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

Right Care, Right Time, Right Place Programme update

1.0 BACKGROUND

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

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

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

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

a) Whether the Committee's recommendations contained in its report 'Response to proposals for future arrangements for hospitals and community health services in Calderdale and Greater Huddersfield ' have been satisfactorily addressed.

b) Exercising the Committee's power of referral to the Secretary of State in accordance with the requirements of the regulations.

2.0 INTRODUCTION

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

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

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

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

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

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

3.0 UPDATED RESPONSE

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

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

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

4.0 RECOMMENDATIONS

The committee is asked to:

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

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

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

13th July, 2017

APPENDICES

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

Calderdale CCG's and Greater Huddersfield CCG'sResponse - July 2017

3.1 Recommendation 1 – Improving Outcomes

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

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

CCGs' additional information

Quality and Safety Case for Change

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

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

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

Quality Impact Assessment

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

Quality Assurance Process: from Quality impact assessment to Implementation

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

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

- their compliance with the clinical model and agreed standards.

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

The aim of the Panel will be to:

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

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

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

3.2 Recommendation 2 – A Whole System Approach

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

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

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

CCGs' additional information

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

3.3 Recommendation 3 – Workforce

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

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

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

CHFT's additional information is in Appendix B

3.4 Recommendation 4 Finance

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

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

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

CCGs' additional information

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

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

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

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

CHFT's additional information is in Appendix B

3.5 Recommendation 5 Finance

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

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

CHFT's additional information in Appendix B

3.6 Recommendation 6 – Reducing Demand

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

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

CCGs' additional information

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

3.7 Recommendation 7 – Reducing Demand

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

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

CCGs' additional information

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3.8 Recommendation 8 – Reducing Demand

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

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

CCGs' additional information

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

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

3.9 Recommendation 9 – Public Confidence

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

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

CCGs' additional information

Urgent Care Centre Principles

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

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

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

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

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

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

Urgent Care Centre Staffing

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

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

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

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

Children

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

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

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

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

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

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

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

3.10 Recommendation 10 – Public Confidence

The Committee noted that when the Yorkshire and Humber Clinical Senate considered the proposals they concluded that the "lack of detail at this stage left the Senate with questions regarding the ability of this model to deliver the standards proposed"

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

CCGs' additional information

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

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

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

Clinical Senate – Extract from June Letter

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

3.11 Not for the NHS to Progress

3.12 Recommendation 12 - Transport

The CCGs must specify the additional resource that will be required by the Yorkshire Ambulance service to deliver the additional hours of journey time required as a result of hospital reconfiguration. This should include: where that resource will be found; a clear plan to ensure that the Yorkshire Ambulance Service meets its targets; and what measures will be introduced to support a significant improvement in service.

CCGs' additional information

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

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

3.13 Recommendation 13 - Transport

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

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

CCGs' additional information

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

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

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

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

The group will:

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

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

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

The Membership of the Group is:

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

Members – attendance as required

- MYHT
- SWYPFT
- Kirklees CCG

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

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

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

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

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

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

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

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

3.14 Recommendation 14 - Transport.

Not for the CCGs to progress

3.15 Recommendation 15 - Estate

The Committee has serious concerns regarding the capacity and sustainability of the Calderdale Royal Hospital site to support an Emergency Centre and Urgent Care Centre providing services to more than 100,000 people every year. The Committee require evidence that the building can be improved so that this substantial increase in usage could be achieved without detriment to the quality of service.

CHFT's additional information is in Appendix B

3.16 Recommendation 16 - Estate

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

CHFT's additional information is in Appendix B

3.17 Recommendation 17 – Estate

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

CCGS' Additional information

Provided in the response to recommendations 6 and 7

CHFT's additional information is in Appendix B

3.18 Recommendation 18 – Children

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

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

CCGS' Additional information

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

3.19 Recommendation 19 – Local Services

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

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

CCGS' Additional information

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

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

Calderdale and Huddersfield NHS Foundation Trust Response - July 2017

Workforce

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

Response:

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

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

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

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

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

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

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

Finance

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

Response:

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

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

Response:

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

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

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

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

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

Estate

Recommendation 15: *The Committee has serious concerns regarding the capacity and sustainability of the Calderdale Royal Hospital site to support an Emergency Centre and Urgent Care Centre providing services to more than 100,000 people every year. The Committee require evidence that the building can be improved so that this substantial increase in usage could be achieved without detriment to the quality of service.*

Response:

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

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

Response:

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

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

Response:

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

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

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

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

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