Public Document Pack

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Tuesday 27 July 2021

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 **10.00 am** on **Wednesday 4 August 2021.**

This meeting will be live webcast. To access the webcast please go to the Council's website at the time of the meeting and follow the instructions on the page.

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 Harpreet Uppal - Kirklees Council
Councillor Colin Hutchinson - Calderdale Council (Joint Chair)
Councillor Howard Blagbrough - Calderdale Council
Councillor Megan Swift - Calderdale Council
Councillor Mike Barnes - Calderdale Council

Agenda
Reports or Explanatory Notes Attached

Pages

1: Minutes of Previous Meeting

1 - 12

To approve the Minutes of the meeting of the Committee held on 19 March 2021.

2: Interests

13 - 14

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

The meeting will hear any questions from the general public.

Questions should be emailed to richard.dunne@kirklees.gov.uk no later than 10.00 a.m. on Tuesday 3 August 2021.

In accordance with Council Procedure Rule 51(10) each 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.

15 - 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: Update on Development of Community Capacity in Calderdale and Kirklees

21 - 30

The Committee will receive an update on the work that is being undertaken to help manage demand for hospital services through the development of community services (Care Closer to Home).

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

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8: Impact of the pandemic on reconfiguration plans

31 - 36

The Committee will receive details on how the pandemic is informing the plans for service reconfiguration and estate development programmes of work.

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

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9: 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 AND KIRKLEES JOINT HEALTH SCRUTINY COMMITTEE

Friday 19th March 2021

Present:

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

In attendance:

Anna Basford - Calderdale and Huddersfield NHS Foundation Trust (CHFT).
Mark Davies - CHFT
Carol McKenna – Greater Huddersfield Clinical Commissioning Group (CCG).
Rob Moisey - CHFT
Neil Smurthwaite - Calderdale CCG

Apologies: None received

IN MEMORIAM – COUNCILLOR MRS GREENWOOD

The Chair and lead Members recorded their deepest sympathies in tribute to the memory of Councillor Mrs Greenwood who had recently passed away. Elected Members of the Council shared their memories and passed their condolences to Mr Edward Greenwood and family.

1 Minutes of Previous Meeting

IT WAS AGREED that the Minutes of the meeting of the Calderdale and Kirklees Joint Health Scrutiny Committee meeting held on 25th September 2020 be approved as a correct record.

2 Interests

No interests were declared.

3 Admission of the Public

All items were taken in public session.

4 Deputations/Petitions

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

Deputation 1 – Hands off HRI

The latest plans for Transport are not based on good evidence. How can a survey on transport undertaken in November 2020 hold water? This country was in the middle of a pandemic. Hospital services were not running as they had been 12 months ago. Visitors were not allowed into the hospital and many outpatient clinics were being held remotely. People were being told not to use public transport unless it was necessary, and many people were either shielding or staying at home as the government had asked

Deputation 2 – Care Closer to Home

The Clinical Commissioning Groups must produce evidence that Care Closer to Home services are on track to cut A&E attendance and reduce emergency decisions by more than 10% over five years. The assumption that they will is the basis for the hospitals' planned capacity, which keeps 2019 bed numbers rather than provide more to absorb the forecast increase in A&E attendance and emergency admissions activity caused by demographic growth.

Deputation 3 – Clinical co-dependencies and A&E at HRI

The question of clinical co-dependencies for A&E departments has been considered by, in particular, the NHS South East Coast Clinical Senate and by the Kings Fund. The SECCS carried out an extensive review of the evidence base and a comprehensive clinical review of interdependencies between acute services and A&E departments. They concluded that necessary on-site services required to support any A&E department (even those not taking acute patients) include acute medicine, respiratory medicine, urgent GI endoscopy (upper and lower), cardiology, trauma, adult critical care, urgent diagnostic haematology, and acute mental health services. Similarly, the Kings Fund review of evidence on service reconfiguration2 finds that 'key clinical and service interdependencies' for A&E departments include critical care, acute medicine, acute surgery, paediatric expertise and access to inpatient beds.

Deputation 4 - Calderdale and Kirklees 999 Call for the NHS

Calderdale and Kirklees 999 Call for the NHS response to CHFT's Future Plans engagement is that it is invalid.

The Future Plans public engagement does not provide any information about the capacity of the new A&E buildings.

6 Estate and Service Developments for Calderdale Royal Hospital and Huddersfield Royal Infirmary

The Director, Transformation and Partnerships, Calderdale and Huddersfield NHS Foundation Trust (CHFT) presented the design plans for Calderdale Royal Hospital and Huddersfield Royal Infirmary.

The purpose of this report was to provide the Calderdale and Kirklees JHSC with a further update in relation to:

- The reconfiguration programme timeline;
- The actions taken to involve members of the public and colleagues to inform the proposed development plans for Calderdale Royal Hospital and Huddersfield Royal Infirmary;
- A summary of the current proposed development plans;
- The next steps for public involvement to provide feedback on the proposed development plans.

A detailed Programme plan and timescale was developed in March 2020 however it became clear the plan would need to be revised due to the Covid-19 pandemic impact. In September 2020 an updated timeline was shared with the JHSC.

Since September 2020 there had been a third wave of the pandemic which impacted the programme and led to further slippage of approximately 3 months on the timescale previously advised. However, whilst this had required adjustment of some key in-year milestones during 2021 it had not impacted on the overall programme timescale with completion of the build of the new A&E at Huddersfield Royal Infirmary HRI in 2023 and completion of the hospital build at Calderdale Royal Hospital CRH in 2025 remained on track.

Ms Basford advised that the planned dates for submission of planning applications to Calderdale and Kirklees Councils had moved from January / February 2021 to May 2021.

Ms Basford outlined that the detailed design and appearance of the proposals at CRH and HRI had not yet been confirmed and that further information and details were available to view at chftfutureplans.co.uk. The website that was launched on 8th March provided opportunity for members of the public to provide feedback and comments on the proposed plans. Public input would be considered alongside other partners/stakeholders and statutory consultees would be used to inform the design development discussions at this stage of the process, this would also play a key part in the detailed design development at future stages.

The Chair requested clarity around the accident and emergency department which was planned at Huddersfield Royal Infirmary. He advised that the NHS England used a categorisation for accident and emergency departments (type 1, type 2 etc.), which would be helpful for people to understand which category the proposed service at Huddersfield would fall into.

Mr Davies responded to the Chair and stated that they had defined what category of emergency department it would be. In terms of the categories that would be used; Level one was described as a consultant emergency department which would cater for patients with all presentations but advised that this would be for NHS England to define.

