CALDERDALE AND KIRKLEES JOINT HEALTH SCRUTINY COMMITTEE, 6th April 2015

PRESENT: Councillor James (Chair)
Councillors Barraclough, Blagbrough, Burton, Marchington, Smaje, Walton, Wilkinson

IN ATTENDANCE:
Dr Alan Brook, Chair of Calderdale Clinical Commissioning Group (CCCG)
Julie Lawreniuk, Chief Finance Officer, CCCG and Greater Huddersfield CCG
Jen Mulcahy, CCCG and Greater Huddersfield CCG
Julie Dawes, Director of Nursing, (Calderdale and Huddersfield NHS Foundation Trust (CHFT)
Kristina Arnold, Assistant Divisional Director Surgery and Anaesthetics, CHFT
Dr Martin DeBono, Divisional Director Families and Support Services, CHFT
Anne-Marie Henshaw, Associate Director of Nursing and Head of Midwifery, CHFT
Dr Heshan Panditaratne, Clinical Director Radiology, CHFT
Anna Basford, Director of Transformation and Partnerships, CHFT
Catherine Riley, Assistant Director Strategic Planning. CHFT
Mike Lodge, Senior Scrutiny Support Officer, Calderdale Council
Richard Dunne, Principal Governance and Democratic Engagement Officer Kirklees Council
Deborah Tynan, Committee Administrator, Calderdale Council
Dr Matt Walsh, Chief Officer, CCCG
Penny Woodhead, CCCG and Greater Huddersfield CCG

1 INTERESTS

No interests were declared.

2 ADMISSION OF THE PUBLIC

The Committee considered the question of the admission of the public and agreed that all items be considered in public session.

3 DEPUTATIONS/PETITIONS

The Committee received deputations from the following people regarding the proposals for the Provision of Hospital Services in Calderdale and Greater Huddersfield: John Garside, Chris Owen and Dr Hutchinson.

4 MINUTES OF THE MEETING HELD ON 9TH MARCH 2016

IT WAS AGREED that the Minutes of the meeting of the Calderdale and Kirklees, Joint Health Scrutiny Committee meeting held on 9th March 2016 be approved as a correct record.

5 FUTURE MODEL OF CARE

The Senior Scrutiny Support Officer submitted a written report providing Members of the Joint Committee with the context to the discussions with Calderdale and Greater Huddersfield Clinical Commissioning Groups, Calderdale and Huddersfield NHS Foundation Trust and other key health stakeholders on the proposals for the future provision of hospital services in Calderdale and Greater Huddersfield, particularly with regard to planned services, maternity services, paediatric services and diagnostics.

Calderdale and Greater Huddersfield Clinical Commissioning Groups had published a Pre-Consultation Business Case (PCBC) that set out their case for transforming

health services in Calderdale and Greater Huddersfield. Included in the PCBC was a description of the in-hospital future model and an outline of the services that were included in the scope of the in hospital services programme. The evidence used at this meeting would be used to inform the Joint Committee's assessment of the proposals and recommendations it may choose to make to the Clinical Commissioning Groups.

The Committee welcomed representatives from the Calderdale and Huddersfield NHS Foundation Trust (CHFT), Calderdale CCG and Greater Huddersfield CCG to the meeting.

Planned Care

Dr Alan Brook advised that the proposals would include an acute site and state of the art unit at Acre Mill in Huddersfield with the opportunity for plenty of cases to be seen at both sites. The following services would be available at both hospital sites: outpatients, midwifery, urgent care, therapies, diagnostics and day surgery. There would be 120 beds available at Acre Mill for planned surgery.

Members commented on the following issues:-

- There are plans for an acute unit at Calderdale and a planned surgery unit at Huddersfield, How many planned operations will go to the planned hospital and how many will go to the acute unit? In response, Ms Rutherford advised that patients from the acute unit would be moved to the planned unit if they required a long period of rehabilitation. There were plans for 3000 inpatients to the planned unit and 10,500 patients to the acute unit.

- Where are the intermediate care beds? In response, Dr Brook advised that Huddersfield patients would be transferred to the planned care site even if they are operated on in Halifax.

