Public Document Pack

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Tuesday 18 October 2022

Notice of Meeting

Dear Member

Calderdale and Kirklees Joint Health Scrutiny Committee

The **Calderdale and Kirklees Joint Health Scrutiny Committee** will meet in the **Council Chamber - Town Hall, Huddersfield** at **1.30 pm** on **Wednesday 26 October 2022.**

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 Jackie Ramsay - Kirklees Council
Councillor Elizabeth Smaje - Kirklees Council (Joint Chair)
Councillor Alison Munro - Kirklees Council
Councillor Aleks Lukic - Kirklees Council
Councillor Colin Hutchinson - Calderdale Council (Joint Chair)
Councillor Howard Blagbrough - Calderdale Council
Councillor Mike Barnes - Calderdale Council
Councillor Christine Prashad - Calderdale Council

Agenda
Reports or Explanatory Notes Attached

Pages

1: Minutes of Previous Meeting

1 - 8

To approve the Minutes of the meeting of the Committee held on 16 November 2021.

2: Interests

9 - 10

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.

6: Report of the Calderdale and Kirklees Joint Health Scrutiny Committee workshop on the Outline Business Case

11 - 66

The Calderdale and Kirklees Joint Health Scrutiny Committee (JHSC) will receive a report that summarises the key areas discussed with representatives from Calderdale and Huddersfield NHS Foundation Trust (CHFT) on the Outline Business Case (OBC) at an informal workshop held in June 2022.

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

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7: Update on progress of the new Huddersfield Royal Infirmary Accident and Emergency Department

Representatives from Calderdale and Huddersfield NHS Foundation Trust will be in attendance to provide a verbal update on progress of the new Huddersfield Royal Infirmary Accident and Emergency Department.

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

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8: Yorkshire Ambulance Service revised modelling report

67 - 76

Representatives from the Yorkshire Ambulance Service NHS Trust (YAS) will be in attendance to present the revised YAS modelling report 2021 that is referenced in the OBC and will be used to determine the impact of changes and the additional ambulance capacity required.

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

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9: Next Steps

The JHSC 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 OVERVIEW SCRUTINY COMMITTEE, Tuesday, 16th November, 2021

PRESENT: Councillor
Councillors: Blagbrough, Cooper, Hutchinson, Munro, Smaje, M Swift and Uppal

10 APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillor Barnes.

(The meeting closed at 11:58.)

11 MINUTES OF THE MEETING HELD ON 4TH AUGUST 2021 TO BE AGREED AS A CORRECT RECORD AND SIGNED BY THE CHAIR.

IT WAS AGREED that:

(a) the Minutes of the meeting held on 4th August 2021, be approved as a correct record and signed by the Chair;
(b) a summary be produced of the answers given to Members' questions during discussions.

12 DEPUTATIONS AND PETITIONS

No deputations or petitions were received.

13 HUDDERSFIELD ROYAL INFIRMARY NEW ACCIDENT AND EMERGENCY DEPARTMENT - SUMMARY OVERVIEW OF THE DRAFT FULL BUSINESS CASE (DIRECTOR OF TRANSFORMATION AND PARTNERSHIPS,CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST)

The Director, Transformation and Partnerships, Calderdale and Huddersfield NHS Foundation Trust (CHFT) presented a report and a presentation on the Huddersfield Royal Infirmary (HRI), new Accident and Emergency (A&E) Department, Summary Overview of the Draft Full Business Case. The purpose of this report was to provide the Calderdale and Kirklees JHSC summary information and an update related to the planned development of a new A&E at HRI. The Full Business Case (FBC) had been drafted and was currently progressing through NHS governance processes of review.

The presentation provided a high-level overview of the information included in the draft FBC, background and context information, the scope of the draft FBC, the required content (chapters) of the FBC, a summary of each of the chapters in the draft FBC, and a conclusion. The plan for development of a new A&E at HRI had made significant progress and was potentially one of the most advanced hospital development schemes nationally with potential for early delivery of significant service benefits. The scheme continued to fit with the overall strategy for the development of better health and care services for West Yorkshire. Subject to NHS England and Improvement (NHSEI) approval of the draft FBC the construction of the new A&E at HRI was ready to commence in December 2021 with completion planned in 2023.

During discussions, the Chair and Councillors Blagbrough, Cooper, Munro, Smaje and Uppal commented on the following issues:

- Why had a presentation been submitted for scrutiny rather than the documents which underpinned the project? In response, Officers advised that the FBC document was not available for publication as it was progressing through regional and national approval.

- It was critical that this scrutiny board receive the Outline Business Case (OBC) as well as the FBC to ensure that Health Services were delivering for the residents of Calderdale and Kirklees.

- There were concerns in relation to escalating costs, were officers confident in completing on time and within budget? In response, Officers advised that a construction partner had already been appointed and had been involved in the design and costing. The Guaranteed Maximum Price (GMP) was reflected in the FBC and steps had been taken to ensure the price remained affordable.

- What precautions had been taken to ensure that any changes intended to enable to project to stay within budget did not have a significant impact on the long term operation of the facility? In response, Officers advised that the design for the new department was compliant with the Health Building Notification's Health Technical Memorandums; the guidance which the organisation follows to ensure it was designed compliant to modern standards.

- It was stated in the Strategic Outline Case (SOC) that the proposal did not fully address backlog maintenance requirements at HRI and that it continued to manage a very high risk in terms of the reliability of buildings. What was there about this in the FBC? In response, Officers advised that the FBC was purely around the investment and development of the new A&E. Officers advised that they could provide a profile of capital spend going forward.

- Had the impact of Covid-19 been taken into account and what additional safety precautions have been put in place? In response, Officers advised that the plans were undertaken during the height of the pandemic, infection control processes in particular had been paramount.

- Would the existing A&E department continue to operate until the new department opened? In response, Officers advised that the existing emergency department would continue to operate until the move into the new department, and the move would be communicated to the public.

- What plans were there to communicate to people who live between Calderdale A&E department and the new Huddersfield A&E department which they should attend? In response, Officers advised that a communications exercise would be undertaken in due course, so that members of the public would be aware of which services were available on each site.

- Could Officers clarify whether the construction would begin in December 2021 or early 2022? In response, Officers advised that they had previously aspired to commence construction in late 2021 but were dependent on the conclusion of the approvals process and so now planned to begin in early 2022.

- Had Officers discussed labour shortages in construction with construction partners? In response, Officers advised that this had not been highlighted by the contractors as an area of concern.

- Could Officers provide more information about plans to target Social Value in terms of apprenticeships and local jobs and supporting economic recovery from the Covid-19 pandemic? In response, Officers advised that work was done with the Social Value Portal to look at how job creation could be targeted through procurement and construction to areas of greatest need or people with protected characteristics.

- Could the Social Value Action Plan be provided to Members? In response, Officers advised that they could share the Social Value work which had been undertaken.

- Could more detail be provided on how the FBC addressed compliance with best practice and supporting the local and regional system affordability? In response, Officers gave examples of ways in which the existing emergency department was not compliant with standards of care. The facilities in the new department would meet these standards. A full detailed report could be provided.

- Would the new A&E department support Ambulatory Care and how would it fit in with the model of care provided? In response, Officers advised that the new emergency department would effectively take on the work of the existing department but in a building which was fit for purpose.

- Would the model being developed lead to a sustainable staffing situation across Calderdale and Kirklees? In response, Officers advised that by concentrating the majority of acute inpatient services at the site in Calderdale, the medical workforce at Calderdale could be expanded while maintaining support of the other site.

- What were the positive impacts identified and were there any detrimental impacts? In response, Officers advised that additional information could be provided.

- Scrutiny needed to understand the financial sustainability for services and if there was a risk of greater debt. In response, Officers advised that the purpose of the business case was to demonstrate the proposed investments delivered benefits and supported longer term financial sustainability. These areas were being reviewed by NHS England and the Department of Health and Social Care (DHSC) in their processes around approval of business cases.

- How much influence was there over the design or could this be influenced? In response, Officers advised that the architects made use of designs in existence, of “repeatable rooms”, which were a DHSC approved design. Officers advised that they had worked with the architects and building partner to use their experience whilst still creating a design which met the clinician’s needs.

Members agreed to explore the possibility of the board having a direct working relationship with the construction company.

IT WAS AGREED that the report be noted.

14 RECONFIGURATION OF CHFT SERVICES AND ESTATE DEVELOPMENTS - SUMMARY OF THE STRATEGIC CASE SECTION OF THE DRAFT OUTLINE BUSINESS CASE (DIRECTOR OF TRANSFORMATION AND PARTNERSHIPS | CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST)

The Director, Transformation and Partnerships, Calderdale and Huddersfield NHS Foundation Trust (CHFT) presented a written report providing the CHFT Trust Services and Estate Development, Summary of the Strategic Case Section of the Draft Outline Business Case. The purpose of the report was to provide the Calderdale and Kirklees JHSC with an update in relation to the developing a draft Outline Business Case (OBC) for the Reconfiguration of Services. The illustration showed the different type of business cases that could be required by HM Treasury for major capital investment projects. The draft OBC would be structured in accordance with HM Treasury, Department of Health and Social Care guidance aligned to the Five Case Business Model. This means that the draft OBC would be structured in 5 chapters setting out the Strategic Case, the Economic Case, the Commercial Case, the Financial Case and the Management Case. The report also provided a summary of the information included in the draft Strategic Case section of the OBC.

The Strategic Case in the draft OBC provided an overview of the profile of the Trust and described the national, regional and local policy context for the Trust's Hospital Reconfiguration plans. In doing so, it described the Trust's planned response to strategic policy in terms of new models of care, demand and capacity planning and ultimately the objectives for the planned investment. The West Yorkshire Health and Care Partnership (Integrated Care System) had agreed the estate developments and reconfiguration proposals were their top priority, confirming that the Partnership was confident that these proposals fit with the overall strategy for the development of better health and care services for West Yorkshire as a whole.

During discussions, the Chair and Councillors Blagbrough, Munro, Smaje, Swift and Uppal commented on the following issues:

- Would the OBC be updated with health needs based on the latest census information once it became available? In response, Officers advised that there was not a refreshed health needs analysis available to them at that time, but they were alert to taking this into account once it became available. Officers advised that they did have documents from work undertaken by Calderdale and Kirklees Councils detailing the impact of the Covid-19 pandemic on local communities and health inequalities which had been considered during strategic planning of how the system responds to support communities.

- Information was provided about a reduction in non-elective beds by 30% over 5 years, how was this modelled in the OBC and was this still achievable? In response, Officers advised that there wasn't a firm commitment to deliver a 30% reduction in bed days and in the Strategic OBC there were no plans for a reduction in bed numbers across the 2 hospital sites. Maintaining bed

numbers was a key recommendation arising from the Independent Reconfiguration Panel.

- What modelling had been given from the Clinical Commissioning Group (CCG) and community services to input into the OBC? In response, Officers advised that the OBC did not include a quantified modelling of assumed reduction in non-elective admissions, processes around detail of the community developments were being dealt with separately and were not a key chapter in the OBC.

