Approval Process

Developed

The assessment has been collaboratively developed by the HAS senior leadership team, the PMO and C&E team, the Citizen's Panel and finally assured by the programme's Clinical leads.

Insight gathered from engagement with staff, patients, public and equality groups has been used alongside content from the PCBC, activity data, public health data and impact analysis data to inform this assessment.

This assessment will continually be updated as further information, data and insight becomes available.

Reviewed

The impacts, scores and mitigations have been reviewed and assured by the programme's clinical leads and the Consultation Institue as part of our Quality Assurance review.

The IIA was presented to NHSE as part of the Gateway assurance process and formed part of the documentation required for approval to proceed to formal public consultation. The information has been reviewed and updated following completion of the NHSE review.

Next Steps

This assessment will be refreshed following the Public Consultation, using evidence and insight gathered during the consultation process, and form part of the documentation required alongside the Decision-Making Business Case (DMBC) to support decision-making post-consultation.

Title of Scheme/Project:	

Name	Organisation	Version number	Action	Date	Notes
Beth Norovock / Samantha Thompson	NLaG / Humber and North Yorkshire ICB	1	Initial creation	Nov-22	Positive/Negative impacts pulled from PCBC, data modelling, engagement insight
Samantha Thompson	Humber and North Yorkshire ICB	2	update and refinement of criteria, removal of scoring in readiness for clinical input on 22.05.23	May-23	Included in discussions were LC and BN
Beth Norvock	NLaG	3	Updating of activity data modelling and refinement of model description/summary	May-23	
Samantha Thompson	Humber and North Yorkshire ICB	4	Clinical Leads input on scoring, impacts and mitigation. Updating of impacts within the Equality tab based on insight gathered from recent equality groups workshops	Jun-23	
Kia Alvani	NLaG	5	Removal of references to maternity and neonatal care, due to decision made at ICB board on 14/06/23	15-Jun-23	
Linsay Cunningham	NLaG / Humber and North Yorkshire ICB	6	Financial, workforce and activity updated following NHSE Gateway review Additional population mapping document added	18-Sep-23	

Humber and North Yorkshire Integrated Care Board
Integrated Impact Assessment

Title of Scheme/Project:	Humber Acute Service Programme - DPoW as Acute Hospital / SGH Local Emergency hospital for Urgent and Emergency Care and Paediatrics

Project Manager:	
Clinical Lead:	Jennifer Smith
Programme Lead:	Claire Hansen
Senior Responsible Officer (SRO):	Ivan McConnell
Finance Lead:	
Quality Lead:	
Equality Lead:	
Business Intelligence Lead:	

Proposed change:

The business case sets out a proposed new model of care for (hospital-based) urgent and emergency care and paediatric services across Northern Lincolnshire – for care that is needed unexpectedly.

Within the proposed new model of care, the following specialist services would be collocated at a single hospital (DPoW) in Northern Lincolnshire:
- Trauma Unit
- Specialist Medical Inpatients (for longer stays >72 hours)
- Acute Surgery Inpatients (>24 hours or requiring overnight surgery)
- Paediatric Inpatients (for longer stays >24 hours)

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

The following services would continue to be provided at both hospitals in Northern Lincolnshire and are out of scope for the proposed changes:
- Urgent and emergency care from a 24/7 Emergency Department, assessment unit and short stay (up to 72 hours)
- Day case emergency surgery
- Longer stay inpatient care for elderly and general medical patients
- Paediatric Assessment Unit (up to 24 hours)
- Maternity and neonatal care
- Planned care services, including surgery, diagnostics and outpatient services (some of which may be provided in a community location e.g. GP surgery or Community Diagnostic Centre)

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

Which areas are impacted:

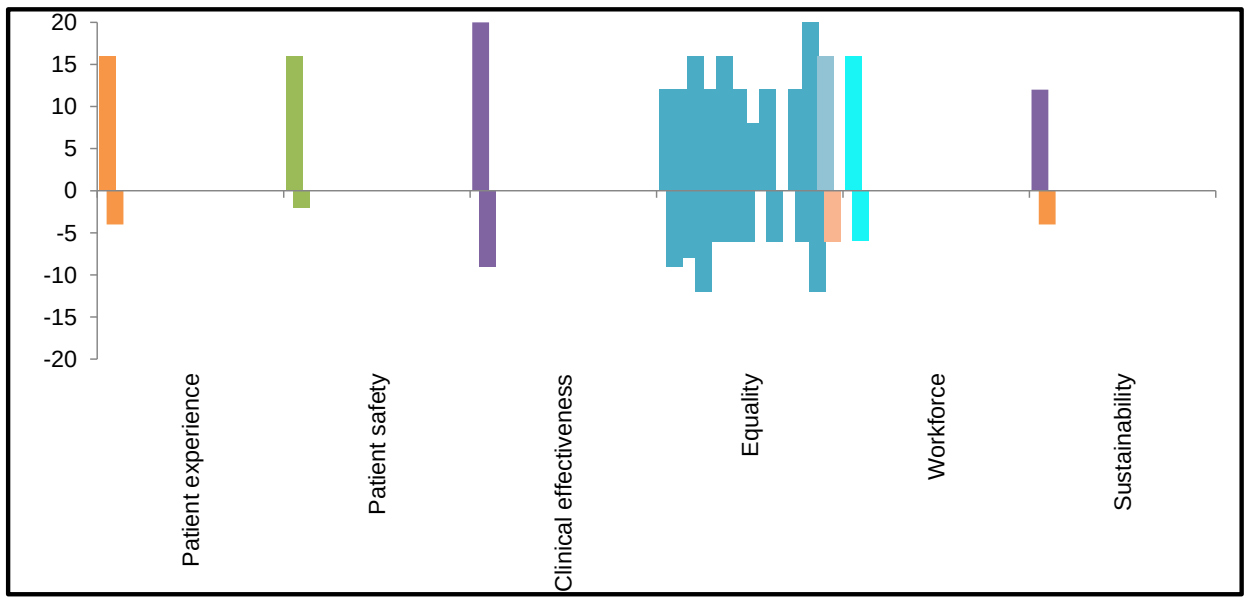
NHS Humber and North Yorkshire ICB	☑	North Yorkshire Health and Care Partnership	☐	Independent Sector	☐
East Riding of Yorkshire Health and Care Partnership	☑	York Health and Care Partnership	☐	Voluntary Sector	☑
Hull Health and Care Partnership	☐	Primary Care	☑		☐
North East Lincolnshire Health and Care Partnership	☑	Trust	☑		☐
North Lincolnshire Health and Care Partnership	☑	Ambulance Service	☑		☐

Summary of impacts graph

Note that scores above zero indicate positive impact and below zero indicate negative impact

Links to each area for further detail:

Patient Experience
Patient Safety
Clinical Effectiveness
Equality
Workforce
Sustainability
Finance (not on graph)
Engagement (not on graph)
Data Protection (not on graph)



Summary of findings:

Assessment completed by (name, role and organisation):	Elizabeth Norvock
Date Assessment completed:	Nov-22

Assessment signed off by:	**Name**	**Date**
Chief Nurse:		
Senior Responsible Officer:		

Full Quality, Equality, Sustainability and Finance Impact Assessment

The initial assessment has indicated that the proposed change will have an impact within theTrust . Therefore you will need to consider each of the areas outlined below and provide a summary of the positive and negative impacts.

Additional information to support completion can be found in the QEIA user guide. Helpful hints can also be seen if you click on the individual boxes within each page

Sections to complete:
Patient Experience
Patient Safety
Clinical Effectiveness
Equality
Workforce
Sustainability
Finance
Engagement
Data Protection

What evidence has been used to inform this assessment?		
iPID	☐	
PID	☐	
Public Health Data	☑	
Commissioning Policy/Threshold	☐	
Pre- Consultation Business Case	☑	
Clinical guidance e.g. NICE	☑	
Reports e.g. patient experience/engagement	☑	
Local demographic data	☑	
Service user equality monitoring data	☑	
Engagement and consultation activity	☑	
Information from other agencies e.g. healthwatch, community groups, other stakeholders	☑	
Other (please state below)	☐	

Attach any supporting files to the 'Documents' tab here:
Link to Documents tab

Initial Impact Assessment - Screening Tool

This is an initial assessment which will help determine whether a more detailed assessment is required.

Please select yes or no for each row from the drop down options

Will the proposal have an impact on:	Yes or No	If yes please complete the relevant section of the tool:	Tab colour:
Patient experience	Yes	Patient Experience	
Patient safety	Yes	Patient Safety	
Clinical Effectiveness	Yes	Clinical Effectiveness	
People with one or more protected characteristics	Yes	Equality	
Staffing within the service area or the wider workforce	Yes	Workforce	
Sustainability	Yes	Sustainability	
If you have answered yes to any of the above questions, in addition to the specified section you must also complete the Finance, Engagement and Data Protection Impact sections of the tool:		Finance	
		Engagement	
		Data Protection	

In addition please consider if the proposal will:		If you have answered yes to any question in this section:
Impact substantially on duties of Humber and North Yorkshire ICB (and partners)	Yes	Full assessment is required
Directly affect the services received by patients, carers and families	Yes	
Be likely to result in political, consumer champion or media interest or has already had significant public interest	Yes	
Impact those eligible to access the service e.g. by changing referral criteria/method of access/where or when service will be delivered	Yes	

Additional considerations:	
What is the size of the impact on people (i.e. how many are affected)	5059 in North Lincolnshire and Goole.
Which localities / populations are most affected	North Lincolnshire, Goole and surrounding villages

Please attach any relevant documents in this worksheet.

To embed a document go to Insert, Object, Create from file, then click browse and select your document from where it is saved. Select the tick box for Display as icon, then select Change icon and you can amend the text that will appear below your document.

Document name	Embedded document
Pre consultation Business Case	*Document Library - https://betterhospitalshumber.nhs.uk/programme-documents/*
IIA - Summary Feedback report	*Combined Feedback Report - Equality Groups*
Engagement Reports	*Document Library - https://betterhospitalshumber.nhs.uk/programme-documents/*
Consultation Planning - population mapping	https://betterhospitalshumber.nhs.uk/wp-content/uploads/2023/09/Consultation-Planning-population-mapping_v4_updated-July23_UECP-only.pdf
Equality Act 2010	*https://www.gov.uk/guidance/equality-act-2010-guidance*
Human Rights Act 1998	*https://www.legislation.gov.uk/ukpga/1998/42/contents*
ACAS Discrimination and the Equality Act 2010	*https://www.acas.org.uk/discrimination-and-the-law*

Clinical Effectiveness impact assessment

Link to guidance

Area Note - you can select more than one box per area if a change may have multiple impacts e.g. both positive and negative	Positive Impact	Neutral Impact	Negative Impact
Patient outcomes including health inequalities	☑	☐	☐
Clinical engagement	☐	☑	☐
Development and improvement of pathways	☑	☐	☐
Implementation of evidence based practice	☑	☐	☐
Will it impact on variation in care	☑	☐	☐
Parity of esteem	☐	☑	☐
Will it deliver care in the most clinically effective way	☑	☐	☐
Other (please state below):			
	☐	☐	☐

Opportunity/Consequence Rating	Consequence	Likelihood	Total Score
Clinical effectiveness positive rating	4	5	**20**
Clinical effectiveness negative rating	-3	3	**-9**