- The planned care model is working on fewer outpatient appointments, the Care Closer to Home model is therefore crucial to these plans. Is Care Closer to Home able to meet these demands? In response, Dr Brook advised that Care Closer to Home wasn't able to meet demands yet and had been given high priority. There were lots of potential developments and there was a five year timeframe to improve the service.

- What will happen if a procedure goes wrong and a person needs emergency care? in response, Dr De Bono advised that in the current model if a person needs emergency care then they are transferred to acute care. Patients can be transferred to other hospitals now depending on the type of care they need.

- Has there been an increase in mortality rates or poor patient outcomes? In response, Dr De Bono advised that the outcome data is similar and in some cases better. There had been no patient harm and in some instances patients had received better care.

- Would preventative care leaving plans be produced for patients? In response, Dr Brook advised that there would be a thorough process to ensure that all

patient information was collated and then a discharge plan would be sorted before the patient was admitted to hospital.

- There is mention in the report of unnecessary follow up appointments which would be reduced. Why were they arranged? In response, Dr De Bono advised that they were working with primary care so that follow up cases could be referred to them so that they happened in the local community.

- Local GP's were already stretched to capacity. How would they accommodate the follow up appointments? In response, Dr Brook advised that GPs would be given help to meet the additional appointments. Some appointments would be made with nurses who had specialist skills. There would be electronic patient notes and communication between the hospital and GP surgeries will be easier. This will enable GPs to liaise with the hospital about a patient. There will be a wider follow up team available. Members were advised that a one stop shop appointment system would be developed to reduce follow up appointments and staff in primary care would be trained and developed to carry out more work and provide more care in the community.

- If patients in the acute unit are going to be moved to planned, how will they be accommodated in the planned unit? Will this create blockages in the system? Will beds in the planned unit be used for this? In response, Members were advised that the modelling profile would look at lengths of stay and that the figures had been added in to the capacity for the planned unit. Planned care would not be used for blocked beds and more patients would be moved to day care.

- Will people still have a choice of where to go for treatment? In response, Members were advised that patients will have a choice where to go for day care services. There would be no choice for planned and elective treatments, in these instances patients would be offered only one hospital.

- Are the key assumptions about the length of stay and reducing numbers based on evidence? Had the models been tried and tested? In response, Members were advised that the evidence looks at a wide range of data depending on the procedure and the recovery model. Being in hospital was not always the best place for a patient. The models had been tested and three days was a well established basis for stays with 90% of patients staying in hospital for three days or less.

- Was the electronic patient record a sustainable and successful system? In response, Dr De Bono advised that the EPR had been introduced in October/November 2015. This area was one of the first in this country to get an electronic record system. The system would not be available countrywide. This had been a major piece of work.

- Would rehab be available on the two sites? In response, Dr Brook advised that high risk cases at Calderdale would go to rehab and a planned procedure would be followed.

- Would the operating theatres for planned care at Huddersfield be used to treat acute patients? In response, Members were advised that there would be eight operating theatres at Calderdale which would be running longer days.

- What time would patients be expected to attend at the planned and acute units? Patient arrival time would depend on their case. Plans were being made to move some cases to the afternoon. Dr De Bono advised that the pre-assessment procedure had been improved and was now done the day before an operation. This meant that patients arrival times could be staggered. Planned surgery would only be carried out on the acute site if intensive care, high dependency care or specialist surgery was needed.

- How are the changes to services being communicated with the public? In response, Dr De Bono advised that the process was outlined in the leaflet. All decisions would be based on improving care. Ms Rutherford advised that a leaflet was being produced which would make the position clearer. Dr Brook advised that the position was that there would be no duplication of procedures over the two sites.

- Patients were already being transferred between hospital sites. How many births had there been whilst a patient was being transferred from one hospital to another? How many patients had died or been adversely affected when being transferred between hospital sites? In response, Mr De Bono advised that births and harm had been monitored and there had been no births whilst a patient was being transferred. The reconfiguration of the maternity service in the past had reduced the risk. There had been one incident when a patient had come to harm when being transferred, however, this had been due to a delay in transfer rather than the transfer itself.