- There had been a 5% increase in population served by the panel in the last 3 years, which was not reflected in the figures provided in the slides. Bed numbers would not necessarily be fit for purpose in 10 or 20 years if they remained static. In response, Officers advised that they had undertaken further work to revisit planning assumptions used in the Strategic OBC and used the most available data to confirm that these remained valid.

- Had any additional investment in Primary Care been tabled for the future? In response, Officers advised that the Government had an ongoing annual investment in General Practice. Investing in Community Services was an ongoing priority, to recognise the needs and demands and to react to available funding which came in through central Government.

- Community Services needed to improve in order to assist people on the Discharge to Assess list. In response, Officers advised that the Discharge to Assess list was quite high which reflected the pressures of the Social Care market and not necessarily Community Services. Work was being done jointly with Social Care colleagues in home care and Care Homes to work towards rectifying this situation.

- Officers had raised that staffing issues would get better following reconfiguration of services, but there was a wider system's issue around social care and primary care. How had this been assessed overall and how was this being registered as risk? In response, Officers advised that the workforce could be increased by combining facilities onto one site. This could extend opening hours, and the increase of Senior Medical workforce would expand workforce opportunities to not be dependent on Junior Doctors and other trainees who were in short supply.

- How had the issues around ambulance waiting times been assessed? In response, Officers advised that an analysis had been undertaken by Yorkshire Ambulance Service, they had identified that there was an increase in need for additional ambulances to transfer patients, and this data had been shared with Clinical Commissioning Groups who had deemed this to be affordable. The specific outcomes of this analysis could be shared at a later date.

- What modelling had been done to show the impact of a normal or a severe winter with the distribution of beds as proposed? In response, Officers advised that the modelling was done based on peak numbers from trends to ensure the plan could cope when demand was up.

- Had service continuity plans changed with the experience gained during the Covid-19 pandemic? In response, Officers advised that experience during the pandemic showed that there were particular crises responses which could occur again in the future. There was key learning operationally and clinically, one of the key areas was the importance of flexibility; having wards designed for generic use rather than specialities so the purpose could be changed when needed.

- It was essential that Scrutiny see the capacity assumptions in the OBC.

- What impact would any delay in this going to planning departments have on the plans moving forward? In response, Officers advised that there had been numerous and positive dialogue with Planning Officers but any delay in determination would have knocked on to the subsequent phases.

- What workforce modelling had been done as part of the OBC and had the links between the numbers of fully qualified nurses and patient outcomes been taken into account? In response, Officers advised that there was a standardised ratio of staff to patients and nursing models had been modified to reflect the increase in numbers of single rooms.

- What was the current thinking on reduced and alternative workforce models and where could Members see a description of these? In response, Officers advised that this related to the consolidation of acute services and economies of scale for managing patients on 1 site rather than 2. More of the detail could be provided following the meeting.

- How could the reconfiguration improve theatre utilisation? In response, Officers advised that work was being done with surgical colleagues around which surgeries would be undertaken at each site. Separating elective and non-elective surgeries would mean that elective surgeries would not need to be cancelled due to emergencies, creating efficiency automatically. Officers wanted to maximise these efficiencies by transforming the way they worked, this would be addressed over the next 5 years to ensure services were delivering to the needs of the patients.

- How could it be ensured that the clinical inputs into design were maintained throughout the process? In response, Officers advised that this was down to the Clinical Leads for the project to ensure features put in were not taken out at a later date. The Clinical Leads were accountable for ensuring the facility would be fit for purpose and were passionate about making sure the designs would work for patients.

- Was there a timeline for when the Intensive Care Unit (ICU) beds would be increased from 18 to 22, and was the capacity for Higher Dependency also able to increase? In response, Officers advised that there would be space available to increase the ICU beds from 18 to 22 should this be needed, to give sustainability for the future. Higher Dependency Care was generally delivered in the ICU but colleagues were increasingly developing High Dependency Services for single illnesses outside of the ICU. This was only possible by consolidating staff onto 1 site.

- The presentation outlined some serious workforce challenges, what concerns were there around care quality given this, and how was this risk being monitored? In response, Officers advised that this was particularly a challenge across acute services. Locums were used where possible, but Officers were conscious of ensuring adequate quality of Locums. This had been recognised as a risk and was flagged as a serious risk on the Trust Risk Register. The way services were being delivered was affecting care quality and this was why things had to change.

- Was the oxygen supply going to be capable of delivering a higher level of oxygen than it currently did? In response, Officers advised that the design had not reached this level of detail but they were conscious that whatever facilities were built at Calderdale would need an increased oxygen supply capability.

- Why was this reconfiguration not included in the list of schemes in the National Hospital Programme and what was the scheme's status regarding funding commitments? In response, Officers advised that this was because the scheme predated that initiative. The funding was announced in 2018 so there was firm commitment of public capital on the planning application.

IT WAS AGREED that the report be noted.

15 NEXT STEPS AND FUTURE MEETINGS

The Committee discussed its next steps and work required which included:

- Meeting with the West Yorkshire Ambulance Service

- Revisiting the travel plan

- Revisiting issues raised around the Carbon Budget

IT WAS AGREED that the Senior Scrutiny Officer in consultation with the joint Chairs be requested to arrange the next meeting of the Calderdale and Kirklees Joint Health Scrutiny Committee.

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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.

Report to Calderdale and Kirklees Joint Health Scrutiny Committee

Meeting Date	26 October 2022
Subject	Report Back on Workshop on the Outline Business Case
Report of	Senior Scrutiny Officer, Calderdale Council

Why is it coming here?

An informal workshop to discuss the Outline Business Case that relates to the plans to develop the sites at Calderdale Royal Hospital and Huddersfield Royal Infirmary was held on 22 June 2022. This report gives a summary of the issues discussed and sets out next steps for the work of Calderdale and Kirklees Joint Health Scrutiny Committee in ensuring that the implementation of the proposals is consistent with the requirements made by the then Secretary of State for Health Jeremy Hunt in 2018, when he responded to the referral to him of the reconfiguration proposals by the Joint Health Scrutiny Committee.

What are the key points?

The report reminds the Joint Scrutiny Committee of the three areas for review identified by the Secretary of State for Health in 2018 and proposes that the future work of the Scrutiny Committee should include a focus on those three issues raised by the Secretary of State.

Possible courses of action

It is recommended that the Joint Health Scrutiny Committee continue to review the revised reconfiguration proposals of the West Yorkshire ICB and Calderdale and Huddersfield NHS Foundation Trust.

Contact Officer

Mike Lodge, Senior Scrutiny Officer, Calderdale Council

Should this report be exempt?

No

Report to Calderdale and Kirklees Joint Health Scrutiny Committee

1. Background

Calderdale and Huddersfield NHS Foundation Trust (CHFT) have prepared an Outline Business Case (OBC) for the developments of Calderdale Royal Hospital and Huddersfield Royal Infirmary.

The OBC includes some information that is extremely commercially sensitive. Only the co-chairs (Councillor Hutchinson and Councillor Smaje) have had access to the whole document.

A workshop was held on 22 June 2022 when colleagues from CHFT gave a detailed briefing to all members of the Joint Health Scrutiny Committee (JHSC), including an overview of the confidential information.

The JHSC's revised terms of reference outlines the role and function of the Joint Committee that includes confirmation that it will review the revised reconfiguration proposals to include reviewing the Strategic Outline Case, Outline Business Case, Full Business Case and assess the clinical and financial sustainability of the proposals.

The JHSC will also continue to take account of the three areas of concern (outlined below) identified by the Secretary of State for Health in his response to the referral from the JHSC.

The Secretary of State concluded:

"The IRP points to failings ranging from a lack of consistency with the original proposals and scepticism about whether proposals of the scale and complexity are actually deliverable. In particular, there is concern about the delivery of out of hospital care and whether the reduction in hospital beds as a result of changing hospital services could be justified. It is also not clear that capital financing of this scale for a project of this type would be available. Further work focussing on out of hospital care, hospital capacity and availability of capital is required for the NHS before a conclusion is reached. In short, the proposals are not in the best interests of the people of Calderdale and Greater Huddersfield, and I would ask the NHS locally and nationally to reconsider".

2. Availability of Capital

£197 million of capital has been allocated for the reconfiguration of Calderdale Royal Hospital and Huddersfield Royal Infirmary. This figure has not changed since it was announced in 2019, and there have been significant changes in the economic picture since then. The West Yorkshire Integrated Care Board has identified the reconfiguration proposals for Calderdale Royal Hospital and Huddersfield Royal Infirmary as its highest priority for capital expenditure.

Building work has begun at Huddersfield Royal Infirmary and will begin in the near future at Calderdale Royal Hospital. The Joint Committee will wish to monitor progress on the building works and budget spend on both sites.

At the workshop, Members expressed concerns that high levels of inflation, in particular for construction materials such as steel, would result in significant budget pressures and wish to ensure that this does not result in any scaling down of the proposals or “value engineering”. Members require ongoing assurance that the resulting buildings will be able to deliver efficiently the services that the local population require.

Members sought explanation of the way in which the new, publicly funded buildings on the Calderdale Royal Hospital site would operate alongside the Private Finance Initiative assets which comprise the majority of buildings.

Members will continue to express concern at the assumptions underlying the workforce model, particularly for clinical staff, in the light of national workforce and financial pressures.

Members would also want to ensure that all aspects of the new hospital buildings and the way that they will operate take account of the climate emergency that has been declared by both Calderdale Council and Kirklees Council. The Joint Committee will consider this aspect of the project and travel plans at a future meeting.

3. Capacity in the Hospitals

Hospital capacity was one of the key issues raised by the Secretary of State for Health in 2018 when he asked the Clinical Commissioning Groups to reconsider their proposals. The proposals at that time were to reduce the number of hospital beds by around 100 across both sites. The revised proposals from the CCGs reinstated those beds, so that number of beds is not reduced in the current proposals, but the distribution of beds across the two sites changes. Members continue to require evidence that the plan for maintaining the current broad number of beds is adequate for the long-term nature of the reconfiguration project.

Members are very conscious that this position is not static and that the populations of both Calderdale and Greater Huddersfield are growing and are predicted to continue growing and that the age-profile of the population continues to change.

Members expressed concern whether the modelling underlying the Strategic Outline Case, particularly the activity growth assumptions, was still applicable and the difficulty in separating the impact of the pandemic response from the long-term capacity requirements of the local population. They will continue to scrutinise available sources of evidence.

Members are also aware that lessons learnt during the pandemic have meant that the design plans for both hospitals have changed including improving ventilation, building more single rooms, better designed waiting areas etc.

Most significantly Members recognise that the capacity in hospitals is not just a factor of the physical design of buildings but also of having sufficient staff with the right qualifications to care for patients and that the planned increase in the proportion of single rooms has an impact on safe staffing levels.

Demand for hospital care will be suppressed by effective preventive actions, which are outside the scope of the work of this Joint Committee. However, the need for hospital care can be reduced by a good supply of community services, both community health services, social care services organised by the local authorities, and services provided by voluntary and community organisations. Delayed transfer of care because of a shortage of social care to support people

on discharge from hospital inevitably increases the occupancy levels of acute hospitals, reducing its capacity to treat the acutely ill and deliver planned care.

