



| RIGHT CARE | RIGHT TIME | RIGHT PLACE

# PRE-CONSULTATION BUSINESS CASE

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## KEY MESSAGES – PROPOSED CHANGES TO HOSPITAL SERVICES

- Our plans will secure the future of health services in Huddersfield and Calderdale for the next 20 years.
- The proposals will require there to be significant investment in both towns.  

We will do this by creating two state of the art hospital buildings; one on the Huddersfield site and one by further developing the existing hospital in Halifax.

We are already re-organising services so that more care is provided in the community, closer to home.
- The proposed changes will ensure that our hospitals improve compliance against national standards for the best clinical care, delivered 7 days a week.
- Urgent care will be provided in both Huddersfield and Calderdale. The Huddersfield site will be developed to enable it to be our Planned Care Hospital.
- The Halifax site will be developed to enable it to be the Emergency care Hospital.
- The proposals will make full use of modern state of art Calderdale Royal Hospital to the benefit of both populations.
- Our proposals will improve quality and safety for the whole population of Calderdale and Greater Huddersfield.
- We have strong foundations for care outside the hospitals. Great steps have already been taken to improve services for local people across the community – at GP practices, health centres and hospitals.
- By doing this we will make the NHS in Huddersfield and Calderdale an attractive place to work, so we can attract and retain the very best staff to provide the right care, at the right time in the right place.
- These plans will also make care more affordable and improve the financial position of both the hospital and the wider health economy.

## Foreword by Clinical Commissioning Groups

Let us be clear, the way in which hospital services in Calderdale and Greater Huddersfield are provided simply isn't sustainable. Simply going forward and accepting the status quo will not enable us to deliver the quality of care that local residents deserve, nor will it provide either of our hospitals with the financial sustainability required to deliver that care. To do this things have to change and change for the better.

We're ambitious for our health and care systems and we believe that in order to realise that ambition things have to change, and that there needs to be a transformation in the way in which care is delivered. The proposals in this document allow us not only to retain both our hospital sites but will also enable us to develop and equip them in such a way that allows them to deliver the kind of improved, high quality specialist care we want our residents to receive for the next 20 years. But to do this our proposals will need significant investment from the government.

Whilst some sacrifices will have to be made what we're arguing for in this document is that the benefits that will result from this investment will enable us to maintain high quality services within the resources that we believe will be available to us in the years to come. And to those who may argue that the sacrifice is too great we say that without the changes we are proposing our hospitals are simply not sustainable; standards of care will fall, our hospitals will become unsafe, we will not be able to recruit and retain the specialist expertise that we need and we will see the gradual move away of services from Calderdale and Huddersfield to other sites in Yorkshire, resulting in patients having to travel even further in order to get the care they need.

But to do this, to secure understanding of our proposals and the kind of significant financial investment in the local health economy that's required to achieve our ambitions, we will need both the people who use our services and those who deliver them to engage and participate in the consultation process. In essence what we're arguing for is the opportunity to significantly improve the way hospital services are delivered, for all our residents, for decades to come.

Healthcare is changing. In the last 15 years, there have been great advances in medical knowledge and technology, and the development of increasingly sophisticated and specialist treatments and procedures. This has enabled more services to be provided outside of hospitals, in GP practices and community-settings, while hospitals increasingly focus on the most seriously ill patients.

Health is changing. People are living longer and have different conditions and health needs: dementia, obesity and alcohol-related disease have become major issues and more and more people have long-term health conditions that require ongoing support and management.

If we are to ensure the best outcomes for our patients, maintain and improve the quality of care and outcomes, and ensure people receive the latest treatments, services need to change too.

Because of the national NHS and local authority financial climate there is an increasing need to use resources effectively and efficiently. We must achieve the best outcomes for our patients within the available budget. We must grapple with improving safety, value and sustainability in financially more austere times.

We need to review the type of services that are available within a community setting and those that are delivered in hospital. We also need to look at integrating some services and providing community outreach services so that more can be delivered locally, close to where people live.

There should be more collaboration between the providers of health and social care to provide a seamless approach.

For hospital services, the development of shared, single services, working across organisational boundaries on a bigger footprint, can deliver better patient outcomes, better patient experience, make best use of the limited specialist workforce, and deliver significant efficiencies.

This approach will safeguard the future of all of our hospitals and emergency care services and is our desired outcome for our patients. The better use of resources will ensure the sustainability of our future NHS services.

The Right Care, Right Time, Right Place programme is one element of wider public service system reform being implemented nationally with the aim of improving outcomes for all local residents. There is a shared ambition of delivering better outcomes for residents and patients through clinically sustainable and financially viable services.

There is common acceptance across the health and social care system that new service models are needed to keep people who do not need hospital services out of hospital. Currently for those who need in-hospital treatment care can be variable as not all hospital or services meet best practice clinical standards or deliver consistent high quality patient experience, and the local health economy is constrained by finance and elements of workforce capacity to deliver services at the level required.

This business case sets out our journey so far in making the case for transforming health services in Calderdale and Greater Huddersfield, and how we have arrived at what we believe to be a sustainable model of care for the future.

It describes the clinical quality and financial drivers for change and the nature of the challenging choices that are presented to commissioners. These state clearly that doing nothing is not an option.

