Public Document Pack

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Thursday 17 September 2020

Notice of Meeting

Dear Member

Calderdale and Kirklees Joint Health Scrutiny Committee

The **Calderdale and Kirklees Joint Health Scrutiny Committee** meeting will take place remotely at **1.30 pm** on **Friday 25 September 2020.**

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

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 - Kirklees Council (Joint Chair)
Councillor Andrew Cooper - Kirklees Council
Councillor Alison Munro - Kirklees Council
Councillor Will Simpson - Kirklees Council
Councillor Colin Hutchinson - Calderdale Council (Joint Chair)
Councillor Anne Collins - Calderdale Council
Councillor Howard Blagbrough - Calderdale Council
Councillor Megan Swift - Calderdale Council

Agenda
Reports or Explanatory Notes Attached

Pages

1: Minutes of Previous Meeting

1 - 10

To approve the Minutes of the meeting of the Committee held on the 18 October 2019.

2: Interests

11 - 12

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.

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.

4: Deputations/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.

In accordance with Council Procedure Rule 10 (2), Members of the Public should provide at least 24 hours' notice of presenting a deputation.

5: Public Question Time

Due to the current covid-19 restrictions, Members of the Public may submit written questions to the Committee.

Questions should be emailed to richard.dunne@kirklees.gov.uk no later than 10:00 am on 24 September 2020. In accordance with Council Procedure Rule 51(10) any person may submit a maximum of 4 written questions.

In accordance with Council Procedure Rule 11(5), the period allowed for the asking and answering of public questions will not exceed 15 minutes.

6: Update on reconfiguration of hospital services at Calderdale and Huddersfield NHS Foundation Trust

13 - 20

The Committee will receive an update on the work being undertaken to progress the planned reconfiguration of hospitals services at Calderdale and Huddersfield NHS Foundation Trust.

Contact: Richard Dunne Principal Governance Officer Tel: 01484 221000, email - richard.dunne@kirklees.gov.uk

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7: Next Steps

The Committee will consider its plans for future meetings and activities.

Contact: Richard Dunne Principal Governance Officer Tel: 01484 221000, email - richard.dunne@kirklees.gov.uk

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CALDERDALE COUNCIL

CALDERDALE AND KIRKLEES JOINT HEALTH SCRUTINY COMMITTEE

FRIDAY, 18TH OCTOBER 2019

PRESENT: Councillor Hutchinson (Calderdale Council) – Joint Chair
Councillor Smaje (Kirklees Council) - Joint Chair
Councillor Blagbrough (Calderdale Council)
Councillor Cooper (Kirklees Council)
Councillor MK Swift (Calderdale Council)
Councillor Munro (Kirklees Council)
Councillor Simpson (Kirklees Council)

IN ATTENDANCE: Anna Basford – Director of Transformation and Partnership (CHFT)
David Birkenhead – Executive Medical Director (CHFT)
Jen Mulcahy – Programme Manager Right Care, Right Time, Right Place (Calderdale and Greater Huddersfield CCG)
Matt Walsh – Chief Officer (Calderdale CCG)
Penny Woodhead – Chief Quality and Nursing Officer (Calderdale and Greater Huddersfield CCG)
Carol McKenna – Chief Officer (Greater Huddersfield and North Kirklees CCG)
Mike Grady – Independent Chair, Travel and Transport Review Group
Richard Binks – Programme Manager, Regeneration and Strategy (Calderdale Council)
Steven Hanley – Project Officer (Major Projects) Economy & Infrastructure (Kirklees Council)

APOLOGIES: Councillor Mrs Collins (Calderdale Council)

1 Minutes of Previous Meetings

RESOLVED that the Minutes of the Calderdale and Kirklees Joint Health Overview Scrutiny Committee held on the 4th July 2019, and the amended Minutes of the 15th February 2019 be approved as an accurate record.

2 Members Interests

Councillor Megan Swift declared an 'other interest' on the grounds that she was a member of Calderdale and Huddersfield NHS Trust Membership Council.

3 Admission of the Public

All items were taken in public session.

4 Deputations and Petitions

The Committee received deputations from the following members of the public: Rosemary Hedges, Jenny Shepherd and Cristina George.

The Chair requested the written deputations be submitted, in order for the relevant Officers to provide a detailed written response.

5 Engagement Involvement Plan and the Report Findings from the Stakeholder Event

The Director, Transformation and Partnerships, Calderdale and Huddersfield Foundation Trust (CHFT) and Programme Manager, Calderdale and Greater Huddersfield Clinical Commissioning Group (CCG) submitted a written report regarding the communication and involvement of local people in the plans relating to Hospital Reconfiguration. The report included the Engagement Plan, Findings from the Stakeholder Event and Healthwatch Report of Findings. The plan looked at a period across 5 years, which included development, implementation. The feedback had been inputted to the work and CHFT had been working closely with Healthwatch and other community groups in order to facilitate discussions with a wide range of groups and individuals, including going out to meet with people rather than the expectation that they would come to the organisations.

There was a commitment to keeping people informed through newsletters, the website, public meetings and Stakeholder Events. The development of design was for new buildings and there would be a number of workshops scheduled prior to Christmas (2019), with invitations being sent to a wide and inclusive group to ensure involvement across Calderdale and Kirklees, with the involvement of Healthwatch and Clinical Commissioners. Continued involvement of input was required as the design plans expanded, and throughout the reconfiguration work the use of digital technology was still a key ambition for CHFT, especially when reaching targeted groups, etc.