- The number of outpatient appointments at Todmorden would increase, however, there would be no funding for Vanguard available. How would this affect Todmorden? In response, Dr Brook advised that Vanguard funding was not crucial to the process and would only allow projects to move quicker. Todmorden would provide the ability to test and adopt a model of care which would be used in other areas.

<u>Maternity Services</u>

Dr Brook advised that there were no proposals to change the maternity model. In future there would be other specialities available.

Members commented on the following issues:

- Has there been an increase in the number of home births? In response, Dr De Bono advised that every pregnant woman was offered a choice based on risk and that would continue. There would be two birth centres. Home births would not be refused if the risk was low, even though the support required was more intensive.

- Would there be more or less obstetricians? In response, Mr De Bono advised that there were no plans to increase the number of obstetricians and no plans to extend the service.

- The maternity unit in Huddersfield was state of the art. In response, Mr De Bono advised that he was very proud of the birthing unit at Huddersfield which provided a service for low risk pregnancies and had delivered 500 babies in the last year. Antenatal services were also provided.

- Women with low risk pregnancies could choose to go to Huddersfield, however, complicated pregnancies were referred to Halifax. Will that still happen? In response, Mr De Bono advised that this would still be the process, however, some women with high risk pregnancies still wanted to have their baby at Huddersfield and they would be supported in their decision.

- Can the current aspirations be met with the current staffing demand? It was believed that the aspirations for the service could be met by the current staff. The hospital was seen as an attractive place to work. Dr De Bono advised that the changes to the maternity service started eight years ago and risks would continue to be reduced.

- Would there still be 24 hour consultant cover available in maternity? In response, Dr De Bono advised that currently 98 hours of consultant care was provided and there were no plans to move from this. A consultant was available, if required, for the rest of the time and this was covered on a rota system.

- There were plans in the future to investigate all stillbirths. What was done now? In response, Mr De Bono advised that there had been a lot of work carried out over the last three years to reduce the number of stillbirths and the number had reduced significantly. This work would continue.

<u>Paediatric Services</u>

Dr Brook advised that there was a lack of a specialised paediatric service in the area and the proposals included the installation of a paediatric unit at Calderdale. This would be a major improvement.

Members commented on the following issues:-

- There was a need to raise awareness of what parents should do in an emergency situation. What would the provision be for children under and over the age of five? In response, Dr Brook advised that children were more transportable, however, people would be encouraged to use an ambulance. The 111 telephone service were able to filter cases and parents were being encouraged to ring for advice before taking action. Children under five should be directed to emergency services.

- Was a review of the 111 service being carried out in the area? In response, Dr Brook advised that the 111 service was monitored and quality assured. There were regular surveys and requests for patient experience.

- There needed to be a stronger message about the 111 telephone service. In response, Dr Brook advised that the 111 telephone service was right for non-urgent advice, however, all urgent and emergency cases should contact 999.

- What was the situation regarding consultant cover for paediatrics? In response, Dr De Bono advised that the data for paediatric care and had found that cases dropped off after 10pm. At the moment cover was available until 8pm, however, this would be extended. Currently there was a well established nurse practitioner model in place with two accident and emergency paediatric consultants.

- Was there a traffic light system for paediatric cases? In response, Dr Brook advised that 90% of paediatric cases are dealt with by General Practice. People needed to be given the confidence to deal with things themselves.

- A planned new hospital in another area would have a child assessment unit. Why was this not included in the plans for Huddersfield and Halifax? In response, Dr Brook advised that the paediatric unit would operate 24/7 and children would be taken there for assessment. One of the main anxieties in paediatric care was that children would be taken in the wrong direction. People needed to be directed to the right service. Dr De Bono advised that a paediatric assessment unit was already in place.

- Why can't there be a paediatric unit at both sites? In response, Dr De Bono advised that there was a staffing issue with a shortage of paediatric medical staffing. It would not be viable to have a paediatric unit at both sites. Dr Brook advised that they wanted poorly children to be moved sooner rather than later and children should not be kept in planned care.

- A paediatric assessment unit had been sustainable in Wakefield. In response, Dr De Bono advised that there was a paediatric observation unit at Huddersfield and Halifax. It would be a struggle to maintain two paediatric units medically. Medical cases were currently transferred to Huddersfield. The present configuration did not provide cover for in-patients needing paediatric care. The model we had needed to be developed.