4. Community Services

Community health services are commissioned locally and provided by Locala in Kirklees and by Calderdale and Huddersfield NHS Foundation Trust in Calderdale. Scrutiny of the performance of community health services is therefore undertaken predominantly by the local scrutiny committees in each of the Council areas. However, the impact of community health services on suppressing demand for acute hospital care was one of the three key issues that the Secretary of State for Health raised with the CCGs in 2018 so the Joint Committee reserves the right to consider the adequacy of community services in the planning of hospital provision, while relying on each local Health Overview and Scrutiny Committee, in both Calderdale and Kirklees Councils, to examine the evidence and report their findings.

5. Appendices & Background Documents

Please list any supporting documents and reference where they can be found or requested from.

Appendix 1 – CHFT workshop slides

Appendix 2 - Letter from Jeremy Hunt

Appendix 3 - Letter from the Independent Reconfiguration Panel

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NHS
Calderdale and Huddersfield
NHS Foundation Trust

Reconfiguration of Hospital Services
June 2022

compassionate care

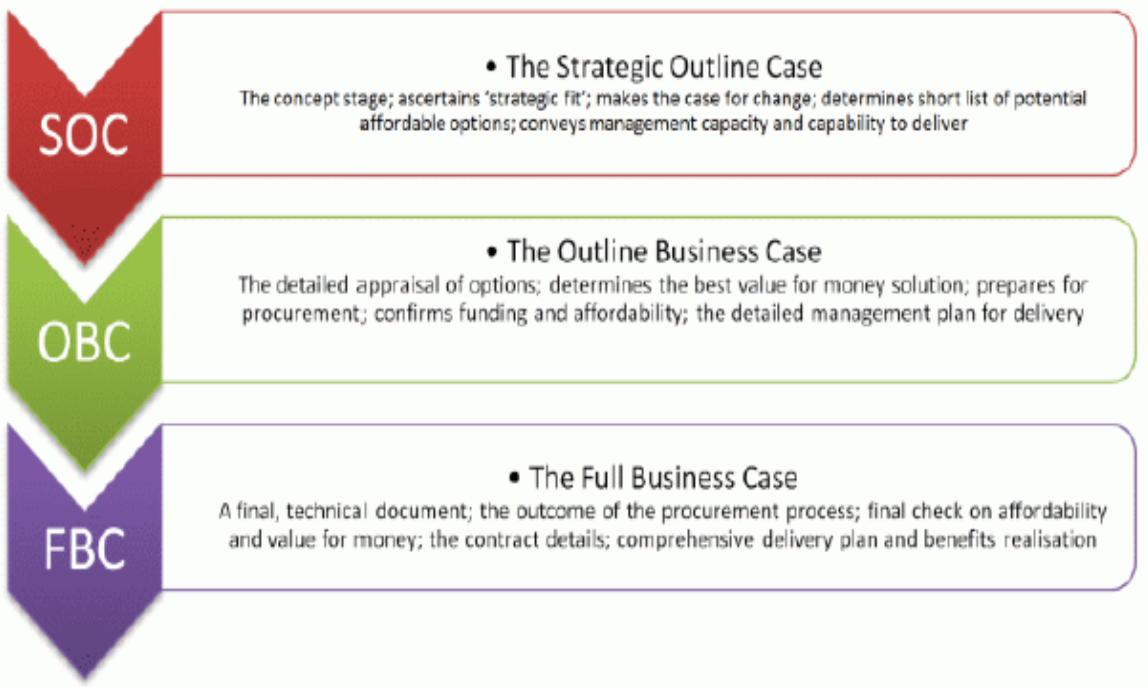
Purpose

NHS
Calderdale and Huddersfield
NHS Foundation Trust

- The purpose is to provide a summary of the information included in the Outline Business Case (OBC) for the Reconfiguration of Services.

- The OBC is structured in accordance with HM Treasury, Department of Health and Social Care guidance aligned to the Five Case Business Model and is structured in 5 chapters setting out the:

  - Strategic Case
  - Economic Case
  - Commercial Case
  - Financial Case
  - Management Case



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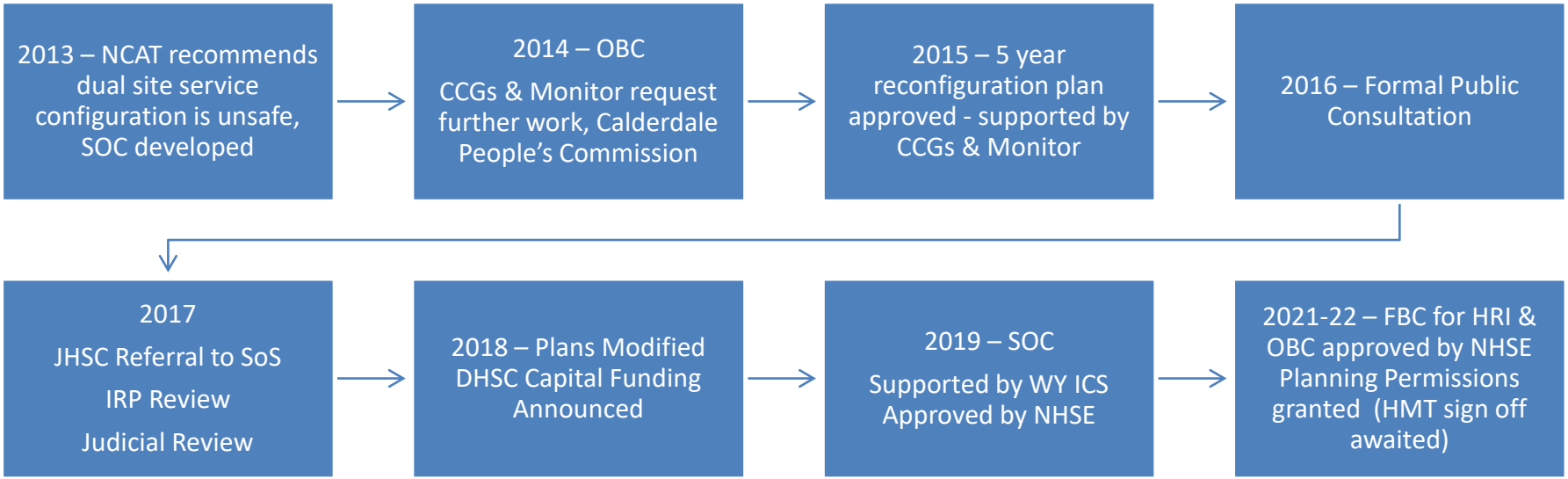
Background



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Background Demonstrates

- Over 9 years there has been extensive involvement and independent scrutiny of the plans
  - NHSE, DHSC, CQC, WY&H Clinical Senate, JHSC, Public, Colleagues, Judicial, Government Infra-Structure Project Authority, stakeholders, WY ICS, WYAAT, Commissioners, SoS, Health Ministers, Independent Reconfiguration Plan
- The Plans have been modified to respond to views.
- Sustained support of Trust Board, Colleagues, Commissioners, WY ICS and NHS England that the reconfiguration of services is needed and will bring important benefits locally and for WY as a whole.

Policy Context – NHS Long Term Plan

- The future model of hospital services in Calderdale and Huddersfield described in the OBC will support and enable delivery of the vision and ambitions described in the NHS Long Term Plan. In particular, the NHS Long Term Plan confirms that:

"separating urgent from planned services can make it easier for NHS hospitals to run efficient surgical services. Planned services are provided from a 'cold' site where capacity can be protected to reduce the risk of operations being postponed at the last minute if more urgent cases come in. Managing complex, urgent care on a separate 'hot' site allows trusts to provide improved trauma assessment and better access to specialist care, so that patients have better access to the right expertise at the right time. So we will continue to back hospitals that wish to pursue this model"

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Case for Change – Why Reconfiguration is Needed

The case for change is driven by the need to improve and future proof:

- Safety and Quality of Patient Services
- Workforce Resilience
- Safety, Quality and long term resilience of Trust Estate
- Long Term Financial Sustainability

Safety and Quality of Patient Services

- Acute inpatient services are not co-located causing delays in definitive care and the need to transfer patients between the hospitals e.g.
  - Stroke services at CRH and Trauma services at HRI
  - Older People care at HRI, and Respiratory services at CRH
  - Obstetric services at CRH, Emergency Surgery at HRI
  - Paediatric Medicine at CRH, Paediatric Surgery at HRI
- Trust is unable to sustain workforce for 2 “blue-light” receiving A&E sites on a 24/7 basis. Nearly 40% of night shifts in A&E are overseen by locum doctors.
- Trust cannot provide access to paediatric specialist trained staff in both A&Es and appropriate audio-visually separate clinical facilities.
- The Trust cannot ‘ring-fence’ elective surgery capacity and sometimes there is need for cancellations to create non-elective capacity.
- The current provision of 2 small ICUs means the Trust is not able to ensure a dedicated ICU consultant for the unit 24 hours a day 7 days a week - generating potential risks to safety.

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Workforce Resilience & Wellbeing

- Trust is not compliant with Royal College of Emergency Medicine workforce recommendations and the standards for Children and Young People in Emergency Care settings, and the Guidelines for the Provision of Intensive Care Services 2015 (GPICS) standards.
- Intense and fragile clinical rotas.
- Recruitment and retention challenges to meet the medical rotas of the two sites resulting in a heavy reliance on bank, locum and agency staff. Recruitment processes have failed due to lack of applicants.
- Consultant staff have left the Trust where the reason given is the current configuration of Trust services across two sites.
- The widespread use of temporary staff can result in a lack of continuity of care, and negative impact on staff morale and sickness absence rates.
- Service models and workplace design improvements are needed to positively impact on colleague health, satisfaction, wellbeing, productivity and recruitment / retention.

Long Term Financial Sustainability

- The Trust has a significant underlying financial deficit.
- Longer term financial viability of the Trust is reliant on service reconfiguration to reduce structural costs associated with dual site working.
- Service Reconfiguration and associated Estate investment will enable:
  - Delivery of patient services in a more sustainable way releasing efficiencies over and above existing CIP plans
  - Reduce the level of external financial support required by the Trust compared to BAU over the period
  - Enable return to financial balance 4 years sooner than BAU.

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Safety, Quality & Long Term Resilience of Trust Estate

- HRI is an aging 1960s District General Hospital with significant estates maintenance backlog challenges. The Trust carries a very high risk in terms of the condition and reliability of its buildings at HRI with high risk of failure of critical estate services and consequent impact on service delivery.
- Calderdale Royal Hospital does not have any backlog maintenance and the condition and reliability of the CRH estate makes this suitable for future estate investment and long-term provision of healthcare for the Trust.
- In determining whether CRH or HRI should be the planned or unplanned site in the future model of care - previous work has demonstrated that there are no clinical, access, or equality grounds to differentiate between the choice of site. Detailed travel and transport assessments, EQIA and engagement with Yorkshire Ambulance Service have informed this conclusion.
- The choice of CRH as the site for acute and emergency care is associated with appraisal of financial and economic grounds to make the best use of the current estate.

