

# Public Document Pack



**Service Director – Legal, Governance and  
Commissioning**

**Julie Muscroft**

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Thursday 13 July 2017

## Notice of Meeting

Dear Member

### **Calderdale and Kirklees Joint Health Scrutiny Committee**

The **Calderdale and Kirklees Joint Health Scrutiny Committee** will meet in the **Council Chamber - Town Hall, Huddersfield** at **10.30 am** on **Friday 21 July 2017**.

**This meeting will be live webcast.**

The items which will be discussed are described in the agenda and there are reports attached which give more details.

A handwritten signature in black ink, appearing to read "Julie Muscroft".

**Julie Muscroft**

**Service Director – Legal, Governance and Commissioning**

Kirklees Council advocates openness and transparency as part of its democratic processes. Anyone wishing to record (film or audio) the public parts of the meeting should inform the Chair/Clerk of their intentions prior to the meeting.

**The Calderdale and Kirklees Joint Health Scrutiny Committee members  
are:-**

**Member**

Councillor Elizabeth Smaje

Councillor Andrew Marchington

Councillor Julie Stewart-Turner

Councillor Carole Pattison

Councillor Adam Wilkinson - Calderdale Council

Councillor Chris Pearson - Calderdale Council

Councillor Ashley Evans - Calderdale Council

Councillor Anne Collins - Calderdale Council

# Agenda

## Reports or Explanatory Notes Attached

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**Pages**

**1: Minutes of Previous Meeting**

1 - 6

To approve the Minutes of the meeting of the Committee held on 23 February 2017.

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**2: Interests**

7 - 8

The Councillors will be asked to say if there are any items on the Agenda in which they have disclosable pecuniary interests, which would prevent them from participating in any discussion of the items or participating in any vote upon the items, or any other interests.

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**3: Admission of the Public**

Most debates take place in public. This only changes when there is a need to consider certain issues, for instance, commercially sensitive information or details concerning an individual. You will be told at this point whether there are any items on the Agenda which are to be discussed in private.

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**4: Deputations and Petitions**

The committee will receive any petitions and hear any deputations from members of the public. A deputation is where up to five people can attend the meeting and make a presentation on some particular issue of concern. A member of the public can also hand in a petition at the meeting but that petition should relate to something on which the body has powers and responsibilities.

**“Please note that due to the numbers of deputations that have been received no more requests to speak at the meeting will be permitted. This decision has been made at the discretion of the Chair in order to ensure there is sufficient time available for the Committee to discuss its business as outlined in item 5 of the agenda.”**

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**5: Update on the response to the recommendations of the Calderdale and Kirklees Joint Health Scrutiny Committee (JHSC)**

9 - 42

The JHSC will consider a report from Calderdale and Greater Huddersfield Clinical Commissioning Groups (CCGs) and Calderdale and Huddersfield NHS Foundation Trust that provides additional information in relation to the JHSC's recommendations contained in its report 'Response to proposals for hospitals and community health services in Calderdale and Greater Huddersfield'.

Contact: Richard Dunne, Principal Governance and Democratic Engagement Officer – 01484 221000

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Contact Officer: Richard Dunne

## KIRKLEES COUNCIL

### CALDERDALE AND KIRKLEES JOINT HEALTH SCRUTINY COMMITTEE

Thursday 23rd February 2017

Present:

Councillor Andrew Marchington  
Councillor Elizabeth Smaje  
Councillor Julie Stewart-Turner  
Councillor Carole Pattison  
Councillor Adam Wilkinson - Calderdale Council  
Councillor Jane Scullion - Calderdale Council  
Councillor Marilyn Greenwood - Calderdale Council  
Councillor Chris Pearson - Calderdale Council

Apologies:

In attendance:

Anna Basford – Calderdale and Huddersfield NHS Foundation Trust (CHFT)  
Ian Currell – Greater Huddersfield Clinical Commissioning Group (CCG)  
Carol McKenna – Greater Huddersfield CCG  
Catherine Riley - CHFT  
Neil Smurthwaite - Calderdale CCG  
Richard Dunne – Principal Governance & Democratic Engagement Officer Kirklees Council  
Mike Lodge – Senior Scrutiny Support Officer Calderdale Council

Observers:

#### **1 Minutes of Previous Meeting**

That the minutes of the meeting held on 16 November 2016 be approved as a correct record.

#### **2 Interests**

Councillor Pearson declared a personal interest as the organisation he owns and is a director of contract with Calderdale Metropolitan Borough Council in relation to adult social care provision for individuals with learning and/or physical disabilities.

Councillor Wilkinson declared an 'other interest' on the basis that he had a share/interest in his father's pharmacy business.

**3 Admission of the Public**

That all items be considered in public.

**4 Deputations and Petitions**

The Committee received deputations from the following people regarding the proposals for the provision of hospital and community services in Calderdale and Greater Huddersfield:

Nicola Jowett (Hands of HRI Campaign Group), Aaron Lilley (Hands off HRI Youth Campaign Group), Cristina George (Hands off HRI Campaign Group), Jenny Shepherd (Calderdale and Kirklees 999 Call for the NHS), Paul Cooney (Huddersfield Keep our NHS Public), Martin Jones (Slaithwaite Health Centre SOS), Terry Hallworth ((Calderdale and Kirklees 999 Call for the NHS), Rosemary Hedges (Calderdale 38 Degrees Campaign Group), Jenny Shepherd on behalf of Christine Hyde (North Kirklees NHS Support Group) and Councillor Gemma Wilson, Lindley Ward

**5 Update on the reconciliation process and progress of the development of the Full Business Case**

Cllr Smaje stated that the Committee would like to thank Brenda Cook the Independent Facilitator for her report which was included in the Committee's agenda papers together with the CCG's report and invited committee members to put forward comments or questions about the reports.

Cllr Wilkinson stated that the CCGs report referenced six planned pieces of work and the risks to achieving the work within the anticipated timescale. Cllr Wilkinson highlighted the risk that related to the Trust and CCG's being dependent on securing additional capacity and questioned what this actually meant.

Ms Basford informed the Committee that there were elements of the Full Business Case (FBC) that would require technical input that was not currently available at CHFT. Ms Basford explained that the Trust had been in dialogue with NHS Improvement (NHSI) and NHS England (NHSE) who had indicated that they would be able to put the Trust in touch with the relevant expertise.

Ms Basford stated that the work on developing the FBC was progressing and that the Trust was on track to deliver a FBC by the end of June 2017.

In response to a committee question regarding the timescales for the other planned pieces of work Ms McKenna stated that the CCG's would be happy to proceed with the Independent Facilitators recommendation to hold a workshop by the end of March to clarify what information could be shared with the Committee including timelines.

Cllr Scullion questioned whether the Treasury's Five Case model that would provide the guidance for developing the FBC would contain sufficient enough information to address some of the Committee's recommendations.

Ms Basford stated that the FBC was a capital case that would set out the Trust's requirement for investment in the proposed hospital reconfiguration. Ms Basford added that the FBC's primary audience would be the Treasury and the Trust was required to follow the technical guidance outlined in the Five Case model.

Ms Basford explained that the Five Case model wouldn't answer all of the issues raised by the Committee's recommendation's as the majority of the work related to the FBC and would not be directly relevant to the recommendations.

Ms Basford informed the Committee that there was a commitment to address the Committee's recommendations. This would in part come from the FBC to address technical aspects such as eliminating the Trust's deficit and the broader elements of the recommendations would be addressed through the accompanying suite of documents.

Cllr Pattison questioned whether the plans to assure the more detailed proposal through the Yorkshire and Humber Clinical Senate and the requirement for the FBC to be signed off by the Treasury would happen before the Committee had been given an opportunity to assess the information or afterwards.

Ms Basford stated that the FBC would be submitted to the Treasury with a request for funding. Ms Basford explained that the Trust had always been clear that its preferred option would be to progress the proposals with treasury funding and the format for requesting the funds was through the submission of a FBC.

In response to a question regarding the certainty of meeting the end of June deadline Ms Basford stated that it was the Trust's intention to meet the deadline. Ms Basford explained that the June deadline wasn't the target date for presenting to treasury but the date by which the FBC would be signed off by the Trust's Board.

In response to a question on the deadline for sign off by the Clinical Senate Ms Basford stated that the Trust would revisit the clinical model although there wasn't an absolute requirement to obtain sign off by the Clinical Senate.

Ms Basford informed that Panel that the Trust was aware that assurance from the Clinical Senate was a key recommendation of the Committee. The Trust would therefore wish to have further dialogue with the Senate and provide additional clarification in order to help offer greater reassurance to the Committee.

Cllr Julie Stewart-Turner stated that she was surprised that the notes on the planned work including a statement that Primary Care was not within the scope of the consultation.

Cllr Julie Stewart-Turner stated that Primary Care had been referenced throughout the consultation and felt that Primary Care was a key dependency of the proposals and without the support of GP's Care Closer to Home could not be delivered.