*See Impact Matrix tab for guidance

Description of positive impacts (must include rationale and be evidence based)	**How will these impacts be monitored**
Urgent and Emergency Care	
Introduction/development of UCS co-located within an ED department could reduce ED attendance by 35-48% each year	
An improved SDEC and Acute Assessment will support a 4% reduction in admissions and improve efficiency by enabling teams to assess treat and discharge more quickly	
Reduction in those people who attend and ED 5 times or more per year	
This proposed model of care for urgent and emergency services will improve compliance with constitutional and clinical standards and will meet the national set criteria of activity numbers	
The proposed new pathway of urgent and emergency services will improve performance on waiting time standards	
Fewer cancelled operations and reduction in waiting times for treatment	
Working as multi-disciplinary teams across pathways creates opportunities for different staff *(GPs, specialty doctors, allied health professionals, and advanced clinical practitioners)* to develop their skills and provide effective and efficient care for our population	
By concentrating the workforce in fewer locations for the most specialist care, those delivering specialist services will have more opportunities to develop their skills, treating a higher number of complex cases and a wider variety of experiences.	
Competency of staff in dealing with more complex cases improves	
The proposed model of care will improve the quality of specialist care and ensure everyone across the Humber can access the most highly skilled professionals when they need them	
Better utilisation of theatres and more efficient workflow	
Swifter discharge of patients by working more closely with local authorities and social care	
Work in a joined up way with ambulance services to ensure patients who need hospital care are directed to a specified area in the most appropriate local, acute or specialist hospital and/or supported by 'hear and treat' / ' see and treat' - ensuring as far as possible patients get to the right place for their care needs first time	
This proposed model of care for emergency services will reduce the number of handovers within and between services, help to improve the flow of patients through the hospital, **reduce ambulance handover delays** and ensure that patients do not stay in hospital any longer than they have to.	
Ambulance services, GPs, primary care practitioners and consultants will be able to send patients directly through to AAU referring via a single point of access or following clinical advice and guidance. Where appropriate this will reduce the delay to handovers and improve flow within the Emergency Department	
Direct booking into UCS, SDEC, AAU and other diversionary pathways will result in better outcomes - patients get to the right place, first time	
Patients can get directly to the service the need and by-pass the Emergency Department	
This proposed model of care is built on a digitally delivered support infrastructure, providing remote assessments, monitoring, shared care planning and diagnostics access	
H@H/ Virtual wards could reduce the number of clinical contacts	
People will be able to manage their own conditions better and go to hospital less often for check-ups.	
Reduction in emergency admissions as more frail or elderly patients would be seen in a community service e.g. Integrated Frailty service	
Integrated frailty services and other proposed pathway changes would improve outcomes and support faster recovery for patients	
Paediatric Care	
Through H@H children can get home more quickly or avoid an admission to hospital in the first place *The impact of Hospital @ Home on paediatric ED attendances and admissions was not included in the activity modelling due to the pilot being in a very early stage when this work was undertaken. Further modelling will be undertaken as part of the development of the Decision-Making Business Case (DMBC) to quantify the impact of H@H on paediatric activity in ED, PAU and inpatients.*	
Re-designing pathways for paediatric care will improve the safety, quality and effectiveness of services	
By concentrating the workforce into a single location for the most specialist care, those delivering specialist services will have more opportunities to develop their skills, treating a higher number of complex cases and a wider variety of experiences.	
This proposed model will develop improved advice and guidance so that hospital-based, specialist teams can support parents, carers, GPs and community staff, to aid prevention and self-management and reduce the need for children to attend hospital unnecessarily	
Consolidation of paediatric inpatient services onto the acute site will help to improve the quality of care and ensure long-term safety and sustainability of inpatient care ensuring everyone across the Humber can access the most highly skilled professionals when they need them	
This proposed model of care for paediatric care will improve compliance with constitutional and clinical standards and will meet the national set criteria of activity numbers	

Description of negative impacts	**Mitigating actions of negative impacts**	**How will this action be monitored**	**How often will this action be reviewed**	**Lead**
Urgent and emergency care				
It is not guaranteed that this model will enable all college guidelines, constitutional standards and clinical standards to be fully met.	*Review as part of planning for implementation*			
If Trauma and emergency surgical needs are not identified at Source *(e.g. at the scene by ambulance)* and patients are taken to LEH (SGH) site this increases the potential of time to treatment standards being breached.	*Extensive work has been undertaken to develop clear transfer conditions and close working with ambulance providers will continue to ensure patients who are likely to need more specialist input at taken directly to the Acute Hospital wherever possible*			
Potential for delays in transferring patients from LEH (SGH), affecting patient flow and clinical effectiveness	*Inter-hospital transport working group established to develop options for inter-hospital transport services which will be right-sized to meet anticipated demand.*			
Potential for delays if insufficient capacity at the acute site to accept transfers	*Right-sized services*			
Paediatric care				
It is not guaranteed that this model will enable college guidelines, constitutional standards and clinical standards to be fully met.	*Review as part of planning for implementation*			
If Trauma and emergency surgical needs are not identified at Source (e.g. at the scene by ambulance) and patients are taken to LEH (SGH) site this increases the potential of time to treatment standards being breached.	*Extensive work has been undertaken to develop clear transfer conditions and close working with ambulance providers will continue to ensure patients who are likely to need more specialist input at taken directly to the Acute Hospital wherever possible*			
Potential for delays in transferring children from LEH (SGH), affecting patient flow and clinical effectiveness	*Inter-hospital transport working group established to develop options for inter-hospital transport services which will be right-sized to meet anticipated demand.*			
Potential for delays if insufficient capacity at the acute site to accept transfers to paeds inpatient ward	*Right-sized services*			

Patient experience impact assessment

Link to guidance

Area Note - you can select more than one box per area if a change may have multiple impacts e.g. both positive and negative	Positive Impact	Neutral Impact	Negative Impact
Patient experience	☑	☐	☑
Patient choice	☑	☐	☑
Patient access	☑	☐	☑
Compassionate and personalised care agenda	☑	☐	☐
Responsiveness	☑	☐	☐
Promotion of self care and support for people to stay well	☑	☐	☐
Other (please state below):			
	☐	☐	☐

Opportunity/Consequence Rating*	Consequence	Likelihood	Total Score
Patient experience positive rating	4	4	**16**
Patient experience negative rating	-2	2	**-4**

*See Impact Matrix tab for guidance

Description of positive impacts (must include rationale and be evidence based)	How will these impacts be monitored
Urgent and Emergency Care	
The proposed model of care retains local urgent and emergency care services at each of the three existing sites and enables the NHS across the Humber to continue to operate three ED in the three main localities; Hull, Grimsby and Scunthorpe	
The proposed model of care would reduce waiting times for patients in the Emergency Department (ED)	
Integrated Acute Assessment model to improve flow through the hospital will provide a better experience for patient (quicker diagnosis and treatment and fewer handoffs)	
The development of an AAU and SDEC would ensure patients can get directly to the service they need and by-pass the Emergency Department	
Better integration of urgent and emergency care across all health and social partners *(including mental health)* would enable patients to be treated and discharged more quickly.	
Improvements to NHS 111 and implementation of 'any-to-any' booking could benefit patients as they would get directed to the service they need and by-pass the Emergency Department.	
Improved continuity of care and patient experience	
Services will be easier to navigate for the public, helping to reduce inequalities and barriers to access	
Developing centres of excellence for acute medical specialties will also build confidence in patients, many of whom have told us through our engagement that they would prefer to be treated where the specialists are and have full specialist team wrapped around them *(Reference: Accident and Emergency - Feedback Report / Healthwatch ED Enter and View - Feedback Report / What Matters to You -Feedback Report).*	
A UCS co-located within an ED woud improve patient experience as it is easier to navigate and signpost to the most appropriate service *(right place, first time)* - public feedback has shown local people are confused about where to go for what care *(Reference: Accident and Emergency - Feedback Report / Healthwatch ED Enter and View - Feedback Report / What Matters to You -Feedback Report).*	
More services provided within the patients home (e.g. virtual wards/hospital@home/pathway changes) would allow patients to be supported at home and recover faster.	
It would be easier for family, friends and loved ones to provide support to the patient if more care was provided at the patient's home.	
People will be able to manage their own conditions better and go to hospital less often for check-ups.	
Integrated frailty services and other proposed pathway changes would improve outcomes and support faster recovery for patients	
Improved discharge prcoessess and investing in social care workforce will help to reduce the length of stay for particularly frail or elderly patients	
Improved use of digital support remote monitoring, more responsive services *(e.g. patient-initiated follow-up)* , and reduce the overall need for patients to travel to hospital	
Paediatric Care	
The proposed model of care retains local paediatric services at each of the three existing sites and enables children to be seen and treated initially at their local hospital in the Paediatric Assessment Unit (PAU)	
A 24/7 PAU provides better care and a better experience for patients than a time limited PAU	
A 24/7 PAU will enable children to be seen, treated and discharged more quickly	
A 24/7 PAU will reduce hospital admissions. CYP told us that they don't like staying in hospital. *(Source: What Matters to You: Children and Young People)*	
Hospital at Home - Could support a reduction of paediatric inpatients by enabling children to get home more quickly or avoid admission to hospital in the first place, improving experiences and outcomes for patients and their families.	
Hospital at Home improves continuity of carer as the needs of the child and family are known	
Hospital at Home improves mental and emotional wellbeing for children and their families as they feel more comfortable and at ease in their own environment	

Description of negative impacts	Mitigating actions of negative impacts	How will this action be monitored	How often will this action be reviewed	Lead
Urgent and Emergency Care				
Potential increased stress and anxiety for both patients and family members from North Lincolnshire area if there is a need for the patient to be transferred from the LEH (SGH) to the acute site (DPoW), which is likely to be further away from their home. *modelling indicates this will impact approx 5,059 people per year (including paediatric patients) - this is compared to 5,604 people per year in the option where SGH is the Acute site*	*Extensive work has been undertaken to develop clear transfer conditions and close working with ambulance providers will continue to ensure patients who are likely to need more specialist input at taken directly to the Acute Hospital wherever possible.*			
Potential delays for patients in transferring from LEH (SGH) site to the acute site (DPoW) could negatively impact patient experience.	*Inter-hospital transport working group established to develop options for inter-hospital transport services which will be right-sized to meet anticipated demand.*			
Potential negative impact on families/carers living in North Lincs and/or Goole area in being able to visit as DPoW is further away *modelling indicates that 3,714 patients per year would have more than 30mins additional travel in this model - this is compared to 4,635 people per year in the option where SGH is the Acute site*	*Multi-agency transport working group established to develop innovative transport solutions for families, carers and loved ones.*			
NL has high levels of deprivation and areas of low car ownership so families may not be able to afford to travel to visit the patient at the acute site (DPoW) *In North Lincs 18.5% of households do not own a car, and 20% of neighbourhoods are in the most income deprived quintile in England (Compared with 26.9% of households do not have a car and 40% of neighbourhoods are in the most income deprived quintile in North East Lincolnshire)*	*Multi-agency transport working group established to develop innovative transport solutions for families, carers and loved ones.*			
Potential delay in recovery and/or if admitted to a hospital further away or in another local authority from home with reduced access to relatives to support recovery.	*Multi-agency transport working group established to develop innovative transport solutions for families, carers and loved ones.*			
Poor, expensive and unreliable public transport links between hospital sites would impact patients/families and carers being able to visit	*Work is ongoing with local authority partners to review and potentially redesign bus routes, exploring the possibility for direct transport between the hospital sites for patients, visitors and staff.*			
Patients and service users have told us that availability of parking and cost of parking makes travelling to hospital difficult. Consolidating specialst and inpatient care onto one site could reduce the availabilty of parking event more. *Source: Travel and Transport Feedback Report*	*Multi-agency transport working group established to develop innovative transport solutions for families, carers and loved ones.*			
Paediatric Care				
Children from North Lincs needing to be admitted will have to be transferred from the LEH (SGH) to DPOW (acute), this could have a negative impact on their experience and that of their families.	*Continued development of the Hospital at Home model to support reduction in admissions and length of stay*			
Children and young people told us that being at home, with their family and toys would help them to feel better more quickly, being in a hospital further from home and family is contrary to this. *Reference: What Matters to You: Children and Young People*	*Continued development of the Hospital at Home model to support reduction in admissions and length of stay*			
18.5% of households in North Lincs do not own a car or have access to a car so would potentially find it difficult to visit the young person in hospital at the acute site as alternative travel options could be expensive. *Car ownership rates are lowest in the central wards of Scunthorpe where deprivation is highest - in North Lincs 18.5% of households do not own a car (Compared with 26.9% of households in North East Lincolnshire)*	*Multi-agency transport working group established to develop innovative transport solutions for families, carers and loved ones.*			
Harder to arrange child care for other dependents if a child is admitted into a hospital further away from home				
The young person may not know any of the nurses or clincal teams looking after them at the acute site (DPoW), this could have a negative impact on their experience				