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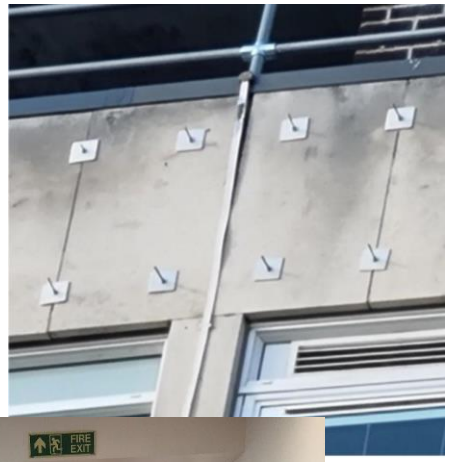
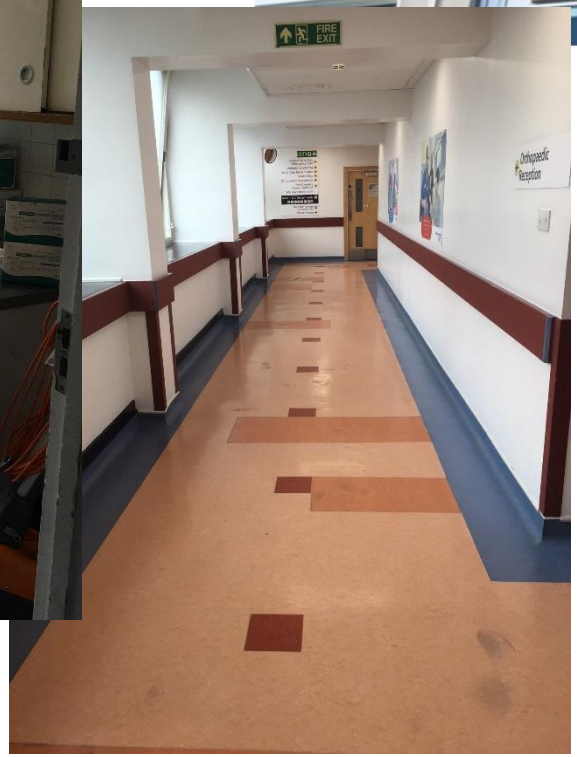
HRI Estate





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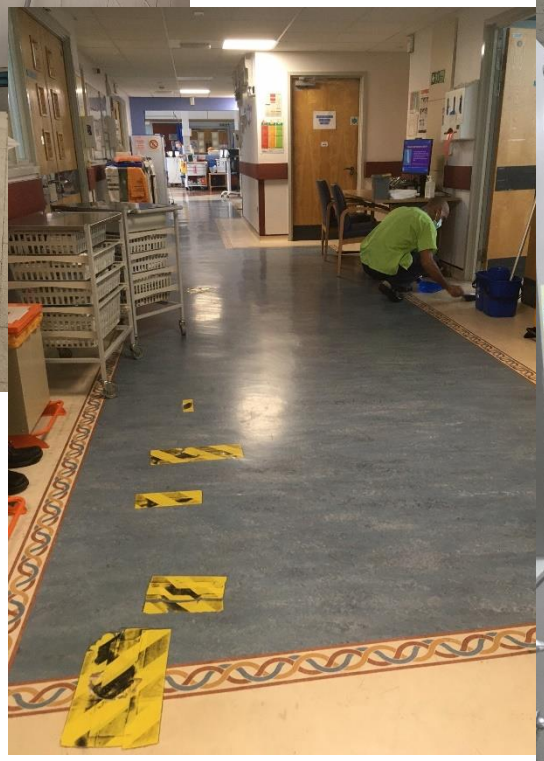
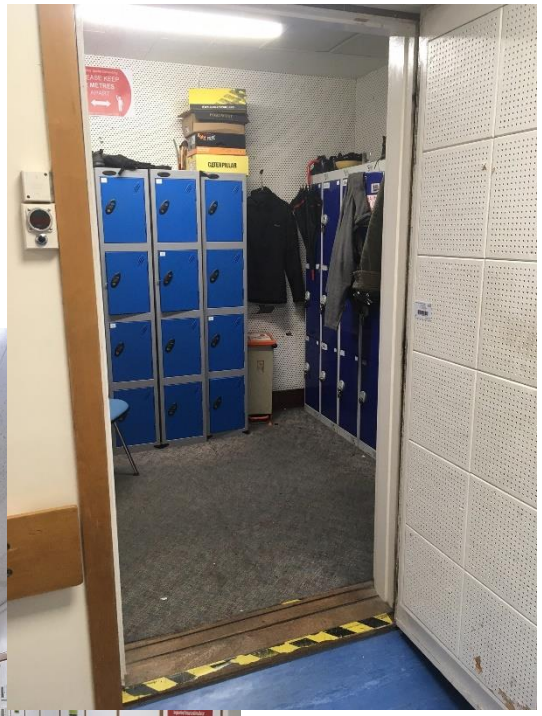
HRI Estate





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Digital Technology

- CHFT recognises the transforming power that digital has to improve access to services and support people in managing their health, to ensure health and care professionals can access patient records wherever they are, and to provide decision support and artificial intelligence to apply best practice and eliminate unwarranted variation in care and outcomes.
- Over the past five years CHFT has implemented significant investment in digital technology and is recognised as one of the most digitally advanced Trusts in the UK.
- The Trust's ambition is to develop beyond clinical systems to ensure that all colleagues and the processes used by them are digitally enabled.
- A key principle underpinning the draft Outline Business Case (OBC) is that both hospitals will be "Digital by Design", ensuring processes, operating models and technologies are in place. The use of technology will be fully optimised in the design, project-management, construction and estate life-cycle management of the reconfigured estate described in the draft outline business case.

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Climate Change & Sustainability

- The impact of human activity on the natural environment is well documented and largely understood, and our influence on the climate system is now clear. There is overwhelming evidence that increased levels of carbon dioxide and other greenhouse gas emissions are amplifying the temperature of the Earth's atmosphere, oceans, and land surface. In response, several local authorities, including both Kirklees and Calderdale Councils in 2019, have announced climate emergencies and are looking at ways in which they can effect a change.
- During 2019/20 the Trust furthered its ambitions to reduce its environmental impacts. The Trust's Green Plan has been updated with focus on embedding sustainable behaviour throughout the workforce.
- A design brief was written to encourage sustainability within the Trust's plans for reconfiguration outlining the strategic case for sustainability within development. A number of socio-environmental themes have emerged throughout the design brief and these are largely guided by the United Nations Sustainable Development Goals (UN SDGs) and recommendations from the Royal Institute of British Architects (RIBA).
- A Building Research Establishment Environmental Assessment Method (BREEAM) methodology will be utilised to ensure sustainability throughout the design and construction process.
- The Trust's aim is to achieve a BREEAM score of Excellent for the developments described in the OBC.

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CHFT Performance

- CHFT has an excellent track record in the delivery of safe and timely access for patients across all pathways. This performance has been achieved in the context of the challenges of dual site working and estate constraints previously described however this is not sustainable longer term in relation to patient experience and outcomes, workforce resilience, financial and estate sustainability.
- Prior to the pandemic CHFT has consistently been rated one of the top performing Trusts nationally across the key regulatory standards (e.g. Referral to Treatment Times (RTT), Emergency Care Standard (ECS) and Cancer waiting time less than 62 Days) and has a CQC rating of Good. The Trust's ambition is to achieve a CQC rating of Outstanding.
- 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.
- 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 for the Trust. In 2021, CHFT agreed a framework and plan for restoring elective care (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 whilst still coping with the output reduction that results from Infection Prevention and Control measures and the uncertainties of Covid.

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Place Based Integrated Partnerships

- In Calderdale and Kirklees CHFT is working closely with local system partners to support the development of local Integrated Care Partnerships and Provider Networks. The aim is to establish strong place-based partnerships (between the NHS, Councils, voluntary organisations, local residents, people who access services, and their carers and families) to lead the detailed design and delivery of integrated services in each Place.
- NHS Calderdale and NHS Kirklees Clinical Commissioning Groups (CCGs) have agreed that there is a compelling case for changing the way that local health services are provided and that if the local system is unable to redesign and transform services in a way that drives up quality, then patients will experience poorer outcomes as a result.
- There has been on-going engagement with Calderdale and Kirklees Councils over several years in relation to the reconfiguration plans described in the draft. This includes regular updates and discussion at Health and Wellbeing Boards and at the Calderdale and Kirklees Joint Scrutiny Committee.
- Calderdale Council has supported the proposals and agreed that they are wholly consistent with the Council's strategic intent and plans. Kirklees Council has advised that whilst the Council welcomes investment into local health services and recognises that there are some urgent short term estates issues, the Council would not want to see investment in solutions that constrain future change.

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Care Closer to Home

- For several years Calderdale and Kirklees 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 for reconfiguration of hospital services across Calderdale Royal Hospital and Huddersfield Royal Infirmary (described in the OBC) confirm that hospital bed capacity across the two hospitals will be maintained.
- The care closer to home plans in each Place align with the NHS Long Term Plan and with the West Yorkshire 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.
- There is 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 a 2018 review as internationally-evidenced to have high impact on population health management. 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.

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Huddersfield Royal Infirmary

- 24/7 A&E and clinical decision unit
- 24/7 urgent care centre
- 24/7 anaesthetic cover
- diagnostics
- Planned medical & surgical procedures
- Outpatient services and therapies
- Midwifery-led maternity unit
- Physician-led step-down inpatient care.

Calderdale Royal Hospital

- 24/7 A&E and clinical decision unit
- paediatric emergency centre
- 24/7 urgent care centre
- 24/7 anaesthetic cover
- Diagnostics
- Critical care unit
- Inpatient paediatrics (medical and surgical care)
- Outpatient services and therapies
- Obstetrics & midwifery led maternity care
- Acute inpatient medical admissions and care (eg respiratory, stroke, cardiology).
- Acute emergency and complex surgery services

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Model of Care

- HRI and CRH will both provide 24/7 consultant-led A&E services.
- The A&E at CRH will receive all blue light emergency ambulances for patients that have serious life-threatening conditions and all patients likely to require hospital admission following triage by the Yorkshire Ambulance Service (YAS). The A&E at HRI will receive self-presenting patients. All patients requiring acute inpatient admission will be transferred by ambulance from HRI to CRH.
- CRH and HRI will both provide medically led 24/7 urgent care and will be able to treat children 5 years and older with minor illness or injuries and those children considered to have a minor illness after triage by 111. Children, who are more seriously ill, have a serious injury or are under 5 years old will be quickly triaged, stabilised, and, if necessary, transported to CRH. Paediatric emergency care and all inpatient paediatric services will be provided at CRH.
- 24/7 anaesthetic cover will be provided at HRI to enable the safe delivery of accident and emergency services.
- Critical care services, emergency surgical and paediatric surgical services will be provided at CRH.
- Physician-led inpatient care will be provided at HRI. This is for people who do not require the most acute clinical inpatient healthcare but do require extra support whilst arrangements are made to meet their future needs.
- The total number of hospital beds will remain broadly as they are now.
- Midwifery led maternity services will be provided on both hospital sites. Consultant led obstetrics and neo-natal care will be provided at CRH.