Mr Davies further advised that they have emergency physicians on site 24 hours a day, as required for level one emergency department, there would also be senior anaesthetics support to the department 24 hours a day. He clarified that they would have a 24-hour emergency department and specialists on site to manage and

stabilise any patient or transfer them to a more appropriate place such as Halifax or Leeds.

Mr Davies further advised that the availability of surgical specialists at Calderdale was at a level one , but stated there was no acute general surgical orthopaedic provision on the site, which meant that if anyone needed urgent intervention from a surgeon they would be stabilised by the emergency department staff and the anaesthetic staff and then transferred to Huddersfield.

Councillor Smaje wanted to understand how the inequalities would be addressed; the ones that were known before the pandemic and also ones that had widened as a result.

Ms Basford advised that they were actively using the inequalities data to understand the variation in those waiting times, and to proactively ensure that there were not differential waiting times for different parts of the populations to address that inequality. She further advised that she was chairing the Calderdale Black Asian Minority Ethnic (BAME) action plan for Calderdale, working with many partners about what actions could be taken with local populations to better understand their experiences and what adaptations would help to support them.

Ms McKenna advised that the work on health inequalities was system focused and that they needed to be able to build on what was learnt from the events of the previous year.

Ms McKenna stated that the health inequalities was a standing item on the agenda at the Kirklees Integrated Health & Care Board and advised they were using this time to understand more deeply in certain areas. She mentioned that they had done a piece of work on the news of cancer and learning disabilities, and the sort of inequalities that were seen. Colleagues within Calderdale & Huddersfield Foundation Trust CHFT have worked alongside Calderdale Commissioning Group CCG to understand the impact on particular groups within society.

The Chair stated that it was important for digital exclusion not to be added to the inequalities, as there had been a huge impact in the education system over the past year, and also in the retail banking system for many years; so, this should not be aggravated within the NHS system, and hoped that this would be actively considered in the reconfiguration proposals as well as the wider health system.

Councillor Swift commented on the multi-story car park plans at the Calderdale Royal Hospital and wanted to be assured that this would not affect the allotments.

Ms Basford advised provided an absolute assurance that the proposed developments would not impact the allotments.

Councillor Cooper commented on the criticisms received regarding the travel survey, which was carried out in November 2020, during the pandemic. He wanted to know what the Officers views were from the response of this survey.

Councillor Cooper also wanted to know if the capacity had been assessed and if the demographic change had been considered with all the changes that were going to happen within Calderdale & Kirklees. Councillor Cooper wanted to know how many people who were currently being treated in Huddersfield were going to be expected to move across to Calderdale under the new arrangements.

Mr Sugarman advised that they received a really good response from the travel survey which was conducted during a global pandemic. 1500 responses were received from staff which was about 25% of the workforce. He further advised that Leeds had conducted a similar survey which was not during a pandemic and only had a 2.52% response rate from staff. They also encouraged the staff to think how they might have travelled pre pandemic.

The Chair wanted to know how many visitors and patients participated in the travel survey.

Mr Sugarman advised that 240 patients and visitors had completed the travel survey however he did not have a breakdown of this figure.

Councillor Cooper requested for some clarification to Mr Sugarman's response and asked how it would it have been possible for visitors and patients to conduct the survey and encouraged to think 'pre pandemic'.

Mr Sugarman's advised that the statement on the survey was for visitors and patients to think about how they would typically travel to hospital before the coronavirus. He further advised that they had regular outpatients and visitors who made regular trips to the hospital. They acknowledged that the travel survey had been undertaken during a global pandemic and would be difficult.

Ms Basford responded to Councillor Cooper's second question regarding capacity. She advised that she did not have all the numbers to hand but could advise in terms of process around capacity modelling. The strategic outline case had gone through a rigorous scrutiny, through NHS England. They looked at the plans based on activity modelling and the projections forward over the next 5 years.

Ms Basford informed the Committee that they had looked at activity on the two sites, Calderdale & Huddersfield and confirmed that both hospitals would provide outpatient services, diagnostic services and midwifery services locally.

Mr Davies advised that a significant number of Huddersfield residents currently went to Halifax for inpatient care and a significant number of Calderdale residents had their care in Huddersfield. He confirmed that they would be able to provide an estimate net movement for Councillor Cooper.

Councillor Cooper commented on the response from the Officers and mentioned that they had been providing qualitative answers and not quantitative answers and advised that if that assessment had been done, they would have been able to advise on how many patients would be requiring services at Calderdale Hospital.

Mr Davies advised that the calculations had been up to date and was based around how much space they required to deliver the care. The modelling was based on a 2% per annum increase in non-elective attendance to the emergency department and operations, which was an average of the last five years demographic growth, before the Coronavirus pandemic.

Councillor Simpson mentioned that as reflected in one of the deputations, the key issues were around the integrated care closer to home, which had a demonstrable impact in reducing the demand for hospital services. He stated that as a committee they had not yet seen the evidence of the impact in a sustained way. He asked the Officers if the Trust would be able to provide this to them so they could provide an evidenced recommendation.

Ms McKenna advised that Care Commissioning Group CCG had been working on a strategy for care closer to home and the levels of investment to support this. They had continued to focus efforts in responding to the pandemic. In Huddersfield they commissioned an interim community phlebotomy service, which supported the backlog and also continued providing support to care homes above national requirements.

Ms McKenna informed the committee that the CCG had introduced dedicated services that specifically focussed on the impact of Covid-19. Pulse Oximetry was introduced where patients were given equipment at home to monitor oxygen levels.

Councillor Munroe notified the Board that Kirklees had a population of 420,000 and Calderdale 210,000. She further advised that the Government had proposed 32,000 new homes to be built in Kirklees and 10,000 new homes to be built in Calderdale.

Councillor Munro wanted to know if the strategic assessment could be revisited due to the predicted increases in population within Kirklees and Calderdale in the future years.

Councillor Munro also mentioned that the plan stated to increase the parking by 50% at Calderdale. She wanted to know would there be enough places for the public to park as there would be additional staff to consider as well.

Councillor Munro wanted to know how the carbon footprint would be reduced and requested for quantitative data to be provided regarding this.

Mr Sugarman advised that they had promoted cycling, active travel and public transport for staff. They were working on improving the bike storage and looking to install electric vehicle charging in car parks at both sites. He further advised that they had received a promotion of the metro bus schemes which would develop park and ride for staff.