Cllr Julie Stewart-Turner stated that Primary Care was a key concern of the Committee and would want to see the concerns addressed in the suite of documents that were being developed alongside the FBC.

Ms McKenna informed the Committee that there had been no specific proposals to change Primary Care in the model that the CCG's had consulted on. However the CCG's did recognise that Primary Care would have a crucial role in supporting the new model of care.

Ms McKenna explained that Primary Care Strategies had been developed and these would be discussed with scrutiny and the CCG's would fully expect to maintain an ongoing dialogue on the plans.

Cllr Marchington stated that early in the discussions on the proposals the Committee had been advised that there need to be a shift of staff working in the acute sector to primary care and it was concerning that this had not been further developed.

Cllr Marchington stated that the Committee would appreciate if the FBC could include looking at a work force strategy to include addressing the retention of staff in the acute sector that had key and transferable skills.

Ms McKenna informed the Committee that the CCG's would consider the Committee's comments regarding the workforce and would look to reflect this in the next stage of the planned work.

Cllr Marchington questioned why it wasn't possible to provide an analysis of absolute travel times.

Ms McKenna informed the Committee that the CCG's would be revisiting some of the work on travel times but because of the way the information was recorded it wasn't possible to provide absolute travel times.

Ms McKenna explained that she didn't have the full information on travel times to hand but would look at this again and provide a detailed explanation.

Cllr Marchington stated that from a public transport perspective it would also be useful to understand the journeys that people would have to make in order to get to the locations where their care would be provided.

Ms Riley informed the Committee that the Yorkshire Ambulance Service (YAS) didn't capture the information that would measure absolute travel times. Ms Riley explained that YAS captured the data which showed the time that the ambulance got to the incident because that was when the care of the patient started.

Cllr Smaje stated that the Committee would like to see the absolute travelling times and that YAS should be modelling overall travel times based on the proposed model.

Cllr Wilkinson stated that in the previous travel analysis it had showed the additional times that people were expected to travel and the Committee's point was that it



would not be possible to work out the additional times under the new model unless you knew what the absolute travel time was.

Cllr Greenwood stated that to have more confidence in the proposed reconfiguration the FBC would have to demonstrate more assurance to the Committee and members of the public.

Cllr Greenwood made reference to the planned work on benefits and outcomes and expressed a concern that social care services wouldn't be able to cope with the reductions in admissions in respect of frail elderly people living with disabilities.

Cllr Greenwood stated that the focus on early preventative measures did not take into consideration a generation that would not see the outcomes and the ever growing elderly population with life threatening chronic illness would impact on the system over the next 20 years.

Cllr Greenwood stated that preventive measures would not correct the system in the next three of four years and the current proposals did not take fully account the increased demand on the health and social care system.

Mr Currell informed the committee that the CCG's modelling work did take account of the increase demand from the growing elderly population and that it would be factored into the FBC and other planned work.

In response to a question on how this acknowledgement of the increased demand would provide assurance to the Committee Mr Currell explained that the next phase of the process would include working through the detail in order to provide that assurance.

Cllr Smaje highlighted the issue that had been raised by a deputation which had suggested that Sustainability and Transformation Plan (STP) Boards were able to overrule CCG's.

Ms McKenna outlined the approach and process that had been followed in developing the West Yorkshire STP and explained that although there wasn't a West Yorkshire STP Board from April 2017 the West Yorkshire CCG's would come together to form a joint committee but only to make decisions in those areas where CCG's governing bodies had given delegated authority to take a decision on a West Yorkshire basis.

Ms McKenna explained that the Joint Committee would not have the power to overrule CCG boards because the CCGs would remain the statutory and accountable organisations.

In response to a question on the timescales for obtaining the Clinical Senates views Ms Basford stated that there wasn't a definitive timescale arranged with the Senate but the Trust had been in dialogue through NHSE with a number of colleagues and clinical leads who were working on the clinical model and the Trust would be looking to schedule the work with the Senate.

In response to a question on the decision making processes that the Trust and CCG's would have to follow in developing the FBC and associated documentation Ms Basford stated that the FBC was a capital case and the document would be submitted to NHSI to seek support and subject to that support it would be presented to treasury.

Cllr Marchington highlighted a number of key areas from the Committee's recommendations and stated that it would be helpful for the Committee to have early sight of the planned work that was relevant to these areas of concern.

Cllr Smaje summarised the views of the Committee which included requiring the views of the Clinical Senate and the FBC and associated documentation by the end of June 2017 and that the Committee would continue to keep lines of communication open with the CCG's and the Trust.

**RESOLVED -**

- 1 That representatives from Greater Huddersfield Clinical Commissioning Group (CCG), Calderdale CCG and Calderdale and Huddersfield NHS Foundation Trust (CHFT) be thanked for attending the meeting.
- 2 That the CCG's and CHFT submit to the Committee the completed Full Business Case and associated documentation by the end of June 2017.
- 3 That a meeting of the Committee be arranged by the end of July 2017 to consider:
  - a. Whether the Committee's recommendations contained in its report 'Response to proposals for future arrangements for hospital and community health services in Calderdale and Greater Huddersfield' have been satisfactorily addressed.
  - b. Exercising the Committee's power of referral to the Secretary of State in accordance with the requirements of the regulations.

<b>KIRKLEES COUNCIL</b>			
<b>COUNCIL/CABINET/COMMITTEE MEETINGS ETC</b>			
<b>DECLARATION OF INTERESTS</b>			
<b>Name of Councillor</b>			
<b>Item in which you have an interest</b>	<b>Type of interest (eg a disclosable pecuniary interest or an "Other Interest")</b>	<b>Does the nature of the interest require you to withdraw from the meeting while the item in which you have an interest is under consideration? [Y/N]</b>	<b>Brief description of your interest</b>

Signed: ..... Dated: .....

## NOTES

### Disclosable Pecuniary Interests

If you have any of the following pecuniary interests, they are your disclosable pecuniary interests under the new national rules. Any reference to spouse or civil partner includes any person with whom you are living as husband or wife, or as if they were your civil partner.

Any employment, office, trade, profession or vocation carried on for profit or gain, which you, or your spouse or civil partner, undertakes.

Any payment or provision of any other financial benefit (other than from your council or authority) made or provided within the relevant period in respect of any expenses incurred by you in carrying out duties as a member, or towards your election expenses.

Any contract which is made between you, or your spouse or your civil partner (or a body in which you, or your spouse or your civil partner, has a beneficial interest) and your council or authority -

- under which goods or services are to be provided or works are to be executed; and
- which has not been fully discharged.

Any beneficial interest in land which you, or your spouse or your civil partner, have and which is within the area of your council or authority.

Any licence (alone or jointly with others) which you, or your spouse or your civil partner, holds to occupy land in the area of your council or authority for a month or longer.

Any tenancy where (to your knowledge) - the landlord is your council or authority; and the tenant is a body in which you, or your spouse or your civil partner, has a beneficial interest.

Any beneficial interest which you, or your spouse or your civil partner has in securities of a body where -

- (a) that body (to your knowledge) has a place of business or land in the area of your council or authority; and
- (b) either -

the total nominal value of the securities exceeds £25,000 or one hundredth of the total issued share capital of that body; or

if the share capital of that body is of more than one class, the total nominal value of the shares of any one class in which you, or your spouse or your civil partner, has a beneficial interest exceeds one hundredth of the total issued share capital of that class.



**Name of meeting: Calderdale and Kirklees Joint Health Scrutiny Committee (JHSC)**

**Date: 21 July 2017**

**Title of report: Update on the Response to the recommendations of the Calderdale and Kirklees JHSC.**

**Purpose of report:**

To provide members of the Calderdale and Kirklees JHSC with an update on the work that has been developed by Calderdale Clinical Commissioning Group (CCG), Greater Huddersfield CCG and Calderdale and Huddersfield NHS Foundation Trust (CHFT) to address the JHSC's recommendations contained in its report 'Response to proposals for future arrangements for hospital and community health services in Calderdale and Greater Huddersfield'.