Members discussed the following issues:

- The Stakeholder Events had been held every 6 months and it was felt that although some people understood the proposals, other people were not as clear. It was hoped that this would be really clear to the public moving forward so that people could see what was being proposed as part of the work. From the list provided in reference to the last event, it appeared there were more people attending from Calderdale than Kirklees, was this due to the location on this occasion (Brighouse) and would CHFT consider alternating the events, as this Board did with meetings, to enable a wider attendance? Members would also be able to suggest additional groups and invitees to be added to this list. In response, Officers advised that this would be a welcomed suggestion in terms of the invitations to be shared and attendance to be increased. The organisations involved wanted this to be a wide opportunity to engage and involve people.

- A suggestion was made regarding reaching out to a larger number of people in events leading up to the Christmas period, for example: utilising supermarkets and shopping centres. There was an event which was due to be held in Brighouse for older people on 8th November 2019, and last year more than 800 people had attended, so this would be a great opportunity for the Trust to host a marketplace or small information stand and

collate views. Christmas was a good time to catch a wider group of people and this would give an opportunity to expand on this, especially when people had more time to find out about or take interest in what was going on.

- In terms of digital technology, if the service was dependant on this, what parallel measures were there in terms of letting people know of the proposals and ensuring their voices were getting heard? In response, Officers advised that this was a good point and one which had been considered in terms of building in face-to-face sessions for people to feed into the process. There was a need to attend where people accessed (for example: practices and other events), and there were also opportunities through newsletters and the Strategic Outline Case (SOC); although it was recognised that the SOC was not the most concise document to share.

- In terms of 'bringing alive' what the work meant to people, (e.g. scenarios and people being able to throw in some 'for instances', what happened if something occurred, etc.), it was important to understand the real impacts on real people using the services and this method would perhaps provide people with something to engage in rather than it being one way feedback. In response, Officers advised that in the past, case studies had been used for engagement work (e.g. how patient care may change or the different access routes to care) and then CHFT provided responses to various scenarios. This was a good message which should be used across all engagement as it had been really useful.

- In terms of the Healthwatch report, the temperature diagram shown had limited feedback displayed on it. How many members of the public were at the Brighouse Event? It would be good to engage further and wider with the public. In response, Officers advised that there were 101 people at this event; however people could not be forced to respond. It was agreed that it would be good to have more people engaging with things such as the temperature check, however there were other methods of consultation and engagement on the day which supported this. Healthwatch had facilitated lots of conversations on the day, and there was lots going on, which was recognised in the report on post-consultation phase. Officers agreed that all services were understanding of the need to take on every opportunity created and ones which were created for services; it was important to talk to people about what the future needs to be like and what it looked like now. There were always occasions when people presented to the wrong place and this required constant attention, however much of the work was around reminding people of the next steps and the now.

- It was recognised that the work was an ongoing engagement, however there were concerns raised regarding the lack of clarity in the Healthwatch report. This was about working with them and linking with the communications plan and assistance in help for people, which needed to be different; as soon as it was different, the more understanding people would have in the complicated proposals. In response, Officers advised that it was complicated for people who worked in the service as well as members of the public, so it was acknowledged that it needed to be simplified as much as possible externally. There was particular clarity required around the urgency of care in Calderdale, and more so in Kirklees, where there had been lots of descriptions put forward. Although there was lots of work to be done to have the vision clear in mind, but this Board was able to build into its discussion some of the key aspects of this work, such as discussions regarding the ambulance service requirements, etc. Ultimately something needed to be produced to allow people to picture in their minds what the service would look like.

- In terms of engagement groups, it would be useful from a climate change perspective that input from environmental groups be sought as this would be helpful feedback as part of the work. In response, Officers advised that this would be welcomed with open arms, and some support from the Local Authority in terms of how they do this would be welcomed.

- Members commented on the update and commitments which were much appreciated.

RESOLVED that the report be noted.

6 Future Arrangements for Hospital and Community Services in Calderdale and Huddersfield - Progress Report for the Minister of State for Health

The Programme Manager, Calderdale and Greater Huddersfield Clinical Commissioning Group (CCG) submitted a written report regarding the Future Arrangements for Hospital and Community Services in Calderdale and Huddersfield Progress Report for the Minister of State for Health.

The letter which was submitted to the Secretary of State provided an update on the previous report which had been submitted to this Committee in January 2019, and the purpose of it being brought to the attention of Members today was by way of update.

Members discussed the following issues:

- In terms of clarity, would the number of beds remain the same? There is no plan to reduce the number of hospital beds. There was also a further piece of work to be done in terms of setting out the ambition to services in the community and tracking progress as ambition, not as a target. This was the prediction in relation to demographic growth and bed days; the assessment in existing plans would be able to accommodate the demographic and reduce the demand on hospital by10%.