Planned surgery will be provided at HRI. Patients that require complex surgery or it is known that they will require critical care after surgery will be treated at CRH.

Learning from the Pandemic

- Learning from the pandemic has emphasised the urgent need for investment and improvement of the estate. This has informed the future estate design plans included in the OBC:
  - Increased number of single rooms in design plans
  - Increased provision of shower and change areas for colleagues
  - 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)

Model of Care – Capacity

- The OBC builds on the commitment within the SOC that the Trust will continue to provide broadly the same bed capacity.
- It is anticipated that the future proposed hospital model will require circa 670 acute inpatient beds at CRH (an increase of 240 to be provided in 10 new wards of 24 beds) and 168 inpatient beds required at HRI for planned care and step-down medical care. This will provide a total bed capacity of 838 across the 2 hospitals.
- Within this total are included 18 ICU beds (at CRH) with the ability to increase this to 22 in future years. This provides a growth of 5-9 ICU beds compared to current total provision across the two sites of 13 (i.e. 5 at CRH and 8 at HRI).
- The future theatre capacity requirement is for 8 theatres at HRI and 11 at CRH. This is a growth of one theatre compared to the current 18 provided across HRI and CRH.

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Model of Care - Ambulances

- Discussions between CHFT and YAS have determined the clinical protocols required within the reconfigured model for acute, emergency care at the hospital sites. This will ensure following the full reconfiguration of hospital services, all patients requiring emergency attendance at A&E will travel by ambulance to CRH or the nearest A&E department depending on the clinical need of the patient. As part of the most recent modelling (2021) completed by Yorkshire Ambulance Service (YAS), patient travel times to both Calderdale and Huddersfield A&E sites were reviewed and the potential impact on neighbouring emergency care providers was also calculated. Once CRH becomes the only site for Ambulance conveyances and admissions, some patients will be conveyed and admitted to the next nearest A&E Department and the modelling has been based on ambulance travel times to the nearest A&E Department.
- The impact on neighbouring hospitals has previously been shared and discussed with all the hospitals affected and the West Yorkshire Association of Acute Trusts. The impact is relatively low with additional attendances between 1-3 per day.

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Model of Care - EQIA

- The Trust has ensured that there has been a continuous process to consider and analyse the potential impact of the service reconfiguration proposals described in the OBC on those protected under the Equality Act.
- During 2020-21 as part of the process of continuous assessment in relation to the Trust's Public Sector Equality Duty, a refreshed assessment of the EQIA and QIA impact of the proposed service changes has been undertaken. It has used a strengthened process to assess the EQIA and QIA impact. This has included meeting with groups of people that have protected characteristics to directly inform, advise and confirm the assessment and any mitigations required. The conclusion of this work is that the overall impact in relation to EQIA and QIA is positive, there is no differential discriminatory impact, and appropriate mitigating actions have been identified. Engagement will continue and expand further into community groups throughout the development of the building proposals and changes to care pathways.

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Travel Plan

- The OBC refers to the Travel Plan (approved by the Trust) in February 2021 to support the reconfiguration plans.
- The Travel Plan describes site-specific practical measures designed to improve access to each site by sustainable modes of travel. (This plan has previously been published and shared with JHSC).
- By aiming to reduce the number and length of car trips generated, the Travel Plan will reduce the linked social and environmental impacts of the development and reduce economic costs. The Plan will evolve and accommodate the changing characteristics of the two sites over time.
- The Travel Plan offers real benefits not only to the Trust and its colleagues, but also the community that surrounds it. The plan will help to relieve local parking and congestion problems in the immediate area, in addition to improving air quality, reduced carbon emissions and pollution.

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The Benefits of Service Reconfiguration

- Patient Safety
- Workforce Resilience and Wellbeing
- Learning from the Pandemic included in Designs
- Support reduction in carbon use and emissions
- Estate Safety & Reduce Backlog Maintenance
- Support Economic Regeneration and Social Value
- Improve Financial Efficiency and Sustainability
- Modern state of the art environment for patients and colleagues

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Estate Development Plans

At Huddersfield Royal Infirmary a new A&E will be built alongside investment in existing buildings to improve safety and reduce maintenance requirements.

At Calderdale Royal Hospital 10 additional wards, 2 theatres a new A&E including dedicated paediatric A&E, expansion of ICU and a new multi-storey car park will be built.

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A&E at HRI

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HRI A&E Update

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CRH – Post Reconfiguration

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New Clinical Build - CRH

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New Clinical Build - CRH

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New Clinical Build - CRH

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Multi-Storey Car Park CRH

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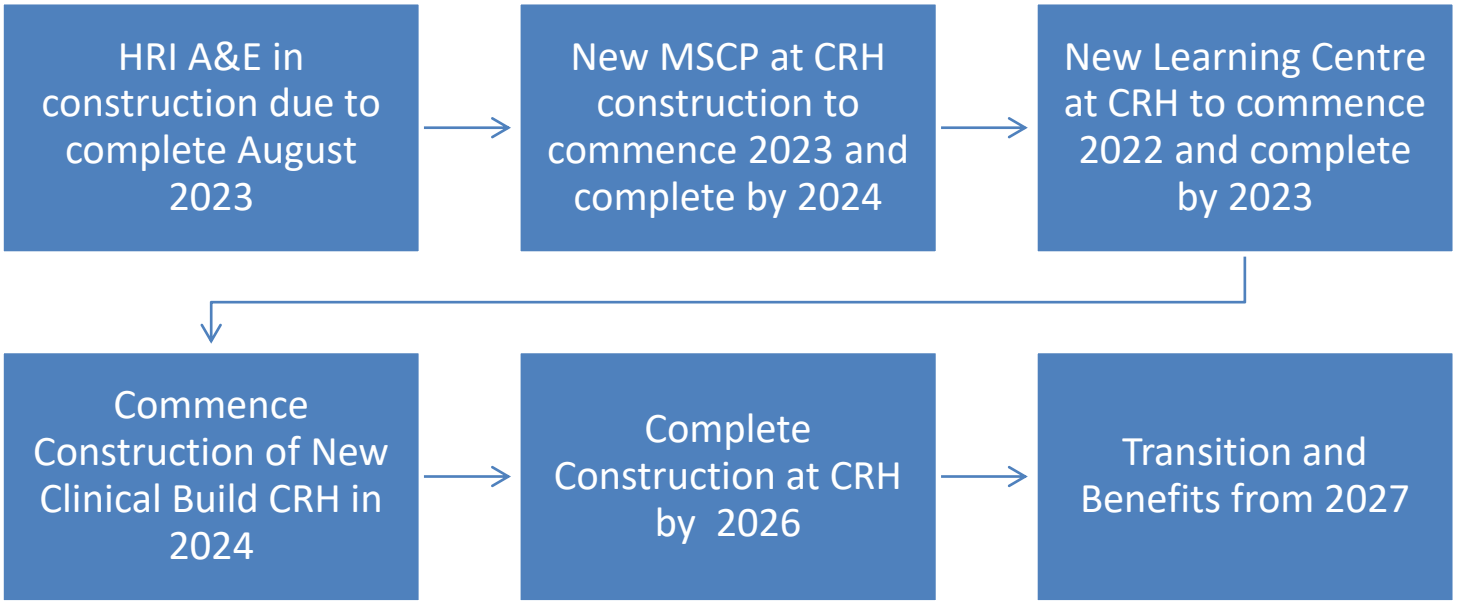
The Timeline and Next Steps



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Conclusion

- There is a compelling Case for Change of the need to reconfigure hospital services to improve the safety of services for patients.
- The plans have been extensively 'tested' and scrutinised by independent expert review, public consultation and scrutiny.
- The Trust has listened to public and stakeholder views and modified the plans to respond.
- The CHFT programme of service reconfiguration and estate investment is one of the most advanced NHS service reconfiguration and investment schemes nationally.
- The reconfiguration will secure much needed capital into the local Calderdale and Huddersfield economy and deliver significant wellbeing and economic benefits for our local communities.

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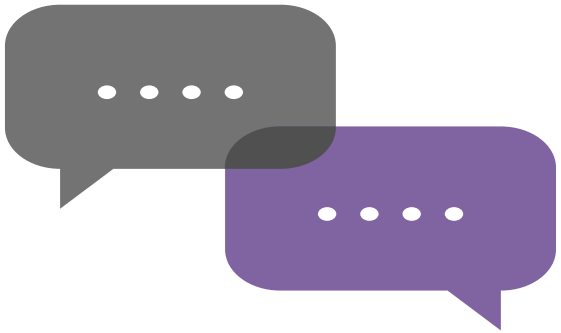
Discussion – Q&A



Department of Health

From the Rt Hon Jeremy Hunt MP
Secretary of State for Health and Social Care

39 Victoria Street
London
SW1H 0EU

020 7210 4850

POC_1116484

Councillors Liz Smaje and Adam Wilkinson
Joint Chairs
Calderdale and Kirklees Joint Health Scrutiny Committee
Governance and Democratic Services
First Floor, Civic Centre 3
High Street
Huddersfield HD1 2TG

10 MAY 2018

Dear Cllrs Smaje and Wilkinson,

Referral of NHS Proposal – Right Care Right Time Right Place – Proposed future arrangements for hospital and community health services in Calderdale and Greater Huddersfield

As you know this case was referred to me for consideration and I asked the Independent Reconfiguration Panel for their advice. They have now reported to me and I have accepted their advice.

As you will know, the proposed changes have provoked huge anxiety among local people who have raised a variety of concerns, many of which have been made to me directly. Despite these concerns, I have felt it important to ensure local health leaders were able to develop their plans without interference from government, and that the expert and independent process of the IRP was given the proper chance to scrutinise these plans. In reaching its judgement, the IRP has observed a wide variety of failings which call into question the benefits of this scheme and the way in which the process has been managed so far.

The IRP points to failings ranging from a lack of consistency with the original proposals and scepticism about whether proposals of this scale and complexity are actually deliverable. In particular, there is concern about the delivery of out of hospital care and whether the reduction in hospital beds as a result of changing hospital services could be justified. It is also not clear that capital financing of this scale, for a project of this type, would be available. Further work focussing on out of hospital care, hospital capacity and availability of capital is required from the NHS before a conclusion is reached. In short, the proposals are not in the best interests of

the people of Calderdale and Greater Huddersfield and I would ask the NHS locally and nationally to reconsider.

After careful consideration, the IRP is of the view that further action is required before a final decision is made about the future arrangements for hospital and community health services in Calderdale and Greater Huddersfield.

I have therefore asked NHSE and NHSI to work with the relevant CCGs and the JHSC, and to report back to me on progress.

I enclose a copy of the IRP's advice and would be grateful if you would report back to me in three months on progress with implementing its recommendations.

I am copying this letter to The Lord Ribeiro, Chair of the IRP.

I have written in similar terms to NHSE, NHSI, Calderdale CCG, and Greater Huddersfield CCG.