Key Decision - Is it likely to result in spending or saving £250k or more, or to have a significant effect on two or more electoral wards?	N/A – Report produced for information only
Key Decision - Is it in the <a href="#">Council's Forward Plan (key decisions and private reports?)</a>	No
The Decision - Is it eligible for call in by Scrutiny?	No
Date signed off by <u>Director</u> & name  Is it also signed off by the Assistant Director for Financial Management, IT, Risk and Performance?  Is it also signed off by the Assistant Director (Legal Governance and Monitoring)?	N/A – The report has been produced to provide the context and background to support the Committee discussions.
Cabinet member <a href="#">portfolio</a>	Cllr Viv Kendrick and Cllr Cathy Scott Adults and Public Health

**Electoral wards affected: All**

**Ward councillors consulted: N/A**

**Public or private: Public**

## 1. **Summary**

- 1.1 At its meeting on the 23 February 2017 the Calderdale and Kirklees JHSC considered: the outcomes of the consensus building session with the CCGs and CHFT; and a report produced by the CCGs and CHFT which provided committee members with an overview of the planned work to develop the Full Business Case (FBC) and associated information.
- 1.2 The report stated that the CCGs and CHFT anticipated that the timescale for completion of the FBC and associated information would be the end of June 2017. The report included a table that set out the relationship between the planned pieces of work and the JHSC's recommendations and is attached to this report. For reference a summary of the JHSC's recommendations are also attached
- 1.3 The resolution agreed at the February meeting included the following actions:
1. That the CCGs and CHFT submit to the Committee the completed Full Business Case and associated documentation by the end of June 2017.
  2. That a meeting of the Committee be arranged by the end of July 2017 to consider:
    - a) Whether the Committee's recommendations contained in its report 'Response to proposals for future arrangements for hospital and community health services in Calderdale and Greater Huddersfield' have been satisfactorily addressed.
    - b) Exercising the Committee's power of referral to the Secretary of State in accordance with the requirements of the regulations.
- 1.4 Since the February meeting the JHSC has been made aware that the FBC that is being developed by CHFT is predominantly a document that outlines the case for capital funding. The JHSC has also been informed that because the FBC will contain commercially sensitive information the whole document will not be immediately available to the JHSC or public. The associated documentation that is being produced by the CCGs continues to be developed.
- 1.5 The CCGs and CHFT have committed to provide relevant information which will include extracts from the FBC and associated documentation to address the JHSC's recommendations and is contained in the attached report.
- 1.6 Representatives from the CCGs and CHFT will be in attendance to assist the JHSC should members require clarification on the information that has been submitted.

## 2. **Information required to take a decision**

N/A

## 3. **Implications for the Council**

N/A

## 4. **Consultees and their opinions**

N/A

## 5. **Next steps**

That the JHSC takes account of the information presented and considers the next steps it wishes to take.

6. **Officer recommendations and reasons**

That the JHSC:

1. Considers and determines whether the information submitted by the CCGs and CHFT satisfactorily addresses the JHSC's recommendations contained in its report 'Response to proposals for future arrangements for hospital and community health services in Calderdale and Greater Huddersfield'.
2. If the JHSC determines it is not satisfied that its recommendations have been fully addressed, then consideration be given to exercising the JHSC's power of referral to the Secretary of State for Health, which in accordance with the requirements of the regulation must include consideration of the evidence and whether the grounds for referral are satisfied
3. That the JHSC makes a determination as to the most appropriate course of action following consideration of the above.

7. **Cabinet portfolio holder's recommendations**

N/A

8. **Contact officer**

Richard Dunne, Principal Governance and Democratic Engagement Officer, Tel: 01484 221000 Email: [richard.dunne@kirklees.gov.uk](mailto:richard.dunne@kirklees.gov.uk)

9. **Background Papers and History of Decisions**

[Response to proposals for future arrangements for hospital and community health services in Calderdale and Greater Huddersfield](#)

10. **Service Director responsible**

Julie Muscroft, Legal, Governance & Monitoring

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JHOSC No	Planned Work	Notes
1	<p><b>Benefits and Outcomes:</b> Refresh of the Benefits and Outcomes in line with any updated clinical standards and any changes to the proposed model.                      Further review by the Clinical Senate to provide assurance.                      Development of supporting metrics and indicators in line with expected benefits and outcomes and the findings from the updated QIA.</p> <hr/> <p><b>Integrated Quality Impact Assessment:</b> The Integrated Quality Impact Assessment will consider the implications of service change across Hospital and community as a consequence of proposed service change</p>	<p>We expect a positive impact on mortality rates.                      We are unable to provide an explicit target to reduce mortality</p> <p>The development of clear targets to be included in contracts will form part of the subsequent contract negotiations.</p> <p>The Health and Wellbeing objectives for the place of Calderdale include:</p> <ul style="list-style-type: none"> <li>• 10% fall in mortality from causes considered preventable by 2020</li> <li>• Increase number of physically active adults by 10 % by 2020 equal to over 9000 people being more active.</li> <li>• Reduce the health inequalities gap by focussing action with vulnerable communities such as for people with severe and enduring mental health needs. Right Care data suggests we can save 43 lives by working together on this. National benchmarks suggest we can add 10-15 years to the lives of people with long term mental health needs. Our integrated locality model of care will support achievement (under 75 excess mortality indicator).</li> </ul> <p>The Kirklees Health and Wellbeing Strategy is focussed on achieving shared outcomes on Economy, Health and Wellbeing. It identifies system change priorities which feed into commissioning and service planning. Specific measures to demonstrate outcomes and benefits will be developed for each system change priority.</p> <p>Right Care, Right Time, Right Place is an important component of both the Calderdale STP and the Kirklees STP, and as such its implementation will contribute to</p>

JHOSC No	Planned Work	Notes
		the delivery of the Calderdale HWB objectives and the Kirklees HWB system change priorities.
2	Whole system approach – Partnership working across the whole of the Health and Social Care systems is undertaken through the work with the Calderdale and Kirklees Health and Wellbeing Boards and the supporting work related to the Better Care Fund.to support the changes is undertaken through the Better Care Fund	
3	<b>Full Business Case:</b> The workforce strategy will be developed as part of the strategic case. The outline workforce model proposed in the CHFT 5YR Plan will receive a full review. The specific detail of the hospital workforce model will be part of a longer term process. This will take into account potential service changes in hospital delivery models across WYAAT and horizon scanning of likely changes in workforce supply and demand. It will also take into account the workforce model for the Urgent care Centres.	
4,5	<b>Full Business Case:</b> In the Financial Case the trust will undertake an assessment of affordability. The Trust will set out the capital and revenue requirement for the proposal over the expected life span of the service, together with an assessment of how implementation of the preferred option will impact upon the Trust’s balance sheet and the income and expenditure account. This will build on and update the work previously undertaken in the CHFT 5YR PLAN with the aim of further improving reduction in the Trust’s underlying deficit and the return on investment.	
6,7, 17,18	<b>Activity Modelling – Community:</b> The work to develop the activity and capacity modelling for the hospital sites would be informed by this work which would provide clarity on how capacity will be provided in community and primary care to support the reduction in bed numbers – including the approach to improving efficiencies in bed occupancy and assumptions used in modelling community care- and the phasing necessary to maintain system balance across community and hospital services. The 111 service will be developed in tandem with the proposed changes to community as the revised pathways they can refer into become clearer. This would be updated further as a greater understanding of the changes to hospital services and their timing is developed. For example the ability to make GP appointments at UCCs..	Primary Care was not within the scope of the consultation.
8	The provision of Primary Care was not within the scope of the consultation.	Both CCGs have developed their Strategies for Primary Care. These have been developed with the full involvement of the respective LMCs and the

JHOSC No	Planned Work	Notes
		CCGs’ member practices. Both recognise the need to improve access to high quality Primary Care. The Scrutiny of these plans will be undertaken by the Calderdale and Kirklees Scrutiny committees.
9	<b>Full Business Case:</b> Public Confidence – In the Strategic Case, the proposed service model will be reviewed and described. It is unlikely to fundamentally change. The rationale for a planned and unplanned site is consistent with Keogh. The review will identify if any potential service changes in hospital delivery models across WYAAT.	For example, there is currently a West Yorkshire wide engagement on the provision of Hyper Acute Stroke care. Should this proceed to consultation and then to implementation, any implications for this system would need to be taken into account
10	Yorkshire and Humber Clinical Senate review. This will be undertaken following the development of further detail as described above.	
11	Not for the NHS to progress	
12,13	<b>Refresh of Public and Ambulance Travel Analyses:</b> The Public and Ambulance Travel analysis will be refreshed. Those who are currently able to transport themselves to hospital are unlikely to require emergency care and will continue to receive their care at the Urgent Care centre at the location where they currently attend.	The specification and agreement of additional YAS resource would be undertaken as part of existing commissioning arrangements. It is not possible to model the impact of other changes to community that are proposed or any efficiencies resulting from the A629 improvements. The provision of existing Ambulance services was not within the scope of the consultation. It is not possible to provide absolute travel times.
14	Not for the NHS to Progress	
15, 16	<b>Full Business Case:</b> More work is being undertaken to review the hospital capacity requirements on the proposed unplanned site at CRH and how this can be delivered. This will include assessment of car parking capacity and effective access for emergency vehicles. This will build on the work previously undertaken in the Trust’s 5 year strategic plan.	
17	See information above. Activity and Capacity modelling will be revisited.	
18	<b>Full Business Case:</b> See information above. The further development of the clinical model will identify appropriate pathways which would allow the processes and protocols to be updated	
19	Local Services – No further information to add	

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## **CALDERDALE AND KIRKLEES JOINT HEALTH SCRUTINY COMMITTEE**

### **RECOMMENDATIONS ON PROPOSALS FOR FUTURE ARRANGEMENTS FOR HOSPITAL AND COMMUNITY HEALTH SERVICES IN CALDERDALE AND GREATER HUDDERSFIELD**

#### **Improving Outcomes**

##### **Recommendation 1**

The prime objective of Right Care Right Time Right Place should be to improve health outcomes for the people of Calderdale and Greater Huddersfield. The Committee accepts that the status quo is not an option and wishes to see improvements in the quality of services provided through hospitals, care closer to home provision and primary care.