Mr Sugarman mentioned that sustainability was being incorporated throughout the design stage of the reconfiguration plans and all the work that was carried out had been designed to be as sustainable as possible. He stated that they were committed to construct a new estate which would help to ensure maximise sustainability in all areas; energy efficiency, mitigating pollution, waste segregation and recycling.

Mr Sugarman advised that they would be incorporating low carbon heating within the design, including air source and ground source heating pumps and looking at other technologies such as solar photovoltaic.

Councillor Munro advised that she would like to see some hard data and asked if an assessment had been done to assess how many people were currently travelling from Kirklees to Calderdale.

Mr Sugarman confirmed that they had worked on the park and ride scheme where they analysed data in relation to staff travelling to the hospital. They analysed postcodes and the site they work at and designed a park and ride scheme following this; information which had been picked up from the travel survey.

Mr Rob Dadzie further advised that there was a lot that they had achieved in trying to address carbon emissions. They embarked on an LED lighting replacement scheme, approved the green plan for the next five years across the Trust and the next steps was to try and reach the net zero target for 2040.

The Chair advised that there was not enough time to discuss the carbon budget and for this to be returned to at a future meeting, to see what the carbon budget was and if this building was working for its construction and its operations to the future; so this could be fully understood.

Mr Baron responded to Councillor Munro's question regarding the parking provisions at Calderdale Hospital. He advised that they were looking for a multi-story car park which would increase the number of spaces on site for Calderdale. The spaces would increase by 1300 spaces which would provide increased access for patients, visitors and staff.

Councillor Munro wanted to know how many additional staff would be recruited for Calderdale.

Mr Baron confirmed that additional staff/recruitment was not required for the Trust, however they would expect around 900 more colleagues to be working at the site, this would however be within the 24 hour provision. He stated that through the pandemic more colleagues had been working off site and this so this would be encouraged post reconfiguration as well.

Councillor Collins advised the officers to get the data as soon as possible so the plans could be amended if they needed to be, as she stated that from a Calderdale point of view the committee was determined that care closer to home worked and they got these reductions in demand, and advised if this was not to work then it would be a disaster.

Councillor Smaje asked the following questions:

- Not received the changes to the financial case or the pin in the proposals, could we have details of this?
- They required the clarification on the timelines for the Business Cases

- Officer mentioned that they would start building once there is a final Business Case. Councillor Smaje wanted to know why they had not done an OBC for Huddersfield Royal Infirmary and why the full business case had not been done?
- With regards to the Travel Plan, she wanted to know why the results contradicted previous travel surveys, in terms of the distance travelled, the number of people travelling, patients and visitors travelling; and does not consider the travel group recommendations.

Mr Baron responded to the financial modelling of the business case. He advised that they were commencing the modelling for financial modelling for Huddersfield Royal Infirmary and this would be developed as a full business case by May. He further advised that the financial modelling for the Outline Business Case would be available in August.

Mr Baron further commented on the £30m that was invested overall in Huddersfield Royal Infirmary and advised that this would be phased due to the residual element of the investment through the Outline Business Case for total reconfiguration.

Ms Basford clarified the dates for business cases being completed and advised that there would be an internal process to go through and mentioned that the business case for Huddersfield Royal Infirmary would be ready by August and the business case for Calderdale Royal Hospital would be ready by November.

The Chair asked if the timelines for submission of the business cases to this committee, was distinct from the submission of the business cases to NHS England and Department of Health and Social Care? Ms Basford advised that in terms of the dates the documents would need to be submitted by the above dates and then forwarded to the NHS England for a thorough review.

Ms Basford clarified that the business case would be not be ready until late Autumn so they would not be able to bring anything to discuss at the committee meeting with regards to this, however points around care closer to home, detail around sustainability and ongoing scrutiny could be discussed and that she would welcome any questions regarding this at the next meeting.

Councillor Smaje advised that the JHSC should be looking at the information which will be going in the business case, in tandem with it going to the NHS and stated that they needed to see the full business case. Councillor Smaje also mentioned that the JHSC needed to be aware of the financial assumptions that had been made to support the reconfiguration. She clarified to the committee that the Full Business Case was only for the A&E part of Huddersfield reconfiguration and the Calderdale reconfiguration was be set out in an Outline Business Case.

IT WAS AGREED that the updated be noted.

7 Travel and Transport Update

Managing Director, Calderdale Solutions, Stuart Sugarman submitted a written report and provided a Travel and Transport update to the committee. In May 2017, a Travel and Transport group was established following the public consultation on the

proposed future arrangements for hospital and community health services in Calderdale and Greater Huddersfield, after analysis identified travel and transport as key areas highlighted by the public.

The Travel and Transport Group included a wide ranging membership, with representatives from Calderdale and Greater Huddersfield CCGs, Calderdale and Huddersfield NHS Foundation Trust, South West Yorkshire Partnership NHS Foundation Trust, Calderdale Council, Kirklees Council, Healthwatch, Upper Calder Valley Renaissance Sustainable Transport Group, West Yorkshire Combined Authority and others.

The purpose of the report was to provide the Calderdale and Kirklees JHSC with an update in relation to the Travel and Transport work that had been undertaken recently and to share the Travel Plan that had been developed. This followed and refreshed the previous work done by the Travel and Transport Working Group and set out the current and future actions around travel and transport.

The Trust had established a travel and transport workstream as part of the reconfiguration work to consider related travel matters and had most recently developed a Travel Plan which was shared within the update report.

Members of the Joint Health Scrutiny Committee were requested to:

- Note the Travel and Transport update provided;
- Note the Travel Plan included and the associated action plan which had been developed by the Trust.

The Chair mentioned that they had been told from within the report that the responsibility for travel transport and highways was led primarily by local authorities rather than the NHS.

Ms Basford clarified that Stuart Sugarman, was the board level director lead for travel and transport in the trust.

Mr Sugarman advised that CHFT had continuing dialogue with the West Yorkshire Combined Authority, which was to seek the improved provision of commercial bus services between the two sites.

Mr Sugarman further advised that the commercial bus service was available, bus number 343 which linked between the two hospital sites, and with ongoing dialogue with both authorities, this could be further developed.

The following points were raised during discussion:

- Specific points about the shuttle bus service recommendations were made by the independent chair that it was required to be upgraded, so that it would be

suitable for patients, including people with wheelchairs and limited mobility and children, whereas the shuttle bus service currently was very much directed at staff who were travelling between the two sites.

- Recommendations for improving the patient transport service, which did not start early enough in the day to be able to get patients to hospital in time for morning operating lists.

The Chair wanted to know if the shuttle bus and patient transport service was being addressed.

