1.0 Summary

Following the Secretary of State's response of 10 May 2018 to the advice from the Independent Reconfiguration Panel on "Right Care Right Time Right Place – Proposed future arrangements for hospital and community health services in Calderdale and Greater Huddersfield", this paper sets out how the proposals have been developed to reflect his concerns. The plan will require approval by all relevant governing bodies.

The key enhancements are:

- Huddersfield Royal Infirmary and Calderdale Royal Hospital 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 (working closely with Yorkshire Ambulance Service). The A&E at HRI will receive self-presenting emergency patients. P atients requiring acute inpatient admission wh o p r e s e n t a t H R I wi l l b e transferred by ambulance from HRI to CRH.
- There will continue to be a clinical decision unit at both CRH and HRI.
- 24/7 consultant anaesthetic cover will be provided at HRI to enable the safe delivery of A&E services.
- A single expert team model at CRH for critical care services, emergency surgical and paediatric surgical services.
- The urgent care centres at each hospital will be medically led.
- Strengthened community and primary care services to reduce demand for hospital services.
- Physician-led inpatient care 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.
- Bed capacity across CRH and HRI will be maintained, (managed as now in line with seasonal demand).
- Maximise the opportunities offered by digital technology.

2.0 Context

People in Calderdale and Greater Huddersfield are living longer lives, however, more people are likely to have multiple long term conditions and thereby increase the demands on our health and social system. There is a growing population, with more complex health needs, putting more demand on healthcare services in both Calderdale and Greater Huddersfield as can be seen from Figure 1 below.

Figure 1.

	Calderdale	**Greater Huddersfield**
Population Growth	The population is increasing and will continue to grow, especially in the over 65 and the 0-15 year old age group. It is expected that the population that Calderdale CCG commission services for will increase by 10% over the next 25 years.	The population is increasing and will continue to grow, especially in the over 65 and the 0-15 year old age group. Estimates suggest that by 2030 the population will be 278,700 (an increase of >15.2% since 2010).
Mental health and dementia	In Calderdale it is estimated there are 2,300 people living with dementia and this is forecast to increase by about 75% over the next 15 years.	In Kirklees it is estimated there are 4,000 people living with dementia and this is forecast to increase by about 75% over the next 15 years. 1 in 5 adults are reported to be suffering from depression, anxiety or other mental health conditions.
Deprivation	Fuel poverty is estimated to affect a quarter of all households in Calderdale. An estimated 1 in 5 children are living in poverty. Higher rates of infant mortality are associated with higher levels of deprivation, and the infant mortality rate (MR) for Calderdale is significantly higher than the England average (7.53 per 1,000 live births compared to 4.69 per 1,000 births).	There are high poverty and deprivation levels in Huddersfield with higher rates of unhealthy behaviours and higher disease burden. Long term pain, depression and anxiety have the largest impact on local health.
Lifestyle factors and obesity	Behavioural factors which relate to health are not improving. Smoking prevalence and the harm caused by alcohol and obesity is increasing. There is rising childhood obesity and it is estimated that 40% of all illness in Calderdale can be attributed to lifestyle factors.	Lifestyle choices have a significant impact on the major causes of ill health and premature death in Greater Huddersfield. 53% of adults in the GHCCG area are overweight or obese, and 1 in 5 children are overweight or obese.
Life expectancy and inequalities	More people are living longer with multiple health problems. There is a growing health gap, with those living in Calderdale's most disadvantaged communities experiencing greater ill health than elsewhere in the district (there is a life expectancy gap within wards within Calderdale of up to 9 years).	More people are living longer with multiple health problems. Life expectancy varies across GHCCG, with the gap in life expectancy at birth at 3.4 years for men and 3 years for women. Average life expectancy at birth is also lower than the national average: 78.1 year for men (78.5 national) and 81.8 for women (82.5 national).

Nationally there has been a rapid rise in demand for hospital nurses and other health professionals, and difficulties in recruiting consultants in several specialties. Growing shortages of qualified clinical staff has resulted in increased use of agency and other temporary workers to fill vacancies, and this has increased NHS expenditure and made services less stable.

At Calderdale and Huddersfield NHS Foundation Trust (CHFT) the current two site configuration of most services means that it is difficult to recruit and retain staff and there is a heavy reliance on agency staff - costing £17m in 2017/18. CHFT has a significant financial deficit and is reliant on financial support from the Department of Health to provide the cash to pay creditors and staff. Structural costs associated with the dual site configuration of services (which require higher workforce expenditure) and the high finance costs of the PFI are key factors driving the underlying deficit.