Evidence of quality improvement will be demonstrated through clear targets that will be included in contracts between health commissioners and providers that will set out in a clear and transparent way the expectation that there will be better outcomes for people who use services. This should include an explicit target to reduce mortality rates in hospitals. The Committee would wish to see these targets and details of how they will be measured.

#### **A Whole System Approach**

##### **Recommendation 2**

Any changes in hospital services should be in partnership with the whole of the health and social care systems across Calderdale and Greater Huddersfield in order to provide better outcomes in the future. There should be a whole system approach rather than making changes to one part of the system which may detrimentally affect others.

The Committee wants to see that better outcomes are embedded across the whole health and social care system and be satisfied that there is sufficient capacity to serve the diverse populations and address the health inequalities that exist in both areas.

The Committee therefore recommends that the CCGs, in conjunction with key health and social care partners including public health, develop strategies in Calderdale and Kirklees that will strengthen and improve partnership working and support the changes that will be required to improve the health outcomes of our local populations.

## **Workforce**

### **Recommendation 3**

The Committee accepts that improvements and changes to services cannot be made without addressing the workforce challenges, but is not convinced that sufficient attention was given to this issue or that the plans sufficiently take into account the wider challenges that the NHS faces particularly in recruiting specialist staff.

The Committee and the public will only be more confident in these proposals if a clear and costed Workforce Strategy, with timescales, is produced by CHFT and agreed with the CCGs, which demonstrates how shortages of clinical and other staff will be addressed.

In addition the Committee would wish to see consideration given to how increased partnership working across neighbouring NHS Trusts might contribute to addressing workforce issues to develop a financially sustainable model for the future.

## **Finance**

### **Recommendation 4**

The Committee notes that the proposals do not fully eliminate the financial deficit and is aware of the national and regional context to generate further efficiency savings. The Committee is extremely disappointed that the CCGs have not taken this opportunity to produce proposals that fully addresses the revenue deficit.

The Committee is concerned that if CHFT remains in deficit, then local services will not be sustainable and further reconfigurations may result.

The Committee wishes to see a financial plan produced by the CCGs and CHFT that addresses the financial deficit and clearly identifies how local services will be delivered in a safe and sustainable way.

### **Recommendation 5**

The proposals from the CCGs are dependent on capital funding to build a new hospital in Huddersfield and to enhance Calderdale Royal Hospital and the Committee would wish to see full assurance that this proposal will be fully financed without increasing the Trust's deficit.

Should this assurance not be forthcoming the CCGs must inform the public and the Committee how it intends to proceed.

## **Reducing Demand**

The Committee feels that the plans to reduce demand were inconsistent and were not supported by any detailed plans. The following recommendations address the different aspects of the proposals relating to the reduction of demand in the system.

### **Recommendation 6**

The Committee welcomes the target to reduce unplanned hospital admissions by 6% per annum which is ambitious and challenging.

To help support the reductions in unplanned admissions the CCGs and CHFT must develop a plan that has clear targets to reduce attendances at both Accident and Emergency Units and outlines what actions and measures will be introduced to ensure that: the 111 service is effective at directing patients to the right place; there is improved access to GPs; and that the Care Closer to Home programmes provide earlier interventions that will reduce the numbers of those patients with long term conditions needing to attend A&E.

### **Recommendation 7**

The Committee supports the proposals to enhance Care Closer to Home services. Improvements to these services are a matter of priority regardless of any proposals to reconfigure hospital services. However, the CCGs have not demonstrated that there will be sufficient capacity in the Care Closer to Home programmes and Primary Care to reduce demand on hospital services.

CCGs must provide full assurance to the Committee and the public on how they will develop this capacity to the scale that will be required and how this will be measured.

### **Recommendation 8**

The Committee believes that GPs and other primary care stakeholders have a key role to play in any developments in health services and is disappointed that, in the Committee's view, most GPs have not been sufficiently involved or engaged in developing these proposals.

The Committee recommends that the CCGs further develop their Primary Care Strategies with the full engagement of GPs and other key primary care services in order to improve access to high quality primary care and help manage and reduce the demand on hospital services.

## **Public Confidence**

### **Recommendation 9**

The Committee believes that the CCGs have not sufficiently explained the model of an Urgent Care Centre to the public and how it will be resourced and this has contributed to a lack of public confidence in the proposals.

The Committee recommends that before a decision on hospital and community health services is taken the CCGs must develop a detailed description of the model and how it will be resourced.

### **Recommendation 10**

The Committee noted that when the Yorkshire and Humber Clinical Senate considered the proposals they concluded that 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 recommends that before a decision on hospital and community health services is taken the CCGs should request the Yorkshire and Humber Clinical Senate to reappraise the proposed model of care and seek assurance that there is sufficient enough detail in the proposals to satisfy the Senate that the new model of care will deliver the required standards of care.

## **Transport**

The Committee has a responsibility to reflect the strongly expressed concerns of the public about the potential transport issues following any changes and the following recommendations are focussed on these issues.

### **Recommendation 11**

The CCGs, Calderdale Council, Kirklees Council and 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. This should include introducing a “loop” that will not materially impact on the journey times to some existing services that includes at least one of the hospitals on their route.

### **Recommendation 12**

The CCGs must specify 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. This should include: where that resource will be found; a clear plan to ensure that the Yorkshire Ambulance Service meets its targets; and what measures will be introduced to support a significant improvement in service.



### **Recommendation 13**

In order to fully assess the impact of the proposals the CCGs should commission an up to date Travel Analysis and Journey Time Assessment Study that details the absolute travel times and distances to both hospitals. The study should take account of: patients and visitors using their own private vehicles and public transport; and residents that live at the furthest outlying areas of Calderdale and Greater Huddersfield.

### **Recommendation 14**

To support improved access to both hospital sites, regardless of any hospital implementation, the Committee would wish to see Calderdale Council and Kirklees Council working with the West Yorkshire Combined Authority to make improvements to the A629 a high priority in their road improvement programmes.

### **Estate**

### **Recommendation 15**

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 100,000 people every year. The Committee require evidence that the building can be improved so that this substantial increase in usage could be achieved without detriment to the quality of service.

### **Recommendation 16**

To support the increased demand at Calderdale Royal Hospital , CHFT must prepare a clear costed plan that will ensure: that there is sufficient parking available at Calderdale Royal Hospital; accessibility for the potential increase in the numbers of emergency vehicles is fully addressed; and impact on the surrounding neighbourhood is minimised.

### **Recommendation 17**

To address the concerns of the Committee that the proposed numbers of inpatient beds will not be sufficient to meet demand the CCGs must develop a plan that demonstrates how capacity in community services will be provided to support the reduction in bed numbers. This must include details of the approach that will be taken to improving efficiencies in bed occupancy and the modelling and assumptions used in developing alternative provision in a community setting.

## **Children**

### **Recommendation 18**

The new model of care will include a focus on encouraging parents and carers with a sick child to contact NHS 111 for advice.

To ensure that the pathways of care for sick children are clearly understood by the public the CCGs should develop a framework that outlines the processes and protocols for dealing with a sick young child. This should include details of the resources that will be made available to support the quick and easy access to appropriate clinical advice.

## **Local Services**

### **Recommendation 19**

The proposals of NHS providers in 2014 included specialist community centres at Todmorden Health Centre and Holme Valley Memorial Hospital, which the Committee considers would help: manage demand in the hospital setting; contribute to the development of the Care of Closer to Home programmes; and reduce travel time for some patients.

The Committee recommends that the CCGs consider developing plans to maximise the use of these facilities together with other local facilities. This should include a focus on the provision of integrated and specialist services.

**Right Care, Right Time, Right Place Programme update**

**1.0 BACKGROUND**

In October, 2016, The Governing Bodies of both Calderdale CCG and Greater Huddersfield CCG noted that the consultation in relation to the proposed future arrangements for hospital and community health services had finished and that the findings from consultation and the subsequent deliberation provided sufficient grounds to proceed to explore implementation in the Full Business Case (FBC).

At its meeting on 16<sup>th</sup> November, the Calderdale and Kirklees Joint Health Overview and Scrutiny Committee (JHOSC) met to formally consider the CCG's response to the recommendations which they submitted in response to the RCRTTRP consultation. Broadly speaking, the CCGs accepted each of the recommendations that were directly within the scope of responsibility of the CCGs, save for two recommendations which they were not able to accept for which a clear rationale was provided. The CCGs' commitment was to pick up each of the recommendations from JHOSC in the next stage of the process.

The Committee determined that they were not satisfied with the CCGs' response and agreed to put in place arrangements for the committee and the CCGs to reach agreement; and also that if agreement could not be reached within an agreed timescale then it would consider other steps.