Mr Sugarman confirmed that the shuttle bus was being addressed and that changes were being made; however, the Trusts view was that shuttle service was only for staff use.

Mr Sugarman further advised that CHFT had previously advised the shuttle should be provided by the bus providers and not the trust, as they had more licenses experience and the infrastructure. He also confirmed that they had been working on improving the shuttle bus and looking at different routes and park and ride options; however, stated that this would be for the staff, and not visitors and patients.

Councillor Smaje advised that this had been done before in the Northern part of Kirklees where a shuttle bus was reconfigured as a park and ride service for patients and visitors and stated that this was commercially viable.

Mr Sugarman advised that they had been in discussion with the combined authorities to implement this.

The Chair advised that this discussion would need to return to the committee so that they could ensure there was equity in certain services that people accessed and were not limited by the cost of accessing transport to get to those health services.

IT WAS AGREED that the updated be noted.

VOTE OF THANKS – COUNCILLOR ANNE COLLINS

The Chair advised the committee that this would be the last meeting for Councillor Collins as she would not be standing for re-election and thanked her for the hard work and dedication she had shown to this committee over the years and that she would be missed.

IT WAS AGREED that the Calderdale and Kirklees Joint Health Scrutiny Committee extended its gratitude and best wishes to Councillor Collins.

The Chair advised that they would need to arrange a date with Officers for the next meeting which was to be held in June. He mentioned that Councillor Smaje and himself could conduct an informal meeting to discuss the following points and for these to be brought to the future Calderdale and Kirklees Joint Health Scrutiny meeting:

- The delivery of care close to home, and how it matched up with the assumptions in the capacity plans in the strategic outline case.

- The written report on the financial actual case underpinning the strategic outline case, including the impact of the write off of the trust's historic debt.
- The impact of the pandemic and the recovery projections
- The impact on the financial case on the chain, in turn, changes in NHS financing that had taken place with the rollback from payment by results to block contracts.
- Revisit the travel arrangements
- Further details about the carbon budget of the building work and the subsequent operation of services that its working to.
- Need to be assured that the hospital capacity planning is fit for purpose, now and in the future, bearing in mind the capacity needs that will be needed in the future.
- The committee would need to see the revised modelling business case for the Yorkshire Ambulance Service before they are submitted.

The Chair thanked the committee members for their attendance and closed the meeting.

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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
4th August 2021

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 an Outline Business Case (OBC) for CRH and a Full Business Case (FBC) for HRI will be submitted to NHSE and DHSC for approval in 2021.

A progress report was previously submitted to the Calderdale and Kirklees Joint Health Scrutiny Committee in March 2021.

2. Purpose

The purpose of this report is to provide the Calderdale and Kirklees JHSC with a further update in relation to:

- the reconfiguration programme timeline;
- the structure and content of the business case documents;
- an update on the engagement undertaken during 2021

3. Programme Update

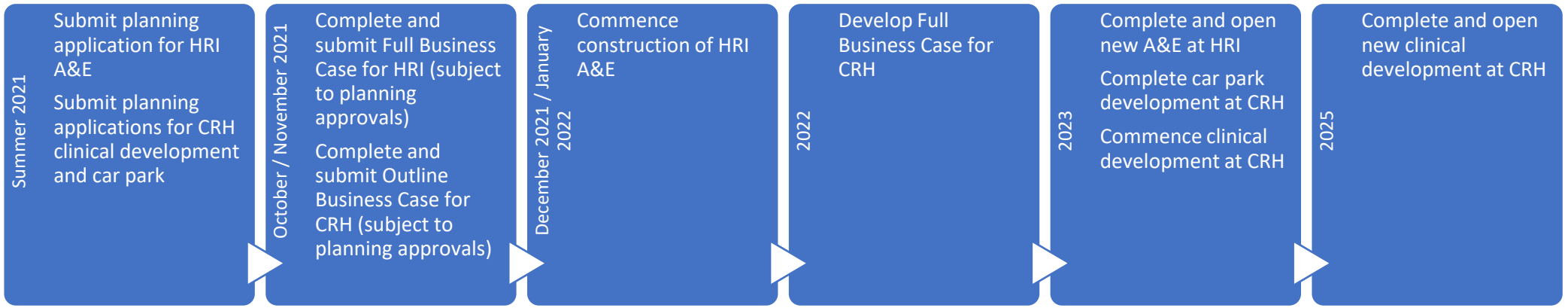
Following approval of the SOC in January 2020, work has been undertaken to clarify the process of developing the next stage of business cases required by NHSE and DHSC. This has taken account of the fact that the estate at HRI carries a high risk in relation to the condition and reliability of the existing 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.

A detailed Programme plan and timeline was developed and shared with JHSC in March 2021 when it was reported that the planned dates for submission of planning applications to Calderdale and Kirklees Councils was planned for May 2021, however these dates were further revised.

The planning application for the new A&E at HRI was submitted to Kirklees Council on 16th June 2021 and the planning applications for the clinical development and car park at CRH will be submitted to Calderdale Council at the end of July 2021.

The programme timeline is shown below.


Summer 2021
Submit planning application for HRI A&E
Submit planning applications for CRH clinical development and car park
October / November 2021
Complete and submit Full Business Case for HRI (subject to planning approvals)
Complete and submit Outline Business Case for CRH (subject to planning approvals)
December 2021 / January 2022
Commence construction of HRI A&E
2022
Develop Full Business Case for CRH
2023
Complete and open new A&E at HRI
Complete car park development at CRH
Commence clinical development at CRH
2025
Complete and open new clinical development at CRH

4. Business Case Structure

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.

The OBC and FBC documents will be structured to explain the proposed service changes from 5 interdependent dimensions, known as the Five Case Model and these are described below.

Strategic Case	The strategic case sets out the rationale for the proposal, it makes the case for change at a strategic level. It sets out the background to the proposal and explain the objective that is to be achieved. The strategic policy context and the fit with the wider public policy objectives and the department's corporate plan must also be satisfactorily explained.
Economic Case	This section of the business case assesses the economic costs and benefits of the proposal to society as a whole. These are not the same as the financial costs to the department or body undertaking the expenditure
Commercial Case	The commercial case is concerned with issues of commercial feasibility and sets out to answer the question "can the proposed solution be effectively delivered through a workable commercial deal or deals?" The procurement strategy should be clearly set out in the commercial case and the ownership of any assets should be clearly defined and key contractual issues identified and explained, together with the proposed solution.
Financial Case	The financial case is concerned with issues of affordability, and sources of budget funding. It covers the lifespan of the scheme and all attributable costs.
Management Case	The management case is concerned with the deliverability of the proposal and is sometimes referred to as programme management or project management case. The management case must clearly set out management responsibilities, governance and reporting arrangements

5. Engagement Update

In the last update report to JHSC we outlined the pre-planning engagement and involvement completed in March 2021 to support the development proposals.