The future cost of commissioning services is not affordable to the CCGs in Calderdale and Greater Huddersfield. Increasing demand for services and financial stress is making it increasingly difficult to maintain access to NHS services and quality of care. CHFT has delivered a high level of performance against national access targets but this is fragile as it is reliant on continued high agency staff use and cost.

Nationally standards are also being raised, including the expectation that services are offered 7 days a week. These changes will lead to better outcomes – people living longer and healthier lives – but they present District General Hospitals (DGH) such as those at Huddersfield and Halifax with a challenge in trying to deliver a comprehensive set of services, at sufficient scale to meet standards 7 days a week.

3.0 Where we are now

CHFT has two DGH sites, Huddersfield Royal Infirmary (HRI) and Calderdale Royal Hospital (CRH) located 5 miles apart in Huddersfield and Halifax.

HRI is an aging 1960s DGH with significant estates maintenance challenges. The Trust carries a high risk in terms of the condition and reliability of its buildings at HRI. The age and condition of the estate means that some are not clinically fit for purpose. Without a significant capital injection there is a high risk of failure of critical estate services and consequent impact on service delivery.

CRH opened in 2001. It was built using PFI funding and remains a DGH suitable for modern models of healthcare provision. Acre Mills, adjacent to HRI, is a modern base for outpatient appointments, and opened in February 2015.

There is a compelling quality and financial case for change in the local health system.

Quality - Without change too many people in our community:

- are admitted to residential or nursing home care;

- stay longer in hospital than is clinically necessary (which can be a factor which contributes to deteriorating health);
- are admitted to hospital with a long term condition;
- are readmitted within 30 days
- report that they do not have a good experience when they attend A&E and leave A&E without having been seen.
- the Trust is not compliant with many standards for Children and Young People in Emergency Care settings.
- planned operations are cancelled as surgeons need to respond to meet the needs of emergency patients.
- Patients experience inter-hospital transfers increasing the risk of a poor experience and outcomes.

Finances – The financial challenge facing the local NHS and care system is significant. In 2018/19 the Trust must deliver savings of £20.8m (4.9%) in order to achieve a planned deficit of £43.1m. In addition Greater Huddersfield CCG must deliver a savings target of £7.7m (2.3%) and Calderdale CCG £8.1m (2.5%). The local NHS cannot continue to spend above the funding allocated to it and an efficient model of service delivery is required to ensure that the quality and safety of services are protected whilst spending is brought back into balance.

All parties accept that to do nothing is not an option.

4.0 A new opportunity

Having taken full account of the IRP's advice and the views of local stakeholders, we believe we have a fresh opportunity to reshape services, a track record which demonstrates our ability to deliver, and a clear proposal.

The opportunity: Benchmarking data shows a substantial opportunity compared to comparator systems to reduce admission to hospital. The level of activity we are aiming for is being achieved in some other systems. We recognise the pace which we need to get there is very challenging.

Our track record of delivery: Since the inception of the CCGs non-elective activity has remained broadly flat against a rising trend elsewhere – this reflects the transformation that has been introduced in the last 5-6 years.

Our clear plan for change: we now have a set of variations to our proposals which provide a basis for delivering safe, sustainable services for the medium term.

5.0 The enhanced plan – A&E services in both Huddersfield and Halifax

We are proposing an enhanced plan for services across Calderdale and Greater Huddersfield, which keeps A&E services in both Huddersfield and Halifax, builds on

the strengths of existing services, addresses our key challenges, makes improvements where required and also seeks to make the most of digital technology.

The foundation for this plan is strengthening out of hospital services and fully integrating in and out of hospital care so that services are built around patients.

We want to make the best use of technology to help support people to have care at, or closer to home, complemented by a hospital model that provides essential clinical adjacencies and the critical mass required to sustain staff recruitment, ensure quality and develop revenue savings.

The emerging model will make use of both existing hospitals. Both sites will provide 24/7 A&E services and a range of day-case, outpatient and diagnostic services - although where possible services will be delivered in the community and closer to people's homes.

Major trauma, acute stroke and interventional and surgical cardiac services will continue as now to be provided in Leeds and Bradford along with a range of other tertiary and specialised services.

We propose to develop the out of hospital model further, building on existing links with primary care, social care and community services. Both CCGs have committed to a significant investment in Community and Primary Care over the next three years. The total number of hospital beds will remain broadly as they are now whilst services are developed in the community and demonstrate a sustainable reduction in the demand for in-patient hospital care.

Enhanced Digital Health capability such as the Electronic Patient Record will enable 'real-time' review and advice on patient's care to be provided by specialist staff where required. We also plan to implement the enhanced Summary Care Record, providing more detailed information and of particular benefit in the delivery of care for people with complex or long term conditions, or patients reaching end of life.