At its meeting on 23<sup>rd</sup> February JHOSC decided that the Committee would meet at the end of July to consider:

- a) Whether the Committee's recommendations contained in its report 'Response to proposals for future arrangements for hospitals and community health services in Calderdale and Greater Huddersfield ' have been satisfactorily addressed.
- b) Exercising the Committee's power of referral to the Secretary of State in accordance with the requirements of the regulations.

**2.0 INTRODUCTION**

Calderdale and Huddersfield NHS Foundation Trust (CHFT) together with Calderdale and Greater Huddersfield Clinical Commissioning Groups (CCGs) continue to progress the Full Business Case (FBC) and associated documents for the changes on which we consulted.

The Trust has been developing the Full Business Case and this work will shortly be completed.

This draft Full Business Case will then go through the Trust's governance and sign off processes during July prior to agreeing the formal process of submission of the document with NHS Improvement.

Following conclusion of CHFT'S Board Sign off of the document, the CCGs' Governing Bodies will, separately, consider the FBC together with the associated documents.

The Governing Bodies will be receiving the FBC in the context of three considerations:

**REPORT TO THE JOINT CALDERDALE AND KIRKLEES HEALTH OVERVIEW AND SCRUTINY PANEL  
JULY, 2017**

- Is the FBC in line with the model on which we consulted?
- Is the FBC affordable to Commissioners?
- Does the FBC improve the financial sustainability of the system?

### **3.0 UPDATED RESPONSE**

The purpose of this report is to provide the Committee with additional information, in relation to those recommendations for which the CCGs and CHFT have agreed that they will respond, in order to assist it in determining its next steps.

Recommendations which were directed at other organisations are not addressed. Information that has been previously provided to the Committee is not repeated.

To aid clarity, the additional information that is being provided has been separated into the CCGs' response (Appendix A) and CHFT's response (Appendix B).

### **4.0 RECOMMENDATIONS**

The committee is asked to:

- Consider whether the additional information contained with the report provides sufficient information to satisfactorily address its recommendations.

**Anna Basford, Director of Transformation and Partnerships, NHS Calderdale and Huddersfield Foundation Trust**

**Jen Mulcahy, Programme Manager, NHS Calderdale CCG and NHS Greater Huddersfield CCG**

**13<sup>th</sup> July, 2017**

### **APPENDICES**

**Appendix A – Additional information from CCGs in relation to Joint Scrutiny's recommendations.**

**Appendix B - Additional information from CHFT in relation to Joint Scrutiny's recommendations**

**Calderdale CCG's and Greater Huddersfield CCG's Response - July 2017**

**3.1 Recommendation 1 – Improving Outcomes**

*The prime objective of Right Care Right Time Right Place should be to improve health outcomes for the people of Calderdale and Greater Huddersfield. The Committee accepts that the status quo is not an option and wishes to see improvements in the quality of services provided through hospitals, care closer to home provision and primary care.*

*Evidence of quality improvement will be demonstrated through clear targets that will be included in contracts between health commissioners and providers that will set out in a clear and transparent way the expectation that there will be better outcomes for people who use services. This should include an explicit target to reduce mortality rates in hospitals. The Committee would wish to see these targets and details of how they will be measured.*

**CCGs' additional information**

**Quality and Safety Case for Change**

The Quality and Safety Case for Change, originally produced prior to consultation, and published as part of the Pre Consultation Business Case (PCBC), has been refreshed and submitted to both CCGs' Quality Committees. The refresh has taken account of material changes since the previous one was approved in October, 2015. This includes:

- The current position in relation to CHFT's performance
- Clinical Consensus on the provision of Paediatric Urgent Care;
- Updates to the in-hospital clinical standards; and
- The clinical Case for Change that is being progressed as part of the FBC

As part of the refresh of the quality and safety case for change, there has been a review of the Summarised Benefits and Outcomes that supported the previous case. This has not resulted in any changes.

**Quality Impact Assessment**

The Programme QIA produced by Ernst and Young on behalf of CHFT which was included in the PCBC is also being refreshed. The refresh is being undertaken by CHFT and as part of the update it is also being converted to the standard CHFT format.

**Quality Assurance Process: from Quality impact assessment to Implementation**

Following the refresh of the Programme QIA, the CCGs' Quality Committees have approved the introduction of a continuing and separate quality assurance process in order to ensure that as the planned service line changes are introduced there is a full understanding of:

- their impact in relation to patient safety and service quality;
- their alignment with the overall Programme QIA;
- their contribution to the overall benefits and outcomes as identified in the Quality and Safety Case for Change; and

- their compliance with the clinical model and agreed standards.

The programme will adopt the 'star chamber process' as detailed in the National Quality Board report 'Quality Impact assess Provider Cost Improvements plans' March 2013 to take forward plans into implementation. This is a formal process developed by the National Quality Board to analyse the potential risks and consequences of service transformation and transition. The programme will refer to this as the Quality and Safety Assurance panel.

The aim of the Panel will be to:

- Ensure the impact of the proposed service line changes is fully understood.
- Confirm that there would be no negative impact quality of care
- Identify any actions, including the implications that the decision as to whether or not to proceed could have on the overall programme
- Make recommendations to the respective Governing Bodies / Trust Board

The Panel would be presented with a range of information including, but not limited to:

- Capacity including the demand, activity and occupancy assumptions and trajectories set out in the original Full Business Case (FBC) and performance against these.
- The clinical model and evidence of the interdependencies between schemes
- Evidence to support compliance with agreed standards, metrics, and outcomes as described in the FBC.
- The findings of the QIA process

### **3.2 Recommendation 2 – A Whole System Approach**

*Any changes in hospital services should be in partnership with the whole of the health and social care systems across Calderdale and Greater Huddersfield in order to provide better outcomes in the future. There should be a whole system approach rather than making changes to one part of the system which may detrimentally affect others.*

*The Committee wants to see that better outcomes are embedded across the whole health and social care system and be satisfied that there is sufficient capacity to serve the diverse populations and address the health inequalities that exist in both areas.*

*The Committee therefore recommends that the CCGs, in conjunction with key health and social care partners including public health, develop strategies in Calderdale and Kirklees that will strengthen and improve partnership working and support the changes that will be required to improve the health outcomes of our local populations.*

#### **CCGs' additional information**

Partnership working across the whole of the Health and Social Care systems continues to be undertaken through the work with the Calderdale and Kirklees Health and Wellbeing Boards and the supporting work related to the Better Care Fund to support the changes is undertaken through the Better Care Fund.

### 3.3 Recommendation 3 – Workforce

*The Committee accepts that improvements and changes to services cannot be made without addressing the workforce challenges, but is not convinced that sufficient attention was given to this issue or that the plans sufficiently take into account the wider challenges that the NHS faces particularly in recruiting specialist staff.*

*The Committee and the public will only be more confident in these proposals if a clear and costed Workforce Strategy, with timescales, is produced by CHFT and agreed with the CCGs, which demonstrates how shortages of clinical and other staff will be addressed.*

*In addition the Committee would wish to see consideration given to how increased partnership working across neighbouring NHS Trusts might contribute to addressing workforce issues to develop a financially sustainable model for the future.*

**CHFT's additional information is in Appendix B**

### 3.4 Recommendation 4 Finance

*The Committee notes that the proposals do not fully eliminate the financial deficit and is aware of the national and regional context to generate further efficiency savings. The Committee is extremely disappointed that the CCGs have not taken this opportunity to produce proposals that fully addresses the revenue deficit.*

*The Committee is concerned that if CHFT remains in deficit, then local services will not be sustainable and further reconfigurations may result.*

*The Committee wishes to see a financial plan produced by the CCGs and CHFT that addresses the financial deficit and clearly identifies how local services will be delivered in a safe and sustainable way.*

#### **CCGs' additional information**

Should the FBC receive the support of CHFT's Board, the CCGs' Governing Bodies will, separately, consider the FBC together with the associated documents.

The Governing Bodies will be receiving the FBC in the context of three considerations:

- Is the FBC in line with the model on which we consulted?
- Is the FBC affordable to Commissioners?
- Does the FBC improve the financial sustainability of the system?

CCG support for the submission of CHFT's business case will only be forthcoming if the CCGs are persuaded that the FBC forms a part of a coherent and jointly owned strategy to deliver system financial balance within an appropriate timescale.