We believe the case to make the changes outlined is overwhelming and that we should now consult the public on our proposals in order that we can begin the work needed to transform health and social care services across Calderdale and Greater Huddersfield.

**Dr Alan Brook,**  
**Chair, NHS Calderdale CCG**

**Dr Steve Ollerton,**  
**Chair, NHS Greater Huddersfield CCG**

**Dr Matt Walsh,**  
**Chief Officer, NHS Calderdale CCG**

**Carol McKenna**  
**Chief Officer, NHS Greater Huddersfield CCG**

## 1. INTRODUCTION AND BACKGROUND

### 1.1 Introduction

The aims of this pre-consultation business case (PCBC) are to:

- Make the case for transforming health services in Calderdale and Greater Huddersfield.
- Describe the Future Model of Care for Hospital Services and how it has been developed
- Give details of the pre consultation engagement that has been undertaken with the public, clinicians, staff and other stakeholders in developing the Future Model of Care; and
- Make the case to commence public consultation on proposals for changes in the way hospital services in Calderdale and Greater Huddersfield are delivered.

The pre-consultation business case builds upon a significant period of engagement that started in May 2014. Pre-consultation engagement started at the beginning of July 2015 and concluded with a stakeholder event on the 10<sup>th</sup> December, 2015. The pre-consultation business case summarises key documents that have been approved and endorsed during the programme and seeks to make a clear recommendation to commence a public consultation on the proposed model of future service delivery for hospital services in Calderdale and Greater Huddersfield.

This case for change will:

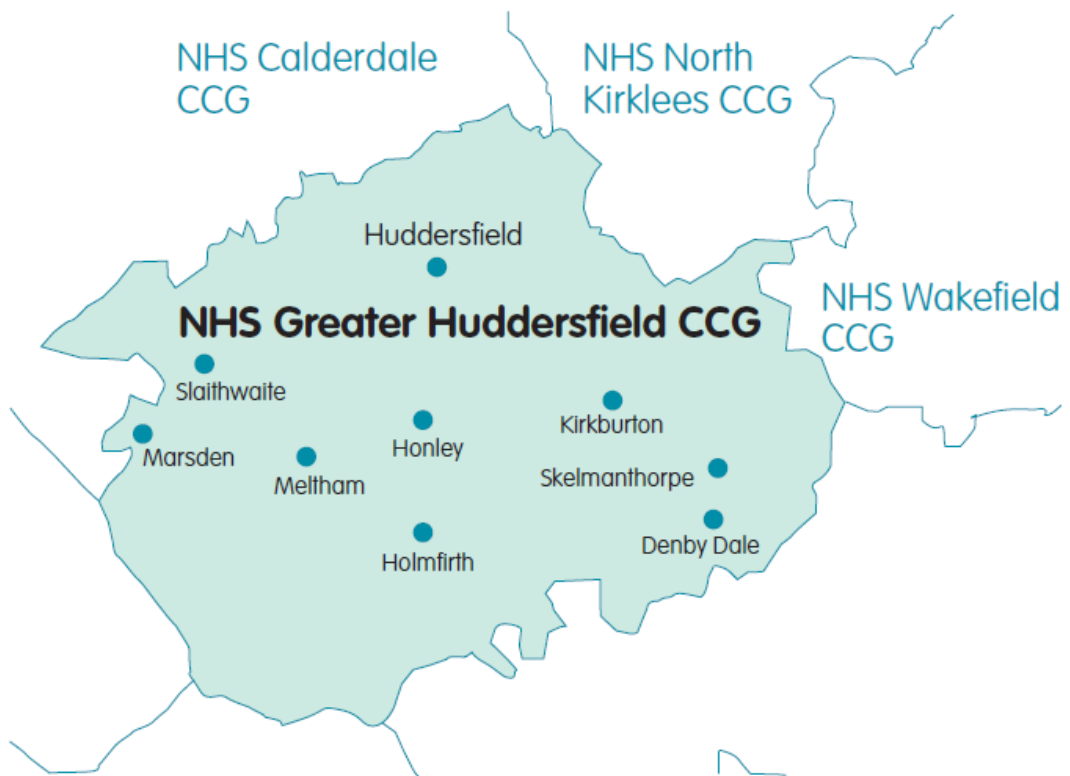
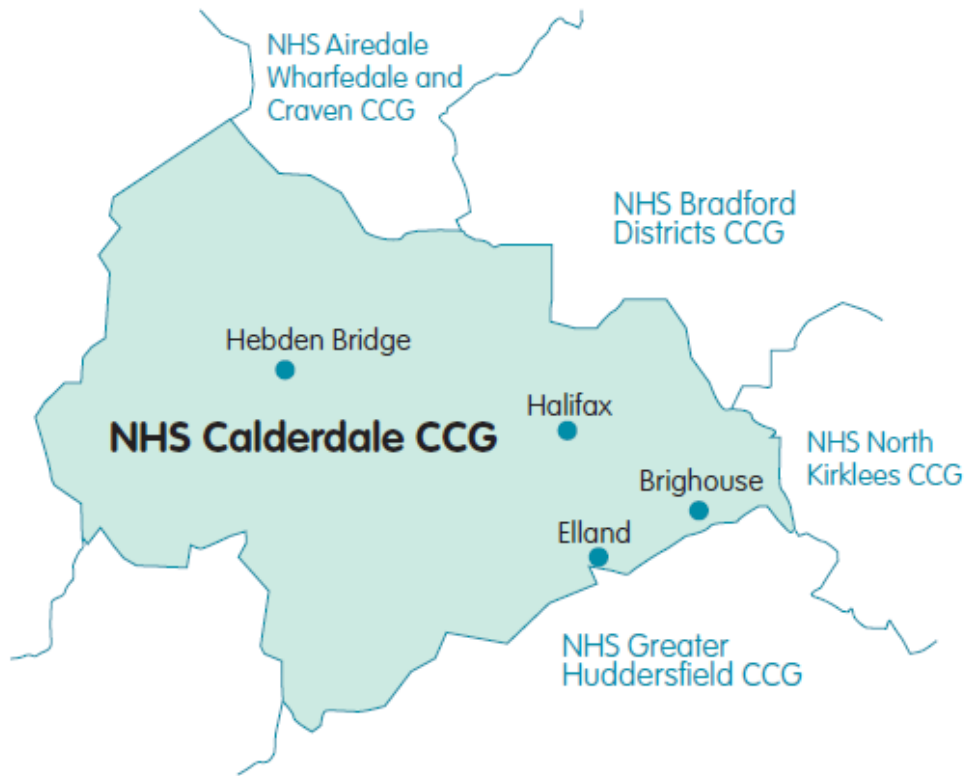
- State clearly the benefits for patients, quality and finance.
- Demonstrate that the clinical case conforms to national best practice.
- Be aligned with:
  - Long term Strategic Plans for both CCGs
  - Health and Wellbeing Board Strategic Priorities
  - the work being developed by the 10 West Yorkshire CCGs
  - QIPP work streams.
- Take account of the recommendations of Calderdale Council's People's Commission 'Improving health Together', the National Clinical Advisory Team review of A&E services, and the Yorkshire and the Humber Clinical Senate's Reviews of both Community Services Specifications and Hospital Services.
- Have clear details of how we have engaged and prepared for formal consultation.