Yours sincerely

Jeremy Hunt

JEREMY HUNT

IRP

157 – 197 Buckingham Palace Road
London
SW1W 9SP

The Rt Hon Jeremy Hunt MP
Secretary of State for Health and Social Care
39 Victoria Street
London SW1H 0EU

9 March 2018

Dear Secretary of State

REFERRAL TO SECRETARY OF STATE FOR HEALTH
***Right Care Right Time Right Place* – Proposed future arrangements for hospital and community health services in Calderdale and Greater Huddersfield**
Calderdale and Huddersfield Joint Health Scrutiny Committee

Thank you for forwarding copies of the referral letter and supporting documentation from Cllr Liz Smaje (Kirklees Council) and Cllr Adam Wilkinson (Calderdale Council), Joint Chairs, Calderdale and Huddersfield Joint Health Scrutiny Committee (JHSC). NHS England North provided assessment information on 12 February 2018. A list of all the documents received is at Appendix One. The IRP has undertaken an assessment in accordance with our agreed protocol for handling contested proposals for the reconfiguration of NHS services that specifies that advice will be provided within 20 working days of the date of receipt of all required information.

In considering any proposal for a substantial development or variation to health services, the Local Authority (Public Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 require NHS bodies and local authorities to fulfil certain requirements before a report to the Secretary of State for Health may be made. The IRP provides the advice below on the basis that the Department of Health is satisfied the referral meets the requirements of the regulations.

The Panel considers each referral on its merits and concludes that further action is required before a final decision is made about the future arrangements for hospital and community health services in Calderdale and Greater Huddersfield.

Background
Calderdale and Huddersfield NHS Foundation Trust (CHFT) provides hospital services at Calderdale Royal Hospital in Halifax (CRH, a 1990s PFI development) and at Huddersfield Royal Infirmary (HRI, a 1960s build). The two hospitals are approximately five miles apart. Both hospitals currently provide accident and emergency services, outpatient and day-case services, acute inpatient medical services, midwife-led maternity

services, theatres and anaesthetics and level 3 intensive care for adults. Other services are provided at one site only.

CRH is situated within the area covered by NHS Calderdale Clinical Commissioning Group (CCG) which is broadly co-terminous with Calderdale Council. HRI lies within the area covered by NHS Greater Huddersfield CCG. Combined, the two CCGs commission services for a population of around 450,000. Greater Huddersfield CCG and the neighbouring North Kirklees CCG are, together, broadly co-terminous with Kirklees Council. Dewsbury and District Hospital, part of the Mid Yorkshire Hospitals NHS Trust, is around eight miles north east of Huddersfield within the area covered by North Kirklees CCG – this hospital and CCG are not part of the proposals that are the subject of this referral.

Right Care Right Time Right Place is a programme of work to transform hospital services. The programme runs alongside two *'Care Closer to Home'* programmes, one in Calderdale and one in Greater Huddersfield.

In July 2012, a strategic review of health services across Calderdale and Greater Huddersfield was launched involving seven healthcare and local authority partner organisations. Four 'care streams' were included in the review – planned care, unplanned care, long term care and children's care.

A review of CHFT's accident and emergency services, carried out in June 2013 by the National Clinical Advisory Team (NCAT), supported *"a one acute care site option as the best for the future safety, value and sustainability of healthcare".*

A strategic outline case, published in February 2014 by CHFT together with the community services provider and mental health and learning disability services provider, proposed the creation of specialist planned and unplanned hospitals in Halifax and Huddersfield and that the option of Huddersfield as the site for unplanned services be tested through stakeholder engagement and public consultation. In April 2014, Calderdale Council established a "People's Commission" to take evidence, lead consultation and produce proposals for the future provision of integrated health and social care services across Calderdale and Greater Huddersfield. Local providers and commissioners held a stakeholder event in August 2014 as part of an engagement process. In November 2014, the provider organisations published an outline business case proposing a 551 bedded unplanned care hospital at Huddersfield and an 85 bedded planned care hospital at CRH.

A report by the Calderdale People's Commission was approved by the Council in February 2015. In April 2015, the Yorkshire and the Humber Clinical Senate completed a report on behalf of Calderdale, North Kirklees and Greater Huddersfield CCGs about proposals for changes to the provision of community services. In September 2015, the

Governing Bodies of Calderdale and Greater Huddersfield CCGs considered their readiness to proceed to consultation and concluded that they were not yet ready to proceed. The CCGs and CHFT established a clinical consensus in October 2015 on the potential outline future model of care. A joint stakeholder event with the public was held in December 2015 to update and seek further views on the developing model and the appraisal criteria to be used to evaluate options. The Yorkshire and the Humber Clinical Senate completed a review of the proposed future model of hospital services.

In mid-January 2016, the CCGs finalised a pre-consultation business case (PCBC) in preparation for NHS England (NHSE) assurance and a formal public consultation. As well as describing the case for change, it summarised the engagement undertaken to inform the proposed model of care, the changes to services and their benefits. With regard to acute hospital services, a shortlist of five options was appraised against various criteria. The main difference between the options was finance and as a consequence the CCG's preferred option would see the emergency centre based at CRH with planned care at Acre Mills in Huddersfield, a site adjacent to HRI. On 20 January 2016, the CCGs Governing Bodies agreed to proceed to consultation on a specialist hospital model with CRH as the site for unplanned care. On 16 February, NHSE confirmed that they were assured that the CCGs had met the 4 key tests and were in a position to commence a consultation exercise on the future model of service delivery. A draft consultation document and consultation materials concerning future arrangements for hospital and community health services was presented by the Chief Officers of the CCGs to a meeting of the Calderdale and Kirklees JHSC on 22 February 2016.

A formal public consultation titled *Right Care, Right Time, Right Plac*e began on 15 March 2016, to run for 14 weeks. The consultation document proposed a single option for emergency care, including emergency paediatric care, based at CRH. A new hospital with around 120 beds at Acre Mills was proposed as a centre for planned care. Both sites would have urgent care centres staffed by doctors and emergency nurses. Other proposals included strengthening maternity services provided in the community and strengthening community services. During the consultation period, NHS officials met five times with the JHSC. Three public meetings were held along with 17 information sessions and drop-in events. Consultation closed on 21 June 2016. An independent 'Report of Findings' was published in August 2016 and a stakeholder event to consider the report was held in September 2016. In the same month, the Consultation Institute confirmed that the consultation had been consistent with the Institute's good practice standards. The JHSC considered the proposals at its meeting on 30 September 2016 and, on 3 October 2016, submitted a report to the CCGs setting out 19 recommendations. The Joint Committee accepted that *"the status quo is not an option and wishes to see improvements in the quality of services provided through hospitals, care closer to home provision and primary care"*. It recommended that *"any changes in hospital services should be in partnership with the whole of the health and social care systems across Calderdale and Greater*

Huddersfield in order to provide better outcomes in the future" as well as making recommendations on workforce, finance, reducing demand, public confidence, transport, estate, children's services and other local services.

The Governing Bodies of the two CCGs met separately on 20 October 2016 to consider findings from the consultation and to consider how to proceed. They both decided *"that the findings from the consultation and the subsequent deliberation provided sufficient grounds to proceed to explore implementation in [a/the] Full Business Case".* The CCG Governing Bodies also approved a response to the JHSC's report which was sent to the Committee on 21 October 2016. The response was considered at a JHSC meeting on 16 November 2016. The Committee expressed disappointment with the level of detail included in the response and concluded that arrangements should be put in place *"to take steps to reach agreement on areas of difference between the Joint Committee and the CCGs".*

An independently facilitated mediation workshop between the organisations was held on 30 January 2017. Amongst the outcomes of the workshop it was agreed that the CCGs and Trust would provide a proposed timeline for producing the Full Business Case (FBC)[1] and that the JHSC would identify the time required to review the FBC, make recommendations and decide whether or not to refer the proposals to the Secretary of State. Further informal workshops between the JHSC, CCGs and CHFT were held in April and June 2017.

Work to develop the FBC progressed during the first half of 2017. In July 2017, the NHS Transformation Unit reported its findings on the likelihood of the delivery of an additional 18 per cent capacity in community services to support proposed changes to hospital services. The report stated that such improvements *"would require the CCGs to achieve the best in class upper quartile position".* On 12 July 2017, the JHSC received a report from the CCGs and CHFT providing an update on programme progress and to be presented to the Committee's meeting on 21 July 2017. The draft FBC was made available to the JHSC at a short private meeting prior to the start of the main Committee meeting. A number of changes to the proposals consulted on were noted including the reduction in beds planned for the new hospital at Acre Mills in Huddersfield from 120 to 64 and that building work required at CRH and the new hospital would be financed through a private finance initiative (PFI) arrangement rather than through public funding. Other concerns noted by the JHSC related to reducing demand on hospital services and unplanned admissions, financial sustainability, primary care and a whole system approach, urgent care centre staffing and travel, transport and parking issues. The JHSC concluded that it

[1] The JHSC's referral letter of 1 September 2017 states that *"it was agreed with CHFT and the CCGs that the Full Business Case would be made available by the end of June* [2017]*".* The report of the workshop held on 30 January 2017 states only *"completion of the FBC, currently aimed for June 2017"*

"had not been given sufficient time to fully assess the Full Business Case in line with agreed timescales" and that *"the report presented to the Joint Committee at this meeting does not adequately address the concerns of the Joint Committee expressed through their* [19] *recommendations".* The Committee resolved to exercise its right to refer the proposals to the Secretary of State for Health. A letter of referral was sent on 1 September 2017.

On 3 August 2017, the CHFT Board met to consider the findings of the consultation and, following deliberation, approved the FBC. The Governing Bodies of the CCGs met separately on 12 October 2017 and both agreed *"that the FBC is in line with the model on which we consulted…is affordable to commissioners and…does improve and achieve the financial sustainability of the Calderdale and Greater Huddersfield system of care".* They agreed to indicate to NHS England that they were *"supportive of CHFT's Full Business Case".* Information provided to the IRP by NHS England (North) in response to the JHSC's referral indicates that CHFT has submitted the FBC to its regulator, NHS Improvement (NHSI), but *"that no approval process will commence until the outcome of the JHOSC referral to the Secretary of State has been resolved".*

In November 2017, local campaigners submitted an application for a judicial review of CHFT's decision to approve the FBC. The application was refused permission on papers on 17 January 2018. A notice of renewal of claim was lodged on 22 January 2018.

