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Response to proposals for future arrangements for hospital and community health services in Calderdale and Greater Huddersfield

Calderdale and Kirklees Joint Health Scrutiny Committee
September 2016

CONTENTS **Page No.**

1	Chairs' Introduction	3
2	Recommendations – To be agreed at the Joint Committee meeting 30 September 2016	6
3	Terms of Reference and Working Arrangements	7
4	Profile of Kirklees and Greater Huddersfield	12
5	Background	14
6	The Case for Change	16
7	Emergency and Urgent Care	21
8	Transport and Patient Flow	26
9	Community Health Services	30
10	Primary Care	34
11	Planned Care and Bed Capacity	36
12	Hospital Estate	41
13	Maternity Services	42
14	Paediatric Services	43
15	Diagnostics	45
16	Adult Social Care	45
17	Public Health	47
18	West Yorkshire Context	47
19	NHS 111	50
20	The Consultation and Engagement Process	52

Appendix: List of people giving evidence

DRAFT

1. CHAIRS' INTRODUCTION

Our report responds to the proposals of Calderdale and Greater Huddersfield Clinical Commissioning Groups for future arrangements for hospital and community health services in Calderdale and Greater Huddersfield.

The changes proposed are major and far-reaching. They will affect the healthcare of Calderdale and Greater Huddersfield residents for many years to come, which is why we have examined all the issues in considerable detail and prepared a comprehensive and detailed report. As councillors we care passionately about the health of local people and we want the best possible outcomes for them.

Our report sets out the evidence we have received and our conclusions which will be used to inform our discussions when we meet on 30 September 2016 to agree our recommendations to Calderdale CCG and Greater Huddersfield CCG. We hope that the CCGs will respond positively to all of them when they reach their decision on the way forward on 20 October 2016.

Our Committee will need to consider after the decision has been taken by the CCGs in October whether we are assured that our concerns have been met or will be fully addressed by the CCGs and we plan to meet again in early November to consider our response.

We would like to thank all the Members of the Committee (14 in total) who have worked tirelessly to help produce this report.

We would also like to thank everyone who has helped us in our work by attending our meetings to give evidence, responding to our many and various requests for detailed information and for arranging for us to visit both hospitals. In particular Jen Mulcahy (CCGs) and Catherine Riley (CHFT) have spent many hours providing the Joint Committee with invaluable assistance. Thank you.

We also would like pass on our gratitude to Rory Deighton Director of Healthwatch Kirklees and his team whose work during the consultation has been invaluable to the Committee.

The Committee is grateful to the members of the public who took time to submit their views including the written and verbal presentations received at the Committee's formal meetings and the involvement of those who attended the Committee's drop-in sessions.

The Committee is also grateful to the wide range of individuals and organisations who were invited to attend the public meetings of the Committee and to provide evidence.

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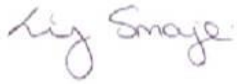
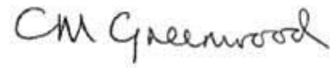
And thank you to the officers from Calderdale and Kirklees Councils – Mike Lodge (Senior Scrutiny Support Officer) and Richard Dunne (Principal Governance & Democratic Engagement Officer) who supported the work of the Committee.





Councillor Liz Smaje Councillor Marilyn Greenwood

September 2016

DRAFT

Membership of the Committee

Membership of the Joint Health Scrutiny Committee from September 2014 – May 2016

Cllr Robert Barraclough	Kirklees Council
Cllr Howard Blagbrough	Calderdale Council
Cllr Martin Burton	Calderdale Council
Cllr Malcolm James (Co-Chair)	Calderdale Council
Cllr Andrew Marchington	Kirklees Council
Cllr Elizabeth Smaje (Co-Chair)	Kirklees Council
Cllr Molly Walton	Kirklees Council
Cllr Adam Wilkinson	Calderdale Council

Membership of the Joint Health Scrutiny Committee changed as a result of the elections in May 2016.

Membership from May 2016 – to date

Cllr Marilyn Greenwood (Co-Chair)	Calderdale Council
Cllr Andrew Marchington	Kirklees Council
Cllr Chris Pearson	Calderdale Council
Cllr Jane Scullion	Calderdale Council
Cllr Elizabeth Smaje (Co-Chair)	Kirklees Council
Cllr Julie Stewart-Turner	Kirklees Council
Cllr Adam Wilkinson	Calderdale Council
Cllr Viv Kendrick	Kirklees Council (May 2016 – July 2016)
Cllr Carole Pattison	Kirklees Council (July 2016)

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2 Summary of Recommendations

To be included following agreement at the Joint Committee meeting 30 September 2016

DRAFT

3. Terms of Reference and Working Arrangements

The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 provide for local NHS bodies to consult with the appropriate health scrutiny committee where there are any proposed substantial developments or variations in the provisions of the health service in the area(s) of a local authority.

Under the legislation officers from NHS bodies are required to attend committee meetings; provide information about the planning, provisions and operation of health services; and must consult with the health scrutiny committee on any proposed substantial developments or variations in the provision of the health service.

Where proposals to change health services cross local authority boundaries there is a requirement to establish a joint health committee. In Yorkshire and the Humber, a protocol has been established between the 15 upper tier local authorities for establishing a joint health scrutiny committee where proposed changes affect more than one local authority area.

Over the past few years work has been undertaken on a strategic review that has looked at the way that health and social care in Calderdale and Kirklees is delivered. In February 2014 CHFT, Locala Community Partnerships and South West Yorkshire Partnership NHS Foundation Trust published the Greater Huddersfield and Calderdale Strategic Outline Case (SOC) which presented a case for changing the way NHS community and hospital services are provided.

Health scrutiny members from both Calderdale and Kirklees considered the implications of the SOC and members from both authorities concluded that should the options outlined in the document be developed into formal proposals they would constitute a substantial development and variation to health service.

In response to the conclusion of health scrutiny members this joint committee was established to review any proposals that might emerge from the strategic review and consider the impact on the residents of Calderdale and Kirklees.

Following publication of the SOC Greater Huddersfield CCG and Calderdale CCG in conjunction with Calderdale and Huddersfield NHS Foundation Trust (CHFT) further developed proposals on a model for future hospital and community health services.

In January 2016 commissioners published the Pre-Consultation Business Case (PCBC) which described: the future model of care for hospital services and community health services; how it had been developed ; and outlined the preferred option that Calderdale Royal Hospital should be the unplanned hospital site and Huddersfield Royal Infirmary should be developed to provide the planned hospital site.

Taking account of the proposed future model of hospital services the Calderdale and Kirklees Joint Health Scrutiny Committee has the following roles and functions:

DRAFT

- To scrutinise the proposed service configuration and its impact on patients and the public.
- To require the commissioners (Calderdale Clinical Commissioning Group and Greater Huddersfield Clinical Commissioning Group) to provide information about any proposed hospital and community based service configuration and where appropriate to require the attendance of representatives from relevant organisations to answer such questions as reasonably required.
- To prepare a report for the Calderdale and Greater Huddersfield Clinical Commissioning Groups (CCG's), Calderdale Council and Kirklees Council, setting out the matter reviewed; a summary of the evidence considered; a list of the participants involved; and an explanation of any recommendations on any service configuration.
- To receive from the CCG's their formal response to the Calderdale and Kirklees Joint Health Scrutiny report and to determine whether any concerns expressed by the Committee have been addressed.
- To take reasonable steps to reach agreement if the CCG's disagree with any of the Committees' concerns or recommendations.
- To report to the Secretary of State in writing if it is not satisfied that the consultation with the Committee on the proposals has been adequate in relation to the content or time allowed.
- To report to the Secretary of State in writing if it considers that the proposals are not in the interests of the health service in Calderdale and Kirklees.

The Calderdale and Kirklees Joint Health Scrutiny Committee will consider the likely implications across Calderdale and Kirklees (Greater Huddersfield). This will include consideration of the:

- Projected improvements in patient outcomes;
- Likely impact on patients and their families, in particular in terms of access to services and travel times;
- Views of local people and of local service users and/or their representatives;
- Potential impact on the local health economy; the local economy in general; and any financial implications
- Any other pertinent matters that arise as part of the Committee's review.

In addition where it is deemed appropriate the Calderdale and Kirklees Joint Health Scrutiny Committee will seek independent advice to help support and inform its work.

<u>**Working arrangements**</u>

Membership
Each participating local authority will be eligible to nominate 4 councillors.

With the exception of the permanent replacement of a committee member(s) neither authority will establish a panel of substitute members.

There will be no appointment of non-voting co-optees to the Committee.

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Choice of Chair
Calderdale Council and Kirklees Council will nominate a lead member to represent its authority. The lead member of the authority that hosts a meeting of the Committee will have the responsibility of organising and chairing the meeting.

Quorum of Joint Committee
The quorum of a Committee meeting shall be at least three members of the Committee and must include representation from both authorities.

Venues for Meetings
Meetings will be hosted by both local authorities.

There will be no strict rule that governs the number of meetings that will be hosted by each authority although the intention will be to ensure that residents from both Calderdale and Kirklees are given as much opportunity as possible to access the meetings and inform the work of the Committee.

Rules of procedure at meetings
The authority that hosts the meeting will be responsible for conducting the meeting in accordance with its own procedure rules.

Committee activity
During the consultation period the Joint Committee held a series of meetings between March 2016 and September 2016, to receive information and evidence from a wide range of individuals and organisations.

All of the formal meetings included an item for the Committee to receive public deputations and individuals, organisations and campaign groups that presented verbal and written deputations have been acknowledged in the minutes of the meetings.

The Committee also carried out a number of other activities which included two drop-in sessions and visits to the two hospital sites.

The Committee was keen to ensure that local people and other key stakeholders had an opportunity to inform the work of the Committee and were grateful to everyone who took time to submit their views including the written and verbal presentations received at the formal meetings.

The Committee would wish to emphasise that seeking public comment was intended to gauge the public's opinion on the proposals, highlight key issues and areas of concern and should not be considered as a public consultation exercise.

Details of the Committee's activities are shown below.

DATE	COMMITTEE ACTIVITY
2 March 2016	Committee site visit to Huddersfield Royal Infirmary (HRI) and Calderdale Royal Hospital(CRH) to: • Look at the current estates layout

DRAFT

	• Visit the site of the planned development of the new Huddersfield hospital • Assess the current estate challenges • Look at the potential for further development at the CRH site.
9 March 2016	Meeting to review the case for change to include: • Quality and safety of patient care • Workforce challenges to include staff recruitment and retention. • The Financial case to include input from Monitor.
22 March 2016	To review the future model of Care to include: • Urgent Care • Emergency and Specialist Emergency Care • Intensive Care Unit • Yorkshire Ambulance Service (NHS 111 Service) • West Yorkshire Urgent & Emergency Care Network • NHS England • Yorkshire & the Humber Clinical Senate
6 April 2016	To review the future model of Care to include: • Planned Care • Maternity Services • Paediatric Services • Diagnostics
19 April 2016	To review: • Patient accessibility to include transport, travel, parking and costs. • Patient flows to include impact on surrounding acute trusts. • Yorkshire Ambulance Service. • Calderdale and Huddersfield NHS Foundation Trust estates.
14 June 2016	To review the future model of care to include: • Community based care proposals to include Calderdale CCG Care Closer to Home programme and Greater Huddersfield CCG Care Closer to Home programme. • Primary Care • Impact on social care
7 July 2016	Drop-in session Huddersfield Town Hall – to provide members of the public with an opportunity to have 1:1 discussions with committee members about the proposals

DRAFT

12 July 2016	Drop-in session Halifax Town Hall – to provide members of the public with an opportunity to have 1:1 discussions with committee members about the proposals
1 August 2016	Committee site visit to Huddersfield Royal Infirmary • Visit to the Emergency Department to view facilities; working methods; and diagnostics. • Visit to the Medical Assessment Unit to view facilities; and working methods.
7 September 2016	• To consider the results of the CCGs consultation exercise • To consider a report from Healthwatch on its consultation exercise • To receive some further information
30 September 2016	To consider the Committee's final report

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4. A Profile of Calderdale and Kirklees[1]

KIRKLEES

The Metropolitan Borough of Kirklees is one of five Local Authorities in West Yorkshire. It covers an area of 157 square miles and has a population of around 431,000 which is predicted to rise to nearly 459,000 by 2024.

It has three distinct areas:

1. North Kirklees, which includes the urban centres of Mirfield, Dewsbury, Batley and Cleckheaton along with the more rural Spen Valley:
2. Huddersfield; the largest town in Kirklees with about 137,000 residents
3. The rural and semi-rural area south and west of Huddersfield, including small towns such as Holmfirth, Meltham, Skelmanthorpe, Kirkburton, Slaithwaite, Marsden, Honley and Denby Dale.