- In terms of the McKinsey. work, the assessment in existing plans would be able to accommodate the current demographic at 10%, bed days and reduction in the demand on hospital to 10% to absorb demographic growth. The prediction was in relation to demographic growth and bed days, and the report then went onto say what was being done and what the proposal was to do in terms of the best performance systems (England and international studies which had between 20-40% reductions). For Calderdale and Kirklees, it had been suggested that as people wanted care closer to home, the realistic ambition was at 30%. Officers discussed the earlier reports which had focused on ambition rather than assumption; the hospital needed to have ability to flex its capacity and its current position was full capacity in hospital on bed days; for example: there were 100 people in hospital today who were ‘medically fit’, but due to the waiting times for social care, assessments, care homes or home care capacity, they were unable for discharge. Some of these issues were beginning to be addressed and there had been real progress made in discharges in the system in the last few months. Overall this was going well however the whole NHS was under significant pressure currently. In summary, bed base flexes and seasonal variations needed to be flexible in addressing these issues and for patient care. The McKinsey report explained that if more as done in care closer to home, this would provide more overall flexibility.

- In terms of the 'best of class' ambition indicated in the early reports, was the work achievable? In response, Officers advised that in response to the challenges, this was not just about the NHS.

- In reference to the number of people in hospital beds that should not be there, to some extent this would always be the case. Of these, how many people would move in a couple of days and how many people would remain until the other issues (preventing them from discharge) were sorted? In response, Officers advised that the A&E Delivery Board were doing some joint work on this to see the sort of information trend lines on this to give some clear sense of the bigger picture. It was clear that this dialogue needed to be continued and progressed, but the best the service had been able to get to in terms of figures had been 40-50 in the last year (approximate). Resources were stretched currently.

- There were peaks and troughs of demand, but based on higher occupancy level – would most people provide that flexibility in terms of their circumstances? Why choose 90% occupancy for certain disciplines? In response, Officers advised that the as determined in the Strategic Outline Case, the number of beds would be kept the same as they were currently. There will be 838 beds at physical capacity (676 at Calderdale Royal Hospital and 162 at Huddersfield Royal Infirmary). In recent years this had fluctuated between 700-800 (as determined by the graph in the report), but in keeping flexibility and making no assumptions to the reductions, this would keep it moving forward and more up to date modelling would be undertaken this year.

- Were we still on track for a response on the SOC by November 2019, as stated in the letter? In response, Officers advised that yes the Trust was still on track for an expected end of November 2019.

- As referenced under the deputations item at this meeting, there was currently a pilot scheme for rehabilitation beds ongoing; although the pilot was time limited; were there plans to what rehabilitation services might be on a longer term basis? In response, Officers advised that this was the 'Choice of Recovery Base', and there were a whole range of measures to address the issues, for example: those who were medically fit to be discharged, e.g. individuals with support from families regarding future care homes, etc. These cases were reviewed all of the time and matched with information CHFT and CCG were provided with in order to see the trajectory.

- In terms of the response from the Secretary of State to the Committee, there were three main issues they had requested a response on to ensure satisfaction with the progress of plans to increase community care (in settings) allowing the Trust to work in its 'bed base' and ensure that there was availability in the community provision and delivering what was required to deal with an increased demand. Could the Committee be rest assured that the integrated system was delivering the background on which reconfigurations were in place? In response, Officers advised that the established relationships were in place and as part of the ongoing work of this Committee; and much of the work had been picked up through various Scrutiny Boards. Members agreed that there was no interest in duplicating conversations and work, but there would be a need to make a response in due course and awareness was key.

RESOLVED that the report be noted.

7 Wider Highways Matters (A629)

Steven Hanley (Kirklees Council) and Richard Binks (Calderdale Council) attended the meeting and provided a presentation and written report to Members. The detailed presentation provided an overview of the different Phases (1a – 5) of the projects and investments relating to the highways between Calderdale and Kirklees hospitals, including reduction in travel/journey times, handling congestion and smarter roads and traffic systems.

Members discussed the following issues:

- When modelling, had the relevant services been asked about the fastest routes for ambulances? In response, Officers advised that although the scheme had not looked at ambulances per say, it did look at the congestion of vehicles and 'pinch points, with a key focus on people using public transport to reduce use of cars and it was anticipated that this would reduce the congestion for emergency vehicles.

- In terms of traffic demand and the growth of the scheme became overwhelmed, how long would this be a solution for? Had there been any reflection in terms of an electric structure to build into the systems discussed? In response, Officers advised that the development of phases had been based of existing capacity, anticipated capacity through the work of the Local Plan and some natural growth. It was suggested that most people would continue to drive cars if that was their preferred mode of transport, and this work had provided an opportunity to do infrastructure work, which was very much required. In terms of the short-to-medium term, doing nothing was not an option. Electric structures had not been considered in lots of resource at this time as this was more around people acknowledging the sustainable mode of transport, and there had been more work done around express public transport and encouraging people to use this. It was about finding some balance and encouraging a switch over, however there was lots more to do to make that happen. The work was modelled on future steps to 2034-2036, in line with other plans.

- We needed to ensure there was a holistic approach in the choices which were being made; for example: What else did we do with the health service and what were the sensitivities around this? If all vehicles were electric by 2030, there would be a need to gear up all car parking spaces to facilitate this, rather than just a few. In response, Officers advised that there were pilot schemes of electric charging infrastructure and this was mostly invested in by private sector organisations, and facilitated by Local Authorities. There were various grants from the Government which were based on supply and demand; however the growth in future uses needed to be considered first.