### 1.2 Introduction to Calderdale and Greater Huddersfield

We are NHS Calderdale Clinical Commissioning Group (CCG) and NHS Greater Huddersfield CCG. We are led by local GPs and it is our role to commission (plan and buy) the majority of hospital and community health services for our local population. It is our responsibility to ensure that the services we commission are high quality, safe and sustainable and that in doing so we manage our budgets efficiently and effectively.

We face substantial challenges to improve hospital and community health services and as such we are now consulting the public on some far reaching proposals which are explained in this document.

The areas we cover are shown in the maps below. NHS Calderdale CCG shares the same boundaries as Calderdale Council and NHS Greater Huddersfield CCG and its neighbour, NHS North Kirklees CCG, come within the boundaries of Kirklees Council.





### 1.3 Context of Calderdale and Greater Huddersfield

The areas of Calderdale and Huddersfield have seen many changes in recent years with populations and life expectancy increasing. Many people now live well into their 80s and 90s. Modern lifestyles are also creating new health issues. Smoking is still the UK's largest cause of preventable illness and early death. Obesity is increasing and brings health issues such as diabetes and cardiovascular disease.

Clinical commissioning groups and local authorities have drawn up Joint Strategic Needs Assessments (JSNA) which identifies some common themes that drive the health needs of the local populations. For Calderdale and Greater Huddersfield these are:

- **Population Growth:** The population for Kirklees is c. 434,000 and for Calderdale is c. 209,000, giving a combined population of c. 643,000 people. This is forecast to increase by 12% in Calderdale and 13% in Kirklees by 2037<sup>1</sup>; which is consistent with England's expected population growth of 14%.
- **Ageing population:** The populations of Kirklees and Calderdale are ageing: in 2012 there were 102,000 people aged 65 years and over<sup>5</sup> (16% of the population). This is forecast to increase to 169,000 people over the age of 65 years<sup>5</sup> by 2037 (23% of the population). These increases represent a compound annual growth rate of 2% for the 65 plus age group and 0.5% for the full population. This is a significant challenge, as the likelihood of having long term conditions increases with age and so does the likelihood of having multiple conditions, increasing the demand on the health system. Kirklees Joint Strategic Needs Assessment 2013 report that by the age of 55-64, one in four people had at least one of the conditions identified in the Current Living in Kirklees 2012 survey. Additionally, by the age of 75, almost two in three had two or more conditions. In Calderdale and Kirklees it is estimated there are c.2,400 people<sup>2</sup> and c.4,200 people<sup>3</sup> respectively living with dementia. Statistics show that more people in Calderdale are admitted to long-term residential care than in other parts of the country.
- **Levels of deprivation:** There are high poverty and deprivation levels in Huddersfield along with higher rates of unhealthy eating and levels of exercise and higher disease burden. The infant mortality rate for Calderdale is significantly higher than England average (7.7 per 1,000 live births compared to 4.6 per 1,000 live births)<sup>4</sup>.
- **Health profiles:** The JSNA for the Greater Huddersfield area identified frailty, emotional welfare, obesity and cardio-vascular disease (CVD) as cause for specific concern locally. Priority areas for Calderdale in their JSNA include the management of long term conditions such as diabetes, asthma and epilepsy, mental health and the abuse of alcohol.
- **Lifestyle factors:** Smoking prevalence and the harm caused by alcohol and obesity is increasing. There is arising childhood obesity and it is estimated that 40% of all illness in