In 2012 the total number of people in Greater Huddersfield was 245,218, having risen by 1.4% since 2010. 1 in 6 (16%) was aged 65 years and older; 1 in 14 (7.2%) was 75 years and older. Estimates show that by 2030 the population will be 278,700, an increase of over 36,000 (15%) since 2010, with over 65s almost 1 in 4 (23%) of the population.

This represents a 70% rise in the over 65s from 2010 to 2030. In the same period the proportion of the population aged under 18 will rise by 11% to 1 in 5 (20%) of the population and the working age population will shrink by 2030 from 64% to 57%.

The prevalence of most long term conditions (LTCs) such as diabetes, heart disease, chronic lung disease and long-term pain increases with age and it is currently estimated that over 24,000 people aged 65 and over in Kirklees are living with 3 or more long term conditions.

Kirklees has a diverse mix of ethnic, faith and language communities. Post-war in-migration, largely from the Caribbean, India, Pakistan and Bangladesh, means that Kirklees' minority ethnic communities make up 21% of its resident population. Most live in the District's urban centres of Huddersfield, Dewsbury and Batley. Kirklees' Muslim population of 61,300 is the 18th highest in England and Wales.

Kirklees has a mix of relatively affluent and poor areas. The poorest areas are concentrated in inner urban Wards in Huddersfield, Dewsbury and Batley and on edge of town estates. The 2015 Index of Multiple Deprivation showed a relative improvement, with 23 Lower Super Output Areas ranked in the worst 10% in England compared to 37 in 2010. Minority ethnic communities tend to live in these poorest areas.

[1] Sources - Kirklees Joint Strategic Needs Analysis Summary for Greater Huddersfield and Office for National Statistics revised 2012 –based subnational population revised 2012 ;

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CALDERDALE

Calderdale is a metropolitan district and includes the towns of Halifax, Elland, Brighouse, Sowerby Bridge, Hebden Bridge and Todmorden, as well as a number of villages.

The district has a population density of 5.70 per hectare, the lowest of any local authority in West Yorkshire. In Bradford it is 14.20, 10.55 in Kirklees, 13.89 in Leeds and 9.70 in Wakefield (Office for National Statistics (ONS) 2014 Mid-year population estimates).

Calderdale is one of the smallest districts in England in terms of population, but one of the largest in terms of area. Over four-fifths of the Calderdale area is described as rural by the national Census 2011 (ONS, 2011). In contrast the local authority population is described as "Urban with major conurbations" by the Government Statistical Service in its 2011 Rural-Urban Classification for Local Authority Districts in England. This is because over three quarters of the population live in urban areas. Calderdale's topography and its pattern of settlement have implications for the location of facilities, for transport, and for how close people are to health and other care services.

There are 207,400 people in Calderdale according to the ONS 2014 Mid-year population estimates. This is an increase of approximately 3,500 people since the 2011 Census.

The largest ethnic group in Calderdale is White British (88.7%), as recorded in the national Census 2011. The second largest ethnic group is Asian / Asian British (8.3%) of which the majority (6.8%) are Pakistani.

Over 18% of Calderdale residents reported (Census 2011) that they have a long term condition that affects their ability to carry out every day activities.

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5 Background

The proposals for hospital and community health reconfiguration arose from a **Strategic Review** that began in July 2012. The Strategic Review was undertaken by a partnership of seven organisations: Calderdale CCG, Greater Huddersfield CCG, CHFT, Locala, South West Yorkshire Partnership Foundation Trust (SWYPFT), Calderdale Council and Kirklees Council.

The Strategic Review worked through four care streams: planned care, unplanned care, long term care and children's care. Each of the care streams had a working group which included representation from all seven partners.

In 2012 the Strategic Review:

- Developed understanding and gained ownership of the case for change – internally and externally with partners including the Health and Wellbeing Boards, Overview and scrutiny and NHS England.
- Undertook significant engagement – identified what local people said they wanted to see.
- Developed clinical standards, assessed the position and ambition in relation to the standards and described this as the outcomes to be achieved and the benefits delivered.
- Agreed scope, high level vision and principles for future model of care.

In February 2014 three providers – CHFT, SWYPFT and Locala, published their Strategic Outline Case (SOC), which proposed the establishment of a specialist hospital model, one providing unplanned care and the other planned care. The providers stated that their preferred option was that Huddersfield Royal Infirmary become the unplanned hospital and the Calderdale Royal Hospital become an 85 bed planned hospital site.

This initially included Urgent Care Centres at Todmorden and Holme Valley.

In April 2014 Calderdale Council decided to establish a People's Commission to investigate these proposals. The People's Commission reported to Calderdale Council in February 2015.

In June 2014 the Strategic Outline Case (SOC) was followed up with an Outline Business Case.

The model for changes to community health services was developed in 2014/15 and these proposals were considered by the Yorkshire and Humber Clinical Senate in April 2015.

Delivery of community health service improvements – phase 1 – also began in 2014/5.

From November 2014 until August 2015 work was undertaken by the CCGs on developing the future model of care for hospital services, based on clinical standards and baseline Quality, Safety and Patient experience. This work was undertaken

DRAFT

through five *clinical workshops* and four *clinical design groups*. Clinical consensus on the potential outline future model of care was achieved in October 2015 and the clinical model was reviewed by the Yorkshire and Humber Clinical Senate from October 2015 until December 2015.

Over the same period, work was undertaken on the pre consultation business case, the financial implications (this included CHFT and Monitor), and on the preferred location for the unplanned and planned hospitals.

In January 2016 the proposal went through the NHS Assurance Process Stage 2 and in January 2016 the two Governing Bodies decided to proceed to consultation.

Whilst the proposals set out in the consultation document and the pre consultation business case broadly followed the clinical model included in the SOC by CHFT, the proposed location for the unplanned hospital at this stage was Calderdale Royal Hospital.

Consultation by the Clinical Commissioning Groups ran from 15 March 2016 until 21 June 2016. The results of the consultation were considered by the Committee on 7 September 2016.

Key decision points during this process were:

A report to the Governing Bodies of both CCGs in August 2014 made recommendations in relation to:

- The commissioning and phasing of changes
- Options for consultation
- The work still to be undertaken
- The assurance process used to validate that these changes will bring improvement in quality, safety, effectiveness of care and that they are clinically sustainable within available resources.

A report to both CCG Governing Bodies in September 2015 recommended that as the CCGs were unable to set out: the proposed future model of care; the financial implications; and the preferred location of services, they were not ready to proceed to consultation. This recommendation was accepted by both CCG Governing Bodies.

On 20 January 2016, both CCG Governing Bodies meeting in parallel approved the following recommendations:

1. To agree that we have completed the work to set out: the proposed future model of care; the financial implications; and the preferred location of services.
2. To note that the publication date for the Pre-Consultation Business Case is 15th January, 2016.
3. To note that the view from both CCGs is that we are confident that we will be in a position to submit sufficient evidence to satisfy the requirements of the NHS England assurance process.

DRAFT

4. To note that at the time of writing, we still need to secure final approval from NHS England.
5. To agree that we are ready to proceed to consultation and to agree a timescale for that.

6 The Case for Change

6.1 Introduction

Calderdale CCG and Greater Huddersfield CCG set out their case for change in their consultation document and in the Pre Consultation Business Case.

CHFT published its '*5 Year Strategic Plan for Calderdale and Huddersfield NHS Foundation Trust'*, which also includes detailed information about the case for change from the Trust's perspective.

The Joint Committee considered the case for change when it met on 9 March 2016. At that meeting the Committee heard from: Calderdale CCG, Greater Huddersfield CCG, CHFT, Healthwatch and Monitor.

The Joint Committee meeting on 22 March 2016, which focused on Urgent and Emergency Care, also considered some aspects of the case for change. That meeting heard from CCGs, CHFT, Healthwatch, NHS England, West Yorkshire Urgent and Emergency Care Network, Yorkshire Ambulance Service, Yorkshire and Humber Clinical Senate.

The CCG Consultation Document sets out the case for change in the following six areas. This section of the report summarises the CCGs analysis and includes a comments and views from the Committee.

6.2 Meeting the Needs of the Population

The challenges set out in the Pre Consultation Business Case are:

- Increases in the population.
- Increases in the number of older people, which means more people living longer often with long term illnesses such as heart disease, diabetes and chronic chest problems and more with dementia.
- Modern lifestyles are creating new health issues, including smoking, drug and alcohol abuse and obesity.
- Inequalities in health across Calderdale and Greater Huddersfield.

6.3 Committee Views and Comments

The Committee accepts that these are considerable challenges to the local health system. The Committee considers that clear targets for improvement in outcomes for the benefit of users of the service should play an integral part in any changes that may take place.

6.4 **Meeting Quality and Safety Standards**

The challenges are:

- Non-compliance with national standards
- High mortality rates
- Too many patients are re-admitted within 30 days
- Too many patients are admitted to hospital with a long term condition.
- Patients stay too long in hospital
- Too many patients don't have a good experience in hospital
- Advances in healthcare
- Advances in medical knowledge and technology have enabled more services to be provided outside hospital.

6.5 **Committee Views and Comments**

The Committee accepts that maintaining the status quo is not an option and that change needs to take place to achieve quality and safety standards.

The Committee understands the CCGs clinical and quality case for change. Hospital services are not achieving the quality standards that people in Calderdale and Greater Huddersfield need and deserve. In several areas they do not comply with national guidance. Mortality rates are too high. The service is far too reliant on locum and agency staff, costing more than it should and in danger of compromising patient safety.

Whilst the Committee accepts that advances in medical knowledge and technology have enabled more services to be provided outside hospital, it has also heard evidence that continuing to provide some services in hospital may be a more efficient way of delivering some of those services.

6.6 **Workforce Issues**

- The two hospital sites do not satisfy the Royal College's recommendation of a minimum of ten consultants per emergency Department and 14 hours a day consultant on site cover.
- Doctors work more overnight and weekend shifts than elsewhere.
- There are difficulties in recruiting and retaining staff to cover services in some specialities.
- The Trust relies heavily on agency and locum staff.

6.7 Evidence Received

The Joint Committee received evidence about the challenges created by workforce shortages. The challenges include staff working more onerous shift patterns than staff in neighbouring Trusts, lack of availability of senior doctors, and increased reliance on locum and agency staff. All of which is detrimental to the quality of care and is also expensive.

The CCGs and CHFT argued that introducing the specialist hospital model so that teams are based on one site rather than two would make the Trust more attractive to potential employees and will contribute towards retaining staff. CHFT have advised that dual site working is being reported by some staff as a factor in their decision to find work elsewhere.

Trade unions, staff and members of the public were not convinced that – in employment areas where there are national shortages, reconfiguration alone would be sufficient to attract staff to work at CHFT rather than neighbouring Trusts which are larger, have a higher profile and have teaching hospitals. The Committee shares these concerns.

6.8 **Committee Views and Comments**

The Committee accepts the analysis that hospital services are over reliant on agency and locum staff and have considerable difficulty in recruiting to particular specialisms, especially at senior levels. The difficulty in recruiting emergency care consultants is one particularly important example of this.

The Committee accepts that – in some instances – delivering services from one site rather than two reduces the number of senior staff needed so that the current need for 20 emergency care consultants might reduce to 12.

However, the Committee is deeply concerned that the plans to address these staff shortages consist of little more than a hope that people will be attracted to work at CHFT under the new arrangements because of single site working and because "things will be better". CHFT will still be trying to attract staff in a very competitive market, when neighbouring Trusts have more prestigious teaching hospitals and when other health systems are implementing similar changes that may be just as attractive. The Committee is not convinced that reconfiguration alone would address the very real recruitment problems.

The Committee wishes to see a much clearer statement about how the CCGs and CHFT plan to address these significant workforce challenges.

6.9 **Financial Situation**

- The local health economy is facing a very difficult financial situation.
- Without change the system would become financially unstable.
- The local savings challenge across the NHS is £270m by 2020.

6.10 Evidence Received

The financial situation of CHFT was generally accepted by all who gave evidence to the Joint Committee as being accurate. Some members of the public disagreed that the financial situation is a legitimate part of the case for change.

- Monitor told the Committee that the financial basis for Right Care Right Time Right Place is not sustainable as it will still leave an annual deficit of £9.5m

with Calderdale Royal Hospital as the unplanned site and £21.6m per annum deficit if HRI is the unplanned site.