- The scheme would be much fuller than anticipated and there were some new schemes, such as the railway station at Elland and various bus routes which would speed up journey times which would assist in the transport delivery for hospitals and health services.

- The challenge of access between the two hospitals had been a concern for some time. Had there been any learning shared from the Salterhebble contract and works in terms of implementing the work and delays, etc. Also, had consideration to the additional housing in Brighouse area been made as part of the work? In response, Officers advised there had been some design scheme and contractual learning from Salterhebble; it had been

one of the biggest schemes at local and WYCA level and a number of design changes had been made throughout the duration of the scheme, changing the scope of contractors work. As a result the service was better informed as the strategic corridor project came about and there was a strong desire to pursue this. In terms of perspective, there was consideration to be made in whether this was done in the same way and more initial planning to completed ahead of the work commencing. For Brighouse, the A641 scheme would address much of the work and the Local Plan was being 'tapped into' to help determine the need in the area. This would also provide synergy between Brighouse and other areas.

- Was there any capacity to include a bus lane for further improvements to be made for people who were accessing hospitals? In response, Officers advised that Phase 1 for Stainland Road would see a dedicated infrastructure introduced to Wakefield Road. The modelling had pointed out huge assimilations and anticipated a better flow of traffic through the areas. In terms of urban traffic management, this was recognised and it would be possible that buses could prioritise them, however Phase 4 work would look at the level of detail in this, due to the additional bus lane having land implications if it were to be agreed, etc.

- Would there be pick up and drop off sites at both hospitals to make it usable for patients to get between the two sites, with them being fairly extensive? And in terms of the existing bus provider in the area, how much control and assurance did Officers have that they would be providing a rapid service, and that express buses would not just by-pass the hospitals, serving the infrastructure and not just the bus stations? In response, Officers advised that there was no reassurance as yet. Conversations had been had with the existing provider, and would be heading to full business case approval from the initial outline case. This would be of a benefit to the provider as it would be a commercial enterprise opportunity but also support those patients accessing the hospitals. There was also consideration to be made in terms of the technology needed to look at this and one which complimented the scheme, although this was a potential and not yet confirmed.

- Members agreed that representation to WYCA should be made to ensure assurance for bus services which would address the health sector needs and ensure that involvement with CHFT should continue.

RESOLVED that:

(a) the report be noted; and

(b) the Calderdale and Kirklees Joint Health Overview Scrutiny Committee recommended to the West Yorkshire Combined Authority that involvement with Calderdale and Huddersfield Foundation Trust (CHFT) be continued, to ensure that the Highways works and phased schemes addressed the needs of Calderdale and Kirklees patients, and health sector needs.

8 Travel and Transport Review

Mike Grady, the Independent Chair of the Travel and Transport Review Group (TTRG) attended the meeting and addressed Members of the Committee regarding the submitted written report. The TTRG had met for 13 meetings and had been well-represented across the statutory and

voluntary sector; they ensure that the meetings were held in a range of locations and saw protected groups as part of this work, producing a comprehensive agenda, issues of infrastructure in public transport, parking and care closer to home.

There had been eight recommendations made in the report, which were accepted by the Partnership Board. One of these recommendations addressed communication, as it had been evidenced at the Working Group that few local people were aware of progress that had been made in relation to Care Closer to Home. Much of this type of work was about repeating the same messages and the same story so people were aware of the work and were able to have informed opinions when change came about. Parking had been highlighted as a key issue, with approximately 80% of people accessing hospital by car or taxi and the feasibility of extending car parking be explored further. It was also suggested that West Yorkshire Combined Authority (WYCA) seek to influence its commercial partners in relation to bus services, although it was deemed to be limited influence, it was felt this Committee should make representation.

The existing shuttlebus service between the hospitals was a really good service, however it needed upgrading. There was a similar service being provided between Pinderfields and Pontefract and this would be a good term of reference for the work. The A629 issue had been addressed, and although the complicated project had been rolled out, it was important that each strategic plan to cognisance of the others.

Members discussed the following issues:

- What did ‘maximum average journey time’ (referenced in the report) mean? In response, Officers advised that this was analysed by traffic engineers who had advised that rather than an average across the district as a whole, this was an average for each district, based on the highest value in relation to journey time to hospital. For example: A journey from Walsden to Huddersfield, etc.

- The impact on shuttlebus times was strong in rush hour, however the impacts of the A641 and A629 were positive and they needed to be more equitable and accessible for families and users who were disabled.

- What was the reason for not being able to capture figures for those attending surgery? There were earlier times in the day when public transport was less effective. The Dewsbury/Pinderfields/Pontefract route was an access bus and this was a joint piece of work between CHFT, WYCA and a local company; the bus ran free of charge and expanded the size of the bus to enable more frequent stops. Had WYCA been approached to manage the service for CHFT and why in the meantime, could there not be an access or shuttlebus? In response, Officers advised that the bus had the potential to provide at least a ‘stop gap’ ahead of any commercial changes in terms of bus company changes which might have been made. Service users rated the service, however there were issues in the service not being able to take wheelchairs, prams and children under 3 years of age. In regards to the data, there had been 12 months worth of data used to account for season variation; in this instance the group would have been looking at a lot of hospitals in the catchment areas so it was not just surgery numbers, it looked at A&E due to the broader hospital arrangements to ensure no one was missed out.