**CHFT's additional information is in Appendix B**

### 3.5 Recommendation 5 Finance

*The proposals from the CCGs are dependent on capital funding to build a new hospital in Huddersfield and to enhance Calderdale Royal Hospital and the Committee would wish to see full assurance that this proposal will be fully financed without increasing the Trust's deficit.*

*Should this assurance not be forthcoming the CCGs must inform the public and the Committee how it intends to proceed.*

### CHFT's additional information in Appendix B

### 3.6 Recommendation 6 – Reducing Demand

*The Committee welcomes the target to reduce unplanned hospital admissions by 6% per annum which is ambitious and challenging.*

*To help support the reductions in unplanned admissions the CCGs and CHFT must develop a plan that has clear targets to reduce attendances at both Accident and Emergency Units and outlines what actions and measures will be introduced to ensure that: the 111 service is effective at directing patients to the right place; there is improved access to GPs; and that the Care Closer to Home programmes provide earlier interventions that will reduce the numbers of those patients with long term conditions needing to attend A&E.*

### CCGs' additional information

The proposed changes to both hospital and community services are inextricably linked. The reduction in demand on hospital services, is delivered through prevention of ill health and the better management of Long Term Conditions and Frailty through CC2H and the associated increase in the capacity of community services. In recognition of this, Scrutiny's Recommendation 6 and Recommendation 7 have been dealt with jointly.

### 3.7 Recommendation 7 – Reducing Demand

*The Committee supports the proposals to enhance Care Closer to Home services. Improvements to these services are a matter of priority regardless of any proposals to reconfigure hospital services. However, the CCGs have not demonstrated that there will be sufficient capacity in the Care Closer to Home programmes and Primary Care to reduce demand on hospital services.*

*CCGs must provide full assurance to the Committee and the public on how they will develop this capacity to the scale that will be required and how this will be measured.*

### CCGs' additional information

Prior to the decision to proceed to consultation, the CCGs were required to demonstrate to NHS England that the proposals had met their four formal public consultation tests. The information to support this assessment was included in the Pre- Consultation Business Case. From 1 April, 2017, local NHS organisations will have to show that significant hospital bed closures subject to the current formal public consultation tests can meet one of three new conditions before NHS England will approve them to go ahead:



1. Demonstrate that sufficient alternative provision, such as increased GP or community services, is being put in place alongside or ahead of bed closures, and that the new workforce will be there to deliver it; and/or
2. Show that specific new treatments or therapies, such as new anti-coagulation drugs used to treat strokes, will reduce specific categories of admissions; or
3. Where a hospital has been using beds less efficiently than the national average, that it has a credible plan to improve performance without affecting patient care (for example in line with the Getting it Right First Time programme)

The CCGs recognise that this test applies to the decision to proceed to consultation, but have chosen to apply it at this stage in recognition of the relevance to the proposed changes.

In relation to condition one, the CCGs' have undertaken an assessment of their planned work in Community to identify the predicted movement of activity from hospital to community. This Community activity modelling work will identify the changes in activity to deliver reduced unplanned hospital admissions by 18% over five years.

The CCGs have engaged the NHS Transformation Unit to provide assurance of this work. Their work will consider 5 questions

**Question 1** - Given the health system current baseline position and the current evidence available in the UK and internationally, is the range of proposed secondary care activity reduction targets (in-patient admissions) over a five year period a realistic assumption or an aspirational target.

**Question 2** - If the scale of secondary care activity change is considered aspirational in this area, to what extent are the proposed changes in line with the commissioning of emerging new care models across the whole system and in particular urgent care models.

**Question 3** – To what extent do the current plans and proposed change interventions focus on the right areas to deliver the scale of change expected **and** do the two CCGs have the appropriate commissioning and contracting approaches to deliver this change.

**Question 4** – Is the approach to delivery of the proposed commissioning changes in line with best evidence available or, considering UK and International evidence on the key enablers that might improve the impact of the plans, are there areas of the approach that have significant gaps or could be developed further.

**Question 5** – What are the key recommendations on what additional focus or work is required across the system to improve the plans of the two CCG's.

The final report from the Transformation has not yet been produced, however a draft report has been received and the draft key findings are:

- To achieve 18% over 5 years would require an improvement of 3.5% pa over 5 years
- This is a realistic assumption and is potentially achievable. However, few UK Health Systems have achieved this and it would require the CCGs to achieve the best in Class Upper Quartile position.
- The CCGs' proposed schemes are aligned to the approaches being pursued in many other health communities and international evidence.

- There are too many individual schemes and there would be benefit in joining up some schemes; the balance between schemes which improve planned care and those which improve unplanned care, needs to be adjusted so that more emphasis is placed on schemes which improve unplanned care. Greater alignment of contract levers would support delivery of the changes.
- They identify a number of risks in relation to the CCGs' proposed changes: As identified above, few systems have achieved 18% over 5 years; some of the targets in the schemes would require performance above the CCGs' top five peers; and the CCGs' achievement in 2016/17 was a reduction of 2% in non-elective admissions.

In relation to condition two of the NHS Test, the CCGs' are progressing a number of schemes which could impact on admissions as part of their continuing work in relation to medicines management, but at this stage it is not possible to quantify their impact in either numbers or specific categories of admissions.

In relation to condition three of the NHS Test, the approach to more efficient use of beds is outlined in the additional information provided in relation to Recommendation 17.

Recommendation 6 also makes specific reference to the 111 Service and Primary Care

The 111 service will be developed in tandem with the proposed changes to community as the revised pathways they can refer into become clearer. This would be updated further as a greater understanding of the changes to hospital services and their timing is developed. For example, the ability to make GP appointments through the 111 service.

The Primary Care strategies and associated plans to provide improved access to GPs are subject to Scrutiny by the respective Calderdale and Kirklees Scrutiny committees.

### **3.8 Recommendation 8 – Reducing Demand**

*The Committee believes that GPs and other primary care stakeholders have a key role to play in any developments in health services and is disappointed that, in the Committee's view, most GPs have not been sufficiently involved or engaged in developing these proposals.*

*The Committee recommends that the CCGs further develop their Primary Care Strategies with the full engagement of GPs and other key primary care services in order to improve access to high quality primary care and help manage and reduce the demand on hospital services.*

#### **CCGs' additional information**

The provision of Primary Care was not within the scope of the consultation.

Both CCGs have developed their Strategies for Primary Care. These have been developed with the full involvement of the respective LMCs and the CCGs' member practices. Both recognise the need to improve access to high quality Primary Care. The Scrutiny of these plans will be undertaken by the Calderdale and Kirklees Scrutiny committees.

### 3.9 Recommendation 9 – Public Confidence

*The Committee believes that the CCGs have not sufficiently explained the model of an Urgent Care Centre to the public and how it will be resourced and this has contributed to a lack of public confidence in the proposals.*

*The Committee recommends that before a decision on hospital and community health services is taken the CCGs must develop a detailed description of the model and how it will be resourced.*

#### CCGs' additional information

##### Urgent Care Centre Principles

There needs to be extensive / comprehensive marketing campaign telling people what the "offer" is at each site with clear examples of types of conditions that should or should not be taken to a UCC

Patients should be encouraged to phone 111 for any urgent needs to obtain the best advice about where they should attend (this may not be a hospital site at all). There will be direct booking of appointments in the UCC by 111

The urgent care offer at Calderdale and Huddersfield UCCs must be essentially the same

The UCC will provide clinical triage for all "walk-in" patients and redirection if appropriate.

Patients only access the Emergency department via clinical triage, via ambulance (triaged) or referred from either UCC. Patients with life-threatening illness and injury will be taken by ambulance directly to the Emergency Department (or to a specialist emergency / trauma centre).

The GP OOH service will be co-located with the UCC on both sites and will run 24/7

##### Urgent Care Centre Staffing

The UCC is medically led by a Doctor who is a "generalist" i.e. qualified to deal with the full spectrum of urgent care illness / injury for adults and children. There will be a 24/7 rota where this Doctor is clinically responsible for patients within the UCC although may not physically be in the dept. 24/7.

Diagnostic facilities (including Point of Care and X-Ray) to support triage and decision making will be available.

There will be 24/7 presence of ENP (s) to deal with minor injuries and ANP (s) to deal with minor illness. These will be supervised by the "generalist" Doctor. They will be capable of autonomous clinical decision making and trained in advanced life support.

There will be readily available access 24/7 (either via video technology or adjacent ED) to A&E middle grade or consultant clinical advice if patient requires specialist A&E clinical skills.

Children

The Paediatric Emergency Centre (part of the Emergency centre at Calderdale) will have staff and facilities that conform to the RCPCH guidelines and will clearly be marketed as the place to take children who are very unwell or likely to need specialist treatment

Parents of unwell / injured children should be firstly advised to phone 111 to obtain best advice as to where their child should be seen. Parents of children who are more seriously ill or have serious injury would be advised to phone 999.

Protocols will be in place for 111 and the Ambulance service to ensure that any children with injury or illness requiring emergency care is directed to the specialist Paediatric Emergency Department (paediatric surgery and acute inpatient medical care will be co-located with the Emergency Department).