Patient safety impact assessment

Link to guidance

Area Note - you can select more than one box per area if a change may have multiple impacts e.g. both positive and negative	Positive Impact	Neutral Impact	Negative Impact
Preventable Harm	☑	☐	☑
Robustness of systems and processes	☑	☐	☐
Environment	☐	☑	☐
Safeguarding	☑	☐	☐
Other (please state below):			
	☐	☐	☐

Opportunity/Consequence Rating	Consequence	Likelihood	Total Score
Patient safety positive rating	4	4	**16**
Patient safety negative rating	-1	2	**-2**

*See Impact Matrix tab for guidance

Description of positive impacts (must include rationale and be evidence based)	**How will these impacts be monitored**
Urgent and Emergency Care	
This proposed model provides 7 day specialty services (not currently available in all services)	Performance against 7 day service standards
By concentrating the workforce in fewer locations for the most specialist care, those delivering specialist services will have more opportunities to develop their skills by treating a higher number of complex cases, and therefore able to provide high quality, safe care for patients.	*Incidents* *Quality indicators* *Mortality / Patient feedback*
Consolidating specialist acute services improves the quality of specialist care and ensures everyone across the Humber can access the most highly skilled professionals when they need them. Compentency of staff in dealing with more complex cases improves	*Staff feedback* *Recritment & Retention*
Patients will receive better quality of care as they will be seen quicker in the right place, first time *(supported by a 35-48% reduction in ED attendances via the UCS)*	*Standards of care - SEDIT data*
Improved outcomes for patients through reduced length of stay *(reduced Hospital Acquired Infection / deconditioning etc)*	*LoS & HAI data*
Due to the reduction in admissions to ED, emergency services will be less pressured and able to treat emergency patients more quickly, minimising the risk of patients conditions deteriorating resulting in better outcomes and safer care	*KPI and Emergency care standards*
Operating an integrated AAU reduces handoffs between departments, reducing the risk to patients and speeding up assessment and treatment pathways.	*Time of arrival to review or procedure by service decsion makers*
Work in a joined up way with ambulance services to ensure patients who need hospital care are directed to a specifiifed area in the most appropriate local, acute or specialist hospital and/or supported by 'hear and treat' / ' see and treat' - ensuring as far as possible patients get to the right place for their care needs first time	*Ambulance handover data* *Use of other services by Amb providers*
Provide better support for people and their families to avoid crisis situations through self-care and prevention	*Prevelance of ambulatory care and in attendance due to long term conditioning*
Paediatric Care	
24/7 PAU will continue to improve safety for paediatric patients because a paediatrician would be available 24/7.	
Children and young people will continue to be assessed at their local hospital, treated and discharged within 24 hours in the Paediatric Assessment Unit (PAU).	
Consolidating paediatric inpatient services onto the Acute site enables CYP with more complex needs to access the specialist care they need from well-supported, experienced teams of highly skilled professionals where the needs of the child and their family are known	
Children can have shorter hospital stays or avoid them all together and be investigated and treated at home instead	
Re-designing pathways for paediatric care will improve the safety, quality and effectiveness of services	

Description of negative impacts	**Mitigating actions of negative impacts**	**How will this action be monitored**	**How often will this action be reviewed**	**Lead**
Urgent and Emergency Care				
Potential risk to patients needing to be transferred from the LEH (SGH) to the acute (DPoW) or specialist hospital (HRI) due to travel time/distance if any delays are incurred *(e.g. lack of staff/ambulances)* - their condition could deteriorate whilst waiting for the transfer or on route.	*Internal transport* *Escalation policies /pathway* *Efficiency flows* *Programme of work with EMAS*	*Number of transfer delays* *Any clinical incidents due to delay in treatment*	*Monthly*	*COO*
No beds available at the acute/specialist hospital resulting in the patient **not** receiving a quick responsive service for more serious or life-threatening emergencies in the right place with the right skilled staff and facilities available.	*Transfer to clinical teams* *Right-sized services*	*Activity Numbers*	*weekly*	*Speciality leads*
Minor increased demand on the ambulance service resulting fewer ambulances available to attend high priority 999 calls *Modelling tells us this is approximately 0.52 additional Ambulance required /88 additional hours a week*	*Invest in additional ambulance crews in line with ORH modelling (data to be refreshed at DMBC stage)*	Number Ambulance delays	*Daily by Ops team*	*COO*
Ambulance service brings the patient to the incorrect site.	*Initial management & transfers* *Development of robust ambulance protocols*		*Daily by Ops team*	*Ambulance Providers*
People being supported to manage their own condition are not medically trained and may miss warning signs / play it down, putting their health at risk and resutling in a more serious admission.	*Safety netting advice*	Numbers Presenting at wrong site	*Daily by Ops team*	*ED Clinical leads*
Increased risk that North Lincs patients may discharge themselves before they are clinically ready to be discharged to get home quicker if transferred to the acute site and away from family.	*Reassurance /Assurance to patients general repuation* *Need to be able to manage post acute care at LEH site*	*Number of Acute admissions diagnosed at LEH & self discharge from acute site*	*Daily by Ops team*	*COO*
Paediatric Care				
Potential risk to CYP patients needing to be transferred from the LEH (SGH) to the acute (DPoW) or specialist hospital (HRI) due to travel time/distance if any delays are incurred *(e.g. lack of staff/ambulances)* - their condition could deteriorate whilst waiting for the transfer or on route.	*Safe transfer & inreach*			
This proposed model of care may deter clinicians and nurses living near the LEH (SGH) from remaining within the Trust and look for alternative employment, putting the sustainability of services at risk.	*Development of rotational posts and new career pathways to ensure strong pipeline of new staff coming through*			
Potential risk if no beds available at the acute/specialist hospital resulting in delays and the patient not receiving a quick responsive service for more serious or life-threatening emergencies in the right place with the right skilled staff and facilities available.	*Right-sized services* *Inreach*			
Increased risk that North Lincs parents may discharge the patients themselves before they are clincially ready to be discharged to get home quicker if transferred to the acute site, especially if they have other dependants at home.	*pathways of care /support of clinical teams*			

Equality impact assessment

Link to guidance

Area* *see Equality guidance, Human Rights Act guidance and Population Profile tabs for further information. **Note - you can select more than one box per area if a change may have multiple impacts e.g. both positive and negative**	Positive Impact	Neutral Impact	Negative Impact
Socio-economic deprivation	☑	☐	☑
Age	☑	☐	☑
Disability	☑	☐	☑
Pregnancy and maternity	☐	☑	☐
Ethnicity	☑	☐	☑
Religion or belief	☑	☐	☑
Sex	☐	☑	☐
Sexual orientation	☐	☑	☐
Marital status	☐	☑	☐
Gender reassignment	☐	☑	☐
Carers	☑	☐	☑
Any other groups	☑	☐	☑
Compliance with Human Rights Act	☐	☑	☐

Opportunity/Consequence Rating	Consequence	Likelihood	Total Score
Socio-economic deprivation positive rating	3	4	**12**
Socio-economic deprivation negative rating	-3	3	**-9**
Age positive rating	3	4	**12**
Age negative rating	-2	4	**-8**
Disability positive rating	4	4	**16**
Disability negative rating	-3	4	**-12**
Pregnancy and maternity positive rating	3	4	**12**
Pregnancy and maternity negative rating	-2	3	**-6**
Ethnicity positive rating	4	4	**16**
Ethnicity negative rating	-2	3	**-6**
Religion or belief positive rating	4	3	**12**
Religion or belief negative rating	-2	3	**-6**
Sex positive rating	2	4	**8**
Sex negative rating	0	0	**0**
Sexual orientation positive rating	3	4	**12**
Sexual orientation negative rating	-2	3	**-6**
Marital status positive rating	0	0	**0**
Marital status negative rating	0	0	**0**
Gender reassignment positive rating	3	4	**12**
Gender reassignment negative rating	-2	3	**-6**
Carers positive rating	4	5	**20**
Carers negative rating	-3	4	**-12**
Any other groups positive rating	4	4	**16**
Any other groups negative rating	-2	3	**-6**