- Monitor also told the Committee that CHFT should seek to get maximum value out of the PFI site.
- Some members of the public felt that the case for change is being driven solely by the cost of the PFI arrangement to which CHFT is committed.
- Some were concerned about the capital costs of building a new hospital for planned care.

The PFI arrangement put in place in 1998 to finance building Calderdale Royal Hospital is a 60 year agreement. The interest repayment is currently £11m pa and there is a further £11m pa required to cover the cost of facilities management.

Whilst there is a generally accepted view that the PFI agreement is not favourable to CHFT in particular and the local health system in general, the size of the penalty clauses makes buy-out from the agreement financially impossible.

Options considered by the CCGs did include building a new hospital on a site between Halifax and Huddersfield, but this option was dismissed as being very unlikely to be funded and would still leave the PFI debt to be covered.

The maintenance backlog for the hospital buildings is more than £95m. Most of the work required is at Huddersfield Royal Infirmary. As well as hearing evidence in meetings, Committee members saw evidence of this on their visits to both hospitals.

6.11 **Committee Views and Comments**

CHFT is running at a significant revenue deficit. The Committee accepts that the CCGs need to plan to reduce the current level of revenue deficit in the local health system. Although the Committee would like to see additional resources made available to the local health economy by Government, it accepts that in the current financial climate the chance of attracting sufficient resource to close the revenue deficit is highly unlikely. Calderdale and Kirklees Councils have to set "legal budgets": it would be unfair to have other expectations on the Clinical Commissioning Groups.

The maintenance backlog for the estate is approaching £100m. The service will not be sustainable unless both the revenue and the capital shortfalls are addressed.

Much attention has been given to the Private Finance Initiative that supported the construction of Calderdale Royal Hospital. The Committee accepts – with some considerable reluctance – that it is not possible to renegotiate the PFI to reduce the burden of this debt. The Committee notes that Monitor has advised that the Trust should get maximum value out of the PFI site.

The Committee is concerned that the CCG proposal for reconfiguration does not fully eliminate the deficit and so was described by Monitor as unsustainable. A key concern is that, unless this is addressed, further

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reconfiguration proposals will be developed within the medium term that may be less subject to local influence.

6.12 **National Policy**

The clinical model that the CCGs have developed is in line with national guidance for urgent and emergency care services and for 7 day working in the NHS.

In summary, the proposed changes are:

- To develop a single Emergency Centre
- Develop Urgent Care Centres at both hospitals
- Maintain the current arrangements in hospitals for maternity services, but strengthen community services.
- Develop a Paediatric Emergency Centre
- Develop a new hospital for Planned Care
- Further develop Care Closer to Home.

6.13 Evidence Received

The Committee was told that the clinical model proposed, i.e. two specialist hospitals, one providing unplanned services and the other one providing planned services was strongly supported by Calderdale CCG, Greater Huddersfield CCG, CHFT, NHS England, the Yorkshire and Humber Clinical Senate, and Monitor.

Some members of the public and campaigners challenged the clinical model and felt that a perceived increased risk to patients arising from longer ambulance journeys outweighed any improvements in clinical outcomes achieved by increased access to senior doctors that may occur under the specialist model.

Others felt that there would still need to be transfers from the Urgent Care Centre to the Emergency Centre which would again increase risks to patients and reduce the benefits arising from the specialist hospital model.

6.14 **Committee Views and Comments**

The CCGs have proposed that hospital services are reorganised so that the local area is served by two specialist hospitals. One would be for *unplanned* services with an Emergency Centre. The other would be for *planned* services. Both hospitals would have an Urgent Care Centre, open 24 hours a day, seven days a week.

The Committee has heard strong support for this model from the CCGs, CHFT, NHS England, the Yorkshire and Humber Clinical Senate and Monitor. It appears consistent with national policy and in particular with the findings of the Keogh Report.

Concern from the public has been about the consequences of the clinical model and the Committee shares that concern.

7 Urgent and Emergency Care

7.1 Evidence Received – the National Picture

Demands that are being placed on urgent and emergency care services have been increasing significantly over the past decade. In 2003/4 national attendances at Accident and Emergency (A&E) Departments were around 16.5 million and since then the numbers of attendances have increased significantly rising by 35% to 22.3 million in 2014/15.

Across the country NHS organisations have continued to work extremely hard to ensure that key performance standards are maintained but it is clear that nationally the service is operating close to its capacity.

Nationally the demand for services such as A&E is likely to continue to rise as a result of people living longer with increasingly complex conditions resulting in multiple needs.[2] In addition to these challenges the NHS also faces huge financial pressures and as highlighted in the NHS Five Year Forward View without further efficiencies and assuming only inflation linked increases the NHS could face a shortfall between resources and patient needs of nearly £30 billion a year by 2020/21.

7.2 Evidence Received - the Local Picture

The Clinical Commissioning Groups (CCG's) gave evidence that the way in which hospital services in Calderdale and Greater Huddersfield are provided is creating immediate financial pressures and is not sustainable in the medium term. The CCG's Pre-Consultation Business Case makes it clear that to deliver the quality of care that local residents deserve changes will have to be made to the way services are delivered.

This view was also supported by the Calderdale and Huddersfield NHS Foundation Trust and its 5 Year Strategic Plan highlights the significant clinical, operational and financial challenges that face the Trust.

The CHFT 5 Year Strategic Plan outlines the specific issues that relate to the Trust's emergency departments which include an unequivocal statement that the Trust is not able to provide sustainable levels of service from two sites.

This view was also supported by the National Clinical Advisory Team (NCAT) which undertook a review of the Trust's Accident and Emergency (A&E) services in June 2013 to assess options and identify a preferred option for future provisions of A&E services. NCAT concluded that a single site model for all acute services and a single site model for planned services was the safest and most sustainable option.

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[2] NHS England - Transforming urgent and emergency care services in England - Urgent and Emergency Care Review

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The Yorkshire and Humber Clinical Senate also considered the CCGs proposals in November 2015 and concluded:

"As a high level strategic document for whole system change, the Senate agrees with the aspirations outlined in the Model of Care. The Senate recommends however, that as the work develops, the commissioners describe the model with greater clarity, particularly focussing on detail about the workforce and activity. The lack of detail at this stage left the Senate with questions regarding the ability of this model to deliver the standards proposed".

The Committee was pleased to see that CQC rated Accident and Emergency at both Calderdale Royal Hospital and Huddersfield Royal Infirmary as "good".

7.3 Evidence Received – The Emergency Centre

The Committee was informed of a number of issues about the current A&E services configuration across the two hospitals that included:

- Non–compliance with Royal College recommendations and standards (in emergency care settings)[3];
- Difficulties in the recruitment and retention of senior emergency department clinicians;
- Pressures in providing safe staffing due to overnight rota vacancies which has resulted in significant reliance on locums ;
- Limited access for patients to senior decision makers.

The Committee was told that the current configuration of services was not sustainable and that the care delivered by the Trust was therefore less safe than it could be. CHFT cited as an example the difference that the centralisation of the Trust's Trauma and Acute Surgery Services had made which included a significant improvement in the quality of care and mortality rates which were 50% below the national benchmark figure

The CCGs and CHFT commented that the centralisation of emergency care services in a single specialist emergency centre would enable the Trust to tackle many of the issues that related to staff recruitment and retention. It would also reduce the need for reliance on locums; and provide patients with access to senior decision makers which would improve the outcomes and quality of care for patients.

An overview of the services that would be located at the emergency centre site was presented to the Committee which included confirmation that it would include a Paediatric Emergency Department which would have the facilities that would enable the Trust to comply with the standards for Children and Young People in Emergency Care Settings.

In addition the Committee was told that Specialist Emergency Care would continue to be provided on a West Yorkshire basis. This means that people living in

[3] Details of areas of non-compliance can be found on page 102 of the 5 Year Strategic Plan for Calderdale and Huddersfield NHS Foundation Trust.

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Calderdale and Kirklees with serious or life threatening needs would be taken to the most appropriate specialist emergency centre that had the right facilities and expertise to maximise their chances of survival and making a good recovery.

The Committee heard that there were already a number of transfers to other hospitals, particularly Leeds (e.g. for heart patients) and that there were regular transfers between the two CHFT hospitals for particular conditions which presented at A&E, for example gastro-intestinal bleeds.

The CCGs stated that the proposals were in line with national thinking as outlined in the Keogh review of urgent and emergency care services[4] and that the proposals had been based on the best clinical evidence. They stressed that the location of services had not been a consideration in the development of the future model of care.

7.4 Evidence Received - Emergency Attendances

The Committee was provided with data that showed the numbers of A&E attendances at Calderdale Royal Hospital (CRH) and Huddersfield Royal Infirmary (HRI) over the last four years. The data showed that activity had been relatively stable over the years with slightly higher numbers attending Calderdale Royal Hospital.

YEAR	ATTENDANCES	
	CRH	HRI
2012/13	72,048	69,089
2013/14	71,745	67,776
2014/15	72,503	69,775
2015/16	74,804	72,814

An analysis of attendances that had been undertaken by the Trust indicated that approximately 50% of people who currently attend the A & E department at HRI would be able to be treated at the Urgent Care Centre at Huddersfield under the new model. Evidence presented by CHFT indicated that no assumptions have been made in the modelling to take account of any reductions in emergency and urgent care attendances as a result of the work that was being developed through the primary care strategies and the care closer to home programme.

The CHFT 5 Year Strategic Plan provides details of the potential impact on emergency attendances using the proposed clinical model of having an urgent care centre co-located at each hospital site. The modelling indicates that total emergency attendances will not vary significantly under reconfiguration, although there will be a large increase in the overall numbers of people being seen at the Calderdale site with over 115,000 attending the UCC and ECC.

7.5 Evidence Received - Urgent Care Centres

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[4] Transforming urgent and emergency care services in England - A review of urgent and emergency care services led by Sir Bruce Keogh National Medical Director NHS England.

A key element of the proposals is the introduction of Urgent Care on both hospital sites. The public consultation on the proposals describes Urgent Care Centres as "the front door to urgent and emergency care for people who make their own way to hospital"

The consultation document states that the Urgent Care Centres will be open 24/7 to provide access to the right advice in the right place *first time* at any hour of the day and any day of the week. The centres would be staffed by doctors and emergency nurses, with x-ray and blood testing available. Equipment available would include a full resuscitation trolley, oxygen, suction and emergency drugs.

The consultation document also outlines the types of injuries and conditions that could be treated at an Urgent Care Centre including; sprains and strains; broken limb bones; infections that may require treatment; minor burns and scalds; minor head injuries; insect and animal bites; and minor eye injuries.

In addition the CCGs promote the use of urgent care centres as places where people can attend to receive treatment for a condition that would normally be treated at a GP practice.This would be in instances where people cannot gain access to the practice because it is either closed or they cannot get an appointment as early as they would have liked.

The Committee was informed that the Centres would be staffed by Emergency Nurse Practitioners, the type of nurses who currently treat minor injuries in both A & E departments. These nurses would be supported by doctors at a primary care or General Practitioner level who would have the skills needed to treat the groups of patients that are expected to attend the Urgent Care Centres. No details were given of the availability, recruitment or retention of these Emergency Nurse Practitioners.

The Committee was also informed that the exact workforce model has not yet been fully developed in any detail, although the CCGs have stated that the model requires the doctors to be "generalists" in order to cope with large numbers of non-life threatening emergency conditions. This is a similar skill level to doctors working in general practice. No details were given of the availability, recruitment or retention of these doctors.

An issue that has been highlighted during consultation is a concern regarding access to a specialist clinician should an individual's health start to rapidly deteriorate while at the Huddersfield UCC. Evidence presented indicated that staff at the UCC would be able to contact appropriate clinicians if required for advice. In addition UCC staff would also be capable of resuscitating and stabilising someone in readiness for an emergency transfer by ambulance to the ECC.

The Strategic Outline Case published in 2014 included two specialist community centres, Todmorden Health Centre and Holme Valley Memorial Hospital that would provide a hub for the provision of integrated and specialist services including access to treatment for minor injuries.

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7.6 **Committee Views and Comments**

The Committee acknowledges the significant challenges and pressures that A&E departments across the country face and understands that locally these pressures are compounded by the additional challenge of recruiting sufficient specialist staff.

The Committee notes that the Yorkshire and Humber Clinical Senate considered that "lack of detail at this stage left the Senate with questions regarding the ability of this model to deliver the standards proposed". Consequently the Committee considers that the CCGs should seek further assurance from the Clinical Senate before proceeding with the Right Care Right Time Right Place plans.