- It was suggested that an accessible and extended bus service be looked at with some urgency, including the function to park at the hospital and get shuttlebuses between the

sites. In response, Officers advised that the broad travel approach indicated through A629 and other works would be moved forward, and CHFT would be working with partners and how choice could be influenced in terms of an express option, which would assist in the long term approach of a service. It was anticipated that this would be taken forward at pace through the coming year, in liaison with the relevant organisations.

- Did the report reference links to other forms of transport such as trains, and had this been considered or factored in to alleviate the problems discussed? Incentives for cheaper use should also be considered if this were to be taken forward. In response, Officers advised that the new railway in Elland the opportunities of this and other stations supporting the hospital links would be beneficial. However, the thoughts around the upgraded shuttlebus service would be beneficial before providing linkage between the hospitals and railway stations.

- There had been useful and informative presentation from Yorkshire Ambulance Service (YAS) to the TTRG to address coping with capacity and drawing a parallel between blue light access on A629 was better than the A6250.

- In regards to the perceptions around parking, did CHFT know the demand in establishing parking as yet? In response, Officers advised that there was need to further plan the demand and projection of demand for services, use and the impact on future need. CHFT were undertaking work around the site and feasibility of function, e.g. multi-storey car park, etc.

- There were issues in Skircoat Ward with staff parking and residents in the area reporting this, which also needed to be considered as part of the work.

- One of the difficulties was education of new drivers, and there was a need to re-educate people in looking out for emergency services and the use of digital technology or signage to increase awareness.

- For outpatients, were the 'Park and Ride' suggestions still required in each place? If operating a 'Park and Ride' service, were people able to get compensation when clinics were overrunning as in other systems? How did people know these services were available? In response, Officers advised it was not specifically known how this was communicated and there needed to be a continuous effort in the significant development in Care Closer to Home and ensuring a seamless care service. Where there was any period of reconfiguring services, there was a need to constantly tell people what was going on, and as part of the TTRG recommendations, they urged both Health Providers and the Local Authority to continue to do this in various versions.

- One way in having Care Closer to Home was to reduce outpatient access from hospital, unless there was a need for face-to-face consultation, e.g. use of digital technology for patients in Todmorden or Queensbury, or to help parents with young children, etc. Members discussed the need to use public transport and have access to secondary services, especially where there were heavy impacts on staffing and resources. What were the thoughts of CHFT on matters such as these? In response, Officers advised that CHFT were still very interested in this and had continued to provide Outpatient Care at Todmorden which had had positive feedback from patients who had used digital technology for consultations/appointments. They had however learned, through working

with Healthwatch, that people did not always like to use devices at home or alone, so it might be that there was a requirement for a 'hub' in localities (or possibly GP Practices) for people to use. Virtual consultations for young people and their parents had been very beneficial for the reasons as suggested (accessing hospital as an outpatient was not always convenient), so this was something CHFT very much wanted to take forward. What needed to be considered in further detail was whether the future model committed to future provision of sites, for example, attendance at hospital being required only when necessary.

- In terms of Care Closer to Home, were there any updates regarding the new Health Centre in Brighouse? In response, Officers advised that they would take this away and feedback.

There was a discussion regarding the Strategic Outline Case. The Investment Plan for Huddersfield Royal Infirmary was currently being worked on and publication was expected in early 2020 due to the processes of governance that this had to be taken through with CHFT. The design brief for Calderdale Royal Hospital was anticipated by the end of January 2020 and then there would be a process of commissioned expertise to complete at this time, followed by consideration, sharing and governance prior to its completion. It was agreed in terms of the consideration of items for this agenda that this would be kept fluid in terms of scheduling dates, for the time being.

RESOLVED that:

(a) the report and recommendations of the Travel and Transport Review Group (TTRG) be noted; and

(b) the TTRG be thanked for their hard work and contributions.

(The meeting closed at 15:14 hours).

KIRKLEES COUNCIL			
COUNCIL/CABINET/COMMITTEE MEETINGS ETC DECLARATION OF INTERESTS			
Name of Councillor			
Item in which you have an interest	**Type of interest (eg a disclosable pecuniary interest or an "Other Interest")**	**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]**	**Brief description of your interest**

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.

Calderdale and Huddersfield Service Reconfiguration
Update Report for the Calderdale and Kirklees Joint Health Scrutiny Meeting
25th September 2020

1. Background

In December 2018 the Department of Health and Social Care (DHSC) announced that £196.5m of public capital funding had been allocated for investment at Huddersfield Royal Infirmary (HRI) and Calderdale Royal Hospital (CRH). In 2019 the Strategic Outline Case (SOC) describing the future service model this investment will enable was completed and NHS England (NHSE) and the Department of Health and Social Care (DHSC) confirmed approval of the SOC in January 2020.

At CRH the investment will enable the provision of additional wards, theatres and a new A&E including a dedicated paediatric emergency department. At HRI the investment will enable the build of a new A&E department and the improvement of existing buildings to address the most critical estate maintenance and safety requirements.

To progress the programme of service reconfiguration and estate development further detail of the service model and estate design at each site will be developed and described in an Outline Business Case (OBC) for CRH and a Full Business Case (FBC) for HRI that will be submitted to NHSE and DHSC for approval in 2021.