Basis for referral

The JHSC's letter of 1 September 2017 states that:

"This referral is made in accordance with Regulation 23(9) of the Local Authority (Public Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 on the grounds that the Joint Committee:

1. *It is not satisfied with the adequacy of the consultation with the Joint Committee.*
2. *The amended proposals presented to the Joint Committee are not consistent with the proposals originally consulted on by the CCGs in 2016.*
3. *It considers that the proposal would not be in the interests of the people of Calderdale and Greater Huddersfield and hence not in the interests of the health service of the area."*

IRP view

With regard to the referral by the Calderdale and Huddersfield Joint Health Scrutiny Committee, the Panel notes that:

Consultation with JHSC

- There has been a clear effort throughout on the part of the JHSC and NHS to work together in overseeing and scrutinising the development of these major, complicated and controversial changes
- A draft consultation document and associated materials, containing the single option for the location of the emergency centre, were discussed with the JHSC prior to the commencement of the consultation period
- Concerns now relate to action post-consultation, in particular the non-adherence to an apparently agreed timetable for providing further information through the full business case and associated documentation

Lack of consistency with the original proposals consulted on

- The proposals that have evolved into the FBC show a number of changes to those originally described in the consultation
- Concern is expressed about the credibility of workforce, financial projections for the future and a lack of detail on associated community initiatives
- The NHS recognises the need for continuing engagement and even consultation should further changes to the proposals emerge

The proposals are not in the best interests of the people of Calderdale and Greater Huddersfield

- For five years, the case for change and options for service change have been the subject of debate, engagement, external review and consultation
- The JHSC has accepted that maintaining the status quo is not an option and understands the clinical and quality case for change
- Implementation of the proposal for one emergency care and one planned care hospital depends critically on delivering significant changes in out of hospital care and making the case successfully for substantial capital investment
- In the meantime, there are real concerns about the safety and sustainability of some current hospital services

Advice

The Panel considers each referral on its merits and concludes that further action is required before a final decision is made about the future arrangements for hospital and community health services in Calderdale and Greater Huddersfield.

Consultation with the JHSC

The extensive documentation supplied to the IRP makes clear that throughout the review of health services across Calderdale and Greater Huddersfield there has been a commendable effort by both the JHSC and the NHS bodies to support each other in undertaking their respective roles. The Joint Committee has acted with diligence and

patience, adopting a pragmatic approach to the scrutiny of complex and controversial proposals in the face of considerable public disquiet. The Trust and CCGs, in agreeing to hold three joint workshops with the JHSC between January and June 2017, have shown a commitment to explaining the challenges facing the NHS locally and the basis for the changes proposed.

While concern has been expressed by local campaigning groups that the public consultation included a single option for the centralisation of emergency care at CRH, the consultation document and associated materials were discussed with the JHSC ahead of the consultation launch. The IRP has seen no evidence to suggest that the JHSC objected beforehand to the inclusion in the consultation of a single option for centralising emergency care and, indeed, this issue does not form part of the grounds for the Joint Committee's referral.

Concerns now relate to action post-consultation, in particular the non-adherence of the NHS to an apparently agreed timetable for providing further information through the full business case. The JHSC expected to receive the FBC well ahead of its meeting on 21 July 2017. That did not happen with a draft FBC only being made available to the Joint Committee at a private meeting before the main Committee meeting. It is unfortunate that the respective parties should have fallen out of step at that advanced stage. A renewed effort is needed now to re-establish relationships moving forward so that all parties work together on the proposals.

Lack of consistency with the original proposals consulted on

The JHSC has expressed concerned that several of the changes now being proposed differ markedly from those that were consulted upon. The pre-consultation business case approved by NHS England and the consultation document and materials are clear in proposing a new 120 bed hospital at Huddersfield. The CHFT's FBC proposes a new hospital with around half that number of beds and an urgent care centre that, although medically led 24/7, may not have a doctor physically present 24/7. The consultation document states that *"Our proposed changes cannot go ahead if we don't get the money from HM Treasury"*. The FBC now proposes that the changes be funded through private finance arrangements. Local residents will naturally be cautious of this funding approach given concerns raised previously about the PFI for CRH.

Further, the Joint Committee has expressed concern that the FBC does not adequately address other areas where detail was lacking in the consultation. These include the credibility of workforce planning, financial projections for the future and a lack of detail on the associated community initiatives. If the last of these areas can be said to be a 'wider' NHS issue it is nevertheless an integral part of the successful implementation of the proposed hospital-based changes. Workforce, not least the detail of how the proposed urgent care centres will be staffed, and projections on its future finances are clearly within

the Trust's ambit and the Panel would expect it to be possible to provide the clarity sought.

The CCGs, in their meetings on 12 October 2017, determined that the FBC was, in their view, in line with the model that was consulted on. However, the Panel considers that the current proposals differ sufficiently from those contained in the consultation to warrant renewed engagement with local stakeholders. Evidence submitted by NHS England (North) in response to this referral states that *"further consideration of the affordability of proposals and the requirement for capital may have an impact on the scale and scope of proposals to be taken forward".* The FBC itself acknowledges that significant variation from the current proposed model may require consideration of whether consultation is required. Were more changes to be proposed, in particular any changes resulting from the scale of funding that may become available, the need for additional public consultation would need to be discussed with the JHSC.

The proposals are not in the best interests of the people of Calderdale and Greater Huddersfield

With some considerable foresight, in 2012 the local health and care system first identified the need to address the future sustainability of services. Early work considered options for reconfiguration between the two acute hospitals located in Halifax and Huddersfield. The clinical case for concentrating all the relevant services for those with emergency needs in one location, and separating these from planned care, is based on the available evidence, the associated professional consensus and relevant standards. In summary, more availability of senior staff across a range of specialist expertise is better for the sickest patients. The conclusion reached with NCAT support in 2013, that one emergency site offered the best way forward, remains at the heart of what is currently proposed. In the Panel's view this is not surprising. In the intervening period, the evidence in its favour has not been contradicted but rather reinforced as the circumstances of existing services have deteriorated.

The Panel agrees with the JHSC that maintaining the status quo is not an option. Further, through a period of extensive engagement, consultation and external scrutiny, an alternative model to that proposed for acute hospital services has not emerged. In these circumstances it is only reasonable to continue to pursue the proposals in more detail in the interests of local health services.

The CCGs, working with CHFT, have tested further the clinical case for change and developed the proposal for hospital services alongside programmes to transform out of hospital services. These were brought together in a PCBC that demonstrated the interdependencies between them and the potential financial implications in terms of both significant capital required and affordability within expected revenue allocations. The consultation and period leading up to the FBC and referral has highlighted the difficulties

for all parties in navigating the processes for getting decisions made that are fully informed. The scale and complexity of the proposals naturally raises questions about whether they can be delivered successfully, articulated comprehensively in the JHSC's response to the consultation. At the point of consultation and still today, whether the proposals for hospital services are capable of being implemented as proposed remains unknown.

In reviewing the FBC and associated documents, the Panel found material that addresses some of the JHSC's concerns and is conscious that relevant work, for example around travel, is ongoing. The local NHS and JHSC should now take stock of the current position together to ensure a shared understanding as the basis to move forward. To make progress, the NHS (CCGs, CHFT, NHSI and NHSE) must co-ordinate its next steps to address quickly the key questions. In the Panel's view, there must be a focus on three issues. First, clarification of the programme for changes in out of hospital services and the likelihood of achieving the targeted reduction in demand for hospital care. This is required under all scenarios and is critical for hospital capacity planning which must be the subject of sensitivity testing. Secondly, the question of how in practice, over a prolonged period of implementation, the delivery of out of hospital care that enables the proposals for changing hospitals will meet the fifth test for service change - that services will be in place before changes to bed numbers are made. Finally, the terms of availability, timing and cost of potential capital financing must be clearly signalled by NHS Improvement to avoid nugatory effort in progressing from the FBC and give meaning to the proposals.

Conclusion

Some parties have called for the IRP to undertake a full review of this referral. Yet the Panel's task is advise the Secretary of State for Health in his role as the final arbiter on contested proposals. Were the Panel to undertake a review at this stage, it is clear that such an exercise would not be a review at all. It would inevitably need to cover new ground that is the responsibility of the CCGs, CHFT, NHSE and NHSI. At this point it is not possible to know whether the disputed proposals are feasible. Further work focussing on out of hospital care, hospital capacity and availability of capital is required from the NHS before a conclusion is reached. The JHSC should be kept fully informed and involved throughout this work.

In the meantime, foresight about the sustainability of services has been replaced by real concern and a sense of urgency as it has becomes increasingly difficult to recruit and retain key medical staff stretched across two sites. There is now the prospect of needing to make service changes to protect their safety and quality in which case contingency plans should be shared with the JHSC.

Yours sincerely

Lord Ribeiro CBE
Chairman, IRP

APPENDIX ONE

LIST OF DOCUMENTS RECEIVED

Calderdale and Huddersfield Joint Health Scrutiny Committee

1 Referral letter to Secretary of State for Health from Cllr Liz Smaje (Kirklees Council) and Cllr Adam Wilkinson (Calderdale Council), Joint Chairs, Calderdale and Huddersfield Joint Health Scrutiny Committee (JHSC), 1 September 2017
Attachments:
2 Chronology of events, July 2012 – July 2017
3 Resolution of Joint Committee, 21 July 2017
4 Calderdale and Kirklees Joint Health Scrutiny Committee report. Response to proposals for future arrangements for hospital and community health services in Calderdale and Greater Huddersfield
5 Calderdale CCG, Huddersfield CCG, Public consultation on proposed future arrangements for hospital and community health services
6 NHS Calderdale and NHS Greater Huddersfield CCG response to the report and recommendations from JHOSC received on 21 October 2016
7 Calderdale CCG, Huddersfield CCG, CHFT – Right care, Right Time, Right Place programme update, July 2017
8 Calderdale and Kirklees local resolution session, independent report and recommendations, February 2017
Supplementary information:
9 JHSC/NHS workshop agenda, 11 April 2017
10 Guidance to support workshop, 11 April 2017
11 JHSC/NHS workshop agenda, 26 June 2017

NHS

1 IRP template for providing initial assessment information
Attachments:
2 National Clinical Advisory Team report, 14 June 2013
3 Jacobs Travel analysis report, June 2014
4 South East Coast Clinical Senate report on clinical co-dependencies
5 Yorkshire and The Humber Clinical Senate report – community services, April 2015
6 Calderdale and Greater Huddersfield hospital and care closer to home - summary of findings from engagement and pre-engagement, March 2013 – December 2015
7 Calderdale CCG Governing Body minutes of meeting, 24 September 2015
8 Greater Huddersfield CCG Governing Body minutes of meeting, 24 September 2015
9 Yorkshire Ambulance Service, travel analysis, November 2015
10 Yorkshire and The Humber Clinical Senate report – hospital services, December 2015
11 Letter to DCO Yorkshire and Humber from Regional Director, NHS England North, 19 January 2016