The Committee notes that no assumptions have been made that emergency and urgent attendances will reduce. Given the accepted evidence that a substantial number of people who attend A&E could be treated elsewhere, this appears a very cautious approach and the Committee feels that more could have been done to demonstrate how demand can be managed more effectively. Reducing demand on A&E by improving access to GPs, and signposting to alternative provision through 111 or pharmacy, for example, will contribute to addressing the financial challenge and pressures on staffing.

The Committee has serious concerns regarding the capacity and sustainability of the Calderdale Royal Hospital site to support an Emergency Centre and Urgent Care Centre providing services to more than 100000 people every year.

The Committee is not assured that the proposals take sufficient account of the continuing rise in demand. In particular o the predicted increase in the older population where there is a greater prevalence to suffering from long term conditions; the anticipated growth in the local populations; and the future development plans of the two local authorities.

The Committee it does not believe that the CCG's have sufficiently defined an Urgent Care Centre to the public and the Committee. In particular, the CCGs have not fully identified what other services would be available at the planned site.

The Committee accepts that subject to the outcome of this consultation further work will be done on developing the UCC workforce model. However the Committee is concerned that the UCC proposals have been put forward without a clearer description of the roles and responsibilities of staff and an understanding of where the workforce will be drawn from.

The Committee notes that the proposals do not make reference to the specialist community centres, Todmorden Health Centre and Holme Valley Memorial Hospital, which were included in the Strategic Outline Case. The Committee feels that maximising the use of these community centres together with other local existing facilities would help to manage demand in the

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hospital settings and provide a valuable hub for the provision of integrated and specialist services across local communities.

8 Transport and Patient Flow

Many members of the public have told the Committee their concerns about longer journey times to hospital that would arise because of the introduction of two specialist hospitals. Their concerns were both the risks to their health that may occur because of delays in reaching hospital and the cost and difficulties of travel to hospital for patients and visitors.

Some people were also concerned about the availability of parking, particularly at Calderdale Royal Hospital and the Committee was given several examples of stress caused to elderly or disabled people by parking arrangements at both hospitals..

8.1 Evidence Received - Ambulance Journeys

Both CCGs, CHFT and YAS expressed a strong view that any risk arising from a slight increase in ambulance journey times for seriously ill patients would be far outweighed by the improved outcomes achievable at a specialist Emergency Centre. The average increase in journey time would be 7minutes if the Emergency Services Centre is at Calderdale Royal Hospital.

Many members of the public remain unconvinced by this and they have particular concerns about traffic delays on the A629 between Huddersfield and Halifax and the consequences of accidents on the M62. There were 111 collisions between 2010 to 2014 on the M62 between and including J24 to J25.

Yorkshire Ambulance Service told the Committee that journeys on the A629 present no more difficulties for blue light services than arterial roads in Bradford or Leeds.

In response to a Committee request for information on absolute travel times for people accessing care in an ambulance the CCG's and YAS stated that they did not know these times.

The Committee was informed that the analysis commissioned prior to consultation in relation to ambulance travel aimed to establish if there was a material differential impact on YAS should the ECC be located at Huddersfield or Halifax and the total impact on YAS of the increased journey time.

The analysis concluded that there was no material differential impact and that the absolute impact would be an additional 10,000 hours of ambulance travel. This is equivalent to employing two more ambulance crews. Funding for these two additional crews has not yet been identified.

In addition YAS stated that absolute travel time was influenced by many external variables and any attempt to assess a figure would be subjective and dependant on different factors relating to the response time, on scene time, conveyance to the hospital and the handover times at the Emergency Department.

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8.2 Evidence Received - Urgent Care Centre Patients Travelling to Hospital by Car

Most patients who currently visit A&E and do not attend by ambulance will visit the Urgent Care Centre, rather than the Emergency Services Centre. As the CCGs propose that there will be an Urgent Care Centre at both the Huddersfield and Calderdale Hospitals, the CCGs belief is that the new proposals would not have a significant impact on travel time for these patients.

8.3 Evidence Received - Patients travelling to hospital for planned care procedures

Information given to the Committee by CHFT suggests that around 600 more patients a year will travel from Calderdale addresses to HRI for a planned procedure and 200 fewer Huddersfield residents will travel to CRH than currently.

8.4 Evidence Received - Patients and Visitors Who Rely on Public Transport

The proposed changes will have a significant impact on some patients. In particular for those who need to get to planned operations and outpatient appointments, and visitors, particularly those who are reliant on public transport.

The A629 Huddersfield to Halifax highway corridor is included as a priority project for funding within the Combined Authority's (WYCA) West Yorkshire Plus Transport Fund. The scheme is being delivered in phases, including one phase within Kirklees' boundary. Access to funding is subject to each phase achieving approval from WYCA at Outline, Full Business Case and Procurement Stages. Work in Calderdale will begin in 2016 and should take 4-5 years to complete.

According to Calderdale Council, the scheme should have a major effect on reducing congestion, improving air quality – particularly at Bradley Bar, Elland by-pass and Ainley Top. The main problem is the route from Huddersfield to Halifax - once complete there will be perceivable gains, especially at Salterhebble Junction. There are improvements planned at the Calder and Hebble Junction to alleviate the situation and improve ambulance access. The scheme is designed to improve both connectivity and journey times.

West Yorkshire Combined Authority told the Committee that they had not been consulted about the hospital plans and said;

"There are a number of options available e.g. managing the link services between the sites. Funding is a concern – current funding has been reduced by 25% for 2016-2017. Councillors should note that the 503 service is entirely commercial - any increase (or not) in service after the improvements to the A629 will be a commercial decision by the operator. Where there have been similar road improvements on the A65 in Leeds there has been no response by the commercial market to increase the services"

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The Committee also heard from the Upper Calder Valley Renaissance Sustainable Transport Group, who made a number of proposals including re-routing some bus services with a "loop" to take in the hospitals.

The Committee was keen to establish absolute travel times for people who needed to access services such as planned care, were reliant on public transport and lived at the extremities of Calderdale and Kirklees.

As with the ambulance journeys the CCG's stated that they did not know the absolute travel times for people accessing planned care via public transport, although information submitted by the CCGs did indicate that journey times for public transport users was likely to be more significant than those for car users.

The travel analysis[5] that was undertaken prior to consultation stated that "*several areas including the south of Huddersfield, the South of Halifax, the Queensbury/Ovenden area, Stainland, Hebden Bridge and Todmorden are likely to incur a significant increase in journey time in excess of 45 minutes".*

8.5 Evidence Received - Yorkshire Ambulance Service

The PCBC states that the new model of care will require the CCG's to work with the Ambulance Service to direct patients to the right place of care at the right time, including to Community and Primary Care if appropriate as well as to local and specialist services.

The PCBC makes it clear that the Ambulance Service will play a vital role in the future model of care and work will be done with YAS to establish protocols for directing people to the most appropriate service.

There will also be pathways put in place to deal with those patients who may present at a local site with an emergency or requiring specialist emergency care need, this will include the stabilisation and transfer of these patients to the nearest Emergency or Specialist Emergency Centre.

Response times of ambulances to an emergency call out (classed as a red call) is a clear focus for many people and YAS is commissioned to provide a regional service with a target of reaching 75% of red calls within eight minutes.

Previous evidence submitted by YAS to the Kirklees Scrutiny Panel acknowledges that meeting this target presents a real challenge particularly as in recent years YAS has seen a 10% increase in red demand and with 50% of its activity concentrated in West Yorkshire.

Data previously supplied by YAS detailing red call response times across Kirklees over a 2 year period to March 2015, clearly shows that meeting the target in the outlying rural areas of Huddersfield particularly in the post code areas HD8 and HD9 is extremely difficult with significant underperformance in both areas.

[5] Jacobs Journey Time Assessment Study June 2014

DRAFT

YAS has stated on a number of occasions the challenges it faces in retaining paramedic staff particularly as the YAS national pay structure is not competitive with private industry. The Committee was informed that in order to combat this issue YAS decided to fund the Band 6 pay awards for paramedics outside of the national structure which had resulted in improved retention rates and had made YAS a more attractive employer.

During the consultation period the Committee was made aware of plans to reduce the cover at the Honley Ambulance Station. Information supplied indicated that staffing levels were to be reduced and would result in a decrease in ambulance and rapid response vehicle cover in the areas of the Holme Valley, Colne Valley, Dearne Valley and the Huddersfield area.

In response to this information YAS informed the Committee that there was no intention to make any cuts to ambulance provision and that it had invested heavily in staff development and frontline services.

YAS stated that it had been working with an organisation called ORH[6] who had been reviewing YAS's service delivery model including the operational rosters. The review of roster requirements based on local activity had identified that Honley required 1 ambulance 24/7 and a Rapid Response Vehicle available during the day 7 days a week.

The result of the review had also resulted in Huddersfield gaining additional Double Crewed Ambulance cover. In addition it had identified that due to its level of activity Penistone, which was currently an unstaffed standby point, should receive 24/7 ambulance cover. This would assist the capacity of Honley which currently provided part cover for this area.

8.6 Committee Views and Comments

Many members of the public have expressed their concerns about longer journey times to hospital that would arise because of the introduction of two specialist hospitals. Their concerns included risks to their health that may occur because of delays in reaching hospital and the cost and difficulties of travel to hospital for patients and visitors. Some people were also concerned about the availability of parking, particularly at Calderdale Royal Hospital. The Committee feel that these concerns must be fully considered by the CCGs in its deliberations.

The Committee accepts that some patients are already taken to specialist emergency centres at a greater distance and notes the judgement of clinicians that the risk arising from small increases in the length of journeys to hospital by ambulance is outweighed by the benefits of improved care when a patient arrives at hospital.

[6] ORH is a management consultancy that uses advanced operational research techniques to support resource planning in the public sector.

However, the Committee would want to see the impact of the absolute distances from home to hospital, rather than the mean distance, fully modelled. In addition the CCGs proposals will mean an extra 10000 hours of journey time which equates to two more crews. There needs to be clear plans that identify this extra investment in the ambulance service.

The recent CQC inspection of YAS has identified a number of areas for improvement and YAS has regularly not been able to achieve national performance targets. A significant overall improvement in the performance of Yorkshire Ambulance Service is key to the successful implementation of proposals for hospital reconfiguration.

CRH and HRI are five miles apart, but unlike many other areas of the country the topography of Calderdale and Greater Huddersfield often results in areas of congestion that increase the likelihood of delays.

The Committee welcome the planned improvements to the A629 by Calderdale Council and Kirklees Council which will reduce travel time for ambulances, patients and visitors.

The CCGs, Calderdale Council and Kirklees Council with West Yorkshire Combined Authority in conjunction with transport providers should develop a clear public transport plan to improve the speed and frequency of bus services to both Calderdale Royal Hospital and Huddersfield Royal Infirmary.

The additional resource that will be required by the Yorkshire Ambulance service to deliver the additional hours of journey time required as a result of hospital reconfiguration needs to be fully identified and considered.

The Committee is concerned that early discussions have not yet been held with private operators about adding loops to the existing routes. Both Councils, West Yorkshire Combined Authority and CHFT need to work together to identify the improvements that are needed to public transport and to ensure those improvements are introduced.

The Committee welcomes the proposal of the CCGs to establish a Travel Group. The Travel Group should include public transport providers.

9 Community Health Services

9.1 Context and background

The overall programme of change which the CCG's have called Right Care, Right Time, Right Place incorporates three interlinked pieces of work: Calderdale Care Closer to Home Programme; Kirklees Care Closer to Home Programme; and the Hospital Services Programme. Collectively these three programmes form the basis of the proposals for the future arrangements for hospital and community health services.

The Committee was informed that the CCG's would need to progress improvements to community services before they could start to make changes to the hospital services and the changes would be carried out in three phases:

- Phase 1 Strengthen Community Services in line with the new model of care.
- Phase 2 – Enhance Community Services
- Phase 3 – Hospital Services

Kirklees

Greater Huddersfield CCG and North Kirklees CCG have carried out a joint procurement exercise using a competitive dialogue process to commission a lead provider model contract for Care Closer to Home (CC2H) services across Kirklees.

Both CCGs developed specifications that outlined the outcomes and key elements of the model of care that was required. In addition, Greater Huddersfield identified a further set of services which, subject to the outcome of the consultation, could become part of the CC2H services in phase 2 of the programme of changes.

The Committee was informed that including the further set of services in the specification would provide Greater Huddersfield CCG with the option to move them to the new CC2H contractual arrangements without having to undertake a further full procurement exercise.

In July 2015 the formal contract was awarded to Locala Community Partnerships in partnership with South West Yorkshire Partnership Foundation Trust and the contract and implementation of the services commenced on 1 October 2015.