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<sup>1</sup> Office of National Statistics, 2012 based subnational population projections for local authorities in England – this includes the usual resident population as at census day (27<sup>th</sup> March 2011)

<sup>2</sup> Calderdale Joint Strategic Needs Assessment (2012)

<sup>3</sup> Kirklees Joint Strategic Needs Assessment (2010)

<sup>4</sup> Director of Public Health Annual Health Report for Calderdale 2012

Calderdale can be attributed to lifestyle factors. In the Greater Huddersfield area, 52% of adults are overweight or obese and 20% of children are overweight or obese.

The cost of health and social care in Calderdale and Huddersfield is now more than £600 million a year and while that figure is set to continue to grow, increasing demand, inflation and the introduction of new drugs and treatments mean costs are increasing faster. It is not just about how much money we have to spend, we need to look at how we spend it.

#### **1.4 Context and Scope of major transformation across Calderdale and Greater Huddersfield**

The Five year Strategic Plan for Calderdale CCG and the Joint Kirklees five year strategy and two year operational plan for Greater Huddersfield CCG set out the focus of a 5 year change programme which will centralise key services to improve outcomes for patients and continue the shift of services and resources from unplanned hospital care to integrated health and social care - delivered in community and primary care settings.

As commissioners, we have developed proposals for what these future Community and Hospital services in Calderdale and Greater Huddersfield could look like. The proposals seek to transform the organisation of care and the infrastructure by which it is delivered and constitute major change under section 244 on the NHS Act 2006.

There are three interlinked pieces of work: Calderdale Care Closer to Home Programme; Greater Huddersfield Care Closer to Home Programme; and the Hospital services Programme. These proposals will be implemented in three inter-related phases over the next five years:

- Phase 1 - Strengthen existing community services in line with the new model of care.
- Phase 2 - Enhance community services – which is likely to move more services closer to home.
- Phase 3 - Hospital changes.

At their August, 2014 Governing Body meetings, Calderdale CCG and Greater Huddersfield CCG agreed to adopt the phased approach to implementation described above and to Strengthen existing Community Services prior to going to consultation in relation to Hospital Services.

- **Phase One – Strengthen Community Services**

The Calderdale Care Closer to Home (CC2H) Programme and The Greater Huddersfield Care Closer to Home (CC2H) Programme have both set out proposals for the future of Community Services.

**Calderdale CCG's** 5year plan, published in June 2014 confirmed the CCG's aspiration it stated:

“The focus of our change programme over the next 5 years will continue the shift of services and resources from unplanned hospital care to integrated

health and social Care - delivered in community and primary care settings. The first 2 years of our plan will build on the work already started to create and deliver new models of care that are provided closer to home.”

In March 2015, the CCG published a detailed plan for 2015/16 (‘CCG One Year Plan’), which set out in detail how the Care Closer to Home model would be delivered. The document re-committed the CCG to the strategic intent set out in the 5 Year Plan, and to the joint vision of integrated care developed jointly by the CCG and CMBC. This approach included a commitment to alignment of the Better Care Fund Plan with the Care Closer to Home work.

At its Governing Body meeting in August 2015 the CCG received evidence about the early success of care closer to home work, and also the clinical perspectives of our GPs in support of the work and its positive impact on care. These clinical perspectives included; the reductions in unplanned admissions, more people dying in their place of choice, improved MDT working in care homes, more focus on the key role of primary care and the importance of the Support and Independence Teams.

Calderdale CCG, together with partners, was successful in its application to be a Vanguard site. The Vanguard partnership, comprises: CCG, CHFT, CMBC, SWYPFT, Locala CIC, Pennine GP Alliance and Voluntary Action Calderdale.

**Greater Huddersfield CCG** began to develop the plans to shift services and resources closer to people’s homes in 2012, the result of which is a flagship collaborative (with North Kirklees CCG) programme which manages the transition from hospital to community with Phase one services going ‘live’ on 1 October 2015.

From the outset the Care Closer to Home programme was developed based upon intensive and wide engagement with patients, GP member practices, the public, professionals and partners. Our engagement work told us that people wanted services that are delivered closer to people’s homes (although not necessarily within a patients’ home) and ensure that fewer people are admitted to hospital.

The vision of how the services should be delivered required dialogue with providers to enable the most economically advantageous and innovative services to be commissioned whilst ensuring collaboration and, where appropriate, joint services across the Kirklees area.

Greater Huddersfield CCG and North Kirklees CCG undertook a joint procurement exercise during 2014 culminating in the appointment of a lead provider for Care Closer to Home, finalised during July 2015. Locala Community Partnerships in conjunction with partners, commenced delivery of the new Care Closer to Home service on 1 October 2015.

The Care Closer to Home models comprising both Phase 1 and Phase 2 services for both CCGs are described in Section 4.