During March 2021, members of the public were invited to learn more about the project and provide their feedback via a digital consultation. A programme of stakeholder engagement with key politicians, officers, civic and community groups to either inform about the project or to continue existing dialogue also took place. CHFT colleagues, many of whom live local to the hospital sites, were also been engaged throughout this process. This work will continue throughout the project.

The engagement feedback including surveys, written letters, telephone conversations and emails have helped inform the development of the planning application. CHFT has also engaged during the pre-application process with planning and other technical officers at Kirklees and Calderdale Councils to ensure a robust planning application was submitted.

A particular emphasis has been placed on engaging with seldom heard groups and those who are digitally excluded. We made materials available in other languages, sent leaflets or letters to the nearest 1,000 households, printed and sent copies of materials to residents without internet access, discussed the plans on the telephone and via email and promoted the engagement at both hospital sites. During the engagement we analysed the equality monitoring and proactively targeted contact with groups who were underrepresented.

It is clear from the feedback forms completed that the community is broadly supportive of the proposals. In particular, respondents have advised that the project team ensure the future buildings are well-designed, sustainable, and easily navigated.

In summary, it has been demonstrated that a robust and detailed public involvement and stakeholder engagement programme has been undertaken by the Trust in advance of the submission of the planning applications. The Trust will continue to involve local people and stakeholders regarding the development and will provide information via CHFT website.

6. Recommendation

Members of the Joint Health Scrutiny Committee are requested to:

- Note the programme update and timeline, including the detail of the business case document structure;
- Note the process of involvement of public and colleagues that has informed the proposed developments at CRH and HRI.

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Care Closer to Home

Update on Development of Community Capacity in Calderdale and Kirklees

June 2021

1. Background

For several years Calderdale and Greater Huddersfield Clinical Commissioning Groups (CCGs) have worked collaboratively with community groups, health, social care, and voluntary sector organisations in Calderdale and Kirklees to deliver ambitious plans for integrated community services.

The plans in each Place align with the NHS Long Term Plan and with the West Yorkshire and Harrogate Health and Care Partnership's strategic plans. Regular updates on this work is reported to the Calderdale and Kirklees Health and Wellbeing Boards and to Calderdale and Kirklees Place-based Scrutiny Committees.

The COVID-19 pandemic has affected every community in Calderdale and Kirklees with some of the biggest impacts seen for the most disadvantaged people and BAME communities. The experience of the pandemic has made the need and importance of providing integrated care in local communities even stronger.

In December 2018 the findings of an independent review, commissioned by the CCGs, was completed. The purpose of the review was:

> "*To clearly quantify the impact of interventions in primary and community care on reducing demand in acute settings, by being more rigorous about: which interventions work; how we could standardise their application; and the utilisation of underpinning data driven modelling to give confidence in delivery*."

The independent review had a specific focus on identifying best practice interventions that could potentially reduce demand for hospital services. However it is important to note that the plans for reconfiguration of hospital services across Calderdale Royal Hospital and Huddersfield Royal Infirmary (described in the Strategic Outline Case approved by NHSE and DHSC in 2019) confirmed that hospital bed capacity across the two hospitals will be maintained.

2. Purpose

The purpose of this report is to provide an update, since the independent review was undertaken in 2018, in relation to:

- the 'best practice' interventions identified in the review that have been implemented in Calderdale and Kirklees;
- the investment in Community services across Calderdale and Kirklees since the review;
- the observed impact since 2018 on demand for hospital services.

This report provides a summary of the work that has been undertaken to develop community services enabling more patients to be cared for appropriately, for longer, in community settings helping to manage demand for hospital services. More detailed information in relation to the developments in each Place will be reported to the Calderdale and Kirklees Health and Wellbeing Boards and to Calderdale and Kirklees Place-based Scrutiny Committees.

3. Best Practice Interventions Implemented

The independent review undertaken in 2018 identified 13 best-practice interventions which were grouped under three main approaches:

i. Prevention and proactive care;
ii. Swift and appropriate access to care; and
iii. Supporting people with care transition.

The definition of these, under the three categories, is shown below.

1	Prevention and pro-active care	a	Case management: Pro-active case finding, assessment, care planning and care co-ordination for patients with long term conditions, putting them, their families and carers at the centre of decision making
		b	Multidisciplinary teams: A regular whiteboard session with a core group of professionals to pro-actively discuss patients or users who are at risk of requiring increased input. Additional professionals may participate ad hoc
		c	Care co-ordination: Provides a single point of contact and helps the patient and their supporters to navigate complex services. Often provided by a care navigator, or care co-ordinator, but this can also be the patient
		d	Individualised care plan: Develop a patient-centric care plan based on their current and future needs, focusing on what is important to the patient, beyond clinical treatment. It takes a 'whole life' approach
		e	Frequent touch points: Pro-active, regular and frequent contact with health professionals for at-risk patients to reduce the risk of crisis events
		f	Scheduled service user follow-ups: Use of regular scheduled follow-ups to reduce the requirement for urgent care services
		g	Self-empowerment and education: Patient education programs and use of technology to support self-care, with the aim of empowering the patient to become independent and resilient, taking responsibility for their own health
2	Swift and appropriate access to care	h	Rapid response: A multidisciplinary team that can be deployed to assess patients and prevents hospital admissions by providing health or social care support for those experiencing an episode of illness or injury
		i	Rapid access to primary care: Facilitating access to primary care in the acute setting, after appropriate triage. Also includes improved access from extended opening hours or other channels, eg eConsult
		j	Access to specialist care: Access to consultant support and specialist care in the community, including diagnostics
		k	Appropriate referral and medication practices: Avoid unnecessary interventions by only referring patients as appropriate
3	Support with care transition	l	Discharge support: Community, primary and social care in-reach to support early assessment and discharge of patients from acute care. Dovetails with intermediate care and overseen by a care navigator
		m	Intermediate care: Provision of step-up or step-down care in a patient's home or a community hospital inpatient facility to prevent unnecessary admissions to, and to facilitate early discharge from, acute care

In Calderdale and Kirklees many service developments based on these best practice interventions have been implemented. Mapping of the service developments implemented since 2018 to these interventions is provided at Appendix 1.