<u>Diagnostics</u>

Dr Panditaratne advised that there was diagnostic equipment and qualified staff on both sites. Personnel would be moved to whichever hospital held the machinery. This would be determined when it was decided what services would be covered on each site.

- Was there adequate staffing available? In response, Dr Panditaratne advised that staff would be halved in some areas, however there would be parallel rotas with provision to provide full support. There was a national shortage of radiologists, two new radiologists had been appointed and there were plans to appoint more. Reconfiguration was needed to keep the service running.

- Would there be opportunities for diagnostic services to move out to local areas with the introduction of Care Closer to Home? In response, Mr Panditaratne advised that diagnostic services were available in local areas now and systems were linked now. This would not change.

- Would the data analysis continue? In response, Mr Panditaratne advised that this would continue and results would be available quicker.

- Would haemotology at Huddersfield be moving? In response, Mr Panditaratne advised that haemotology would not be moving, however, there were be new tests carried out. Mr De Bono advised that the pathology unit had been designed to support acute care and this would not change. This service would be centralised and rationalised.

- Had staff been consulted on the changes? In response, Ms Riley advised that members of staff had been invited to contribute to the consultation process and staff drop in sessions had been set up.

- Services were needed to support admissions in the acute unit. Where would they be situated? In response, Mr De Bono advised that there was already a split model for acute care across the two sites. The blood bank would be rationalised.

- Some hospitals were using off-shore companies to analyse test results. Would this be considered? In response, Mr Panditaratne advised that a company called TNC which operated from Australia was already doing this work and every Trust used companies such as this. Dr Brook advised that a lot of diagnostic work was already carried out in local communities such as blood pressure checks.

IT WAS AGREED that all attendees be thanked for attending the meeting and addressing questions.

6 CONSULTATION UPDATE

Formal consultation of the Calderdale and Greater Huddersfield CCGs on their proposals for hospital reconfiguration began on 15th March 2015. The CCGs attended the meeting and updated the Joint Committee on how the consultation was progressing.

Members commented on the following issues:

- Sessions in Huddersfield had been better attended than those in Halifax. How was this being addressed? Members were advised that there had been greater attendance to the sessions in Huddersfield. The survey responses had provided an even balance between the two areas. Communications would be sent out.

- Would responses be weighted? In response, Members were advised that there were no plans to weight responses, there would be an overall analysis of the responses received.

- In the main there were two themes coming through from the comments received, these were transport and Accident and Emergency services. Was the whole message of the changes to the hospitals getting through? In response, Dr De Bono advised that people had picked up on these two key themes. It was important that people also looked at the changes as a whole. Dr Brook advised that the fact that these meetings were looking at all the changes was appreciated.

- How will the number of calls and petitions be reported? How were replies dealt with? How are GP's and clinicians being consulted? How are young people being engaged in the consultation process? There had been no exact specification in respect of the petitions. There had been a number of sessions in practices in Huddersfield where the proposals had been discussed and GPs had been given a supply of consultation material so that they could answer questions. There had been a good number of young people at the event which was held at the college and an offer had been made to return in the future. There had been a series of one to one interviews with consultants who in the main had expressed overwhelming support for the proposals. The vast majority of nurses also supported the proposals. Dr Brook advised that GPs in Calderdale had been involved in the consultation process, they had attended presentations and had been invited to challenge the proposals.

- Thousands of people had demonstrated about the proposals but were not attending the meetings. The discussions seemed to have been narrowed down to the closure of the Accident and Emergency unit in Huddersfield and it was clear that people didn't know the full message.

- The consultation was not getting the message across and there were concerns that any recommendations made by this Committee will not cover everything. The changes proposed would result in long term changes. An independent body would be analysing the results. People were being encouraged to attend sessions and give their views.

IT WAS AGREED that the progress be noted.

7 COMMITTEE WORK PROGRAMME AND FUTURE ACTIVITY

The Committee Joint Chair reported orally that the date of the next meeting had been arranged for Tuesday 19th April at 3.30pm.

IT WAS AGREED that the date of the next meeting be noted.