*See Impact Matrix tab for guidance

Description of positive impacts (must include rationale and be evidence based)	**How will these impacts be monitored**
Socio-economic background	
Improved pathways to provide more holistic care, that is more responsive and better at supporting people with multiple co-morbidities to stay well.	
Freeing up staff to improve outreach provision and support *(e.g. outreach clinics, virtual wards, hospital @ home)*	
Reducing waiting times for care and prioritising those most in need	
Improving opportunities for local people to access well-paid jobs and rewarding career pathways *(supporting workforce strategy will develop local workforce of the future in partnership with local education partners, industry etc.).*	
Continued investment in the two major towns *(Grimsby and Scunthorpe)* – keeping money in the local economy.	
When considering the travel impact as a whole, the proposed model (where DPoW is the acute hospital) does not have a disproportionate impact on people living in the most deprived quintile (IMD 1 and 2) - the travel time impact broadly follows the aggregate pattern of deprivation across Northern Lincs	
Age	
Improved experience for CYP due to better joined-up services *(H@H, properly staffed PAU, better quality of care)*	
CYP said that it was really important to them that could be in a place that they feel safe *(toys/home comforts)* H@H will deliver this. *(Reference: What Matters to You: Children and Young People)*	
PCG told us that it was really important that there was well trained staff treating their children. The proposed model supports improved workforce for paeds, specialists in one place. *(Reference: What Matters to You: Parents, Carers and Guardians)*	
Improved frailty services. Enhanced care in care homes and OOH enablers *(falls prevention)*	
Disability	
More care closer to home – reduces overall need to travel *19% of the population in North Lincs are disabled - compared with 20% in North East Lincolnshire*	
Virtual wards will allow for more accessible care – reduces overall need to travel	
People with LD – co-located UCS, easy access to local services. Easier to navigate system and find where they need to be	
Standardising pathways across the Humber – same type of care will make it easier for people with disabilities to navigate	
Ethnicity	
Having a co-located UCS on-site would make it easier for people from BAME backgrounds to access to local services.	
Standardising pathways across the Humber will make it easier for people from BAME backgrounds, and people where English is not their first language to navigate the system . Ethnicity: Asian - 3.3%, Mixed/Multiple Ethnic Group - 0.5%, Black/African/Caribbean/Black British - 1.1% Other Ethnic Groups -0.8%. Language: Cannot speak English well - 0.8%, cannot speak English -0.1%	
Improve opportunities for staff training *(unconscious bias/awareness/equality/disability etc)* – *Patients/Members of the public told us they want this through our engagement.* *Source: Equality Groups - Combined Feedback Report*	
Religion or Belief	
Improve opportunities for staff training (unconscious bias/awareness/equality/disability etc) – *Patients/Members of the public told us they want this through our engagement.* *Source: Equality Groups - Combined Feedback Report*	
Sex	
Sexual Orientation	
Of the LGBTQ+ people we have engaged with so far nobody has identified any barriers to accessing care based on their sexual orientation - in relation to the proposals	*We would like to engage with more members of the LGBTQ+ community as part of the consultation to help provide assurance that this feedback is reflective of the wider experiences of the LGBTQ+ community.*
Gender Reassignment	
Of the LGBTQ+ people we have engaged with so far nobody has identified any barriers to accessing care based on their gender identity - in relation to the proposals	*We would like to engage with more members of the LGBTQ+ community as part of the consultation to help provide assurance that this feedback is reflective of the wider experiences of the LGBTQ+ community.*
Carers	
More care closer to home – reduces overall need for carers to travel *Approximately 3.1% of the population in North Lincs provides 50+ hours of unpaid care per week*	
Virtual wards will allow for more accessible care – reduces overall need to travel	
Care closer to home will reduce the financial strain on carers, particularly unpaid carers	
Any other Groups	
Sex Workers - The proposed model of care would reduce waiting times for patients in ED. Sex workers in North East Lincs told us during our engagement with them that waiting times are one of the main barierrs when accessing care as they feel judged in waiting rooms, so if waiting for any length of time will get up and leave. This proposed model could reduce this barrier for this group of people. *(Source: Equality Groups - Combined Feedback Report)*	
Sex Workers - This proposed model of care allows for increased opportunities for improved joined up working with primary, secondary and community providers and allow sex workers to be looked after by people they trust and who support them on a day-to-day basis *(Source: Equality Groups - Combined Feedback Report)*	
Asylum Seekers - Have told us that they have a lack of knowledge and/or accessible information about what services do exist, what they may be eligible for and what rights they have to access healthcare. Standardising pathways across the Humber will make it easier for people from BAME backgrounds, and people where English is not their first language to navigate the system . *North Lincs Ethnicity: Asian/Asian British - 3.3%, Mixed/Multiple Ethnic Group - 1.1%, Black/African/Caribbean/Black British - 0.5%. White 94.3%* *North Lincs Language: Cannot speak English well - 1.5%, cannot speak English -0.2%* *Migrant Indicator: 0.5% of people living in NL were living at an address outside the UK one year ago* *(Source: Census Data 2021)*	

		How will this action be monitored	**How often will this action be reviewed**	**Lead**
Description of negative impacts	**Mitigating actions of negative impacts**			
Socio-economic background				
Some people in North Lincs and Goole would have to travel further to access care. The proposals increase travel times for some patients, service-users, families and staff members.	*Multi-agency transport working group established to develop innovative transport solutions for families, carers and loved ones.*			
NL has high levels of deprivation and areas of low car ownership so families may not be able to afford to travel to visit the patient at the acute site (DPoW) *In North Lincs 18.5% of households do not own a car, and 20% of neighbourhoods are in the most income deprived quintile in England (Compared with 26.9% of households do not have a car and 40% of neighbourhoods are in the most income deprived quintile in North East Lincolnshire)*	*Work is ongoing with local authority partners to review and potentially redesign bus routes, exploring the possibility for direct transport between the hospital sites for patients, visitors and staff.*			
Low-income families from North Lincs would find it more difficult to afford the additional travel. *(In North Lincs 13.3% of the population are classed as being income deprived and 1 in 5 children in North Lincs are classed as living in poverty .)* *(Source: Fingertips Data)*	*Work is ongoing with local authority partners to review and potentially redesign bus routes, exploring the possibility for direct transport between the hospital sites for patients, visitors and staff.*			
Looking only at maternity and paediatric activity only, both site options (DPoW as the Acute site or SGH as the Acute site) have a disproportionate impact on people living in the most deprived communities, compared with the overall spread of deprivation across the region. This could be accounted for when considering the age profile of deprivation across our region - notably that those living in the most deprived communities are more likely to be younger.				
Age				
Consolidation of paediatric inpatient services would have an impact on people below the age of 18 from North Lincs *Activty modelling tells us that this is approximately 935 paediatric patients per year (compared with 990 in the scenario where these services are consolidated at Scunthorpe)*				

Consolidation of specialist medical inpatient services (Cardiology, Respiratory and Gastroenterology) is likely to have a higher number of impacted patients age 65+ *Activity modelling tells us that this is approximately 1,069 patients per year (compared with 1,584 in the scenario where these services are consolidated at Scunthorpe)*				
Disability				
Disabled people in North Lincolnshire and Goole could face longer journeys to visit relatives or loved ones in hosptial, if they are admitted for care at DPoW 19% of the population in North Lincs are disabled - compared with 20% in North East Lincolnshire	*Multi-agency transport working group established to develop innovative transport solutions for families, carers and loved ones.*			
Disabled people have told us that wheelchairs are not able to travel with patients and that they have no independence when they get to the hospital site	*Multi-agency transport working group established to develop innovative transport solutions for families, carers and loved ones.*			
Disabled people could face more barriers being discharged from hospital if they are admitted to DPoW when this is not their local hospital				
Disabled people from North Lincs have further to travel and may experience difficulties parking *(feedback has told us that there is a lack of accessible parking on sites - Reference: Combined Equalities Group Feedback Report / Transport Survey - Feedback Report)*	*Transport working group to include estates team members to explore potential options to improve car parking*			
Ethnicity				
There is strong evidence that people from Black, Asian and Minority Ethnic (BAME) backgrounds face greater health inequalities. This was highlighted through the COVID-19 pandemic, which had a disproportionate impact on BAME populations in terms of incidence of disease and mortality.	*Ongoing engagement to increase understanding of potential impacts on BAME (in particular Asian/Asian British) communities and develop mitigations*			
The neighbourhoods with the largest concentration of Asian/Asian British Population in the Humber are all in North Lincolnshire, in the areas close to Scunthorpe Hospital - people living in these communities could be impacted if they or a family member is admitted to DPoW.	*Multi-agency transport working group established to develop innovative transport solutions for families, carers and loved ones.*			
Feedback with the BAME and Eastern European community have told us that translation services are currently a barrier - it is unclear whether the proposed model would improve this or not				
Religion or Belief				
Feedback from the Muslim community: Muslim women are less likely to drive or have access to a car, making it more difficult if they have an ill child admitted as an inpatient at DPoW (Acute)	*Multi-agency transport working group established to develop innovative transport solutions for families, carers and loved ones.*			
Feedback from Muslim community: women often chaperoned by male member the family, which could be more difficult if care was further away	*Ongoing engagement to increase understanding of potential impacts on Muslim communities and develop mitigations*			
Sex				
In North Lincs men have a shorter life expectancy than women. *(England Average - Men = 78.7 years, Women = 82.8 years)* *Men = 78.9 years* *Women = 83.3 years* *(Source: Census Data 2021 - Life expectancy at birth)*				
Sexual Orientation				
Of the LGBTQ+ people we have engaged with so far nobody has identified any barriers to accessing care based on their gender reassignment.	*We would like to engage with more members of the LGBTQ+ community as part of the consultation to help provide assurance that this feedback is reflective of the wider experiences of the LGBTQ+ community.*			
Gender reassignment				
Of the LGBTQ+ people we have engaged with so far nobody has identified any barriers to accessing care based on their gender reassignment.	*We would like to engage with more members of the LGBTQ+ community as part of the consultation to help provide assurance that this feedback is reflective of the wider experiences of the LGBTQ+ community.*			
Carers				
Some carers in North Lincs would have to travel further so that the people/person they look after could access care and/or to visit the person they care for should they be admitted to the acute site (DPoW) *Approximately 3.1% of the population in North Lincs provides 50+ hours of unpaid care per week, broadly similar to North East LIncolnshire (3.2%)*	*Multi-agency transport working group established to develop innovative transport solutions for families, carers and loved ones.*			
Low income carers / unpaid carers from North Lincs would find it more difficult to afford the additional travel. *(In North Lincs there are approximately 19,000 carers.* *13.3% of the population are classed as being income deprived and 1 in 5 children in North Lincs are classed as living in poverty)* *(Source: Census Data 2021)*	*Multi-agency transport working group established to develop innovative transport solutions for families, carers and loved ones.*			
Any other Groups				
Sex Workers - We engaged with sex workers in North East Lincs. A key barrier for them when trying to access services is ease of access, for example if the appointment is too dicciculT to get too, they wont attend. By consolidating specialst/maternity services onto one site further away from where they live could create further health inequalites for this group as they will find getting to an appointment too difficult so wont go and get the medical care/treatment they need. *(Source: Equality Groups - Combined Feedback Report)*				
Sex Workers - Many sex workers won't get in an ambulance as they feel it resembles a police car and they are going to be judged by people in uniform. If these women are needing to be transferred to from the LEH (DPoW) to the Acute site (SGH) this could have a negative impact on them and create further barriers and health inequalties. *(Source: Equality Groups - Combined Feedback Report)*	*Multi-agency transport working group established to develop innovative transport solutions for families, carers and loved ones.*			
Asylum Seekers - Many asylum seekers don't have the right paperwork to access means-tested benefits. Many don't drive or have access to a car. By consolidating services onto the acute site (DPoW) could create further barrier for access and health inequalties for this group as they are unable to travel to the appropriate site and cannot afford public transport. *(Source: Equality Groups - Combined Feedback Report)*	*Multi-agency transport working group established to develop innovative transport solutions for families, carers and loved ones.*			
Asylum Seekers - Fear often prevents people from accessing services and/or asking for help – particularly, fear that doing so might impact on asylum status or application process. Lack of knowledge and/or accessible information about what services do exist and where they are may only compound that fear and inhibit them from accessing services at all. *(Source: Equality Groups - Combined Feedback Report)*	*Multi-agency transport working group established to develop innovative transport solutions for families, carers and loved ones.*			

Workforce impact assessment

Link to guidance

Area Note - you can select more than one box per area if a change may have multiple impacts e.g. both positive and negative	Positive Impact	Neutral Impact	Negative Impact
Effective prioritisation and management of workload	☑	☐	☐
Staff experience as a result of workforce changes	☑	☐	☑
Contractual obligations	☑	☐	☑
Workforce diversity	☑	☐	☐
Workplace	☐	☑	☐
Sustainability of service due to workforce issues	☑	☐	☐
Other (please state below):			
	☐	☐	☐

Opportunity/Consequence Rating	Consequence	Likelihood	Total Score
Workforce positive rating	4	4	**16**
Workforce negative rating	-3	2	**-6**