This includes (for illustration) the following examples:

- Virtual Frailty Service that runs 7 days 24 hours to prevent admissions to hospital;
- Digital Capabilities - to support early and preventative remote monitoring such as; Telecare/telehealth in care homes and people's own homes; Pulse Oximeters @ Home; Blood Pressure Monitors;
- Urgent community response service to provide a 0 – 2 hour response for patients diagnosed as moderately or severely frail, in order to prevent avoidable admissions and readmissions through management of the patient at home with appropriate ongoing community support;
- Primary care support to care homes aligning general practices with care homes to improve continuity of care and introducing weekly home rounds.
- Community Discharge to Assess (D2A) – that embeds the Home First ethos and Discharge to Assess approach and includes provision of additional funding for up to 6 weeks to support recovery following hospital discharge.

4. Investment in Community Services

There has been significant additional investment (totalling £62m over three years) to increase community and primary care capacity in Calderdale and Greater Huddersfield in the period 2018/19 to 2020/21. CCGs have also planned for further investment in 2021-22 as shown below.

CCG	3 Year Additional Investment 2018/19 to 2020/21 £(000)	Planned investment 2021/22 £(000)
Calderdale	28,014	15,826
Greater Huddersfield	34,500	23,000
TOTAL	62,514	38,826

This investment has been used to enable implementation of the best practice service developments summarised in section 3.

5. Workforce Capacity Impact

The significant investment has enabled an expansion of primary, mental health and community workforce to increase capacity of services and meet the needs of our population.

For example this includes the establishment of additional roles such as: Advanced Nurse Practitioners, GPs, Care Navigators, Rapid Response Support Workers, Clinical Pharmacists, Pharmacy Technicians, Social Prescribers, First Contact Physiotherapists, Health and Wellbeing Coaches, Dieticians, and Physician Associates.

The approach has not been based solely on increasing numbers of staff but also to enable people to work differently providing skills development and training to make better use of the overall system resource, and importantly to support colleague health and wellbeing.

Through the pandemic there has been a recognised cultural 'shift' in the behaviour of the health and care workforce across the Calderdale and Kirklees system, which has enabled and encouraged working across organisational boundaries. Cross boundary working is a long-standing aspiration, as an enabler to support people to receive the most appropriate care, in the most appropriate setting, first time. The fast paced, responsive environment through the pandemic has required us to mobilise and implement new ways of working. As partner organisations we will retain the positive learning and changes as much as possible to ensure that the benefits are maximised for both our population and staff.

6. Impact on Hospital Demand

The impact of the COVID pandemic, means that comparative data only exists up to 2019/20 and therefore can only (and only partially) reflect community developments that were already underway at the time of the 2018 review. The pandemic has also, and will continue to result in, changed casemix in 2021/22 and beyond as we transform the design and delivery of services and recover and reset the system.

We are therefore unlikely ever to be able to demonstrate a robust causal link between the increased and redesigned capacity in the community, and changes in secondary care demand. However the limited data we do have is consistent with the benefits we expected from the community developments implemented at the time of the 2018 review.

The impact on hospital activity we have observed in the period 2017-18 to 2019-20 is summarised below:

- **Mitigation of the impact of demographic growth -** between 2017 and 2020 non-elective admissions were broadly constant per 1000 population

- **Reduced unplanned admissions for people aged over 90 years –** in Kirklees there has been a 9.1% reduction in unplanned admissions for people aged over 90 years in the period since 2017/18.

- **Reduced length of stay (LoS) for adults** - the LoS reduction has been particularly marked in older age groups. In Kirklees the LoS reduction for people aged 70-89 years has been 7%, equating to 131 bed days per 1000 population and in the 90+ age range the reduction is 16%, equating to 1080 bed days per 1000 related population.

7. Summary and Conclusion

This report provides evidence of significant investment in community and primary care services across Kirklees and Calderdale over the past three years. The investment has increased capacity and enabled the development of integrated services that are well matched to the key interventions identified in the 2018 review as internationally-evidenced to have high impact on population health management.

The limited data available is consistent with our expectations that these developments are enabling more patients to be cared for appropriately, for longer, in community settings and helping to manage demand for non-elective hospital services.

Alongside the investments referenced in this report the Calderdale and Huddersfield health and care system benefits from having some of the most highly developed systems of digital connectivity and inter-operability currently available in UK healthcare. The application of digital technology has been accelerated during the Pandemic and this has enabled many more people to access the care and support they need at home and in more convenient ways over the past year. We will continue to develop these opportunities and benefits whilst ensuring this does not widen health inequalities.

We will continue to work with our communities and partners to deliver integrated care that provides a consistent and high quality experience for patients which is in line with the vision and ambitions articulated in Calderdale and Kirklees place-based plans.

Calderdale – Overview of Service Developments Implemented Mapped to ' Best Practice' Interventions													
Calderdale	(1) Prevention and pro-active care							(2) Swift and appropriate access to care				(3) Support with care transition	
	a	b	c	d	e	f	g	h	i	j	k	l	m
Name of initiatives selected													
End of Life Care	x	x	x	x	x		x			x	x	x	
Frailty Service	x	x		x	x	x					x		
Digital Capabilities	x			x	x		x			x	x	x	
Diabetes Prevention Programme	x	x		x	x	x	x		x	x	x	x	x
Enhanced Health in Care Homes (EHCH)	x	x		x	x	x	x	x	x	x	x	x	x
Learning Disabilities	x	x	x		x	x	x			x			
Adult & Older Adults Mental Health and Autism	x	x			x			x		x			
CYP Thriving	x	x	x		x	x	x			x			
Anticipatory Care DES	x	x	x		x	x	x						
Primary Care Additional Roles Inc Social Prescribing Link Workers	x	x	x		x	x	x						x
Well-being Hub	x	x	x		x	x	x						
Long Covid (0-12 weeks)	x				x	x		x	x		x		
Managing Demand in Primary Care	x		x	x	x	x			x		x	x	
Community Discharge to Assess (D2A)		x	x	x		x	x				x	x	x

Calderdale – Overview of Service Developments Implemented Mapped to ' Best Practice' Interventions													
Calderdale	(1) Prevention and pro-active care							(2) Swift and appropriate access to care				(3) Support with care transition	
	a	b	c	d	e	f	g	h	i	j	k	l	m
Reablement/2hr Response		x						x			x		x
Post Covid Pathway and Virtual Ward (12+ weeks)	x	x	x	x	x	x	x	x	x	x	x	x	
System Coordinator	x	x	x	x	x	x	x	x	x	x			x
Designated Beds (COVID)		x	x					x				x	x
Step Up and Step Down (IMC Beds)		x	x					x				x	x
Pulse Oximetry @Home		x			x		x	x	x				
Cross Cutting/Enablers													
PCN development; population health management													
Carers Count													
Calderdale Integrated Commissioning Executive													
Personalised Care													
Facilitation of provider alliances													