6.0 The Service plan in more detail

What this means for services is:

- Huddersfield Royal Infirmary and Calderdale Royal Hospital 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. The A&E at HRI will receive self-presenting emergency patients. All patients requiring acute inpatient admission wi l l b e transferred by ambulance from HRI to CRH;
- 24/7 consultant anaesthetic cover will be provided at HRI to enable the safe delivery of accident and emergency services.

- A single expert team at CRH for critical care services, emergency surgical and paediatric surgical services
- The urgent care centres at each hospital will be medically led;
- Physician-led inpatient ‘care 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.
- Bed capacity across CRH and HRI will be maintained whilst services are developed in the community and demonstrate a sustainable reduction in the demand for in-patient hospital care.
- Benchmarking tells us that over 11,000 emergency admissions could be avoided. This equates to over 48,000 bed days. The system has already delivered a reduction of 32 beds. The delivery of the remaining 73 beds would require a further 26,426 bed days to be avoided. This equates to 55% of the opportunity for avoidable emergency admissions.

In both Calderdale and Kirklees, integrated community and primary care services are being developed to meet the different levels of need of the local populations. Community based services will be led by multidisciplinary teams of health and care professionals, working together to meet the needs of people who have short-term health needs, individuals with long term conditions and those requiring specialist care for severe or complex needs.

These services will be delivered over populations of 30,000 to 50,000 people in a way that makes it easier for people to access care when closer to home, with a consistent and high quality experience for patients as they move between different parts of the integrated system

This work builds on strong existing working relationships between the GPs, community services and both Kirklees and Calderdale local authorities and good progress to date in developing services closer to home. Examples include over 5,000 MSK patients in Greater Huddersfield treated by a GP led community service rather than being sent to hospital and enhanced enablement across Calderdale and Greater Huddersfield which, in providing rehab in the community rather than hospital, has freed up a total of 12 hospital beds (6 on each site).

New primary and community models being developed in Greater Huddersfield and in Kirklees include:

- Increased support for frail elderly people to prevent avoidable hospital admissions
- Enhanced re-ablement services, providing therapy and rehabilitation input away from the hospital ward for patients in their own home following acute episode in hospital.
- Improved access to primary care services, supported by the development of primary care networks as the basis for place based systems of care
- Transformation of outpatient services
- Enhanced care home support service

Services to be provided from each hospital site are described in Figure 2 below.

Figure 2

Huddersfield Royal Infirmary*	Calderdale Royal Hospital*
• 24/7 Consultant-led A&E • Clinical Decision Unit • 24/7 medically led urgent care centre • 24/7 anaesthetic cover • Diagnostics (x-ray and blood) • Planned medical and surgery day case • Endoscopy • Breast services • Planned orthopaedic inpatient surgery • Outpatient services • Therapy • Midwifery-led maternity unit • Physician-led inpatient care	• 24/7 Consultant-led A&E and paediatric emergency department • Clinical Decision Unit • 24/7 medically led urgent care centre • Diagnostics (including CT/MRI) • Obstetrics • Inpatient paediatrics • Midwifery-led maternity unit • Acute endoscopy • Critical care unit • Complex and unplanned surgery (for patients who may need critical care after surgery) • Outpatient services • Inpatient acute medical services (e.g. respiratory, stroke, cardiology)

*N.B this is not a comprehensive list of all of the services on each site

We have tried wherever possible to maintain services on both hospital sites to provide the ***best access*** for local people, unless this means that we cannot provide the ***best quality*** of care.

Where the best quality of care requires staff and facilities to be available from a single location we are proposing to create single expert teams with the expertise, support services and equipment to meet the highest standards. Something that the workforce, estates and financial pressures described earlier mean it is not possible to provide across two sites. Failing to address the challenges presented by the current model's two sub-scale services would ultimately mean losing those services as quality slips and costs increase. The single expert team model will maintain these services in Calderdale and Greater Huddersfield and ensure they offer high quality care.

When considering how best to locate the single expert teams we examined the possibility of sharing services across sites e.g. HRI for one service and CRH for another. This was ruled out due to the interdependencies between services, and their shared dependencies, for example 24/7 access to specialist diagnostics and the requirement for back up services. Patients often present with multiple conditions and a medical patient for example may also require surgical intervention.

The single expert teams model, working closely with both hospitals A&E departments, means that CRH will be the site that takes blue light emergencies as these patients may require the comprehensive range of acute services around the clock.

Capital constraints and the lead in time to build and commission a new hospital mean this is not currently a realistic prospect in the short to medium term. We therefore need to make the best possible use of our existing estate and decide where best to locate services. Detailed consideration of all the estate options for the planned and unplanned hospital site has previously been undertaken. The clinical service model is not site dependent and therefore appraisal of whether unplanned care would be provided at the CRH or HRI site was required. The option appraisal demonstrated a compelling argument in favour of locating the single expert teams at Calderdale Royal Hospital as this will provide the most positive financial position and provide full utilisation of the PFI estate ensuring the most effective use of resources.