Calderdale

In Calderdale, community health services are provided by CHFT. Changes under Phase 1 of Care Closer to Home have been and continue to be negotiated between Calderdale CCG and CHFT.

Phase 2 of Care Closer to Home has been subject to this consultation exercise. Any changes decided on as a result of this exercise will be negotiated between Calderdale CCG and CHFT.

In November 2016, following the outcome of the October decision on Right Care Right Time Right Place Calderdale CCG Governing Body will decide about the approach to commissioning Care Closer to Home going forward. This decision will focus on the approach and timeline. Currently the contractual arrangements for Care Closer to Home end in March 2017.

9.2 Care Closer to Home

Information supplied to the Committee from the CCG's highlighted that a key aim of the CC2H Programmes was to improve health outcomes; reduce an over-reliance on unplanned hospital care; and shift the balance from unplanned and avoidable

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hospital admissions, to planned, integrated care provided in community and primary care settings.

The Committee was informed that the CCG's had confidence that the changes they were proposing would have a positive impact on non-elective admissions in emergency long stay and emergency short stay; and ambulatory care sensitive conditions and conditions not usually requiring admission

Evidence presented indicated that a key strength of the work of phase one of the CC2H programmes was the collaboration between the various providers including the voluntary sector and the facilitation of greater integration between health and social care.

CCGs outlined the potential areas of weaknesses and challenges of the CC2H programmes that included: the challenges of developing new roles to support the delivery of the new model of care; and the development of digitisation to provide a common platform so that information could be shared by different partners working across the health system.

In response to a Committee question on examples of services from phase one that had provided an improvement in quality and a reduction in costs the Committee was informed of the Calderdale initiative called the Quest for Quality in Care Homes that was highlighted as an example of the model that the CCG would wish to take forward in its future development of Community Services.

The initiative had made a number of high impact changes that included: the introduction of specialist equipment to detect risks such as falls; monitoring equipment to test vital signs; and an integrated social and clinical service to support anticipatory care planning.

The initiative had resulted in a 25% reduction in emergency admissions year-on year at March 2015; in the same period a 16% reduction in hospital occupied bed days; and had delivered an improved value and efficiency saving of approximately £500,000 and a 58% reduction in GP visits to Quest for Quality care homes.

The Committee was advised of a strand of work in the Kirklees CC2H programme that focused on respiratory services. This was an initiative that had been developed in conjunction with the Trust and aimed to provide an improved respiratory offer in the community.

The initiative has been able to provide increased access to respiratory clinics and pulmonary rehabilitation in the community which provided a better quality of care for patients. In addition the Committee was informed of the benefits of the Single Point of Access service which included staff from both health and social care working together to provide patients with the right package of care and support from both a health and social care perspective.

In response to a Committee question on how the CCG's would model the capacity of the CC2H programmes to take the demand out of hospital services and allow the changes to be made the Committee was informed by Greater Huddersfield CCG that

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for the services that had already moved it had undertaken a series of different modelling exercises that had included looking at population growth, current demand, demographic expectations and evidence from best practice.

The Committee was advised that for future services that would be moved from the hospital into a community based setting the CCG would use the same methodology to model the changes.

The Committee was informed that in addition the CCGs in conjunction with CHFT had put in place plans that would have an impact on the hospital usage of non-elective admissions. The Committee heard that there was a commitment that no service would be moved from the hospital setting into the community until both the Trust and the CCGs were confident that there was the capacity in the community and there was clear evidence that plans to reduce demand on the hospital services had worked.

In response to further questioning on how the CCGs would ensure that there was capacity in the system to support the proposed changes to hospital services and manage the increased numbers of people who would be seen in community settings, the Committee was informed that the CCGs would need to design a clear service model that would describe the community based capacity that was needed to support the proposed changes to hospital services.

The CCGs advised that the development of a clear CC2H specification would be one way that the CCGs would be able to provide clarity on the capacity that would be required in the new community service models. Developing the specification would require the CCGs to undertake a process that would enable them to reach an approach to commissioning later in the year.

9.3 **Committee Views and Comments**

The Committee supports the overall objectives of Care Closer to Home. There has been good progress on some aspects of Care Closer to Home, but the programme has not yet been sufficiently developed to support the proposed changes to hospital services and to demonstrate how it will be effective in significantly reducing demand on hospital services.

Care Closer to Home provides an opportunity to radically change the way that health care services are offered to people in the community. A main focus for the CCGs regardless of the outcome of this consultation exercise should be to develop and implement Care Closer to Home <u>at scale</u> across Calderdale and Greater Huddersfield.

The Committee supports the commitment from CHFT and the CCG's that no hospital service will be transferred into a community setting until there is confidence that there is sufficient capacity in the community and there is clear evidence that plans to reduce demand have worked. However, sufficient capacity in Care Closer to Home is a key dependency for any change and the Committee has not received sufficient reassurance on how this will be achieved.

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10 Primary Care

10.1 Evidence Received

Greater Huddersfield CCG has developed a Primary Care Strategy that acknowledges that primary care has had to take on more responsibility, complexity and roles, and often acts as the default provider of all services not seen as within the remit of other services.

The Strategy also highlights the work that has been done on the CC2H model in Greater Huddersfield to strengthen the approach to delivering services to people in the community. It states that fundamental to the success of the model is the integration of primary care with community services.

The Committee was informed by Calderdale CCG that its Primary Care Strategy was still under development but recognised the importance of general practice in its Care Closer to Home strategy and had identified that access to a General Practitioner (GP) was a high priority. Committee members have now seen Calderdale CCG's *Statement of Intent – Primary Care 2020.*

The Committee was advised that there is a recruitment crisis in general practice. Kirklees LMC have informed the consultation process that 'due to retirements and reduced recruitment, the GP workforce is likely to reduce by 30% over the next 5 years nationally.' and the CCGs consider that the recruitment and retention of GP's in Calderdale and Kirklees would be helped if GP's felt that they were part of a better functioning integrated healthcare system.

Greater Huddersfield CCG stated that the Strategy is aimed at addressing the issue of fewer GP's and there was an expectation that there would be more allied health professionals working in primary care that would include nurses coming from secondary care, pharmacists and health care assistants.

10.2 Evidence Received - Local Medical Committees

The Committee also heard from both the Calderdale and Kirklees Local Medical Committees (LMCs) who both stated that they had not been consulted on the proposals and had not had any direct input into the design of the new service model. The LMC's did however accept there was a need to change the hospital configuration which they felt would help protect hospital services provided in the local area.

Kirklees LMC stated that it would have welcomed the opportunity to have been included in making the decisions on the proposals and that there had been a feeling amongst its members that it would have been helpful to have had input during the early discussions on reconfiguration. Calderdale LMC also stated that it would have welcomed early input on reconfiguration.

The LMCs did inform the Committee of a number of concerns that included the accuracy of the financial and demand modelling; the capacity of urgent care and

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emergency services to meet demand; and the impact of the significantly reduced numbers of hospital beds on the whole health and social care system.

Kirklees LMC stated that it agreed that improvement in information technology services would have the potential to improve patient access to primary care and emergency and urgent care services. It was stressed that although there would be an opportunity to provide NHS 111 access to GP appointments this process would need to be limited to ensure that the additional volumes of appointments did not destabilise local practices.

The LMC's informed the Committee that the proposed changes to community services would have a significant impact on those services that were included in the CC2H programme and would require re-engineering in order to meet the anticipated demand. Calderdale LMC stated that it felt more clarity was required on the strategy for community services and how the CC2H programme would work in Calderdale.

The Committee was informed that a key national and local challenge in primary care was how to deal with an ageing GP workforce. The Committee heard that locally the CCGs aim was to raise the importance and attractiveness of the GP role in order to try and retain the services of GPs who were nearing retirement.

Kirklees LMC stated that the recently published General Practice Forward View had signalled a lot of investment in general practice which included the issues of training of staff and looking at allied professional support. If the Forward View was implemented and the funds were forthcoming this would help to utilise and support local resources.

The CCGs informed the Committee that although the LMC's had not had any direct input into the design of the proposals GP members of the Governing Bodies of Greater Huddersfield CCG and Calderdale CCG had all been involved in the design of the new model of care.

10.3 **Committee Views and Comments**

The Committee agrees that success of Care Closer to Home will be reliant on improvements in primary care and community health services and welcomes and support initiatives that will help to accelerate this aspiration.

The Committee notes that Calderdale CCG Primary Care Strategy is still in development and it would have been helpful to have had early sight of the Strategy to reassure the Committee that plans will help address the issues in primary care that have been identified. Taking this forward is a matter of some urgency.

The Committee welcomes the aim of providing greater access to clinical advice through general practice and would wish to see greater clarity and detail on how this would be achieved.

The Committee has concerns about the lack of consultation on the design of the proposals with the LMC's and other key primary care services such as

Community Pharmacy West Yorkshire who the Committee believe are a crucial and important element in the new model of care.

The Committee feel that consultation with the LMC's and other key primary care services would have helped to better inform the discussions on reconfiguration and would have provided the CCG's with a valuable source of expertise and local knowledge.

The Committee would wish to see proposals as to how the confidence and involvement of general practitioners and other key primary care service providers can be regained.

11 Planned Care and Bed Capacity

11.1 Evidence Received – Planned Care

Planned care (or elective care) is a procedure or treatment that is scheduled in advance, not classed as urgent and may require a short stay in hospital.

Currently planned care takes place at both Calderdale Royal Hospital (CRH) and Huddersfield Royal Infirmary (HRI). The consultation documents highlights that although planned care is undertaken at both hospital sites there are some procedures that are only carried out on one site for example vascular surgery at HRI and planned hip or knee surgery at CRH.

This means that at present there is a flow of patients that require planned care that travel from Kirklees to CRH and from Calderdale to HRI.

Information provided by CHFT shows that there are currently around 9,500 inpatient admissions for planned care across both sites with 3,500 admissions seen at HRI and 6,000 at CRH.

Under the proposed new model for hospital care the numbers of inpatient planned care admissions would rise to 4,500 at the Huddersfield site and reduce to 5,000 at CRH. The impact on the geographical flow of patients would see a small reduction in Kirklees residents travelling to Halifax and an extra 600 Calderdale residents travelling to Huddersfield. (see table below)

CURRENT MODEL (estimated 2015/16)				PROPOSED MODEL (based on estimated 15/16 activity)		
SITE	ADMISSIONS	PATIENT FLOWS		ADMISSIONS	PATIENT FLOWS	
		CALDERDALE RESIDENTS INPATIENTS NUMBERS	KIRKLEES RESIDENTS INPATIENT NUMBERS		CALDERDALE RESIDENTS INPATIENTS NUMBERS	KIRKLEES RESIDENTS INPATIENT NUMBERS
CRH	6000		2500	5000 (-17%)		2300 (-8%)
HRI	3500	1600		4500 (+29%)	2200 (+38%)	
TOTAL	9500	1600	2500	9500	2200	2300

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Information on day case surgery showed that there were currently around 50,000 operations a year across both sites with just over 28,000 being carried out at CRH and nearly 22,000 at HRI.

Modelling based on the new proposals shows that the level of activity on each site would effectively be reversed with around 28,500 operations being carried out at the Huddersfield site and close to 21,700 at CRH.

The information also indicated that by 2020/21 there was expected to be a small reduction in the overall level of day case surgery activity to around 49,000 which was predominately due to the reclassification of day case ophthalmology being moved to outpatients treatment. (see table below)

CURRENT MODEL		PROPOSED MODEL	
SITE	DAY CASE ACTIVITY 2015/16	DAY CASE ACTIVITY 2015/16	DAY CASE ACTIVITY 2020/21
CRH	28381	21654 (-24%)	23863 (-16%)
HRI	21842	28569 (+31%)	25346 (+16%)
TOTAL	50223	50223	49209

When activity for both inpatient planned care and day case surgery is taken into account the numbers of people attending CRH reduce by just over 7,700 although the overall numbers of people having operations at CRH still amount to over 26,600.

Under the proposed changes to the configuration of hospital services there will be a new hospital opened on the Acre Mills site at Huddersfield that will be dedicated for planned care. It is proposed that the hospital will have 120 planned care beds and 10 operating theatres.

A key objective of the new model, as outlined in the consultation document, is to bring together planned care in this way so that treatment, surgery or therapy can be delivered without the risk of disruption from emergency cases.