12 Letter to Accountable Officers, Calderdale CCG and Greater Huddersfield CCG from NHE England North, 16 February 2015
13 Letter to officials, Calderdale CCG and Greater Huddersfield CCG, from NHS England (West Yorkshire) 2 December 2016
14 Calderdale CCG Governing Body minutes of meeting, 20 January 2016
15 Greater Huddersfield CCG Governing Body minutes of meeting, 20 January 2016
16 Right Care Right Time Right Place pre-consultation business case, 15 January 2015
17 Right Care Right Time Right Place public consultation on proposed future arrangements for hospital and community health services, 15 March - 21 June 2016
18 Kirklees Local Medical Committee statement on proposals, June 2016
19 Kirklees LMC survey of practices
20 Right Care Right Time Right Place consultation report of findings, August 2016
21 Consultation Institute report on consultation, 5 September 2016
22 Equality and heath inequality impact assessment, September 2016
23 Calderdale CCG Governing Body minutes of meeting, 20 October 2016
24 Greater Huddersfield CCG Governing Body minutes of meeting, 20 October 2016
25 Report to Calderdale CCG Governing Body, 20 October 2016
26 Presentation to Governing Bodies of Calderdale CCG and Greater Huddersfield CCG, 20 October 2016
27 Terms of reference for travel and transport group
28 Travel and transport group final report and appendices, 30 January 2018
29 Letter to Dewsbury MPs from Chair, Mid Yorkshire NHS Trust, 13 January 2017
30 Letter to CHFT from Joint Medical Director, NHS England (North), 4 April 2017
31 Yorkshire and The Humber Clinical Senate letter to Chief Officers, Calderdale CCG and Greater Huddersfield CCG, 6 June 2017
32 CHFT draft full business case for reconfiguration of hospital services
33 CHFT full business case for reconfiguration of hospital services, 3 August 2017
34 CHFT full business case, update quality and safety case for change, June 2017
35 Quality impact assessment, June2017
36 CHFT Board minutes of meeting, 3 August 2017
37 Greater Huddersfield CCG Governing Body minutes of meeting, 11 October 2017
38 Greater Huddersfield CCG Governing Body report, 11 October 2017
39 Calderdale CCG Governing Body minutes of meeting, 12 October 2017
40 Calderdale CCG Governing Body report, 12 October 2017
41 Equality impact assessment, 17 October 2017
42 NHS Transformation unit report, July 2017
43 Outcome of application for judicial review, 17 January 2018
44 Letter to Chief Executive, CHFT from Prof T Briggs, 31 January 2018
45 Equality duty guidance, NHS England
46 s14Z2 NHS Act 2006
47 Planning, assuring and delivering service change, NHS England

Other evidence

1 Letter to Secretary of State for Health from Cllr Liz Smaje (Kirklees Council) and Cllr Adam Wilkinson (Calderdale Council), Joint Chairs, Calderdale and Huddersfield Joint Health Scrutiny Committee (JHSC), 24 November 2017
2 Letter to R Dunne, Principal Governance Democratic Engagement Officer, Kirklees Council, from Phillip Dunne, Minister of State for Health, 22 December 2017
3 JHSC papers for Joint Committee meeting, 22 March 2016
4 Submission to Secretary of State for Health from Huddersfield over 50s Forum
5 Letter and submission to IRP from Calderdale and Kirklees 999 Call for the NHS, 28 September 2017
6 Submission to IRP from Let's Save HRI group, October 2017
7 Letter and submission to IRP from Hands off HRI campaign, 26 January 2018
8 Notification of judge's decision on application for judicial review, 18 January 2018
9 Notice of renewal of claim for permission to apply for judicial review
10 Kirklees Local Medical Committee statement to IRP, 2018
11 Kirklees LMC deposition to JHSC, 21 July 2017
12 Kirklees LMC statement on proposals, June 2016
13 Kirklees LMC – JHSC report, 21 July 2017
14 Kirklees LMC – JHSC decision summary, 21 July 2017
15 Kirklees LMC - CHFT full business case
16 Kirklees LMC – Consultation report of findings, August 2016
17 Kirklees LMC – final statement, 16 October 2016
18 Letter to Secretary of State for Health from Holly Lynch MP for Halifax, 25 October 2017
19 Letter to IRP from Paula Sherriff MP for Dewsbury, 15 February 2018
20 Letter to IRP from Barry Sheerman MP for Huddersfield, 16 February 2018
21 Letter to IRP from Thelma Walker MP for Colne Valley, 20 February 2018
22 Petition, Hands off HRI, signed by 1,122 people (a hard copy petition with around 13,400 signatures was delivered to Secretary of State)

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Yorkshire Ambulance Service NHS Trust

Reconfiguration: Calderdale & Huddersfield NHS Foundation Trust (CHFT) Hospital Services

October 2022

Purpose/Aim

- YAS were asked to prepare a Operational and Quality Impact assessment based on the reconfigured clinical model at CHFT
  - Both CRH and HRI will retain a 24/7 ED
  - All 999 patients will be conveyed to CRH
  - Self presenting patients at HRI who need admission will require an IFT to CRH
- YAS was also asked to model the potential impact on neighbouring ED if HRI was no longer the closest ED for ambulance referrals
- The purpose was to inform the with CHFT outline business case (OBC) local transformation boards and commissioners

Background & Chronology

- **2014** – proposal to change one of the two current A&E departments into a urgent treatment centre (UTC)
  - All 999 ambulances would convey their patient to the next nearest ED
- **2015** – In collaboration with CHFT, YAS undertook two studies to understand the impact of closure of both A&E departments.
  - outputs of this report demonstrated that closure of either site would have an equal impact on YAS A&E and PTS operations
- **2017** – CHFT informed YAS they were moving cardiology and respiratory services in anticipation of winter pressures and patient safety concerns
  - Modelling and costings provided to CHFT by YAS
  - No funding or contract variation agreed
  - Activity is now within our baseline and not part of this report.
- **2018** – following DOH review, the CHFT clinical mode was amended
  - Both sites will retain a 24/7 ED
  - All 999 patients will still be conveyed to CRH
  - Self presenting patients at HRI who need admission will require an IFT to CRH
- **2020** – following a request from CHFT, YAS has prepared a QIA for inclusion in the CHFT outline business case, based on the high level clinical model
- **2021** – modelling shared with Commissioners and support given to increase capacity – informing letters of support for the OBC from Calderdale CCG and Kirklees CCG

Operational & Quality Impact Assessment

YAS NHS Trust capacity and planning and business intelligence teams have produced a report to outline the impact and mitigation of:

1. Extended journey times
2. Additional IFT activity
   - HRI to CRH - self presenting patients requiring acute admission
   - CRH to HRI - it is envisaged patients will require “step down” care and further work underway to confirm the predicted impact

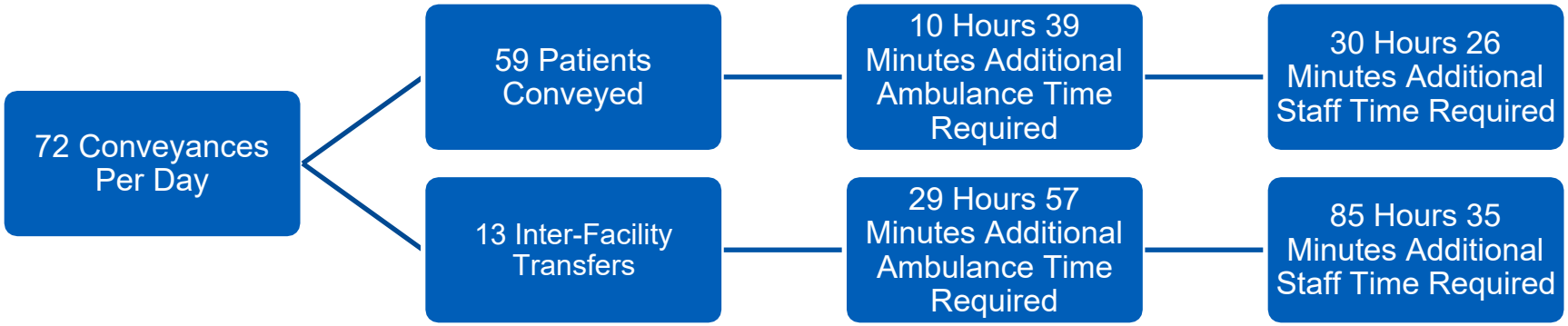
Methodology

- Extended/ reduced journeys – all 999 emergency conveyances between the 1st January 2019 and the 31st December 2019 to Huddersfield Royal Infirmary
- Potential new IFT demand –Time Period – 1st March 2019 to 29th Feb 2020 (i.e. the 12 month period immediately preceding COVID, matching the time period used to model the reconfiguration). All walk in (i.e. non-emergency ambulance) ED attenders at HRI who were subsequently admitted.
- All current IFT data was removed from the analysis to avoid double counting
- Where historical data was not held, times were calculated using AA route planner as a reference.

Assumptions

- Run back times have been calculated based on home despatch point
- The next nearest hospital to the incident was taken from AA route planner in miles (not time)

Impact – Operations



Impact – Clinical Quality

- QIA is based on the clinical model detail and associated information available at the time of developing the OBC

- QIA is therefore subject to refresh at FBC stage and up to full transition and implementation of service reconfiguration

Impact - System

	Conveyances			
Diversion Hospital	Annual	Monthly	Weekly	Daily
Bradford Royal Infirmary	70.0	5.8	1.3	0.2
Calderdale Royal Hospital	19,828.0	1,652.3	381.3	54.3
Airedale General Hospital	2.0	0.2	0.0	0.0
Barnsley District General	1,326.0	110.5	25.5	3.6
Leeds General Infirmary	17.0	1.4	0.3	0.0
St James University Hospital	4.0	0.3	0.1	0.0
Pinderfields General Hospital	118.0	9.8	2.3	0.3

*Based on next nearest ED, does not factor in crew choice, patient choice, time critical nature of patient.

Mitigation

- To offset the increased journey time, runback time and additional IFT, YAS needs to deploy an additional 22 WTE into core rosters
  - 11 WTE Band 6 Paramedics
  - 11 WTE Band 3 Emergency Care Assistants (ECAs)
  - 1 WTE Band 7 Team Leader (*factored into overheads)
  - 1 WTE Band 3/4 Emergency Medical Dispatcher/ Ambulance Dispatcher (0.5 WTE each)
  - 3 Double Crewed Ambulances (DCAs)
- Training, development and support of Paramedics with partner Universities.
- Indicative Cost (inclusive of 999, EOC and overheads at 20%)
  - 1.4 million first year
  - 1.35 million recurrent
  - *based on Jan 2021 costings (Vehicle costs and AFC)

Future Efficiencies/ Evaluation

Yorkshire Ambulance Service NHS Trust

- Integrated Transport / Low-Acuity Transfer models
- EOC and 111 patient re-direction
- Pathways into specialist wards and units – Right place, First Time – Admission Avoidance / Urgent Care Response
- Patient Transport Service – Journeys from ED
- Step down/ repatriations from CRH to HRI

Hospital handover

NHS Yorkshire Ambulance Service NHS Trust

Handover Times

The below table shows the average Handover times broken down by Hospital and Month.

Calderdale Royal Hospital

Month	Average Handover Time
Nov-21	00:21:23
Dec-21	00:23:16
Jan-22	00:20:08
Feb-22	00:21:13
Mar-22	00:18:42
Apr-22	00:19:51
May-22	00:18:12
Jun-22	00:18:26
Total	00:20:12

Huddersfield Royal Infirmary

Month	Average Handover Time
Nov-21	00:19:40
Dec-21	00:22:10
Jan-22	00:21:29
Feb-22	00:17:01
Mar-22	00:17:49
Apr-22	00:19:53
May-22	00:19:06
Jun-22	00:20:24
Average	00:19:43

Pinderfields General Hospital

Month	Average Handover Time
Nov-21	00:27:55
Dec-21	00:23:14
Jan-22	00:20:50
Feb-22	00:20:43
Mar-22	00:23:08
Apr-22	00:22:18
May-22	00:16:56
Jun-22	00:14:54
Average	00:21:08

Delays are monitored by our WY coordination center and escalated early to the duty operational commander.