2. Purpose

The purpose of this report is to:

- Provide a general update on the reconfiguration programme of work and timeline;
- Inform the Joint Scrutiny Committee of public and colleague feedback regarding their involvement to develop the Design Brief for the estate investment at CRH and HRI and share the key design themes identified;
- Inform the Committee of the next steps to continue to involve members of the public and colleagues in the development of the plans for service reconfiguration in Calderdale and Huddersfield;
- Provide an update on progress in developing community care provision including changes to access to the provision of primary and community care services as a result of the pandemic.

3. Programme Update

Following approval of the SOC in January 2020, work has been undertaken to clarify the process of developing the next stage of business cases required by NHSE and DHSC. This has

taken account of the fact that the estate at HRI carries a high risk in relation to the condition and reliability of the existing buildings. It has therefore been agreed with NHSE and DHSC that to enable the commencement of estate improvement work as early as possible a Full Business Case for the investment at HRI will be developed and submitted for approval by NHSE and DHSC in 2021.

For the investment at CRH an Outline Business Case will developed and submitted in 2021 and subject to NHSE and DHSC approval a subsequent Full Business Case will be developed for approval by 2023.

The content of the OBC and FBC(s) will align with and take account of Her Majesty's Treasury (HMT) Green Book guidance on public investment business cases. The necessary external capacity and capability to deliver the business cases has been appointed and this includes specialist technical advisors such as architects, engineers and healthcare planners.

A detailed Programme plan and timescale was developed in March 2020 however it became clear the plan would need to be revised considering the Covid-19 pandemic impact. A review identified the work that it was possible to continue to progress during the COVID-19 crisis and those areas that have been delayed. The areas impacted by delay include for example: workstreams dependent on clinical and public involvement, and; workstreams that require on-site visits and surveys by external contractors. The revised provisional headline milestones are shown below. Where possible actions are being taken to improve on this timescale.

Huddersfield Royal Infirmary		**Calderdale Royal Hospital**	
Milestone Description	**Complete by:**	**Milestone Description**	**Complete by:**
Design completed and full planning application submitted to Kirklees Council	Jan 2021	Design developed and outline planning application submitted to Calderdale Council	Feb 2021
Submission of Full Business Case to NHSE and DHSC for approval	June 2021	Submission of Outline Business Case to NHSE and DHSC for approval	June 2021
Commence Construction Work	Dec 2021	Submission of Full Business Case to NHSE and DHSC for approval	2023
Complete Construction Work	2023	Complete Construction Work	2025

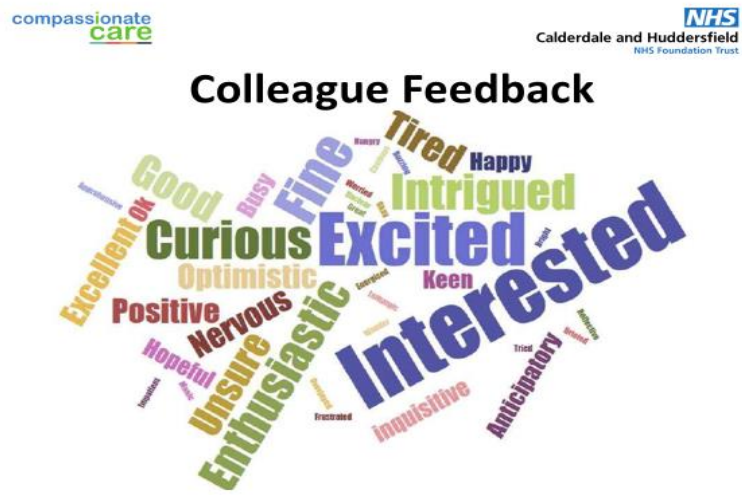
4. Development of the Design Brief and Plans for CRH and HRI

During 2019/20 architects have worked with Calderdale and Huddersfield NHS Foundation Trust (CHFT) to develop a "Design Brief" to inform the future building design and construction schemes at HRI and CRH.

The approach to this aimed to ensure a continuous process of public and colleague involvement and a focus on what's important from a patient, carer, family and colleague perspective in terms of healthcare building design. This included public involvement workshop meetings held in November and December 2019 with invitations sent to over 320

organisations and groups across Calderdale and Kirklees. Involvement meetings also took place at an Older People's Fair in Brighouse and a Young Persons Workshop in Calderdale. 121 people attended the workshops. The invitation list was informed by Healthwatch, CCGs and the Joint Health Scrutiny Committee. 21 colleague involvement workshops (involving more than 100 CHFT colleagues) were also undertaken to discuss key areas of development in relation to the transformation and reconfiguration of services across CHFT. The sessions explored a number of key issues including known best practice and experience; current constraints which are to be improved; linkages and connectivity to key support services; and how digital technology might improve delivery. "Go See" visits to other Hospitals were also undertaken that have implemented significant estate investment and service reconfiguration to understand their learning from this to inform our design plans.

The workshops that were held in 2019 received a very positive response from members of the public and colleagues that attended.



Members of the public and colleagues identified the issues that mattered to them in relation to the future design of health care buildings and facilities and this has been used to develop a design brief. The content of this document follows Department of Health best practice guidance. The following critical success factors identified through public and colleague involvement has been incorporated in the Design Brief.