Planned care covers a number of areas and the Pre-Consultation Business Case (PCBC) lists the following services as being Planned, Day Case/Elective Care:

- Outpatients care for adults and children
- Specialist Psychiatric liaison services
- Day case surgery
- Therapy Services (Physiotherapy, Occupational Therapy, Speech Therapy and Dietetics)
- Endoscopy
- Other specialist services such as specific cancer or chemotherapy treatments and diagnostic tests

The PCBC also states that consideration is being given to providing other elements of specialist services at each site, and the provision of outpatient appointments in a

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local hospital or community setting. However it is currently unclear on which specific services this will cover or the numbers of people that will benefit should this change be implemented.

The Committee was informed that some planned procedures would be carried out on both sites and that a number of services would be available at both sites that included: Outpatient services; Midwife led Maternity; Therapies; Diagnostics; and Day Case Surgery.

The PCBC details a number of initiatives that will be developed to support the new planned model of care which include:

- Care only being delivered in hospital when it cannot be delivered elsewhere.
- A new approach to outpatient care providing better offers to patients, in the community wherever possible, and focusing on a significant reduction in out-patient follow-ups
- Continuing the work to move appropriate elective activity to day cases, and to move appropriate day case activity to out-patient procedures – in line with the evidence base and with specifications for services that would support the new model, e.g. District Nursing.
- The co-location of services on only one site where there is a clinical need due to the interrelationships with other clinical services.
- The location(s) of delivery for individual specialties to be generated on a case by case basis, with consideration given to: safety; quality; patient experience; and proportionality (particularly in small specialties)
- Any split of activity across sites being aligned to quality and the infrastructure requirements needed to deliver safe and effective services.

Evidence presented indicated that the planned care model is based on lower volumes of outpatient appointments being seen in a hospital setting and providing more capacity for appointments to be carried out in a local community setting.

It was also stressed that although there is not yet the capacity within the Care Closer to Home Programme to deal with the increase in outpatient appointments the Clinical Commissioning Groups will be looking to develop sufficient capacity in the system over the next five years.

The Committee was informed work was being done with primary care to enable follow up cases to be referred to a health professional, including General Practitioners (GPs) based in a community setting.

In response to a question on how local GP's who were already stretched could be expected to accommodate the extra demand the Committee was advised that GPs would be provided with additional resource to handle the appointments, although no details were provided. In addition a certain number of the appointments would be dealt with by specialist nurses and the development of a standardised patient health care record would make communication between the GP and hospital much easier.

The Committee was informed that people would still be able to choose to have their planned operations or treatment at NHS hospitals outside their local area. The

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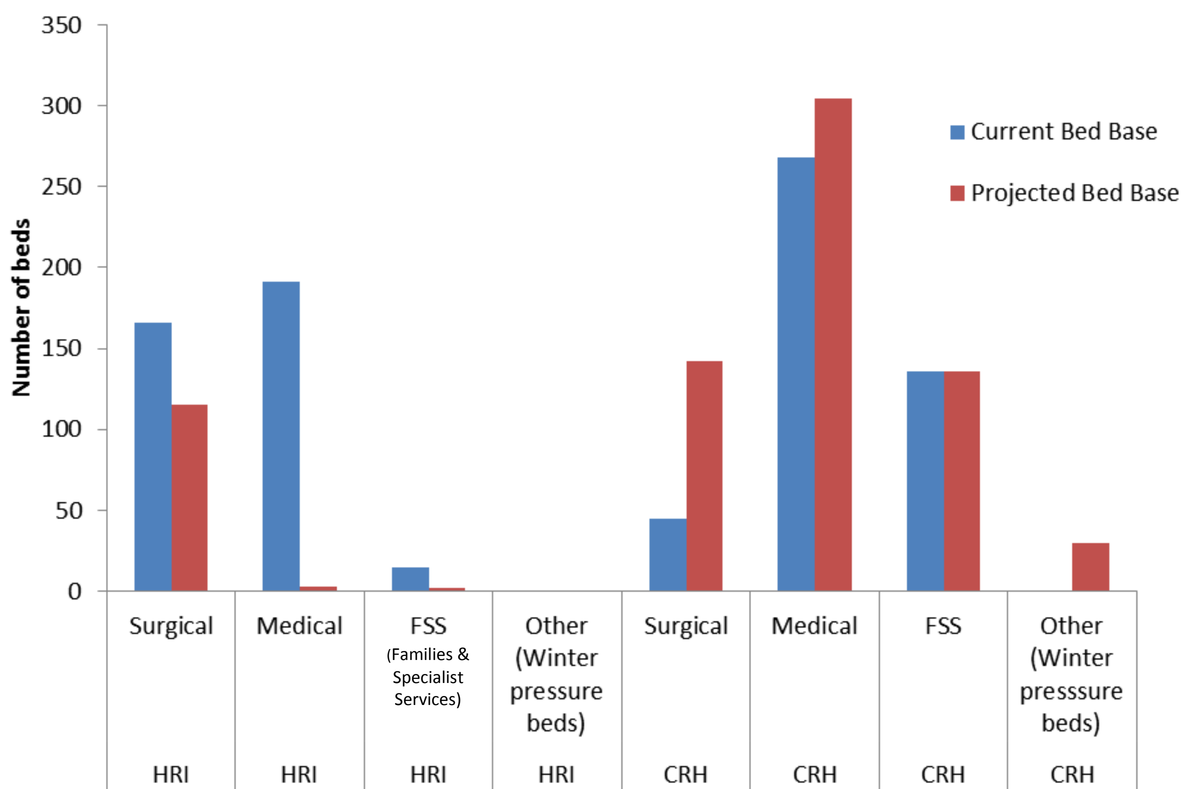
opportunity to choose between Calderdale Royal Hospital or Huddersfield Royal Infirmary will be reduced if these new arrangements are implemented as many procedures will only be available at one site or the other.

In response to a question on what would happen if a patient developed complications during a routine planned operation that required specialist or emergency care, the CCGs stated that a patient at the planned care site would be transferred to the emergency centre site. The patient would only stay for as long as acute or critical care was required before being transferred back to the planned care site.

11.2 Evidence Received - Bed Capacity

Modelling that has been undertaken by CHFT indicates that it would require a total bed base of 732 beds if CRH is the unplanned care site. The Trust's 5 Year Strategic Plan provides details on how the beds numbers are broken down (see graph below) but the overall numbers are 612 beds at the CRH site and 120 at the proposed new hospital in Huddersfield.



Number of beds required at both sites, by division, if CRH is the unplanned care site

CHFT stated that the modelling used to calculate the number of medical beds takes into account the development of services out of hospital and the ability of the Trust to provide some services and treatments that would normally require an admission to hospital, in a community setting.

The modelling also assumes a greater efficiency in managing bed occupancy by reducing the length of time that people spend in hospital. The modelling has factored in reduced numbers of admissions based on nationally benchmarked data that takes account of the numbers of admissions that were classed as ambulatory care conditions. The target in the proposals is for a reduction in unplanned admissions of 6% per annum.

11.3 **Committee Views and Comments**

The Committee understands that a site dedicated to delivering planned care will enhance patient experience by reducing the number of cancelled procedures resulting from surgeons having to respond to the needs of emergency patients. However, it is noted that with the new hospital model CRH will continue to provide significant numbers of planned care procedures which seems to contradict the objective of reducing the number of cancelled procedures.

The Committee welcomes the aim to increase the efficiency in managing bed occupancy and reducing the numbers of unplanned admissions to hospital.

However the Committee feel that more work is required to provide clarity on how capacity in community services will be provided to support these initiatives. Until there is greater clarity the Committee will remain concerned that the proposed number of inpatient beds will not be sufficient to meet demand.

The Committee acknowledges the steps that will be taken should a patient develop unforeseen medical complications during a planned routine operation but feel that more needs to be done to reassure the Committee – and the public – that there are sufficiently robust procedures in place to address concerns about patient safety.

The target to reduce unplanned admissions by 6% pa is challenging and has been described as admirable during the Committee deliberations. The Committee welcome ambitious targets but cannot help but contrast this target with the assumption that A&E attendances will increase by 1% per annum, which the Committee consider to be over- cautious.

Evidence presented indicated that improved ambulatory care pathways and better access to senior doctors under the new arrangements will bring about this reduction. The Committee agree that this may contribute to the reduction however this target will only be achieved if there is greater downward pressure on A&E attendances and if the promised improvements in Care Closer to Home are delivered.

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12 The Hospital Estate

12.1 Evidence Received

The Committee considered estate issues when it met on 19 April 2016. Members of the Committee also visited both Huddersfield Royal Infirmary and Calderdale Royal Hospital on 2 March when they received evidence about the hospital estate.

Another group of Members visited Huddersfield Royal Infirmary on 1 August where they saw the Accident and Emergency Department in action during the evening.

The Committee learnt that the backlog of maintenance and upgrade at Huddersfield Royal Infirmary amounts to £92.4m in order to bring the estate to a “category B” level. Problems at Huddersfield Royal Infirmary include[7]:

- Corroded service pipework that could potentially fail
- Leaks in the roof
- Electricity supplies are not robust
- The majority of windows need replacing
- There is asbestos within the hospital infrastructure
- Poor clinical environments.

In order to implement the CCGs proposal an estimated capital investment of £300.3m will be required to build a new hospital at the Acre Mill site in Huddersfield and to enhance facilities at Calderdale Royal Hospital.

12.2 **Committee Views and Comments**

Huddersfield Royal Infirmary is a fifty year old building and has a substantial maintenance backlog and although Calderdale Royal Hospital is less than twenty years old, it is a building that also has room for improvement.

Members who visited Huddersfield Royal Infirmary saw for themselves that the building is in serious need of repair and upgrading. They were shown the limitations that the 1965 building presents in enhancing the infrastructure.

At Calderdale Royal Hospital Committee Members heard evidence about how the PFI asset and facilities management contract works.

The Committee accepts that the estate at Huddersfield Royal Infirmary needs significant investment. The Committee also has serious concerns that the Calderdale Royal Hospital site has limited capacity for expansion. The CCGs must deliver a significantly better service and the Committee would wish to see clear plans that the Calderdale Royal site can deliver these improvements.

The Committee noted that there are plans to increase parking at Calderdale Royal Hospital and should the proposals go ahead CHFT must recognise the

[7] Source 5 Year Strategic Plan for Calderdale and Huddersfield NHS Foundation Trust

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importance of parking and access to the hospital for patients and visitors and should not regard it as a peripheral matter.

The amount of capital required to implement these plans - £300m - is substantial. This will need to be provided by national government or through further borrowing by CHFT. This gives the Committee major concern. Any borrowing by CHFT needs to be on the best available terms or it will result in the same position that they are in with the current PFI arrangement, where excess interest payments deflect resources from serving patients.

Should these proposals go ahead, the capital cost should be met by NHS England or the Government. We remain to be assured that the finance will be in place to complete the proposed changes to the estate.

The absence of a "plan B" has been a recurring theme throughout the consultation period. The Committee would want to know what the CCGs plan to do if no capital is available or the amount available is less than required.

13 Maternity Services

13.1 Evidence Received

CHFT changed the configuration of maternity services in 2005/06 so that a consultant led maternity service was based at CRH and midwife led units at both hospital sites.

The current proposals would not change the configuration of maternity services although locating the Emergency Centre at CRH would mean that all of the necessary support services would be on the same site as the consultant-led unit.

A key focus of the proposed future arrangements for hospital services is to strengthen community based services for women at all stages of pregnancy and provide more care closer to home.

The Committee was informed that the previous changes to maternity services had enabled the Trust to significantly increase the time that senior clinicians were available on site.

In response to a question on the quality, clinical and safety aspects of maternity services following the previous configuration the Committee was advised that there have been significant clinical improvements following the changes.

CHFT stated that the current proposals would help to further improve maternity services. The service at CRH is separate to the acute surgical site that is currently based in Huddersfield which means that there often delays when the maternity unit needs an acute surgical opinion. The new proposals would result in co-location with the acute surgical service that would provide quicker and easier access to the appropriate senior decision makers.

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CHFT stated that the consultant led maternity unit is fully staffed only because it is located on a single site.

The Committee questioned the aim of the proposals to strengthen community based maternity services which include labour and delivery and queried the success of the previous reconfiguration which also included an aim to increase the numbers of home births.

CQC rated maternity and gynaecology services at Calderdale Royal Hospital as "requiring improvement" and at Huddersfield Royal Infirmary as "good".

13.2 **Committee View and Comments**

The Committee accepts that the co- location of the Acute Surgical Service with the medically led Obstetric Unit should help to further improve the quality and safety of care of the Trust's Maternity Services.

The Committee welcomes the plan to continue to provide maternity services at both hospitals.