- **Phase Three - In-Hospital Services**

In parallel with the above, Calderdale CCG and Greater Huddersfield CCG have been developing their proposals for Hospital Services. In response to: our case for change; what our engagement has told us; our developments in relation to Community Services; the National Clinical Advisory Team’s report in 2013; the KEOGH Review; and other emerging

evidence and best practice<sup>5</sup>, clinicians from both CCGs and CHFT have reached clinical consensus on a potential outline model of care. This is described in section 4.

- **Primary Care**

Responsibility for Primary Care Commissioning is moving from NHS England to CCG. Calderdale CCG has taken on delegated commissioning for primary care from 1 April 2015 and has developed its vision for Primary Care Services to underpin future delivery. Greater Huddersfield CCG will take on delegated commissioning from 1 April 2016 and is currently in the process of developing its Primary Care Strategy. The joining up of commissioning responsibilities across Primary, Community and Hospital Care is a significant enabler in the drive towards integrated commissioning and delivery of healthcare services. More detail on Primary Care is provided in section 4.

- **Relationship with other areas' transformation programmes**

We understand that we do not operate in a vacuum. We also understand that the plans and proposals put forward here will have an impact on and be impacted by plans being developed in neighbouring systems and across west Yorks.

We are active participants in discussions about how these plans and ours align, but we have formed a clear view that we need to bring these proposals forward now in order to create the best opportunity for us to secure services for our population.

## 1.5 Description of the current service provision in Calderdale and Greater Huddersfield

	Calderdale	Greater Huddersfield
Primary Care: GPs	26 GP Practices	38 GP Practices
Community Provider	Calderdale and Huddersfield Foundation Trust	Locala Community interest Company
Secondary Care (Acute Hospital) Services	Calderdale and Huddersfield Foundation Trust	
Mental Health Provider	South West Yorkshire Partnership Foundation Trust	

**Other local service providers:** Calderdale and Huddersfield Foundation Trust is situated between two large West Yorkshire providers of hospital services (Mid-Yorkshire Hospitals NHS Trust and Bradford Teaching Hospitals NHS Trust). The Trust's nearest Tertiary provider is Leeds Teaching Hospitals NHS Trust, which is approximately 20 miles away. The surrounding areas also include providers such as Sheffield Teaching Hospitals NHS Foundation Trust and a number of large hospital Trusts in the Greater Manchester area.

<sup>5</sup> A list is provided as an appendix

## 2. WHY WE NEED TO CHANGE

### 2.1 Why change is needed

#### 2.1.1 Introduction

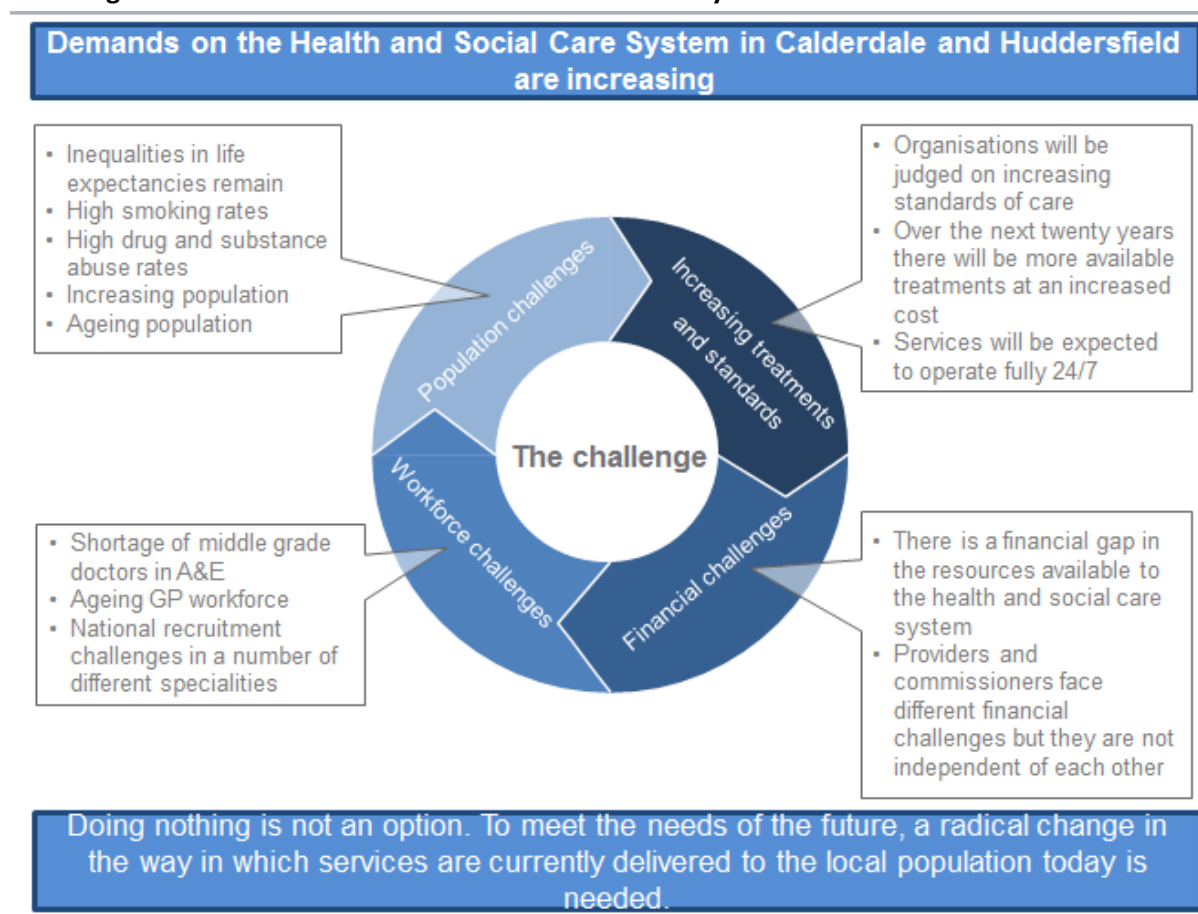
The commissioners' ambition for the quality of care and outcomes delivered for their patients is high: we want to achieve the best outcomes for patients; for patients' experience of health services to be good; and for no harm to occur.