*See Impact Matrix tab for guidance

Description of positive impacts (must include rationale and be evidence based)	**How will these impacts be monitored**
Urgent and Emergency Care	
By concentrating the workforce in fewer locations for the most specialist care, those delivering specialist services will have more opportunities to develop their skills by treating a higher number of complex cases and a wider variety of experiences. They will be able to work in larger teams, which improves resilience and enables us to design rotas to cover services that will be more attractive to current and future workforce. This will create more sustainable services in the longer term	*National Audits* *Local KPI's* *Vacancy rate and recruitment/retention data*
Improved workforce models (MDT/Training) and new models of care within urgent care will reduce demand on current staff	*Staff Surveys /Feedback*
Working as multi-disciplinary teams across pathways creates opportunities for different staff *(GPs, specialty doctors, allied health professionals, and advanced clinical practitioners*) to develop their skills and provide effective and efficient care for our population	*KPI* *Outcomes on standards of Care* *National speciality Audits SEDIT/SAMIT*
A co-located UCS enables us to develop a staffing model that facilitates staff in a wide variety of roles to work across urgent and emergency care pathways and develop their skills and expertise in urgent care and emergency medicine	*Staff Surveys /Feedback*
Centre of excellence can attract / retain more specialist workforce	*Vacancy rate and recruitment/retention data* *Staff Surveys /Feedback*
Anchor institues *(homegrown furture workforce fom local population working closesly with schools, colleges & Universities)*	*%of local residents taking jobs*
Increasing apprenticeship opportunities *(developing new routes into nursing, prgression & frameworks)*	*% local recruitment & Inhouse intake*
Increase Research and Development (R&D) jobs and capacity within our growing medi-health sector through new partnerships	*R & D Statistics*
First Contact Practitioners would rotate between the UCS and GP Practice where they can directly support patients with urgent care needs, thereby avoiding unnecessary referrals into UCS.	*Training posts*
Advanced Clinical Practitioners and Nursing establishments can be complemented by Physician Associates to deliver non-complex clinical interventions	*% of posts taken by AHP's vs Dr's*
Advanced Clinicial Practictioners *(Physiotherapists, Paramedics and Registered Nurses)* with the ability to prescribe will provide high level clinical input to support patients attending the UCS wuth minor illness or injury introdcuing the role of Urgent Care Practictioners	*% of posts taken by AHP's vs Dr's as non-medical prescribers in the UCS & community*
Nursing staff - co-located UCS enables the nursing leadership and nursing workforce to be shared acorss UCS and the ED to build networks, resilience and maintain skills	*% of practitioners able to work*
Nursing teams will largely be site-based but with career development opportunities available across the system	*Training opportunities /programmes*
Consolidating longer-stay medical specialty inpatient beds on the Acute Hospital site will enable nursing teams to develop a higher level of expertise in particular specialties, building confidence and skills in teams who are working in a more specialist way.	*Reduction in speciality nurse roles /% of retention*
Staff maintain skills and meet national targets	*Staff appraisals and training compliance*
Competency of staff in dealing with more complex cases improves	*Staff appraisels and training compliance /reductions in incident reporting*
Acute site will attract more consultants/improve recruitment and improve staff vancanies	*recruitment & retention*
Desirable staff rotas that are to improve recruitment	*Vacancy rate and recruitment/retention data*
Implementing the proposed model of care represents a reduction of approximately 130 WTE posts within the hospitals against the 'do nothing' (BAU) position. This would help to address the significant vacancies across the system and also support reduction in agency and locum spend.	*Vacancy rate and recruitment/retention data* *Agency and locum spend*
More resilient services, less likely to be impacted by key staff leaving	*recruitment/retention data*
Better utilisation of deployment of the workforce /rotational posts	*Trainee Feedback*
Reduce workforce pressures / Improves efficiency / productivity	*Trainee Feedback*
Reduction in duplicated speciality rotas	*Reduction compared to the BAU model*
Decreases some reliance on agency and locum workforce	
On average it takes three years to train a nurse and at least 13 years to train a consultant, so targeted action to address the shortages is critical to ensuring the sustainability of services over the long term.	*Alternative workforce / Recruitment & Retention*
provide continuation of training places across both the Acute Hospital and the Local Emergency Hospital and foster a 'one-team' culture	*HEE rotations PGME data*
Speciality medical consolidation allows targeted workforce and improved training and improves the training offer for staff	*Number of training posts /Trainee feedback*
Allows for increased staff training to support understanding and holistic management of the whole person (e.g. Mental health)	*Trainee Feedback*
In order to improve the sustainability of our services and implement more robust models of care, it will be important to ensure the career opportunities we offer are rewarding so that we can retain existing skills within the system and attract new entrants into the sector.	*Recruitment & Retention*
Staff will be able to work in larger teams, which improves resilience and enables us to design rotas to cover services that will be more attractive to current and future workforce. Improved retention and recruitment of staff ensures the sustainability of services over the long term.	*Staff feedback/vacancy rate*
Paediatric Care	
The proposed model of care has embraced the concept of joint appointments where retiring staff from paediatrics and children's services could return to provide education support, advice and guidance.	
The proposed pathway re-design will ensure staff working in paediatric services have the opportunities they need to keep their skills up to date and have the confidence to handle more complex cases when they arise.	
Consolidation will enable more effective deployment of our skilled and specialist staff by concentrating teams in one location rather than spreading them across multiple units.	
The proposed staffing model for paediatrics has been developed considering the requirements set out in the *National Quality Board on Safe Staffing* and *Facing the Future* standards to deliver their services	
Opportunities for new roles and ways of working across paediatrics, including; rotational induction/preceptorship programmes, dedicated apprenticeship programmes, retire and return mentorship/educational support, young person's nurse specialist roles	
Staff will be able to work in larger teams, which improves resilience and enables us to design rotas to cover services that will be more attractive to current and future workforce. Improved retention and recruitment of staff ensures the sustainability of services over the long term.	

Description of negative impacts	**Mitigating actions of negative impacts**	**How will this action be monitored**	**How often will this action be reviewed**	**Lead**
Urgent and Emergency Care				
Paediatric Care				
Still requires multiple rotas for some specialties, paediatrics/neonatal and ED				
Additional workforce would be needed to support the additional transfers	*Development of transport solutions for inter-hosptial transfers*			
Can the staff working at the LEH sufficiently maintain skills and experience	*Development of rotational posts and new career pathways to ensure strong pipeline of new staff coming through*			
Additional travel and financial impact for staff rotating between sites, staff with young families would be particularly impacted	*Work is ongoing with local authority partners to review and potentially redesign bus routes, exploring the possibility for direct transport between the hospital sites for patients, visitors and staff.*			
Potential for dissatisfaction/low morale amongst staff at the LEH whose site base may change. These existing staff members may choose an alternative role or organisation rather than travel to the acute site, this could potentially have a negative impact on staff vacancy rates	*Development of rotational posts and new career pathways to ensure strong pipeline of new staff coming through*			
Potential for reduced career opportunities/progresion for specialist, paediatric workforce at the LEH and/or perception of reduced opportunities.This could make the LEH a less attractive place to work, and make recruitment difficult.	*Development of rotational posts and new career pathways to ensure strong pipeline of new staff coming through*			
Vacancy rates in NLaG could continue to rise if recruitment/retention initiatives aren't successful making it unsustainable to maintain services.				
Staff have told us that parking and lack of spaces makes travelling to work difficult for them, consolidating some staff/services onto one site could reduce the availabilty of parking event more. *(Source: Travel and Transport Feedback Report)*	*Transport working group to include estates team members to explore potential options to improve car parking*			
Staff have told us that poor public transport links make it difficult for them when travelling to work, and public transport between hospital sites is poor. This could have a negative impact on staff who rely on public transport if required to work at alternative sites as a result of the changes proposed within this model of care. *(Source: Travel and Transport Feedback Report)*	*Work is ongoing with local authority partners to review and potentially redesign bus routes, exploring the possibility for direct transport between the hospital sites for patients, visitors and staff.*			

Sustainability impact assessment

Link to guidance

Area* *See Sustainability guidance tab for more information **Note - you can select more than one box per area if a change may have multiple impacts e.g. both positive and negative**	Positive Impact	Neutral Impact	Negative Impact
Sustainability	☐	☑	☐
CO2 Reduction	☑	☐	☑
Climate Change Adaptation	☐	☑	☐
Rural Proofing	☑	☐	☐

Opportunity/Consequence Rating	Consequence	Likelihood	Total Score
Sustainability positive rating	3	4	**12**
Sustainability negative rating	-2	2	**-4**

*See Impact Matrix tab for guidance

Description of positive impacts (must include rationale and be evidence based)	How will these impacts be monitored
Urgent and Emergency Care	
Improves financial sustainability by reducing the cost of using agency and locum staff to fill vacancies *(In 2022/23 - HUTH spent £18million and NLaG spent £37.7 million)*	
Design and build 'smart buildings' promoting increased environmental sustainability and efficiency. This will also support the delivery of the ICS's Green Plan.	
Improved use of digital to support remote monitoring, more responsive and efficient services will help to reduce the overall need for patients to travel to hospital.	
Digital Infrastrature - systems that interact with each other /providing remote assessments,monitoring, shared care planning and diagnostics access	
Boost economic and productivity growth across the Humber's thriving industries, leveraging the benefits of Freeport status and working with a range of partners to support investment in the region. Our investment plans are backed by a strong "Anchor Network" across the region and integral to the delivery of regional regeneration strategies, Local Authority Master Plans and Town Deals. Planning has been undertaken collaboratively with Local Authorities and wider partners (Universities, LEPs), adopting a "One Public Estate" approach, to ensure maximum return on investment, leveraging wider economic benefits through increased private sector investment in allied industries.	
Raise the Humber's prominence as the UK's Energy Estuary within the emerging green energy sector and generate solutions to help meet the NHS Zero Carbon goals	
Built on a digitally delivered support infrastructure, providing remote assessments, monitoring, shared care planning and diagnostics access.	
Put in place virtual wards to achieve a sustainable shift from hospital to home-based care when safe to do so	
Paediatric Care	
Put in place virtual wards to achieve a sustainable shift from hospital to home-based care when safe to do so	

Description of negative impacts	Mitigating actions of negative impacts	How will this action be monitored	How often will this action be reviewed	Lead
Urgent and emergency care				
Our current buildings are not flexible and cannot easily by adapted to deliver new models of care.				
Paediatric Care				

Financial Impact Assessment - Financial Impact Assessments will be reviewed as part of planning for implementation

Current spend (£ / £k / £million)		
Implementation date		
Type of savings	☐	No savings or minimal anticipated
	☑	Cash-releasing saving or potential for improved productivity
	☑	Both cash savings and improved productivity is expected
Potential Savings (gross) If you have answered 'no savings' above you do not need to complete this question	Part year effect:	
	Full year effect:	
Potential Investment Needed (gross)	Part year effect:	
	Full year effect:	
Net effect	Part year effect:	
	Full year effect:	
Level of confidence in achieving savings - high/medium/low		

Engagement Assessment

*See Impact Matrix tab for guidance

Area Note - you can select more than one box per area if a change may have multiple impacts e.g. both positive and negative (Click on box to see prompts)	Positive Impact	Neutral Impact	Negative Impact	Description of impact (add hyperlink or add copy of document in documents tab)
Good practice	☑	☐	☐	*We will be able to meet clinical and constitutional standards (see clinical effectiveness tab)*
Strategy	☑	☐	☐	*The proposal has been designed and developed in line with current regional and national strategies.*
Reputation	☑	☐	☑	*Whilst there are many positives to be gained from the proposed model of care, there is a chance that stakeholders may see the proposed change as services being taken away from which could have a negative impact on the reputation of the local NHS.*
Patients / Carers	☑	☐	☑	*Significant positive benefits for patients/carers as the quality of care they will receive will be much better through this proposed model of care, however, some may need to travel further to access it. (See patient experience tab)*
Staff	☑	☐	☑	*Significant positive benefits for staff through this proposed model of care, for example, increased career and training opportunities, rotational posts and opportunities to work in larger teams, however, some may need to travel further to get to work. (See workforce tab)*
General public	☑	☐	☑	*Significant positive benefits for the general public as the quality of care they will receive will be much better through this proposed model of care, however, some may need to travel further to access it. (See patient experience tab)*
Protected/other vulnerable groups	☑	☐	☑	*Significant positive benefits for people with protected characteristcs/vulnerable as the proposed changes increase equity in access across the region, meaning the system is also easier to navigate, however, some may need to travel further to access care. (See patient experience tab and Equalities tab)*
Relationships	☑	☐	☐	*The programme has been clinically led from the start,with local authorities, partners and providers all being involved at every stage.*