Kirklees – Overview of Service Developments Implemented Mapped to ' Best Practice' Interventions													
Kirklees	Prevention and pro-active care							Swift and appropriate access to care				Support with care transition	
	a	b	c	d	e	f	g	h	i	j	k	l	m
Medicines Optimisation	x	x	x	x	x	x	x				x	x	x
End of Life care programme, including Hospice investment.	x	x	x	x	x					x	x	x	
Thriving Kirklees (CYP)	x	x	x		x		x			x			
Anticipatory Care	x	x	x		x	x	x						
Healthy Hearts	x	x		x	x	x	x	x	x	x	x	x	x
Respiratory (Community services)	x	x		x	x	x	x	x	x	x	x	x	x
Frailty Programme / Ageing Well	x	x		x	x	x	x				x		
Diabetes (Early identification & prevention; specialist nursing; improving outcomes)	x	x		x	x	x	x		x	x	x	x	
Care Homes (Including Enhanced Health in Care Homes DES and additional primary care support)	x	x		x	x	x		x	x	x	x	x	x
Community Mental Health	x	x			x			x					
BP @ Home	x		x	x	x		x				x		
Primary Care Equitable Funding (Capacity, resilience, consistency)	x		x	x	x	x			x		x		
Digitally-enabled care	x			x	x		x			x	x	x	
Wheelchairs (Engagement; investment)	x			x								x	
Discharge to Assess		x	x	x		x	x				x	x	x
Kirklees Independent Living Team (Intermediate Care)		x	x					x				x	x

Kirklees – Overview of Service Developments Implemented Mapped to ' Best Practice' Interventions													
Urgent Community Response		x						x			x		x
Primary Care Additional Roles			x	x		x	x		x				
Personalised Health Budgets			x	x			x						
Shifting services to community (MSK & Pain)			x				x			x	x		
Community IV (Training & expansion)					x						x	x	
Health Checks for People with Learning Disabilities					x	x	x						
Healthy Weight declaration							x						
Acute Home Visiting								x			x		
Home First								x				x	
Extended Access & Extended Hours									x		x		
Primary Care On-line consultations									x				
Community diagnostics											x		
Covid Oximetry @ Home	x				x	x		x	x		x		
Covid Virtual Ward	x	x		x	x	x	x	x	x	x	x	x	
Long/ Post Covid pathway		x	x	x		x	x			x	x	x	
Cross-cutting / Enablers													
PCN development; population health management													
Carers Count													
Kirklees Integrated Health and Care Leadership Board													
Personalised Care													
Facilitation of provider alliances													

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Calderdale and Huddersfield Service Reconfiguration

Learning from the Pandemic

1. Background

The COVID-19 pandemic has affected every community in Calderdale and Huddersfield with some of the biggest impacts seen for the most disadvantaged people and BAME communities. The experience of the pandemic has made the need and importance of providing resilient and integrated care in Calderdale and Huddersfield even stronger.

Despite the challenging circumstances of the pandemic positive learning has emerged about new ways of working that we need to embed and amplify in our longer terms plans to ensure learning from the pandemic informs the delivery of improved health outcomes, safety and experience of care in the future. Learning from the pandemic is informing the plans for service reconfiguration and estate development programmes of work. One of the most important areas of learning to emerge is the increased understanding that we are part of a bigger system. We need to work in partnership at local and regional level to provide integrated care to ensure the very best services for the populations we serve.

2. Purpose:

The purpose of this report is to provide information in relation to:

i. learning about new ways of working from experience during the pandemic;
ii. approach to providing treatment for people that have had their care delayed due to the pandemic;
iii. how learning from experience during the pandemic has informed the design of estate developments at Calderdale Royal hospital and Huddersfield Royal Infirmary;

3. New Ways of Working

During June 2020 engagement was undertaken to listen to people's views on the service changes implemented during the pandemic and to ask about their aspirations for future service delivery. 185 colleagues, 9 health and care partner organisations (e.g. Councils, CCGs, Locala, SWYPFT, YAS, Primary Care Networks) and; 1,377 patients and members of the public provided input to the engagement.

The feedback provided from the engagement identified key learning themes of new ways of working where there was agreement that this could have potential long-term benefit and should be sustained and amplified. These themes are described below.

LEARNING FROM THE PANDEMIC - BUSINESS BETTER THAN USUAL PLAN ON A PAGE		
Integration & Partnerships There has been a cultural 'shift' in the behaviour of the health and care workforce across Calderdale and Huddersfield, which has enabled working across organisational boundaries to support patients. Integrated models of care were implemented at pace during the pandemic and we want to embed and amplify these developments.	**Remote Patient Appointments** Digital or telephone appointments have been widely used during the pandemic. This has reduced the need for people to visit the hospital. We want to continue to offer this improved access and ensure the benefits of digital technologies are available to everyone, supporting patients who may lack skills, and confidence or have limited or no access to equipment and connectivity.	**Needs based Prioritisation** Some of the biggest impacts of the pandemic have been on the most disadvantaged and BAME communities. We are using Health Inequalities data to complement clinical prioritisation and our system's post Covid-19 recovery for both planned and unplanned care. We are using real time data analysis of patient waiting lists in relation to index of multiple deprivation, ethnicity, and other protected characteristics to inform prioritisation of patient care. .
Workforce There has been increased focus on support for colleagues' well-being and this must continue – to enable 'one culture of care' where we care for our colleagues in the same way we care for our patients.	**Remote / Homeworking** The option of remote working has brought benefits related to colleague wellbeing, productivity, and positive impact on climate change. There is agreement that remote working where it is possible should continue to be supported.	**Theatres – New Ways of Working** The restart of elective surgery has provided opportunity to redesign theatre scheduling to optimise productivity and this will inform long term planning.
Clinical communication, virtual Multi-Disciplinary Teams & Education The increased use of technology to provide virtual training and meetings has worked well for clinical colleagues and made it easier for colleagues to access meetings and education by reducing travel and improving attendance.	**Reducing Health Inequalities** The pandemic has emphasised the significant health inequalities experienced by our communities. We will work with local communities and use our resources and planned investment to target job creation, apprenticeships and training for the most vulnerable communities to create social value.	**Direct Assessment Pathways** New pathways implemented during the pandemic have delivered benefits of patients moving more quickly from A&E to speciality senior assessment. The aim is to continue and embed this way of working.
Pathology Redesign of the service considering options for delivery in the community (e.g. phlebotomy) and to take account of changing patterns of demand.	**Estate** The limitations and constraints of the existing hospital estate facilities at HRI and CRH has created additional risks to service delivery during the pandemic. The design of new buildings must include features that strengthen infection control, include learning from increased technology and support sustainability.	**Digital Options for Visitors** During the pandemic digital options for patient visiting in hospital have been made available and there is support for these to continue as an option available in the future - and potentially could have wider applicability in other care setting.