The overarching case for change (developed by the Strategic Review and articulated in the Outline Business Case which that programme produced) is clear – the demand for and cost of local health services is increasing at a time when the economic situation means resources will be limited for some time. (See Fig 1.). If the local system is unable to redesign and transform services in a way that drives up quality within that available resource then our patients will experience poorer outcomes as a result.

Transformation of the current models of service delivery for our population is required in order to:

- Ensure the delivery of consistently safe, high quality care to all patients by meeting hospital standards
- Deliver care in the most appropriate and cost effective setting to meet patients' clinical needs

**Fig.1. Demands on the local health and social care system**



Aware of the growing pressures, CCGs have begun implementing transformational schemes in order to improve the efficiency and quality of the commissioning and delivery of healthcare services, most notably Phase One – Strengthen Community Services.

### 2.1.2 Independent reviews

The Commissioners requested three independent reviews during the pre-consultation phase to test the model of care and case for change, and to provide assurance that proposals will result in better services for local people which are affordable and sustainable. (See Appendices for full reports).

- **National Clinical Advisory Team (NCAT) A&E review**

On recommendations from the Department of Health Gateway Review conducted in 2013, the Trust invited the National Clinical Advisory Team (NCAT) to review the current hospital configuration. In June 2013 a panel of National Clinical Advisory Team (NCAT) members undertook a formal review of A&E services provided at Calderdale and Huddersfield NHS Foundation Trust to assess options and identify a preferred option for future provision of A&E services.

The panel supported the development of future service plan centred around more care, both planned and unplanned, being provided in the community, and the two hospitals having a clearer focus in terms of planned and unplanned services.

Their view was that a single site model for all acute services and a single site model for planned services was the safest, most sustainable option. This would mean locating all acute services including consultant delivered obstetric care, paediatric medical and surgical and neonatal services on one site and planned care on the other site. This would:

- Ensure that paediatric medical and surgical, neonatal, emergency and consultant delivered obstetric services will meet the required standards
- Ensure that there will be a sustainable workforce for both paediatrics and neonatology.
- Allow for shared care of paediatric surgical patients by surgeons and paediatricians
- Co-locate paediatric, neonatal and consultant delivered obstetric care with anaesthesia, surgery and A&E
- Mean less transfer of children between the 2 sites

The principle of having one service and one ‘team’ for each service is crucial in order to make this model work and for the model to be acceptable to staff and to the public.

They also noted that shared clinical records and clinical pathways across two hospital sites and with community based services will strongly enhance and reduce duplication of care.

- **Yorkshire and the Humber Clinical Senate review of Community Services Specifications**

This was the first stage of a two stage review which took place during December 2014. It considered community Services for Calderdale, Greater Huddersfield and

North Kirklees CCGs. The second stage considered hospital services and is outlined below.

The Senate was approached by commissioners to review whether particular risks are addressed within the proposals and to appraise the proposed scope of services and consider if there are any missed opportunities within these on the basis that the advice from the Senate would be used by the commissioners to inform their proposals for service change and their quality impact assessment.

Overall, the Senate commended the CCGs on their vision for the future of their community services and agree that this has the potential to result in excellent patient care closer to home. In general terms, the Senate review group was very supportive of these comprehensive documents and their values and principles for delivering care closer to home

The Senate published their report in April, 2015.

- **Yorkshire and the Humber Clinical Senate review of the future model of Hospital Services**

This was the second part of the review by the Clinical Senate. The senate were asked to consider the hospital standards and the current baseline position, together with the potential future model of care for hospital services and provide an assessment of the extent to which they support the model's potential to deliver the hospital standards and address the issues outlined in the Quality and Safety Case for Change. They conducted this review during September and October, 2015 and the report was published in December, 2015.

Overall the Senate commended the commissioners on their vision for the future of hospital services and supported the commissioners' aspirations for the service. The Senate agreed that the Quality and Safety Case for Change and the baseline position support the need to move towards greater centralisation of services across hospital sites. The Senate agreed that a clear argument is made that the current configuration of services does not and cannot meet national guidance, and that staying the same is not an option.