Level of Engagement / Consultation		Level of engagement required Please agree level of engagement activity required with your local communications and engagement lead		Examples NB: examples need to be assessed individually and are subject to local circumstances
No engagement	☐	• A small scale change or new service • Affecting small numbers and/or having low impact • There is good evidence that the change will improve or enhance service provision • No obvious impact on patient experience • No requirement for patient information	• Stakeholders have little or no influence over the change • No obvious impact on organisational reputation • Protected groups are not disproportionally affected by the change • Low or no resistance from other key stakeholders	Moving a service out of the hospital into multiple community settings
Level 1 Information giving	☐	• A small scale change or a new service • Affecting small numbers and/or having low impact • There is good evidence that the change will improve or enhance service provision	• Often requires an information-giving exercise (2-4 weeks) • May require some low level engagement	The merger of services where there is either an improvement or no change to the services being offered service users Extending the hours of a service
Level 2 Minor change	☐	• A small/medium scale change or a new service • Affecting low numbers of people • Often requires a small engagement (4-6 weeks)		Changing or reducing the hours of a service
Level 3 Significant change	☐	• A significant service change • Affecting large numbers of people and/or having a significant impact on patient experience • A significant change from the way services are currently provided • Potentially controversial with local people or key stakeholders • A service closure • Limited information about the impact of the change • Requires a significant engagement (3 months)		A significant change to the way a service operates (such as a referral criteria or location)
Level 4 Major change	☑	• A major change that requires formal consultation and follows NHS England guidance • Affects majority of the local population and or having a significant impact on patient experience • A substantial change from the way services are currently provided • High risk of controversy with local people or key stakeholders • A service closure • Limited information about the impact of the change • Requires consultation (3 months+) and potentially pre consultation engagement		A major transformation of a large service The proposed closure of a large service following a national directive

Any additional comments

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

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

Data Protection Impact Assessment - Data protection assessments will be undertaken as part of planning for implementation

Screening Questions		Tick if yes
1	Will the project involve the collection of new identifiable or potentially identifiable data about individuals?	☐
2	Will the project compel individuals to provide data about themselves or involve the processing of personal data not obtained directly from the individual? i.e. where they will have little awareness or choice or where it is impossible, or would involve disproportionate effort, to inform the individuals that the processing is taking place	☐
3	Will identifiable data about individuals be shared with other organisations or people who have not previously had routine access to the data?	☐
4	Are you using data about individuals for a purpose it is not currently used for or in a new way? i.e. using data collected to provide care for a service evaluation; data matching where data obtained from multiple sources is combined, compared or matched.	☐
5	Where data about individuals is being used, would this be likely to raise privacy concerns or expectations? i.e. will it include health records, genetic data, criminal records or other information that people may consider to be sensitive and private and may cause them concern or distress.	☐
6	Will the project require you to contact individuals in ways which they may find intrusive? i.e. telephoning or emailing them without their prior consent.	☐
7	Will the project result in you making decisions in ways which can have a significant impact on individuals? i.e. will it affect the care a person receives? Is it based on automated decision making (including profiling)?	☐
8	Does the project involve you using new technology which might be perceived as being privacy intrusive? i.e. using biometrics, facial recognition, Artificial Intelligence or tracking (such as tracking an individual's geolocation or behaviour)	☐
9	Is a service/processing activity being transferred to a new supplier/organisation (or re-contracted) at the end of an existing contract	☐
10	Will the project involve systematic monitoring of a publicly accessible area on a large scale? i.e. use of CCTV	☐
11	Will the project involve the targeting of children or other vulnerable individuals? i.e. for marketing purposes, profiling or other automated decision making	☐

If you have answered yes to any of these questions, you will need to seek advice from the ICB Information Governance specialist and complete the full data protection impact assessment as provided at the link below:

Select link below to go to the guidance for each area:

Patient Experience
Patient Safety
Clinical Effectiveness
Equality
Workforce
Sustainability
Other Useful Links and Resources

Patient Experience Guidance

Areas to consider		Questions/examples
Patient Reported Experience	National surveys, complaint themes and trends, PALS data, FFT data, incident themes and trends	Based on what we know patients are telling us about the service/area, will the proposal have a positive or negative impact on patient experience?
Patient Choice	Informed choice, choice of provider, choice of location	Will patients have more choice or less choice? Can you include any mitigations if there is a reduction in choice i.e. through personal health budgets?
Patient Access	Physical access, systems or communication, travel and accessibility, threshold criteria, hours of service including out of hours, time waiting for admission or placement in a care setting, appointment waiting times for secondary, primary care or social care	If a service is moving location will access be impacted? Have thresholds changed and therefore may have positive/negative impact on access to a service.
Respect and Compassionate and Personalised Care Agenda	Patient dignity and respect, empathy, control of care, patient/carer involvement, care that is tailored to the patient's needs and preferences Patient-centred values, expressed needs, cultural issues, independence of service users quality-of-life issues and shared decision making	Will this support a patient centred care approach?
Responsiveness and Co-ordination	Communication, waiting times, support to patients Coordination and integration of care across the health and social care system	Will the waiting times increase or decrease? Will there be support to patients and/or carers when they need it? Will care be seamless across providers
Promotion of self-care and support for people to stay well	People with long term conditions, social prescribing initiatives, social isolation, help and advice elements Information that will help patients care for themselves away from a clinical setting, and coordination, planning, and support to ease transitions	Does the proposal support/promote self care? Will is improve transitions and conytinuity?
Involvement	involvement of family, friends, carers and significant others in decision making	Will this support the needs of others as care givers?
Information and Communication	on clinical status, progress, prognosis, and processes of care in order to facilitate autonomy, selfcare and health promotion;	Will this support good communication, education and information sharing?
Emotional support	fear and anxiety about such issues as clinical status, prognosis, and the impact of illness on patients, their families and their finances;	Will this support improvements in emotional support for service users and carers?
Other	Is there anything else that may impact, positively or negatively, on the patient/carer experience?	

Patient Safety Guidance

Areas to consider		Questions/Examples
Preventable Harm	Infection prevention (HCAI), waiting times/delays, staffing levels/competence, Serious incidents and Never Events/Always Events	Based on the information available will the proposal have a negative or positive impact on patient safety? Decrease incidents? Decrease delays in treatment/diagnosis?
Robustness of Systems and Processes	Governance, Clinical Audit, CQC standards, NICE and Royal College compliance, Surgery Checklist, Accreditation	Is the proposal compliant with national /local guidance or processes?
Environment	Cleanliness, suitability, upkeep, equipment, potential fro Healthcare associated infections	Will the environment of the proposal have an impact? Improved facilities? Will the propsal support ensuring a safe environment?
Safeguarding	Adults and children at risk, no one must suffer any form of abuse or improper treatment while receiving care. This includes:	What is the impact on Adults or Children at risk?
		Does the change consider the needs of vulnerable patients?
Other	Is there anything else that may impact, positively or negatively, on the patient safety?	Commissioning for outcomes using incentives e.g. BPT, contracts with outcomes incentives

Clinical Effectiveness Guidance

Areas to consider		Questions/Examples
Improved Patient Outcomes	Population health management	Will the proposal lead to better patient outcomes? Include positive or negative outcomes.
Clinical Engagement	Evidence of clinical leadership and engagement in development of model and implementation plan (not just CCG staff)	Have clinical staff been involved and supportive of the proposal to ensure support for implementation.
Development and improvement of pathways		Does the proposal improve a patient pathway or have an impact on other pathways?
Implementation of evidence based practice	Does the proposal fit with clinical evidence and clinical best practice NICE guidance, Royal College etc.	
Variation in care	Positive or negative variation and will this have an impact on health inequalities?	If the proposal has a positive variation in care will this lead to wider health inequalities?
Delivery of care in the most effective way	LEAN, productive series	Will it utilise staff/equipment in a more productive way?
Other	Is there anything else that may impact, positively or negatively, on effectiveness?	

Equality Guidance

AGE

- Any discriminatory employment practices including recruitment, personal development, promotion, entitlements and retention.
- Services should be provided, regardless of age, on the basis of clinical need alone.
- Services tackling known health inequalities experienced by younger / older people, for example, in relation to isolation and older people.

DISABILITY

- Services tackling known health inequalities experienced by disabled people, for example, people with learning disabilities have a shorter life expectancy than the
- Reasonable steps that can be taken to accommodate the disabled persons requirements, including:

o Physical access
o Format of information
o Time of interview or consultation event
o Personal assistance
o Interpreter
o Induction loop system
o Independent living equipment
o Content of interview of course etc.

- Steps to make reasonable adjustments to service delivery and employment practices to ensure 'accessible to all'.

PREGNANCY AND MATERNITY

- Equal access to recruitment, personal development, promotion and retention for female employees who are pregnant or on maternity leave.
- Equality of opportunity in relation to health care for women irrespective of whether they are pregnant or on maternity leave or breast feeding.
- Unlawful to treat a woman unfavourably because she is breast feeding.

ETHNICITY

- The provision of an interpreter for people whose first language is not English.
- Written communication support / the use of language particularly jargon or colloquialisms etc.
- Services tackling known health inequalities experienced by different ethnic groups, for example, high rates of diabetes amongst the Bangladeshi community etc.

RELIGION / BELIEF AND CULTURE

- Prayer facilities for service users and staff.

· Dietary requirements.
· Gender of staff when caring for patients of the opposite sex.
· Respect for requests from staff to have time off for religious festivals.
· Respect for dress codes
· Respect in terms of religion, belief and culture.

SEX

· Equal access to recruitment, personal development, promotion and retention.
· Childcare arrangements that do not exclude a candidate from employment and the need for flexible working.
· The provision of single sex facilities, toilets, wards etc.
· Equality of opportunity in relation to health care for individuals irrespective of whether they are male, female, single, divorced, separated, living together or married.

SEXUAL ORIENTATION

· Services tackling known health inequalities experienced by LGBT people, for instance, a higher rate of mental health problems.
· Recognition and respect of individual's sexuality.
· Recognition of same sex relationships in respect to consent, next of kin, visiting etc.
· The maintenance of confidentiality about an individual's sexuality.

MARITAL STATUS

· Equal access to recruitment, personal development, promotion and retention.
· Equality of opportunity in relation to health care for individuals irrespective of whether they are single, divorced, separated, living together or married or in a civil

GENDER REASSIGNMENT

The process of transitioning from one gender to another.