The Committee notes that the aim of the previous maternity services reconfiguration to improve early access to maternity services through more community based provision and to promote choice of birth including, where appropriate, home births has not yet been fully realised. The Committee supports the approach to improve and strengthen community based provision for women at all stages of pregnancy.

14 Paediatric Services

14.1 Evidence Received

Following changes to services in 2005/06 CHFT general paediatric services have been centralised at CRH. Since then children who are unwell and require medical services go to CRH; however any surgery that may be required is carried out at HRI.

CHFT's 5 Year Strategic Plan states that the Trust is not currently compliant with many standards for children and young people in emergency care settings and highlights that a particular challenge is ensuring that a consultant paediatrician is present and readily available in the hospital during times of peak activity, seven days a week.

This issue had also been picked up by the NCAT team during the review of the Trust's Accident and Emergency (A & E) services in June 2013. The NCAT report stated that it would not be possible to provide sufficient numbers of adequately trained and skilled staff to meet the level of service that was required and adhere to the standards while operating over two sites.

NCAT concluded that the provision of an Emergency Department on one site would allow for a dedicated Paediatrics Emergency Department which could result in compliance with many, if not all, of the standards. In addition the co-location of

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Paediatrics and Paediatrics Emergency Medicine would allow for Paediatric Emergency Medicine trained staff to work alongside and support acute Paediatrics which was another area which had workforce issues.

The reconfiguration proposes to centralise medical and surgical services in a Paediatric Emergency Centre at CRH. The model includes enhanced services for children, provided where possible in the community, so that children with certain illnesses and conditions could be seen more quickly.

As with the proposed changes for the general Emergency Centre and the Urgent care Centres there would be a focus on encouraging parents and carers who had a sick child to contact NHS 111 for advice so that they could be directed to the best place for assessment or treatment.

The new proposed model of care would also include a refresh of the protocols that were in place for NHS 111 and the ambulance service to ensure that any children with injury or illness requiring emergency care were directed to the specialist Paediatric Emergency Centre.

In response to a Committee question on the approach that would be taken to dealing with very young children who were ill or injured the Committee was informed that all children aged 5 years or under would be directed to the Paediatric Emergency Centre based at CRH.

The Committee was informed that under the new proposed arrangements paediatric care would operate 24 hours a day and seven days a weeks. All children with an illness that required hospital attendance would be seen at the Paediatric Emergency Centre.

In response to questioning by the Committee on the feasibility of maintaining paediatric care on both sites the Committee was informed that in order to maintain a sustainable service and ensure that there was the available expertise to meet national standards the service would have to be concentrated on one site.

14.2 Committee Views and Comments

The Committee acknowledges the challenges that the Trust faces in meeting the standards for children and young people in emergency care settings.

The Committee accepts that having a dedicated Paediatrics Emergency Department on one site will provide the Trust with an opportunity to meet the required standards and help ensure that appropriately trained and skilled staff are available during times of peak activity seven days a week.

The Committee notes that the new model of care will include a focus on encouraging parents and carers with a sick child to contact NHS 111 for advice. The Committee feel that further work is required to ensure that the pathways of care for sick children are understood by the public and sufficient resources are in place to provide quick and easy access to appropriate clinical advice.

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Locating all specialist services for children on one site will have an impact on travel time for some parents, particularly when their child is an inpatient. CHFT need to make sure that they are always able to provide "stay-over" facilities for parents when their child is an in-patient.

15 Diagnostics

15.1 Evidence Received

The Committee discussed diagnostics when it met on 6 April 2016.

The Trust's 5 Year Strategic Plan highlights a workforce gap in its radiology service and is struggling to recruit and fill the vacant consultant posts. This has resulted in a service that is stretched beyond capacity to meet the growing demand for diagnostics across both sites. In order to maintain the quality of patient service the Trust is incurring significant additional costs by having to outsource some of the radiology work to the private sector.

The Committee was informed that under the proposals both sites would provide a range of diagnostics such as x-rays and blood tests but only the emergency centre site would provide 24 hour 7 days a week access to CT/MRI scanning.

The Committee was advised that there was a national shortage of radiologists and reconfiguration of the diagnostic service was needed in order to sustain the service in the long term.

15.2 Committee Views and Comments

The Committee is concerned that reducing the level of diagnostic service at the planned hospital site will increase the number of patient transfers to the unplanned hospital out of hours and when more specialist diagnostic services are required.

16 Adult Social Care

16.1 Evidence Received

The Committee asked Calderdale Council and Kirklees Council to comment on the role of adult social care and public health in the hospital reconfiguration proposals and to help the Committee understand the impact and implications of the proposals for these services.

The Kirklees Council Director responsible for Adult Social Care and Public Health stated that from a social care perspective an important element of the changes was how the Council worked alongside Locala and the broader primary care approach to develop holistic community based teams that would enable people to be as independent as possible.

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The Kirklees Director also stated that although it was important to have robust processes in place to handle hospital discharges it was even more important, from a public perspective, to focus on avoiding admissions to hospital in the first instance.

The Committee heard that where hospital admission was unavoidable it was important that there was a seamless delivery of health and social care and there was a clear plan to provide a holistic package of care that would support the person when they went home.

The Kirklees Director explained that Kirklees had experience in supporting a similar model for the Mid Yorkshire Hospitals Trust although the Council would need to: understand how social care would interact with the new model which would mean more Kirklees staff working on the Calderdale site; and work through the practical operational implications.

The Committee was told that it was likely that people who received complex non-elective activity at the proposed Emergency Centre site in Calderdale were the people who would most likely require a social care need intervention and the Councils would need to assess the volume of demand coming from each site before deciding on how to structure their operations.

Calderdale Council informed the Committee that it agreed with Kirklees Council on the implications for social care and highlighted the role of social care in supporting the wider health care system by preventing people going to hospital and helping to accelerate their discharge home.

There would also be the need to intensify focus on the Councils developing the local home care market. Calderdale Council provided an overview of the activity of its integrated team and its work on re-ablement services. This work had resulted in a number of lessons being highlighted that included the need to get people home through the provision of increased home care support before they benefited from the input of re-ablement services.

The Committee also heard from Calderdale's Director of Adults Health and Social Care services that the location of hospital services would not present Calderdale Council with a significant challenge as the Council was used to working across the two sites.

In response to a Committee question regarding the difficulties facing the care home sector and the impact of care home closures on the flow of patients through the wider health and social system the Committee was informed that the Councils had a duty under the Care Act to develop the market, manage failure and ensure that there was a diverse and sustainable supply of resources although it was a long term problem and would not be fully resolved in the short term.

16.2 Committee Views and Comments

The Committee agrees that in order to provide a consistently high level of quality care locally health and social care services from councils and other providers must be delivered in an integrated and seamless way. The

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Committee would wish to see a continued focus on increasing the range of integrated services that will be available.

The Committee notes that both local authorities indicate that they could manage and adequately support and resource a split site model, although it does have a concern that delayed discharges could be caused by the complexity of patients coming from two different local authority areas with two different adult social care departments.

17 Public Health

17.1 Evidence Received

The Committee was informed that Public Health has an important role to play in helping people to self-manage their own care which would help contribute to managing the demand on subsequent health care services including those in a hospital setting.

Evidence presented by the Director of Public Health in Calderdale indicated that the impact of hospital reconfiguration on health outcomes was expected to be very small as research had indicated that access to hospital care only contributes to a small percentage of life expectancy in the population. The greatest impact on health outcomes comes from areas such as the environment that people lived in and healthy behaviours.

The Director of Public Health stated that there are a number of public health initiatives that could potentially help to take demand out of the hospital system that included: a local focus on better dental hygiene to prevent relatively high numbers of children being admitted as inpatients for tooth extractions; the work that was being done by both Councils through the development of a 'wellness' model that would take a more holistic approach to improving health; enable a more efficient use of resources and increase the chances of helping people to achieve real change in their lifestyles.

17.2 **Committee Views and Comments**

The Committee agrees that the work of Public Health to improve health and change people's lifestyles will be an important factor in helping reduce demand on the hospital and welcome the plans to develop a more holistic approach to improving health.

18. West Yorkshire Context - Urgent and Emergency Care Network and Sustainability and Transformation Plan

18.1 The Committee heard from the West Yorkshire Urgent and Emergency Care Network when it met on 22 March 2016.

Following the Keogh Review on urgent and emergency care services 24 Urgent and Emergency Care Networks have been established across England. These networks have responsibility for progressing the recommendations of the review. The West

Yorkshire Urgent and Emergency Care (UEC) Network covers Bradford, Calderdale, Kirklees, Leeds, Wakefield and the Craven and Harrogate districts in North Yorkshire.

The West Yorkshire UEC Network was awarded Vanguard status in 2015 which means that the network is expected to develop approaches that if possible can be repeated at scale across the rest of the country.
A key purpose of the network is to improve the consistency and quality of UEC within the area that it covers and will do this by working with System Resilience Groups (includes CCGs, councils and other partners) and local organisations.

The Keogh review made a number of recommendations which included: helping people with urgent care needs to get the right advice in the right place, first time and would be supported by developing the NHS 111 services to help deliver this aim; and providing highly responsive urgent care services outside of hospital so people no longer choose to queue in A&E.

The Network's Vanguard programme has a number of work streams that are designed to support the vision for new models of care outlined in the NHS Five Year Forward View and the recommendations from the Keogh review that includes:

- Primary Care – Which aims to create, implement and pilot a potential new care model for roll out across West Yorkshire; Direct booking in and out of hours; Triage for urgent appointments; and wider use of community pharmacy for meeting urgent requests for repeat medicines, across 44 pharmacies.

- Hear, See, Treat – To develop a Clinical Advisory Services (CAS) to ensure patients in need can access specialist clinical advice; 111/999 integration single triage process; and to establish and implement a Mobile Directory of Services available for staff.

The Committee was informed the pace of the development of Urgent Care Centres was not uniform although their development would be informed by national standards which were currently being finalised. The Network was also committed to working with local systems to help progress the development of Urgent Care Centres and the design of emergency centres in line with national standards

During the early part of the Committee's evidence gathering Monitor was asked why the Trust's sustainability plan had not considered the proposals from a West Yorkshire wide perspective.

Monitor responded by saying that the West Yorkshire perspective was a commissioning function and it was for commissioners in conjunction with NHS England to decide on how local proposals configured with wider regional plans.

Monitor stated that its role was to focus on the sustainability of NHS Foundation Trusts as individual organisations and in the case of CHFT it would concentrate on working with the Trust to narrow the deficit over a period of time.

Kirklees residents in particular expressed concerns about the combined effect of these proposals and the changes currently being implemented at Dewsbury hospital. These proposals, along with the Mid Yorkshire changes would leave Kirklees without any local acute hospital service.

Concerns have also been raised that these proposed changes will have an impact on hospitals in neighbouring areas, such as Barnsley and East Lancashire.

18.2 Evidence Received - Sustainability and Transformation Plans.

During the course of the Committee's work the importance of Sustainability and Transformation Plans became increasingly evident.

NHS England has told all areas of England to prepare a Sustainability and Transformation Plan (STP) that will be close the three "gaps" of quality, outcomes and finance. Calderdale and Greater Huddersfield fall under the West Yorkshire area, which also covers Harrogate and Craven.

The STP was only touched upon in the meetings and was not publicly available at the time, but there has been considerable discussion at Health and Wellbeing Boards and in the local and national media. The STP includes workstreams on Urgent and Emergency Care and on hospital reconfiguration, which aim to contribute towards closing all three "gaps".

The financial gap across West Yorkshire is £800m over five years. The NHS has identified £600m worth of plans to close this gap, which include the proposals from Calderdale CCG and Greater Huddersfield CCG currently under consideration.

18.3 **Committee views and Comments**

The Committee notes the work that is being developed through the Network's Vanguard Programme, but is disappointed to learn that funding has been reduced.

The Committee acknowledges that the pace of development of the Urgent Care Centres is not uniform and feels that it would have been useful for the Committee to have had an early sight of the UCC national standards.

There is a clear move towards planning some NHS services on a West Yorkshire basis. Already patients throughout West Yorkshire with very serious conditions receive some services in Leeds. The STP is clearly a very important development and the Committee agrees that a West Yorkshire perspective is important.

The Committee support proposals to address some of the staffing pressures at a West Yorkshire level and agrees that some public health initiatives that will prevent or reduce ill health and so take demand out of the system may work better at scale.

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The Committee is concerned that the pressure to close the West Yorkshire financial gap will have undue influence on the final outcome of our local process. The Committee is also concerned that there is still a further £200m of savings required in West Yorkshire and that further changes to those subject to this consultation may be proposed in order to address financial problems in other parts of the county.