The following documents are available on the CHFT website (links shown below) that provide further detail regarding the public and colleague involvement work that has been undertaken and copy of the Design Brief.

- Public Involvement Report
  https://www.cht.nhs.uk/fileadmin/site_setup/contentUploads/About_us/Hospital_Transformation/CHFT_Design_Brief_Public_Involvement_Report.pdf
- Colleague Involvement Report
  https://www.cht.nhs.uk/fileadmin/site_setup/contentUploads/About_us/Hospital_Transformation/CHFT_Design_Brief_Colleague_Involvement_Report.pdf
- Design Brief
  https://www.cht.nhs.uk/fileadmin/site_setup/contentUploads/About_us/Hospital_Transformation/Design_Brief_Final.pdf

The "Design Brief" describes the principles that will inform the detailed architectural design and construction schemes at both HRI and CRH and will be used to complete the next stage (OBC and FBC) business cases required by NHSE and DHSC. Members of the public and colleagues have described their aspirations for modern health care services, delivered in buildings that offer a healing and therapeutic environment that is welcoming, calm and provides a light environment with external views; is accessible and inclusive supporting diverse patient needs; that ensures privacy and dignity and enables the optimal use of digital technology to deliver care and support. This is described in more detail in the Design Brief document.

Since the development of the design brief the COVID-19 crisis has necessitated many service changes forced by critical need and implemented at pace across the health and social care system.

Despite these challenging circumstances positive learning is emerging. During May and June 2020 CHFT has undertaken further engagement to listen and learn from people's reflections on the service changes implemented during the pandemic and their aspirations for future service delivery. 185 CHFT colleagues, 9 health and care partner organisations across Greater Huddersfield and Calderdale, and; 1,377 patients and members of the public have provided input to this engagement. The views and input from this were reported at the public meeting of the Trust Board held in September 2020 and copy of the report is available on the CHFT website.
https://www.cht.nhs.uk/fileadmin/user_upload/Public_Board_of_Directors_030920_Combined_Report.pdf

The findings from the pandemic will build on the design brief previously developed to incorporate opportunities for improvement and accelerated transformation in some areas. This will also ensure that further design elements that take account of best practice in building design regarding infection control and prevention are included. This includes for example ensuring provision of single rooms and flexibility in the design to enable segregation of areas.

5. Next steps to involve members of the public and colleagues in plans for service

We will ensure there is continuous communication and involvement of patients, families, carers, colleagues and stakeholders in the planning process. We are committed to transparency and meaningful involvement. Our communications and involvement work will be:

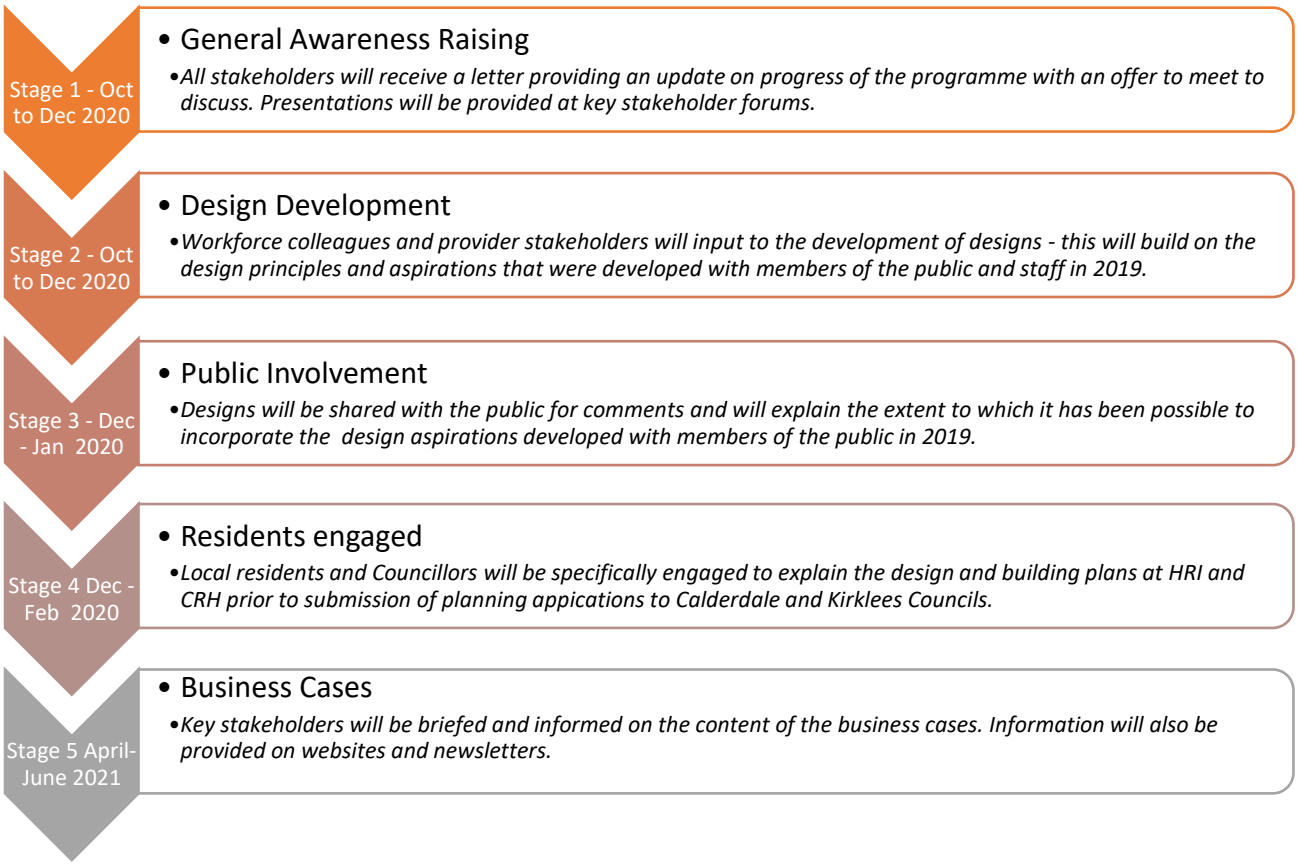
- Open, honest and transparent - clear about our plans and what is and is not negotiable and the reasons why and how decisions are made
- Clear and concise - allowing messages to be understood by all
- Accessible and inclusive - to all audiences at times, places and in formats that make it easier for people to have a say
- Timely – providing enough time for people to consider issues and respond
- Two-way - letting people know the outcome of all conversations

