian Primary Care Network (PCN) to deliver a radically different model of cardiology outpatient care. This involved partners working across traditional boundaries and referral processes by sharing care and putting the patient at the centre of the delivery model.

What's different about the Connected Health Network (CHN) model

The traditional model of patient care often includes patients being referred from primary care (GPs) into secondary care (hospitals) for specialist care and then discharged back from the specialist to the care of their GP once the assessment and treatment has been completed. This cycle is repeated each time the GP needs specialist advice in the care and treatment of the patient.

The CHN model brings GPs and specialists together in partnership to provide ongoing care and support to patients when they need it, enabling fast and easy communication and decision-making between GPs and specialists, with the patient avoiding visiting clinical settings wherever possible.

How the Connected Health Network (CHN) model works

GPs refer into the service using their own primary care patient record system without needing to refer into secondary care. The CHN administration process is jointly managed by administrative staff from the PCN and secondary care, with shared access to the primary care patient record. The administrative team carry out a digital literacy assessment of every patient and obtain their consent for how they would like to be contacted e.g. text, email, telephone, letter.

Specialist will typically review the referral within a week and in most cases the patient does not need to be seen in person and any additional information can be obtained by speaking to the patient directly from any location.

In cases instances where invasive diagnostics are needed and where the patient needs to attend hospital, the specialist will make the necessary arrangements, supported by administrative colleagues who ensure all clinic administration is completed and facilitate arrangements with patients. Both the primary care and secondary care records are also updated to ensure all systems remain up-to-date.

Appendix 2

Humber Acute Services Programme

The Connected Health Network Model

Benefits of the Connected Health Network (CHN) model

The Connected Health Network (CHN) model offers the opportunity to deliver a number of benefits to patients in terms of reduced waiting times, seamless care and only attending hospitals when needed.

The CHN pilot delivered some impressive results from working in a different way:

- waiting times for patients drastically reduced (typical wait time for CHN referral = 1 week compared with 16 weeks wait time for new outpatient appointment).
- The backlog of follow up appointments for Meridian PCN cardiology patients was cleared within 4 months.
- Only 30% of patients required hospital-based intervention.
- Minimised 'in person' clinical attendances and supported patients to make use of digital communication

The CHN model is currently being rolled out in cardiology across additional Primary Care Networks.

Summary

The Connected Health Network (CHN) model is a great example of some of the outcomes we are trying to achieve through the Interim Clinical Plan; and how working differently can help us deliver improved patient experiences, reduce waiting times, and make better use of our collective resources to deliver good patient outcomes.

There are plans to trial the CHN model across additional specialties during 2021/22.

Appendix 3

Humber Acute Services Programme

Examples of other programmes and improvement activity

Work across all areas of the HAS Programme is not being undertaken in isolation; and there are a number or other programmes of work and improvement activities underway across the Humber, Coast and Vale Health and Care Partnership and also at individual acute trusts. Examples of these include:

- **Acute Care Collaborative** – a partnership that brings together NHS trusts that deliver acute hospital services across Humber, Coast and Vale. It is about local hospitals working in partnership with one another to give patients access to the very best facilities and staff.
- **Getting It Right First Time (GIRFT)** – a national programme designed to improve medical care within the NHS by reducing unwarranted variations. By tackling variations in the way services are delivered across the NHS, and by sharing best practice between trusts, GIRFT identifies changes that will help improve care and patient outcomes, as well as delivering efficiencies, such as the reduction of unnecessary procedures, and cost savings.
- **Elective Care Programme and COVID recovery** – focusing on taking a consistent approach to clinical prioritisation to ensure the care and safety of people is maintained whilst they are on a waiting list; as we continue to work hard to restore service levels following the coronavirus pandemic.
- **Cancer Alliance** – The Cancer Alliance brings together all the organisations that commission and provide cancer services in the Humber, Coast and Vale area, enabling effective and co-ordinated partnership working to improve patient experience, awareness and diagnosis, treatment and patient pathways.
- **Outpatients' transformation programme** – working towards a new model of care that will shorten waiting times by moving away from the traditional outpatient models of care with referrals from primary care to specialists in secondary care. The aim being to give patients access expert opinion and advice on patient care without extra referrals to hospital in many cases.
- **Community diagnostics** –aiming to reduce waiting times by providing easier and timelier patient access to planned diagnostics and investigative work and services. Where possible, developing facilities away from the Acute Hospital sites – including dedicated facilities like Community Diagnostic Hubs and mobile diagnostic services, such as mobile MRI and CT scanner equipment.