## 2.2 Quality and Safety Case for Change

### 2.2.1 Why change is needed

Calderdale and Greater Huddersfield CCGs have articulated their over-arching aims on quality and safety as:

- Above average in comparison to peer groups within 3 years
- 'Best in class' with peer groups within 5 years.
- Where performance is already above average, the aim should be to be 'Best in class' in comparison to peer groups within 3 years.
- The Harm free care measure should be 100%, irrespective of performance of other providers.

The CCGs recognise the need to measure and understand their current position against these ambitions and have discussed through its Quality Committees a set of Hospital Standards (see section 4). These Hospital Standards articulate the improvements identified by the CCGs on quality of services and patients' experience of care. These Hospital Standards cover emergency care, planned care, maternity care and paediatric care and have shared ownership with Calderdale and Huddersfield NHS Foundation Trust.

These Hospital Standards (detailed as 'inputs') can be summarised as:

- Improved pathways to best support timely access to senior staff and specialist skills, diagnostics and multi-professional support
- Improved processes to support patients with their conditions and treatment
- Clinical protocols with access times to routine investigations will be made available and followed by service providers
- Improved access to senior clinical staff and improved clinical protocols to reflect co-located services, improved access to diagnostics and reduction in inconsistencies/differences in urgent and elective care pathways and standards and clearly defined responsibilities for Paediatric Assessment Units
- Midwifery-led maternity pathway, with improved access to obstetric input and support, improved pathways and support to diagnostic and support services, including wider support services, and improved staffing levels, including for women in labour (maternity care)
- Outcomes for patients on patient experience, compassionate care and safe and sustainable care across hospital services

The Hospital Standards are descriptions of the areas for improvement and what success will look like. This reflects that there is currently variation in services and the ability to build in new requirements from most recent national guidance. These measurements of success are described by the Hospitals Standards in the 'outcomes' sections of the standards and are a range of metrics that will track and demonstrate success over time.

In order to have strategic oversight of the CCGs' current position against these Hospital Standards, and to monitor progress in achieving the outcomes, the CCGs have developed a Quality and Safety dashboard and also determined the key 26 indicators linked to the Hospital Standards that measure and monitor improvement in outcomes for patients.



These indicators include those that appear directly on the Quality and Safety dashboard, and add to these to provide a more frequent and detailed view on progress/improvement in quality and safety metrics as well as be able to highlight any emerging risks. The Quality and Safety dashboard is a useful and 'at a glance' set of measures of the current status of hospital services delivery with the underpinning 26 indicators providing a greater level of drill down and ability to monitor risks and progress, as well as additional measures that can be benchmarked to indicate when national average and 'best in class' has been achieved.

The Hospital Standards described above link to the dashboard and the 26 indicators to understand the CCGs' current position and outcomes for patients, and will measure the extent to which progress is being made to implement the Hospital Standards and the extent to which improvements in care and outcomes are being achieved for patients.

### **2.2.2 Review of current position – building a case for change**

The Quality and Safety dashboard provides an overview of the current position of outcomes for patients in Calderdale and Greater Huddersfield. The current position of the measures on the dashboard, and headline issues from the underpinning 26 metrics, are analysed in more detail below, and include key measures on the current status of safety, effectiveness and patient experience in hospital care.

As an overall view from the Quality and Safety dashboard, the current position shows that there are inconsistencies in outcomes for patients in different areas in Calderdale and Greater Huddersfield, and this is described below. These are fundamental duties for Commissioners to address. There will be a number of factors affecting this position including demographic issues, differences in being able to access services, it is also due to the current standards that can be achieved, due in part to the way in which services are currently configured. Further than that, there is the opportunity through the Hospital Standards for change to aim for 'best in class' care and standards. These will only be achievable through a programme of planned change and can only be sustainably achieved with a review of current service configurations. This section articulates why, and makes the quality and safety case for change.

The demographic drivers for quality and safety have been articulated earlier in Section 1. In addition to these demographic pressures, there are pressures on the delivery of safe and sustainable hospital services presently, which will continue and grow in the future.

The Hospital Standards, as measured and monitored through the Quality and Safety Dashboard and the 26 supporting metrics, build up a case for change in hospital care from a quality and safety perspective. These are mirrored by the Strategic Review Outline Business Case, and the pressing quality issues and key priorities as detailed from the providers' perspective in the providers' Outline Business Case, including the recommendations from the National Clinical Advisory Team visit in 2013.

The current position on the Hospital Standards, as represented on the Quality and Safety Dashboard and the underpinning 26 key metrics, the evidence bases of the Strategic Review Outline Business Case and the Providers' Outline Business case all demonstrate that there are areas of hospital care for patients in Calderdale and Greater Huddersfield that need to change to be safer and sustainable. In addition there are some areas where improvement is

required to ensure its patients receive best possible care and services benchmark strongly with peers to reach 'best in class'. These form the basis for a case for change.

In certain areas, the current configuration of services does not and cannot meet national guidance, particularly in relation to staffing, patient pathways and the capacity to improve and/or sustain the safety of services. Patient experience data and staff feedback demonstrate that services are appreciated and deliver a standard of care, however there is an issue of sustainability or room for improvement; it is the responsibility of NHS commissioners and providers to aim for optimal, safe and sustainable services in line with best practice standards.

From a quality and safety perspective staying the same is not an option in the future – a review of the configuration of services will be a key way to address underlying issues that affect the current and future levels of quality and patient safety and provide a significant opportunity in the future. The sections that follow provide the analysis to support the case for change, part of which is around the current configuration of services.