Since then a programme of work has been implemented to support and take forward further developments in relation to each of these themes. This work is informing operational planning

and longer term strategic plans in relation to integrated working, digital, estate, and workforce strategies.

4. Providing Treatment for People that have had their Care Delayed

The COVID-19 pandemic has affected every child, adult, family and community in Calderdale and Huddersfield, with some of the biggest impacts seen for the most disadvantaged and people from BAME communities. More than 2,000 patients with Covid have been treated and discharged from our hospitals – but we know some people continue to experience long term health impacts.

CHFT and the wider system has always performed well but management of the pandemic has unfortunately resulted in the development of significant planned care backlogs at CHFT. Throughout the pandemic we have continued to provide timely care for people who have needed urgent care (such as cancer treatments) and emergency care.

Providing treatment for people that have had their care delayed is a top priority. In May 2021, CHFT agreed a framework and plan for restoring elective care (and details of this were reported at the public meeting of the Trust Board). The plan has enabled us to reopen elective services and work towards reducing the waiting lists safely and at pace. This is being delivered in the face of immense challenges post-Covid such as the significant increase in demand for urgent and emergency care that has been experienced and whilst still coping with the output reduction that results from Infection Prevention and Control measures and the uncertainties of COVID.

Since then we have been able to deliver close to, or greater than, pre-pandemic levels of planned care, while at the same time delivering the NHS COVID vaccine programme.

Learning from the Pandemic and new ways of working (described in section 3 of this report) has enabled and informed our approach.

In particular we are:

- Using Health Inequalities data to complement clinical prioritisation to inform our system's post Covid-19 recovery to minimise the risk of treatment delays widening health inequalities in our communities. This includes understanding and taking actions to reduce inequalities experienced by people caused by deprivation, mental health conditions, learning disabilities and for Black, Asian and Minority Ethnic Communities. We have specifically prioritised access to treatment for people with a Learning Disability and over 90% of patients with a Learning Disability who were waiting have now received treatment;

- Optimising the inclusive use of technology and digital capabilities to deliver timely and convenient care for patients. This includes work with partners to ensure the benefits of digital technologies are available to everyone, supporting patients who may lack skills, and confidence or have limited or no access to equipment and connectivity;

- Ensuring “one culture of care” which means that we care for our colleagues in the same way that we care for our patients - ensuring colleague well-being remains a priority;

- Continuing to work closely with all health and social care partners in our local system and across West Yorkshire.

We are committed to reducing the waiting lists and expect the backlogs of care that have arisen due to the pandemic to be eliminated prior to reconfiguration of services in 2025.

5. Learning that is Informing Design Plans at CRH and HRI

5.1 Configuration of Services

During the Covid-19 pandemic dual site working and the limitations and constraints of the existing hospital estate facilities at Huddersfield Royal Infirmary (HRI) and Calderdale Royal Hospital (CRH) has created additional operational risks and challenges to service delivery and infection control.

The current estate configuration and limitations of the physical environment has resulted in a negative impact on patient and colleague experience during this time. Learning from the pandemic has further emphasised the urgent need for reconfiguration of hospital services and investment to improve the Trust’s estate.

As described in the NHS Long Term Plan

“separating urgent from planned services can make it easier for NHS hospitals to run efficient surgical services.”

Experience and learning from the pandemic has really emphasised the benefits of planned care being delivered on a separate site to acute inpatient care as this will provide the best opportunity to ensure continuity of elective care delivery in any future pandemic or similar scenarios.

5.2 Infection Control

The Infection Control and Protection (IPC) team at CHFT (that includes specialist nurses and doctors) have been involved through-out the development of the designs for the estate developments at HRI and CRH. They have worked closely with our clinical teams, architects and specialist advisors to inform our designs.

We have specifically taken account of learning from the pandemic that relates to improved infection control in relation to:

- Space requirements;
- Storage;
- Engineering services (e.g. ventilation)

We are confident our design plans will strengthen our Infection Protection and Control measures and provide increased resilience for future possible pandemic scenarios or similar events. Examples of the learning that has been incorporated in our design plans includes:

- Increased provision of single occupancy en-suite inpatient rooms;
- Increased space between beds in multi-bay areas;
- Improvement of ventilation systems;
- Improved privacy and dignity and infection control in A&E departments by providing glass doors on each cubicle instead of curtains;
- Flexibility and standardisation of room design to enable greater ease to segregate areas if required to support infection control;
- Additional isolation room provision within A&Es;
- improved dedicated storage space in clinical areas (that will reduce movement between areas).

5.3 Travel and Transport

Learning from the pandemic and new ways of working has informed our travel and transport plans. Digital technology has changed the frequency and need for patients and colleagues to travel to our hospitals. During the pandemic we have learnt that many people can conveniently access the care and support they need in their own home using digital technology. Many colleagues are able to effectively work from home or other locations. This learning has been used to inform out future plans and we have developed a sustainable travel plan that incorporates this learning.

5.4 Hospital Capacity

In 2019 the Strategic Outline Case (SOC) approved by DHSC and NHSE described the planning assumptions of the future capacity that would be needed in our hospitals. This included the commitment that we would maintain the total inpatient bed capacity across our two hospital sites.

The planning assumptions used in the SOC included uplift for demographic growth and took account of the projected additional future health needs of the population we serve.

There has been significant investment in community and primary care services across Kirklees and Calderdale over the past three years. These developments are enabling more patients to be cared for appropriately, for longer, in community settings and will help to manage demand for hospital services.

We are continuing to use the capacity assumptions described in the SOC to inform our reconfiguration plans and estate developments for 2025. In the intervening years we plan to eliminate the planned care backlogs that have arisen due to the Covid-19 Pandemic.

6. Conclusion

This report provides information that demonstrates that learning from the Covid-19 Pandemic is informing system recovery post pandemic and the longer term strategic plans for reconfiguration.