· Equal access to recruitment, personal development, promotion and retention.
· Equality of opportunity in relation to healthcare for individuals irrespective of whether they were male or female, Trans or 'cis' or 'whether they identify with the gender
· The maintenance of confidentiality about an individual's trans identity/history

CARERS

· Reasonable steps that can be taken to accommodate carer's requirements, such as:

o Time of meetings or interviews
o Flexible working
o Carer's assessments

HUMAN RIGHTS ACT

Links are provided below to each right:

Article 2: Right to life
Article 3: Freedom from torture and inhuman or degrading treatment
Article 4: Freedom from slavery and forced labour
Article 5: Right to liberty and security
Article 6: Right to a fair trial
Article 7: No punishment without law
Article 8: Respect for your private and family life, home and correspondence
Article 9: Freedom of thought, belief and religion
Article 10: Freedom of expression
Article 11: Freedom of assembly and association
Article 12: Right to marry and start a family
Article 14: Protection from discrimination in respect of these rights and freedoms
Protocol 1, Article 1: Right to peaceful enjoyment of your property
Protocol 1, Article 2: Right to education
Protocol 1, Article 3: Right to participate in free elections
Protocol 13, Article 1: Abolition of the death penalty

Workforce Guidance

Areas to consider	Specific details	Examples
Effective prioritisation and management of workload	Triage and pathways, wider system impact, staff ability to deliver their role effectively and appropriately	Will the proposal impact on the workload of staff? Will staff be able to deliver the same standard of care?
Staff experience as a result of workforce changes	Career progression, specialisation, deskilling/upskilling , staff morale and satisfaction	Will staff be impacted? Does the change enrich staff roles and allow progression?
Contractual obligations	TUPE implications, impact on terms and conditions, recruitment processes or options, safe staffing levels	
Workforce diversity	Differential impacts on staff groups with protected characteristics	Shift patterns longer than childcare provision?
		Does policy/service give due consideration to culture and beliefs of staff?
Workplace	The organisations commitment to high quality workplaces, aiming to be employers of choice, location and facilities	
Sustainability of service due to workforce issues	Resilience and skills, recruitment, retention, career pathways	
Other	Is there anything else that may impact, positively or negatively, on the workforce?	

Sustainability Guidance

Sustainability = how to meet the needs of the current generation without compromising the ability of future generations to meet their needs.

Sustainability

This area includes waste and pollution, recycling, use of resources, ethical purchasing, biodiversity, provision of green spaces. Will this course of action increase the amount of non-recyclable waste? Increase air pollution?

Current issues for the NHS include recycling of unused pharmaceuticals, safe disposal of medical waste, use of anaesthetic gases, purchasing of surgical gloves, and engaging in ethical purchasing that does not harm biodiversity (eg no palm oil) or exploit workers in other countries.

CO2 Reduction

Does this course of action increase or decrease the use of fossil fuels (gas, oil, coal, petrol)? Does it increase or reduce the amount of travel? Will buildings become more efficient, better insulated, use less heating/ air conditioning?

Climate Change Adaptation

Does this take into account climate change risks for the area (increased flooding, higher summer temperatures)?

Rural Proofing

Almost a third of the CCG's population live in rural areas – how will this course of action affect their ability to access services? Increases in age and disability lead to a reduced ability to drive and greater dependence on public transport.

Guidance available here: https://www.gov.uk/government/publications/rural-proofing

For further information see:

The Sustainable Development Unit: https://www.sduhealth.org.uk/

Centre for Sustainable Healthcare: https://sustainablehealthcare.org.uk/

York NHS FT Sustainable Development Plan 2017-20 https://www.yorkhospitals.nhs.uk/seecmsfile/?id=2264

Other Useful Links and Resources

The NHS Constitution
The Social Value Act
Patient Safety
Equality Act
Equality Act 2010 Guidance
Public Sector Equality Duty
Sexual orientation monitoring standard
Planning, assuring and delivering service change for patients

Likelihood		
0	Not applicable	
1	Rare	Not expected to occur for years. Will occur in exceptional circumstances.
2	Unlikely	Expected to occur at least annually. Unlikely to occur.
3	Possible	Expected to occur at least monthly. Reasonable chance of occuring.
4	Likely	Expected to occur at least weekly. Likely to occur.
5	Almost Certain	Expected to occur at least daily. More likely to occur than not.

		Opportunity						Consequence				
		5	4	3	2	1	0	-1	-2	-3	-4	-5
Likelihood	5	25	20	15	10	5	0	-5	-10	-15	-20	-25
	4	20	16	12	8	4	0	-4	-8	-12	-16	-20
	3	15	12	9	6	3	0	-3	-6	-9	-12	-15
	2	10	8	6	4	2	0	-2	-4	-6	-8	-10
	1	5	4	3	2	1	0	-1	-2	-3	-4	-5

Category	
	Opportunity
	Low - Moderate Risk
	High Risk

Opportunity and Consequence			
Impact	**Score**		**The proposed change is anticipated to lead to the following level of opportunity and/or consequence:**
Positive	**5**	Excellence	Multiple enhanced benefits including excellent improvement in access, experience and/or outcomes for all patients, families and carers. Outstanding reduction in health inequalities by narrowing the gap in access, experience and/or outcomes between people with protected characteristics and the general population. Leading to consistently improved standards of experience and an enhancement of public confidence, significant improvements to performance and an improved and sustainable workforce.
	4	Major	Major benefit leading to long term improvements and access, experience and /or outcomes for people with this protected characteristic. Major reduction in health inequalities by narrowing the gap in access, experience and /or outcomes between people with this protected characteristic and the general population. Benefits include improvements in management of patients with long term effects and compliance with national standards.
	3	Moderate	Moderate benefits requiring professional intervention with moderate improvement in access, experience and /or outcomes for people with this protected characteristic. Moderate reduction in health inequalities by narrowing the gap in access, experience and /or outcomes between people with this protected characteristic and the general population.
	2	Minor	Minor improvement in access, experience and /or outcomes for people with this protected characteristic. Minor reduction in health inequalities by narrowing the gap in access, experience and /or outcomes between people with this protected characteristic and the general population.
	1	Negligible	Minimal benefit requiring no/minimal intervention or treatment. Negligible improvement in access, experience and /or outcomes for people with this protected characteristic. Negligible reduction in health inequalities by narrowing the gap in access, experience and /or outcomes between people with this protected characteristic and the general population.
Neutral	**0**	Neutral	No effect either positive or negative
Negative	**-1**	Negligible	Negligible negative impact on access, experience and /or outcomes for people with this protected characteristic. Negligible increase in health inequalities by widening the gap in access, experience and /or outcomes between people with this protected characteristic and the general population. Potential to result in minimal injury requiring no/minimal intervention or treatment, peripheral element of treatment suboptimal and/or informal complaint/inquiry
	-2	Minor	Minor negative impact on access, experience and /or outcomes for people with this protected characteristic. Minor increase in health inequalities by widening the gap in access, experience and /or outcomes between people with this protected characteristic and the general population. Potential to result in minor injury or illness, requiring minor intervention and overall treatment suboptimal
	-3	Moderate	Moderate negative impact on access, experience and /or outcomes for people with this protected characteristic. Moderate increase in health inequalities by widening the gap in access, experience and /or outcomes between people with this protected characteristic and the general population. Potential to result in moderate injury requiring professional intervention.
	-4	Major	Major negative impact on access, experience and /or outcomes for people with this protected characteristic. Major increase in health inequalities by widening the gap in access, experience and /or outcomes between people with this protected characteristic and the general population. Potential to lead to major injury leading to long-term incapacity/disability
	-5	Catastrophic	Catastrophic negative impact on access, experience and /or outcomes for people with this protected characteristic. Catastrophic increase in health inequalities by widening the gap in access, experience and /or outcomes between people with this protected characteristic and the general population. Potential to result in incident leading to death, multiple permanent injuries or irreversible health effects, an event which impacts on a large number of patients, totally unacceptable level or effectiveness of treatment, gross failure of experience and does not meet required standards

Staff Demographic Information

Hull University Teaching Hospitals NHS Trust		Northern Lincolnshire & Goole NHS Foundation Trust	
Total Staff Number	9,703 headcount 7,712 wte	**Total Staff Number**	6,795 headcount 5,698 wte
Age	Staff are under 30: 22.5% Staff aged 30 – 55: 60.8% Staff are over 55: 16.7%	**Age**	Staff are under 30: 20.7% Staff aged 30 – 55: 61.3% Staff are over 55: 18.0%
Disability	% of staff employed declared themselves as: Having no disability 62.2% Having a disability 2.5% Not stated/undefined 35.3%	**Disability**	% of staff employed declared themselves as: Having no disability 85.3% Having a disability 2.5% Not stated/undefined 12.2%
Pregnancy and Maternity	% of staff currently declared themselves as pregnant - not reportable % of staff currently on maternity leave 1.91%	**Pregnancy and Maternity**	% of staff currently declared themselves as pregnant - not reportable % of staff currently on maternity leave 2.44%
Ethnicity	% of staff employed declared themselves as: White 85.2% BAME 13.6% Not stated/undefined 0.2%%	**Ethnicity**	% of staff employed declared themselves as: White 84.6% BAME 11.8% Not stated/undefined 3.6%%
Religion and Belief	% of staff employed declared themselves as: Christian 39.6% Other faith or beliefs 22.6% Not stated/undefined 37.7%	**Religion and Belief**	% of staff employed declared themselves as: Christian 48.38% Other faith or beliefs 29.82% Not stated/undefined 21.8%
Gender	% of staff employed declared themselves as: Female 74.5% Male 25.5%	**Gender**	% of staff employed declared themselves as: Female 77.7% Male 22.3%
Sexual Orientation	% of staff employed declared themselves as: Heterosexual 71.3% LGBTQ+ 2.5% Not stated/undefined 26.2%	**Sexual Orientation**	% of staff employed declared themselves as: Heterosexual 81.79% LGBTQ+ 2.08% Not stated/undefined 16.13%
Gender Reassignment	not accessible	**Gender Reassignment**	not accessible

Marriage and Civil Parenership	% of staff employed declared themselves as: Married/Civil Partnership 51.5% Single/Divorced/Widowed 46% Not stated/undefined 2.4%	**Marriage and Civil Parenership**	% of staff employed declared themselves as: Married/Civil Partnership 53.65% Single/Divorced/Widowed 42.63% Not stated/undefined 3.72%