The Committee needs assurance that the impact of the changes proposed by Calderdale CCG and Greater Huddersfield CCG on neighbouring areas has been taken into account and that any proposed changes in the neighbouring areas do not impact on the future sustainability of CHFT.

The Committee is also conscious of the wider context; in particular the West Yorkshire Sustainability and Transformation Plan which seeks to make the books balance across this NHS region. It is understood that the proposals for hospital reconfiguration in Calderdale and Kirklees make a significant contribution to proposals being considered in the West Yorkshire STP to close the financial gap.

The Committee is also concerned that the proposals are purely focused on trying to address the finance and workforce issues of one Trust and has not taken into consideration opportunities that may be available from working with other CCGs and Trust's to provide a sustainable model that could continue to provide key services that are locally accessible.

19. NHS 111

19.1 Evidence received

The Committee heard evidence that Yorkshire Ambulance Service (YAS) will play a key role in the new proposed future model of care with an emphasis on directing patients to the most appropriate place of care to meet their needs.

The proposed new arrangements for urgent care set out in the PCBC will involve an increased reliance on the NHS 111 service, which is currently provided by YAS. People will be encouraged to contact NHS 111 so that they can receive advice and be signposted to the right service to meet their needs.

The consultation document acknowledges that for the new arrangements for urgent care to be successfully implemented that there will be a need to:

- Help people understand, through the availability of much more public information, when it is appropriate to call for an ambulance, so that those who need emergency care can be taken straight to the Emergency Centre.

- Make sure the NHS 111 "scripts" make sure that people can be signposted to the best place to get the right help.

- Ensure that if people do make their own way to the Urgent Care Centre with problems that need specialist care that staff in the Urgent Care Centre have the necessary skills to make sure they are stabilised and then transferred.

Calls to 111 are currently answered by non-clinical call handlers who used an algorithm called NHS Pathways which take the person through a number or questions designed to eliminate emergency conditions and reach an assessment of the person’s need.

A key objective of the new arrangements is the development of a 111 Clinical Advisory Service that would give patients access to specialist clinical advice and would include a focus on providing faster access to advice from senior clinicians for groups of patients in the under 5’s and over 85’s who are groups at particularly high risk.

The Committee was told that there are two crucial elements that would be required to successfully support the services provided by YAS and NHS 111. The first was the need to establish a standardised patient health care record across West Yorkshire that would enable appropriate health professionals to have access to a patients record and would transform the way that people were advised and treated.

The second crucial element is the agreement of a common workforce plan across West Yorkshire to ensure that there was an understanding between organisations to enable staff movement and reduce competition for staff.

Evidence presented outlined the work currently being undertaken to explore the integration of 111 and the 999 services into a single process. The work includes the introduction of a single triage service that would allow calls received by 999 that did not require an immediate ambulance response to be further assessed which would enable people to be directed to the most appropriate place of care to meet their needs.

19.2 **Committee views and Comments**

The Committee supports the ambition to strengthen and enhance the NHS 111 service and integrate the NHS 111 and 999 services to create a single core process.

The Committee has concerns regarding the capacity of NHS 111 to handle the increase in the volume of calls and to provide sufficient accessibility to specialist clinical advice.

The Committee notes the benefits that would be provided by having a standardised patient health care record and a common workforce plan but have seen no evidence that indicates any significant progress has been made in the introduction of these initiatives.

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20. The Consultation and Engagement Process

20.1 Evidence Received

It is clear that the Clinical Commissioning Groups (CCG's) have overseen an extensive programme of engagement activity in the pre-consultation phase of the process. In August 2015 a composite report was produced that pulled together all of the engagement activity that had taken place and highlighted a number of key themes which were used by the CCG's to inform the proposals for hospital and community health services in Calderdale and Greater Huddersfield.

The formal consultation ran for a 14 week period from 15 March 2016 to 21 June 2016 with an extension until 24 June 2016 for online submissions. The CCGs arranged a communications programme to promote awareness of the consultation which included the use of media, social media, advertising and direct mail.

Information on the proposals including the consultation document was available through a dedicated consultation website and was also distributed at public venues across Calderdale and Greater Huddersfield.

The CCGs provided a number of ways that people could get involved in the consultation which included: completing a survey (available online and as a hard copy); sending submissions direct to the CCGs; attending the three public meetings or 17 information sessions that were arranged by the CCGs.

The Independent Report of Findings[8] states that there were a total of 7,582 surveys submitted and approximately 40,000 individual comments to open questions were read and themed to identify concerns and support for the proposals.

In addition throughout the consultation the Huddersfield local press has reported extensively on the proposed changes and has provided a platform for local campaign groups who oppose the proposals.

20.2 Evidence Received – Independent Report of Findings and Healthwatch Kirklees Consultation Findings report.

The Midlands and Lancashire Commissioning Support Unit (MLCSU) who were commissioned by the CCG's to analyse and produce a report that outlined the findings of the public consultation informed the Committee of the process and methodology that they had followed in reviewing the feedback that had been received from the online survey, public meetings, stakeholder meetings and a comprehensive correspondence log.

MLCSU outlined the six key areas for focus that had been identified following the review of the evidence which included: travel and transport; clinical safety and

[8] Independent Report of Findings of Right Care, Right Time, Right Place Consultation produced by the Midlands and Lancashire Commissioning Support Unit on behalf of NHS Calderdale CCG and NHS Greater Huddersfield CCG – August 2016

DRAFT

capacity; the rationale for change; the consultation process; understanding the proposed model; and the need for change.

HealthWatch Kirklees outlined to the Committee its role throughout the formal consultation process which include listening to what local people were saying about the proposals; to reflect the views of the general public back to the CCG's and the Joint Health Scrutiny Committee; and to remain completely independent of the process.

Healthwatch Kirklees explained the process it followed in gathering the opinions of local people and provided details of the key themes that had emerged which included: a focus on travel and the impact of increased travel times and distances; a concern on the length of time it would take to receive treatment; the increased cost of travel and the disproportionate impact poorer sections of the community; and increased waiting times and a reduction in the availability of beds.

The Committee heard from the MLCSU that a response rate for this type of consultation would normally expected to be just under 1% of the local population and this consultation had significantly exceeded that rate at around 2.5% with the majority of the responses coming from Kirklees (Huddersfield).

In response to a Committee question that the lower response rates from the Calderdale population may indicate that the consultation had not managed to effectively communicate how the proposals would affect residents in both Calderdale and Kirklees the Committee was informed that the CCG's deliberation on the consultation findings would include a focus on whether sufficient weighting had been expressed through the responses, particularly relating to planned care.

In response to a concern that respondents in the 0-20 years age profile were significantly lower that the local demographic profile the CCG's stated that they had recognised at the mid-point review of the consultation that children and young people were under represented in terms of responses.

The CCG's outlined a number of additional activities that had been included in an attempt to engage with more young people and confirmed that it would need to take account of the numbers of respondents in this age group and the views that had been expressed during its deliberations.

Healthwatch Kirklees stated that it felt that the consultation process had been open and that the findings report was an accurate reflection of what people had been saying. The Committee heard that the findings from the HealthWatch work and the analysis of the public consultation had resulted in similar themes emerging.

In response to a Committee question that the findings of the public consultation inferred that respondents had not fully understood the proposals MLCSU stated that there had been a mixture in the responses that had led to this conclusion.

MLCSU explained that in some cases people were looking for more detailed information so they could understand the proposals and in the majority of cases people could not visualise or picture in their mind how the new model would work

and that one solution that may help going forward would be to describe through a story of a patient journey using the new model of care

Healthwatch Kirklees stated that it partly agreed with the idea that many people did not fully understand the proposals and that the conversations with people had been dominated by the location of an A & E and an Urgent Care department. It had also been surprised at the number of times people had expressed a concern that the Huddersfield A&E department and the hospital itself would be entirely closed.

Healthwatch Kirklees also stated that many people had said that they had the got information on the proposals from social media such as facebook and from the local paper which was heavily focused on saving the Huddersfield A & E and with much less focus on the wider proposals such as planned care.

During the discussions the Committee acknowledged the comments from people that were included in the Independent Report of Findings and the Healthwatch report which powerfully illustrated the concerns with the proposals.

The Committee was aware that during the public consultation that significant numbers of people had expressed their concern of the proposals by signing petitions which based on the Independent Report of Findings included in excess of 85.000 signatures.

20.3 **Committee views and Comments**

The Committee is generally satisfied that the public consultation has been undertaken in an open and transparent manner and that the exercise has followed recognised best practice.

The Committee does however have concerns of the low participation rate from people living in Calderdale when compared to people living in Kirklees which it believes is an indication that the CCGs have not effectively communicated how the overall proposals will impact and affect residents in both Calderdale and Kirklees

The Committee notes the concerns regarding the proposals that have been expressed by significant numbers of people particularly when taking account of the petitions. Although the Committee acknowledges that many people have focused on the location of the A&E department, the Committee still feel that this is a genuine and real concern that should not be ignored and would want to see that CCGs take this high level of public concern fully into account in its deliberations.

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APPENDIX 1

LIST OF ATTENDEES WHO PROVIDED EVIDENCE TO THE COMMITEE

Organisation	Individual
Calderdale and Huddersfield NHS Foundation Trust	Kristina Rutherford - Assistant Divisional Director Surgery and Anaesthetics Karen Barnett - Assistant Divisional Director Community Anna Basford - Director of Transformation and Partnerships Gemma Berriman - Matron Emergency Care David Birkenhead – Executive Medical Director Juliette Cosgrove – Assistant Director of Quality Mark Davies- Clinical Director Emergency Medicine, Consultant in Emergency Medicine Julie Dawes – Executive Director of Nurses Dr Martin DeBono – Divisional Director Families and Specialist Services, Consultant Gynaecologist Keith Griffiths - Executive Finance Director Anne - Marie Henshaw - Head of Midwifery Dr Rob Moisey - Clinical Director Acute Medicine, Consultant Endocrinology & Diabetes and Acute Medicine Julie O'Riordan - Divisional Director, Surgery and Anaesthesia, consultant anaesthetist Dr Heshan Panditarartne - Clinical Director Radiology, Consultant Radiologist, Victoria Pickles- Company Secretary Catherine Riley - Assistant Director of Strategic Planning Lindsay Rudge – Deputy Director of Nursing Ashwin Verma - Divisional Director Medicine, Consultant Gastroenterologist Janet Youd - Consultant nurse in emergency care
Greater Huddersfield Clinical Commissioning Group (GHCCG)	Vicky Dutchburn - Head of Strategy, Business Planning and Service Improvement Dr Jane Ford – GP Member Dr David Hughes – GP Member Julie Lawreniuk – Chief Finance Officer (GHCCG & CCCG) Carol McKenna – Chief Officer Dr Steve Ollerton – Clinical Chair Penny Woodhead – Head of Quality (GHCCG & CCCG)
Calderdale Clinical Commissioning Group (CCCG)	Dr Majid Azeb – GP Member Dr Alan Brook – Clinical Chair Debbie Graham – Head of Service Improvement

DRAFT

	Jen Mulcahy – Programme Manager – Right Care, Right Time, Right Place Programme (GHCCG & CCCG) Dr Matt Walsh – Chief Officer
Monitor	Paul Chandler – Regional Director (North)
Healthwatch Kirklees	Rory Deighton – Director
NHS 111	Dr Phil Foster – NHS 111 Clinical Director Urgent Care
NHS England	Brian Hughes – NHS England Locality Director, West Yorkshire
West Yorkshire Urgent and Emergency Care Network	Colin McIlwain – Interim Network Director
Yorkshire Ambulance Service	Andrew Simpson – Head of Emergency Operations
Yorkshire and the Humber Clinical Senate	Professor Chris Welsh – Chair
Locala Community Partnerships CIC	Jim Barwick – Director of Transformation Robert Flack – Chief Executive Jackie Ramsey – Interim Director of Operations
Calderdale Local Medical Committee	Dr Geetha Chandrasekaran Dr Seema Nagpaul
Kirklees Local Medical Committee	Dr Richard Jenkinson Dr Bert Jindal
Calderdale Council	Paul Butcher – Director of Public Health Cllr Barry Collins – Cabinet Member for Regeneration and Economic Development Bev Maybury – Director of Adults, Health and Social Care Kate Thompson – Lead for Corporate Projects
Kirklees Council	Cllr Peter McBride – Cabinet Member for Transportation, Skills, Jobs and Regional Affairs Richard Hadfield – Head of Strategy and Design Richard Parry – Director for Commissioning, Public Health and Adult Social Care
UNISON	Natalie Ratcliffe
West Yorkshire Combined Authority	Neal Wallace

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