Our aim is that through effective communication and involvement we will:

- raise public, stakeholder and colleague awareness of the service and estate plans and capture any comments/issues raised;
- effectively communicate the planned benefits of the reconfiguration and that this will secure the longer-term future of health services, improve quality and safety for patients, and make CHFT a more attractive place to work. This will include explaining how the plans have incorporated learning from experience during the Covid-19 pandemic;
- ensure people who access health and social care services, families, carers and the public are involved and informed as more detailed plans are developed;
- ensure that health and care workforce colleagues are involved and inform the development of plans;

- understand the changing demographics of our local communities and how this relates to service use, access and patient experience;
- demonstrate that any potential impact on health inequalities and on protected groups is captured, analysed and addressed;
- ensure information is accessible in a range of formats and languages and that communication activities are inclusive;
- inform and involve Health and Wellbeing Boards, the Calderdale and Kirklees Joint Health Overview Scrutiny Committee, and local politicians (Councillors and MPs) about our plans, using their expertise and knowledge and keeping them updated throughout the process on timescales;
- ensure key stakeholders are informed of the submission of requests for planning permission submitted to Kirklees and Calderdale Councils and the preparation of business cases;
- engage with residents living in the immediate vicinity of CRH and HRI on the proposed new-build developments and offer them the opportunity to comment on the building plans.

The headline next steps on communication and involvement activities over the next 12 months is shown below.



We will constantly monitor our activity, including equality monitoring, to ensure we are reaching our audiences effectively and provide accessible and appropriate opportunities for

involvement and feedback. Through monitoring and evaluation, we will be able to learn lessons and gain insight into public and stakeholder views, allowing us to tailor our communication and involvement methods accordingly. This will include monitoring the demographics of the people we communicate with and involve ensuring we don't exclude any groups.

Examples of how we will monitor activity include:
- Media and social media monitoring.
- Colleague feedback via briefings, surveys etc.
- Patient and public feedback via various methods.
- Equality monitoring
- Other feedback, for example the public enquiry register, FOI log, media requests

Where necessary we will update our approach to adapt to colleague, clinical, patient, and public and community feedback. We will demonstrate that we listen to comments and suggestions from all our stakeholders so that everyone feels fully involved in the development of our plans.

6. Primary and Community Services

The Strategic Outline Case confirms that the total number of hospital beds will continue to remain broadly as they are now whilst integrated services are developed in the community and demonstrate a sustainable reduction in the demand for in-patient hospital care.

Previous updates to the Joint Scrutiny panel have described the developments that have already progressed in the delivery of integrated services and outlined the overall approach to the way that service provision will be changed to reduce the demand on hospital. This included both CCGs having established Primary Care Networks, agreed the membership, completed Network Contract DES registration requirements and appointed Clinical Directors, together with examples of how improved care was being delivered for patients. These changes to the delivery of Community Services are subject to separate place-based Scrutiny in both Calderdale and Kirklees.

The experience from the Pandemic is that the continued integration of services is able to be implemented at pace across Primary, Community and Social care. Much of this is supported by strong working relationships and adoption of technology by both patients and staff. Examples include:

- a fundamental shift of outpatients from face to face to telephone and video consultation, including demonstrating viability of digital and virtual care in areas previously thought as inappropriate e.g. wound care.

- virtual consultations of Care Home residents in Calderdale and Kirklees, by multi-disciplinary community and primary care teams reducing the need for people to attend hospital;
- Direct access from Primary Care to consultants for advice and guidance regarding treatment reducing need for admissions.
- The Frailty team have been providing support to start IV antibiotics and fluids etc and the requests for this have come directly from the GPs to the Frailty team.
- The experience has demonstrated that the system can train, support, induct and develop competencies quickly and safely.

7. Recommendation

Members of the Joint Health Scrutiny Committee are requested to:

- Note the revised programme timeline and general update;
- Note the process of involvement of public and colleagues that has been undertaken to develop the design brief;
- Note the next steps to involve members of the public and colleagues in the development of plans for service reconfiguration and estate development;
- Note the update on the development of primary and community services.