Population Demographic Information

	Hull	East Riding	North East Lincolnshire	North Lincolnshire
Population	**267,100** (Census 2021)	**342,200** (Census 2021)	**156,900** (Census 2021)	**169,700** (Census 2021)
Age	**Aged under 15 years - 18.7%** Aged 15 to 64 years - 66.0% Aged 65 years and over - 15.3% (Source: Census 2021) *Hull's population is relatively young compared to England: the number of people in their 20s is higher than England due to Hull being a University city. There are also fewer people aged 50+ in Hull compared to England.* (Source: Hull CCG website)	Aged under 15 years - 14.8% Aged 15 to 64 years - 58.8% **Aged 65 years and over - 26.5%** (Source: Census 2021)	Aged under 15 years - 17.6% Aged 15 to 64 years - 61.5% Aged 65 years and over - 20.9% (Source: Census 2021)	Aged under 15 years - 16.6% Aged 15 to 64 years - 61.5% Aged 65 years and over - 21.9% (Source: Census 2021)
Disability	Disabled under the Equality Act: Day-to-day activities limited a lot - 10.3% Disabled under the Equality Act: Day-to-day activities limited a lot - 11.4% Not disabled under the Equality Act - 78.3% Source: Census 2021 - *age-standardised rates*	Disabled under the Equality Act: Day-to-day activities limited a lot - 6.7% Disabled under the Equality Act: Day-to-day activities limited a lot - 10.0% Not disabled under the Equality Act - 83.3%	Disabled under the Equality Act: Day-to-day activities limited a lot - 9.0% Disabled under the Equality Act: Day-to-day activities limited a lot - 11.1% Not disabled under the Equality Act - 79.9%	Disabled under the Equality Act: Day-to-day activities limited a lot - 8.2% Disabled under the Equality Act: Day-to-day activities limited a lot - 10.8% Not disabled under the Equality Act - 81.0%
Pregnancy and Maternity	All conceptions (2020) = 3948 Live births (2020) = 3123 Conception rate (all conceptions) per 1000 - 75 Maternity rate (all conceptions) per 1000 - 56.6 Under 18s conceptions = 111 Conception rate (under 18s) per 1000 - 28.5 Maternity rate (under 18s) per 1000 - 19.5 Source: ONS annual conception data	All conceptions (2020) = 3280 Live births (2020) = 2618 Conception rate (all conceptions) per 1000 - 66.6 Maternity rate (all conceptions) per 1000 - 53 Under 18s conceptions = 77 Conception rate (under 18s) per 1000 - 14.2 Maternity rate (under 18s) per 1000 - 5.5 Source: ONS annual conception data	All conceptions (2020) = 1986 Live births (2020) = 1573 Conception rate (all conceptions) per 1000 - 72.6 Maternity rate (all conceptions) per 1000 - 54.8 Under 18s conceptions = 69 Conception rate (under 18s) per 1000 - 25.0 Maternity rate (under 18s) per 1000 - 17.0 Source: ONS annual conception data	All conceptions (2020) = 1986 Live births (2020) = 1558 Conception rate (all conceptions) per 1000 - 69.5 Maternity rate (all conceptions) per 1000 - 54.6 Under 18s conceptions = 42 Conception rate (under 18s) per 1000 - 14.7 Maternity rate (under 18s) per 1000 - 9.5 Source: ONS annual conception data
Race/Nationality	Asian, Asian British - 2.8% Black, Black British, Caribbean or African - 1.9% Mixed or Multiple ethnic groups - 1.7% White - 91.8% Other ethnic group 1.8% (Source: Census 2021) *White British = 83.9% / Other White = 7.4%*	Asian, Asian British - 1.1% Black, Black British, Caribbean or African - 0.3% Mixed or Multiple ethnic groups - 0.9% White - 97.4% Other ethnic group 0.4% (Source: Census 2021) *White British = 94.6% / Other White = 2.3%*	Asian, Asian British - 1.6% Black, Black British, Caribbean or African - 0.5% Mixed or Multiple ethnic groups - 1.0% White - 96.2% Other ethnic group 0.7% (Source: Census 2021) *White British = 92.6% / Other White = 3.3%*	Asian, Asian British - 3.3% Black, Black British, Caribbean or African - 0.5% Mixed or Multiple ethnic groups - 1.1% White - 94.3% Other ethnic group 0.8% (Source: Census 2021) *White British = 88.7% / Other White = 5.0%*
Religion and Belief	No religion - 49.2% Christian - 39.9% Buddhist - 0.3% Hindu - 0.2% Jewish - 0.1% Muslim - 3.5% Sikh - 0.1% Other religion - 0.4% Not answered - 6.4% (Source: Census 2021)	No religion - 39.1% Christian - 53.3% Buddhist - 0.3% Hindu - 0.2% Jewish - 0.1% Muslim - 0.6% Sikh - 0.1% Other religion - 0.4% Not answered - 6.0% (Source: Census 2021)	No religion - 46.5% Christian - 45.3% Buddhist - 0.3% Hindu - 0.3% Jewish - 0.1% Muslim - 1.2% Sikh - 0.1% Other religion - 0.4% Not answered - 5.9% (Source: Census 2021)	No religion - 38.6% Christian - 52.1% Buddhist - 0.2% Hindu - 0.2% Jewish - 0.0% Muslim - 2.5% Sikh - 0.3% Other religion - 0.4% Not answered - 5.5% (Source: Census 2021)
Gender	Male - 49.9% Female - 50.1% (Source: Census 2021)	Male - 49.0% Female - 51.0% (Source: Census 2021)	Male - 48.9% Female - 51.1% (Source: Census 2021)	Male - 49.3% Female - 50.7% (Source: Census 2021)
Sexual Orientation	Straight or Heterosexual - 88.03% Gay or Lesbian - 1.71% Bisexual - 1.65% All other sexual orientations - 0.41% Not answered - 8.20% (Source: Census 2021)	Straight or Heterosexual - 91.22% Gay or Lesbian - 1.04% Bisexual - 0.81% All other sexual orientations - 0.16% Not answered - 6.77% (Source: Census 2021)	Straight or Heterosexual - 90.79% Gay or Lesbian - 1.23% Bisexual - 1.10% All other sexual orientations - 0.24% Not answered - 6.65% (Source: Census 2021)	Straight or Heterosexual - 90.74% Gay or Lesbian - 1.12% Bisexual - 0.92% All other sexual orientations - 0.28% Not answered - 6.93% (Source: Census 2021)

Menu

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Back to Initial Assessment

Back to Equality

Full Assessment

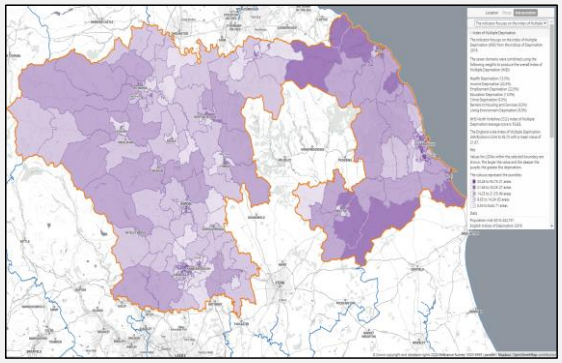
ICS Places IMD SHAPE Maps

ICS LSOA's IMD 2019

Gender Reassignment	Gender identity the same as sex registered at birth - 92.96% Gender identity different from sex registed at birth - 0.64% Not answered - 7.10% (Source: Census 2021)	Gender identity the same as sex registered at birth - 94.62% Gender identity different from sex registed at birth - 0.29% Not answered - 5.09% (Source: Census 2021)	Gender identity the same as sex registered at birth - 94.24% Gender identity different from sex registed at birth - 0.45% Not answered - 5.31% (Source: Census 2021)	Gender identity the same as sex registered at birth - 93.92% Gender identity different from sex registed at birth - 0.52% Not answered - 5.55% (Source: Census 2021)
Marriage and Civil Partnership	Never married/registed a civil partnership - 45.8% Married - 35.4% In a registered civil partnership - 0.2% Separated but still married/in a civil partnership - 2.7% Divorced or formerly in a civil partnership now legally dissolved - 10.1% Widowed or survivng partner from a civil partnership - 5.7% (Source: Census 2021)	Never married/registed a civil partnership - 28.8% Married - 51.0% In a registered civil partnership - 0.2% Separated but still married/in a civil partnership - 2.1% Divorced or formerly in a civil partnership now legally dissolved - 10.0% Widowed or survivng partner from a civil partnership - 7.9% (Source: Census 2021)	Never married/registed a civil partnership - 36.2% Married - 42.6% In a registered civil partnership - 0.2% Separated but still married/in a civil partnership - 2.6% Divorced or formerly in a civil partnership now legally dissolved - 11.2% Widowed or survivng partner from a civil partnership - 7.2% (Source: Census 2021)	Never married/registed a civil partnership - 32.5% Married - 47.1% In a registered civil partnership - 0.2% Separated but still married/in a civil partnership - 2.2% Divorced or formerly in a civil partnership now legally dissolved - 10.6% Widowed or survivng partner from a civil partnership - 7.3% (Source: Census 2021)

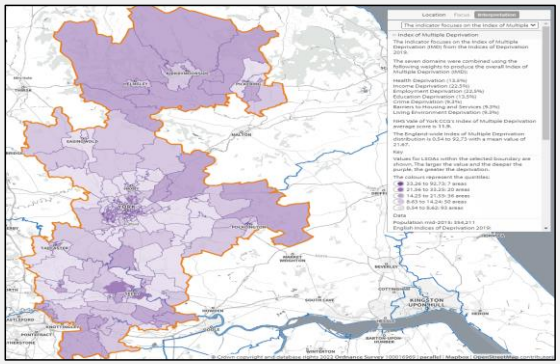
ICS Places IMD SHAPE Maps

North Yorkshire



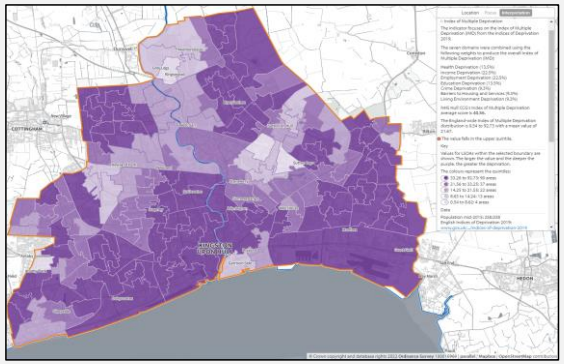
Comments:

York



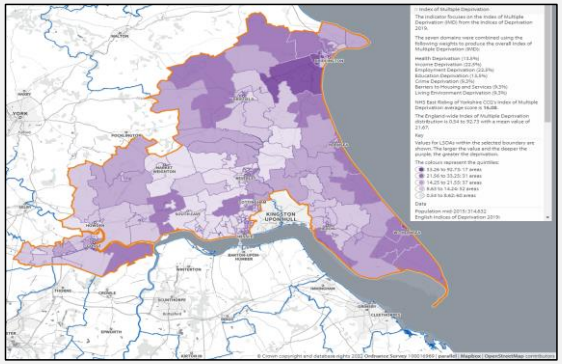
Comments:

Hull



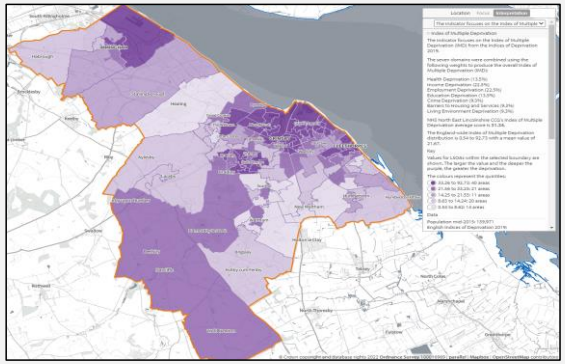
Comments: Hull LSOA which is most deprived in the ICS area, ranked 21st most deprived nationally, whereas the least deprived LSOA in the ICS is in Harrogate, ranked 32, 843 i.e. the 2nd least deprived LSOA nationally – wide range across the geographic footprint.

East Riding



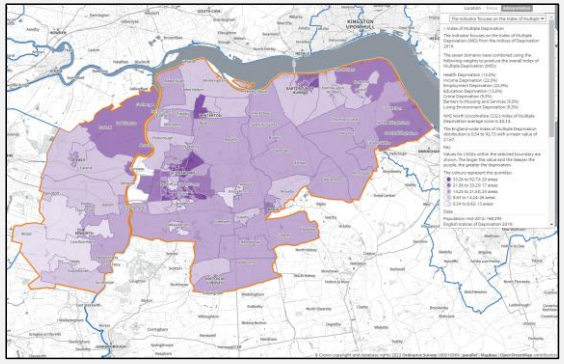
Comments:

North East Lincolnshire



Comments:

North Lincolnshire



Comments:

https://shapeatlas.net/