Children over 5 yrs. of age can generally be seen in a UCC for minor illness or injury

Children who are more seriously ill, have serious injury or are under 5 years old will be quickly triaged, stabilised and, if necessary, transported to the PEC

The Urgent care centres will be able to treat the following:

Minor Injuries	Minor Illnesses
Bites/stings	Allergy (including anaphylaxis)
Burns and scalds	Dermatological conditions
Contusion/abrasion	ENT conditions
Diagnosis not classifiable	Infectious disease
Dislocation/fracture/joint injury/amputation	Local infection
Electric shock	Ophthalmological conditions
Facio-maxillary conditions	Psychiatric conditions
Foreign body	Social problem (includes chronic alcoholism and homelessness)
Head injury	Soft tissue inflammation
Laceration	
Muscle/tendon injury	
Nerve injury	
Sprain/ligament injury	

**3.10 Recommendation 10 – Public Confidence**

*The Committee noted that when the Yorkshire and Humber Clinical Senate considered the proposals they concluded that 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 recommends that before a decision on hospital and community health services is taken the CCGs should request the Yorkshire and Humber Clinical Senate to reappraise the proposed model of care and seek assurance that there is sufficient enough detail in the proposals to satisfy the Senate that the new model of care will deliver the required standards of care.*

### **CCGs' additional information**

The CCGs have been in conversation with the Clinical Senate regarding their recommendation that further work was required to understand the ability of the model to deliver the standards proposed.

The further discussion with the Clinical Senate, we have recognised that the information they require could not be developed until the implementation planning. We have agreed with the Clinical Senate that we will work with them as part of the Quality Assurance panel described in the additional information provided in relation to Recommendation 1.

The Clinical Senate wrote to the CCGs in June and an extract from its letter is shown below

#### **Clinical Senate – Extract from June Letter**

*'The Senate recommended that further work was required, particularly the detail about the workforce and activity, to fully understand the ability of the model to deliver the standards proposed. In further discussion with you, the Senate understands that the detail we referred to cannot be developed until the implementation planning and that you will invite the Senate to work with you during this stage to provide clinical support and scrutiny into the developing models. We welcome the opportunity to work with you again in ensuring that the model provides a quality and sustainable service for the local population.'*

### **3.11 Not for the NHS to Progress**

### **3.12 Recommendation 12 - Transport**

*The CCGs must specify 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. This should include: where that resource will be found; a clear plan to ensure that the Yorkshire Ambulance Service meets its targets; and what measures will be introduced to support a significant improvement in service.*

### **CCGs' additional information**

The CCGs are committed to working collaboratively with the Yorkshire Ambulance Service to ensure that YAS are funded to provide the required support. The specification and agreement of additional YAS resource would be undertaken as part of existing commissioning arrangements.

The provision of existing Ambulance services was not within the scope of the consultation.

### **3.13 Recommendation 13 - Transport**

*In order to fully assess the impact of the proposals the CCGs should commission an up to date Travel Analysis and Journey Time Assessment Study that details the absolute travel times and distances to both hospitals. The study should take account of: patients and visitors using their*

*own private vehicles and public transport; and residents that live at the furthest outlying areas of Calderdale and Greater Huddersfield.*

### CCGs' additional information

The Public Transport Analysis is being refreshed. The work is not complete. One of the factors in the delay is the requirement to include both Postcode and Health Resource Group (HRG)<sup>1</sup> data in order to undertake the analysis. Together, these two elements comprise personal identifiable data, whereby in areas of low population density it could be possible to identify an individual and the treatment that they received. Consequently, we have worked with each organisations' Caldicott Guardian to agree the data that could be released and the security that would need to be applied to any subsequent processing. This has resulted in the Postcode information being restricted to the first part only, e.g., HD2 or HX6 and also required us establish an appropriately secure method of transmission, holding and processing the data so that these elements are separated from the analysis of the data.

Under the proposed changes, the majority of patients who currently attend A&E will either be taken to the Emergency Centre in an Ambulance or attend the Urgent Care Centre at the site where they currently attend. The main travel implications will be for those who would currently attend at Halifax for Planned Care who will now be required to travel to Huddersfield and those people who are visiting patients in hospital. In relation to those who are visiting, the assumption that they would all be starting from their home address/postcode is not a reliable assumption.

In recognition of the travel implications related to the proposed changes, a Travel and Transport Working Group with an Independent Chair has been established. The purpose of the Working Group is to:

'ensure that the programme considers and develops plans to address the implications of the proposed changes in relation to Access, Travel, Parking and Public Transport'.

The group will:

- Review suggestions for improvements to existing access and travel arrangements identified during public consultation and make recommendations.
- Identify the potential implications of the proposed changes in relation to Access, Travel, Parking, and Public Transport, taking account of the timing and potential impact of the sequencing of the movement of services into community and the proposed improvements to the A629.
- Review and take account of the relevant findings from the Equality and Health Inequality Impact Assessment as part of any recommendations.
- Review the existing and updated Patient travel analyses .

The group will only consider the additional implications of the option on which the CCGs consulted.

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<sup>1</sup> Health Resource Groups (HRGs) are standard groupings of clinically similar treatments which use common levels of healthcare resource. They are used as the basis to understand activity in terms of the types of patients cared for and the treatments undertaken.

The Membership of the Group is:

- Healthwatch
- Calderdale Council – Highways
- Kirklees Council - Highways
- West Yorkshire Combined Authority
- Upper Calder Valley Sustainable Transport
- CHFT
- Calderdale CCG
- Greater Huddersfield CCG
- Calderdale Council - Councillor representative.
- Kirklees Council – Councillor representative
- Public Voice Interface

Members – attendance as required

- MYHT
- SWYPFT
- Kirklees CCG

The Public Voice Interface is intended to provide the Group with access to a range of groups representing geographical locations and protected groups. The intention is that there would not be one designated person to sit on the Travel & Transport Group but individuals may be invited to meetings to provide advice and guidance on an ad hoc basis as requested by the Chair.

The CCGs' engagement team has identified organisations and stakeholders from both Calderdale and Greater Huddersfield who have an interest in travel and transport, or are likely to be affected by the issues. A range of groups representing geographical locations and protected groups has been recruited using our existing networks which are:

- Engagement Champions in Calderdale
- Community Voices in Greater Huddersfield
- Patient Reference groups in Calderdale and Greater Huddersfield
- Members of CHFT membership
- Third sector organisations in Calderdale and Greater Huddersfield

A half-day workshop with this Reference Group took place on 19 June. As part of the meeting, demographic information from those attending, both in relation to themselves and also the demographic profile of the groups that they could reach through their networks was collected. Following analysis of this information we would be able to identify if there were gaps in representation from geographical locations and protected groups. Adequate representation would be in line our Equality duties.

The outcome of the session is being analysed to identify preferred approaches as to how the interface with the Travel & Transport Working Group could work. This could include:

- A virtual network of 'experts' who can advise the Travel & Transport Group in a range of areas either individually or collectively depending on the topic.

- A sub group which meets on a regular basis (to be determined) to receive regular information from the Travel & Transport Group and provide advice, guidance or feedback.
- A group that is only brought together for focus groups and workshops as work is progressed.

The Travel and Transport Working Group has met on four occasions. In addition to overseeing the work in relation to the Public Voice – as described above – and agreeing its Terms of Reference and work plan – the Group has also considered information in relation to: the WYCA Transport Strategy; the A629 upgrade (both Halifax and Huddersfield); Primary Care in both Calderdale and Greater Huddersfield; Patient Transport Services, Shuttle Bus and existing CHFT transport methods.

### **3.14 Recommendation 14 - Transport.**

Not for the CCGs to progress

### **3.15 Recommendation 15 - Estate**

*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 100,000 people every year. The Committee require evidence that the building can be improved so that this substantial increase in usage could be achieved without detriment to the quality of service.*

**CHFT's additional information is in Appendix B**

### **3.16 Recommendation 16 - Estate**

*To support the increased demand at Calderdale Royal Hospital, CHFT must prepare a clear costed plan that will ensure: that there is sufficient parking available at Calderdale Royal Hospital; accessibility for the potential increase in the numbers of emergency vehicles is fully addressed; and impact on the surrounding neighbourhood is minimised.*

**CHFT's additional information is in Appendix B**

### **3.17 Recommendation 17 – Estate**

*To address the concerns of the Committee that the proposed numbers of inpatient beds will not be sufficient to meet demand the CCGs must develop a plan that demonstrates how capacity in community services will be provided to support the reduction in bed numbers. This must include details of the approach that will be taken to improving efficiencies in bed occupancy and the modelling and assumptions used in developing alternative provision in a community setting.*

**CCGS' Additional information**

Provided in the response to recommendations 6 and 7

**CHFT's additional information is in Appendix B**

### **3.18 Recommendation 18 – Children**

*The new model of care will include a focus on encouraging parents and carers with a sick child to contact NHS 111 for advice.*



*To ensure that the pathways of care for sick children are clearly understood by the public the CCGs should develop a framework that outlines the processes and protocols for dealing with a sick young child. This should include details of the resources that will be made available to support the quick and easy access to appropriate clinical advice.*

**CCGS' Additional information**

An update in relation to the model for Urgent Care, including children, is provided in the response to recommendation 9. As outlined in the information provided in relation to recommendation 10. More detailed work can only be completed as part of implementation planning and would be subject to the Quality Assurance Process described in the information provided in relation to recommendation 1.