7.0 How we will make the enhanced plan happen

The proposed approach is centred on ensuring the best possible clinical outcomes for patients within available resources. The model remains in development until detailed revenue and capital costings are finalised and approved.

It is clear that this model will require a major capital investment and a bid has been made as part of the national STP/ICS funding prioritisation process. Investment will need to be in both the CRH and the HRI sites to enable adaptation of existing buildings and upgrade some vital service infrastructure.

The preferred funding option is to request 100% public capital funding for this development (rather than, for example a PFI funded option). This would be progressed through the national STP/ICS capital funding prioritisation process. The West Yorkshire and Harrogate ICS has approved these proposals as their highest priority for this source of capital and the West Yorkshire Association of Acute Trusts has also given their support.

The direction of travel outlined in this paper is the result of early thinking and more detailed engagement with stakeholders will be undertaken. Initial discussions have already involved engagement with primary and secondary care senior clinicians; external clinical review via NHSE; system meetings with regional leads for NHSI/E and the ICS; Health & Wellbeing Boards; JOSC; LMCs.

If support can be secured then NHS England and NHS improvement will be able to work with local NHS organisations to seek to refine and secure the revenue and capital costs of the proposed model.

8.0 Why do we think this will work?

We have a significant opportunity to improve care for local people, bring services closer to home and making sure that patients only go to hospital if that really is the best place to receive care. We currently have people going to hospital who could be cared for in the community, this is expensive and not what patients have told us that they want.

The proposed model will help to reduce significantly demand on our hospitals by treating people in the community or in primary care; this means the demographic demands described in section 1 can be met without putting unnecessary pressure on our hospitals.

The intention is to retain the hospital bed base at current levels whilst expanding out of hospital provision. This will be kept under review based on the scale of activity diverted away from hospital following implementation of the community based care model.

The changes to hospital services will ensure the longer term clinical and financial sustainability of services.

9.0 What are the risks?

This model is dependent on significant capital investment, access to which will require successfully navigating a national capital prioritisation process in competition with other health systems. Local agreement will weigh heavily in determining the relative priority of our bid when it is compared to competing demands from elsewhere in the country.

We have a place holder in the priority national list of major capital bids but this is no indication that the scheme will be successful. Capital therefore remains our number one risk. Were we successful in the national capital process we'd hope to make a start on implementation during 2020.

Maintaining the two hospital sites means that we can't make revenue savings at the pace we had originally envisaged. We must plan to live within our means and can't expect other communities in West Yorkshire and beyond to subsidise our system when they have their own challenges to deal with.

We will be looking for further operational savings as part of this programme to make sure that every part of the system is operating to maximum efficiency and productivity. We will seek support from our colleagues in NHS Improvement and NHS England to provide expertise and guidance as well as agreeing an acceptable revenue profile that brings our system into balance as soon as possible.

10.0 Conclusion

In drawing up these variations to our proposals we have attempted to "think like a patient and act like a taxpayer," coming up with the best possible services for local people within the resources available, including potential capital. We want to take account of the feedback we've received on our previous proposals; seize the opportunities to improve the health of our population; take advantage of digital technology and make the best use of our current chance to reduce costs and apply for public capital.

We know that if we keep services as they are we will see a decline in our services as we struggle to staff and fund the care our population rightly expects. We want to make changes that will put our health and care services on a safe and sustainable footing for the long term.

We want to offer as many services as locally as possible and ensure a strong future for both Huddersfield Royal Infirmary and Calderdale Royal Infirmary. For the services that we cannot maintain on two sites we want to maintain access to them within Calderdale and Greater Huddersfield – hence we propose a consultant led A&E on both sites and the creation of single expert teams for a number of services

These proposals mean that the majority of people who need to go to hospital still get their care from their local hospital. A far greater number of people will receive care without having to go to hospital at all.

We will seek to progress these proposals using public rather than private financing but getting that financing remains a significant risk. The potential for higher quality, sustainable care, good quality facilities and significant capital investment in our community is a prize that we all feel is worth pursuing.

We believe these plans are a good response to the challenges we collectively face, and also give us flexibility to address future challenges. We look forward to discussing them further with a broad range of stakeholders to help ensure the best possible care is available for people in Calderdale and Greater Huddersfield.

Signed

Calderdale and Huddersfield Foundation Trust
Calderdale CCG
Greater Huddersfield CCG
West Yorkshire and Harrogate Sustainability and Transformation Partnership

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