**3.19 Recommendation 19 – Local Services**

*The proposals of NHS providers in 2014 included specialist community centres at Todmorden Health Centre and Holme Valley Memorial Hospital, which the Committee considers would help: manage demand in the hospital setting; contribute to the development of the Care of Closer to Home programmes; and reduce travel time for some patients.*

*The Committee recommends that the CCGs consider developing plans to maximise the use of these facilities together with other local facilities. This should include a focus on the provision of integrated and specialist services.*

**CCGS' Additional information**

In the current and future development of CC2H services, the CCGs will seek to maximise the potential of any publically owned premises in their area, and agree that opportunities to increase integration of the delivery of health and social care should be considered wherever possible. The opportunity for the location of services to mitigate travel implications will be considered as part of the work of the Travel and Transport Working Group.

**Calderdale and Kirklees Joint Health Scrutiny Committee Recommendations on Proposals for Future Hospital  
and Community Health Services in Calderdale and Greater Huddersfield**

**Calderdale and Huddersfield NHS Foundation Trust Response - July 2017**

**Workforce**

**Scrutiny Recommendation 3:** *The Committee accepts that improvements and changes to services cannot be made without addressing the workforce challenges, but is not convinced that sufficient attention was given to this issue or that the plans sufficiently take into account the wider challenges that the NHS faces particularly in recruiting specialist staff. The Committee and the public will only be more confident in these proposals if a clear and costed Workforce Strategy, with timescales, is produced by CHFT and agreed with the CCGs, which demonstrates how shortages of clinical and other staff will be addressed. In addition the Committee would wish to see consideration given to how increased partnership working across neighbouring NHS Trusts might contribute to addressing workforce issues to develop a financially sustainable model for the future.*

**Response:**

The Trust continues to face workforce challenges (exacerbated by the current dual-site hospital configuration) that undermine the resilience and safety of clinical services; staff satisfaction, and wellbeing; and finances.

The Trust has developed a workforce strategy (copy available on CHFT website) and updated the workforce plan that was used in public consultation. Changes in the national and local workforce context have been used to test the assumptions previously used to profile the future staff groups and numbers employed by the Trust. Examples of factors that have influenced this include:

- the potential for improvements in efficiency and utilisation of staff as referenced in the Carter report (e.g. consideration of back office support, e-rostering, sickness management and other areas of staff productivity).
- the opportunities to create new or advanced roles to address workforce shortages and gaps and enable qualified staff to maximise patient facing time.
- developing a fully inclusive approach to recruitment and retention to ensure that the Trust is an employer of choice.
- focussing further on the health and wellbeing of colleagues, supported by a fully integrated staff engagement approach, to ensure continuing reduction in absence levels and turnover.
- changes in patient activity assumptions;
- collaboration with other hospitals in West Yorkshire to improve workforce resilience by:
  - developing a 'centres of excellence' approach for higher acuity specialties to eliminate avoidable cost of duplication and drive standardisation.
  - developing standardised operating procedures and pathways across services, building on current best practice to drive out variations in quality as well as operational efficiency and facilitating safer free movement of staff across providers.

- collaborating to develop clinical networks that protect local access for patients whilst consolidating skills (and therefore resilience) and reducing operational cost.
- developing workforce planning at scale to secure the future pipeline of staff and manage workforce risk at system level, and support free movement of bank and agency staff under single shared arrangements with the aim of reducing agency spend and the administration costs of the flexible workforce.
- delivering economies of scale in back office and support functions (e.g. procurement, pathology services, estates, and information technology).

The Trust's updated ten year workforce plan (2017 – 2027) takes account of the above factors and is based on the assessed impact of the following on the workforce profile and numbers employed.

- i. service reconfiguration and redesign to optimise the effectiveness and productivity of the workforce;
- ii. recruitment and retention to reduce agency spend;
- iii. recruiting new professional groups;
- iv. job evaluation approaches to ensure clinically qualified staff can work to the 'top of their licence';
- v. optimising the availability, utilisation and productivity of the entire workforce creating more time to care.

The ten year workforce plan generates a total planned reduction in whole time equivalent staff employed by the Trust of 479. No redundancy costs have been included in the business case since 'business as usual' turnover of staff will be sufficient to achieve this reduction without the need for redundancies.

## Finance

**Recommendation 4:** *The Committee notes that the proposals do not fully eliminate the financial deficit and is aware of the national and regional context to generate further efficiency savings. The Committee is extremely disappointed that the CCGs have not taken this opportunity to produce proposals that fully addresses the revenue deficit. The Committee is concerned that if CHFT remains in deficit, then local services will not be sustainable and further reconfigurations may result. The Committee wishes to see a financial plan produced by the CCGs and CHFT that addresses the financial deficit and clearly identifies how local services will be delivered in a safe and sustainable way.*

### **Response:**

The Full Business Case details a financial plan for implementing the clinical and service model that was consulted on that will eliminate the Trust's underlying deficit in year 8 (2024/25) and maintain financial surplus at circa £6m per annum thereafter.

**Recommendation 5:** *The proposals from the CCGs are dependent on capital funding to build a new hospital in Huddersfield and to enhance Calderdale Royal Hospital and the Committee would wish to see full assurance that this proposal will be fully financed without increasing the Trust's deficit. Should this assurance not be forthcoming the CCGs must inform the public and the Committee how it intends to proceed.*

### **Response:**

In delivering the preferred option of CRH as the unplanned care site, with HRI being the planned site, evaluation of the funding options for the capital build costs has been undertaken. The Trust has given consideration to the following potential funding solutions:

- Public Dividend Capital (PDC) - i.e. Treasury cash funded purchase

- Independent Trust Financing Facility (ITFF) Loan
- Public Works Loans Board (PWLB)/Bonds
- Private Finance Initiative (PFI)/PF2
- PFI and Joint Venture (JV)

The NHS capital environment is severely constrained and the Trust has been advised that the only financing route available to the Trust that meets treasury requirements would be through PFI.

The Full Business Case details a financial case based on PFI funding. This would eliminate the Trust's underlying deficit in year 8 (2024/25) and maintain financial surplus at circa £6m per annum thereafter.

## **Estate**

**Recommendation 15:** *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 100,000 people every year. The Committee require evidence that the building can be improved so that this substantial increase in usage could be achieved without detriment to the quality of service.*

### **Response:**

During the past six months the Trust has obtained further external estates advice that has confirmed that whilst the CRH site is constrained it is of sufficient size to be able to accommodate the additional new build and clinical capacity to deliver the service model for unplanned and emergency services at Calderdale Royal Hospital. A Feasibility Cost Model of the expected build costs for the preferred option has been provided and this has been used in the Full Business Case.

**Recommendation 16:** *To support the increased demand at Calderdale Royal Hospital, CHFT must prepare a clear costed plan that will ensure: that there is sufficient parking available at Calderdale Royal Hospital; accessibility for the potential increase in the numbers of emergency vehicles is fully addressed; and impact on the surrounding neighbourhood is minimised.*

### **Response:**

The estate development cost at CRH includes provision of 600 multi storey car park spaces. This allowance is based on a benchmark norm for car parking spaces. The development at CRH includes the expansion and development of the current emergency department that will ensure sufficient capacity for an increased number of emergency ambulances accessing the site. Work has also been undertaken to develop an outline implementation plan for the new build that aims to keep any disruption during the build to a minimum and also minimises third party and neighbourhood impact.

**Recommendation 17:** *To address the concerns of the Committee that the proposed numbers of inpatient beds will not be sufficient to meet demand the CCGs must develop a plan that demonstrates how capacity in community services will be provided to support the reduction in bed numbers. This must include details of the approach that will be taken to improving efficiencies in bed occupancy and the modelling and assumptions used in developing alternative provision in a community setting.*

### **Response:**

The Trust has been supported by NHSI to review and update the hospital activity and bed modelling assumptions previously used during public consultation. The output from this is a total future bed requirement of 738 beds across the planned and unplanned hospitals (676 at the unplanned care site and 64 at the planned care site). This is a reduction of 105 beds compared to current (circa 843).

The key bed modelling assumptions are that: the development of care closer to home will enable a reduction in non-elective medical admissions and; the Trust will achieve upper quartile length of stay (LOS) performance.

The CCGs have developed a plan to provide capacity in the community that will support the reduction in bed numbers (please see response to recommendations 6 and 7).

The reduction in hospital length of stay will be enabled through actions such as implementation of seven day working and the SAFER programme that includes the safer patient flow bundle (described below).

<b>S</b>	Senior Review. All patients have a consultant review before midday.
<b>A</b>	All patients have an Expected Discharge Date (that patients are made aware of) based on the medically suitable for discharge status agreed by clinical teams.
<b>F</b>	Flow of patients commences at the earliest opportunity (by 10am) from assessment units to inpatient wards.
<b>E</b>	Early discharge, 33% of patients discharged from inpatient wards before midday.
<b>R</b>	Review - a weekly systematic review of patients with extended lengths of stay ( > 14 days) to identify actions required to facilitate discharge.

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