### 2.2.3 Current position

The Quality and Safety Dashboard represents the current position for Calderdale and Greater Huddersfield CCG patients and the way changes to services and quality will be monitored at a high level for the move towards the Hospital Standards. The following analysis is taken from the current measures from the Quality and Safety dashboard:

- Safety Indicators:

The CCGs' main hospital provider, Calderdale and Huddersfield NHS Foundation Trust (CHFT), does not consistently achieve the harm-free care measure per the national Patient Safety Thermometer of 95%, which is the national benchmark rate. The specific areas where the Trust is not meeting the 95% benchmark are pressure ulcer care and falls in medicine and surgery. These represent two out of the four patient safety thermometer measures and demonstrate the need and scope for improvement to the benchmark of 95% consistency and subsequently to 100% avoidable harm-free care per CCG ambitions.

The number of patient safety incidents reported per 100 admissions has remained steady since October 2010; an organisation with a healthy safety culture often sees increases as organisations encourage greater levels of reporting, including near misses, as part of providing open and honest care to patients, and to enable lessons to be learned through higher levels of incident reporting<sup>1</sup>. When compared with peer (acute – non specialist) through the National Patient Safety Agency quarterly incident reports, CHFT is at the top of the middle 50% of Trusts for the overall reporting rate, which is positive. However, within these figures, the Trust is higher than peers for the proportion of patient safety accidents and the proportion of incidents relating to treatment and to medication, therefore there are opportunities to reduce down the level of harm and incidents experienced by patients<sup>2</sup>.

- Patient Experience:

CHFT patient survey and Friends and Family Test (FFT) scores have matched national trends in England for the past two years, and whilst CHFT scores are a little above the

England average score, there is room for improvement, particularly when drilling down to Accident and Emergency care scores in FFT as well as individual measures in the patient survey. The response rate is below the 15% nationally required by the 14-15 Commissioning for Quality and Innovation (CQUIN) scheme, although this is a picture mirrored nationally, a higher proportion of CHFT would not recommend A&E services compared with other services, and CHFT has higher than the national average number of complaints per 1000 inpatient episodes.

- Effectiveness:

Adults with chronic conditions in Calderdale and Greater Huddersfield have higher levels of hospitalisation for their condition than other patients in England, as do under 19s with asthma, diabetes and epilepsy.

Whilst there has been overall progress in the last three years to decrease the number of potential years of life lost towards the national average, there have been fluctuations for both Calderdale and Greater Huddersfield within the last three years that do not match national variation, therefore there is potential scope to reduce this further. Such fluctuations are also seen in quality of life measures for people with long-term conditions and social care related quality of life – whilst these are at or around the national England figure, these have fluctuated in the last three years compared with the England figures.

Other measures contribute to the full picture of current service provision and opportunities and include:

- Emergency, urgent and planned care:

- Mortality: CHFT's most recent mortality figure is 113 (HSMR one-year rolling data to June 2015). The Trust's most recent SHMI mortality figure was 108.9 (March 2015), against an expected benchmark of 100. Whilst the Trust did achieve a reduction in its mortality rate during 2014-15, it is not been able to narrow the gap to a mortality rate (HSMR) of 100, the accepted national standard for which acute Trusts aim. The reduction was also not sustained in 2014-15 and the mortality rate is back to the near 107 mark from the start of the year<sup>3</sup>. During the last two years, a national focus on mortality means that many more acute trusts have made significant progress in mortality, bringing down the overall England average and means that Trusts that are currently outliers, such as CHFT, have to reduce mortality even further in order to move closer to the national average – just to move in to the 'as expected' range<sup>4</sup>

- Emergency readmissions within 30 days of discharge: CHFT has a 30-day re-admission rate that remains above the national average at 7.42% against a target of 7%<sup>6</sup>. There has been little progress to reduce this rate consistently and is a key area of focus for CHFT.

- Maternity care:

- Breastfeeding rates and number of still-births are indicators of the support and effective delivery of care and support to mothers (breast-feeding) and a measure of fundamental safety of services (still-births). Promotion of breast-feeding rates is seen as a measure of the ability to improve babies' health and therefore more likely

to reduce health risks in later life, as well as helping to monitor the health of new mothers and prevent deterioration of her health. The rates of breast-feeding drop off from initiation to GP 6-8 week check was 44.5% for 2014-15 for CHFT services.

- Additional cross-cutting metrics for emergency and urgent care, planned care, maternity and paediatric services.
- Serious Incidents: these are incidents that meet the national criteria of a serious incident: “Serious Incidents include acts or omissions in care that result in; unexpected or avoidable death, unexpected or avoidable injury resulting in serious harm . . . Never Events . . . and incidents that threaten an organisation’s ability to deliver safe services”<sup>5</sup>. Close monitoring of serious incidents enables a proxy view on safety of services and systems in a provider, which can be analysed by particular wards, teams and services to provide assurance that there are no repeated issues, themes or trends that escalate in to a patient safety issue.
- CHFT reported 107 Serious Incidents for 2014-15, 83 of which were in medicine and 19 in surgery, with 4 in children and women’s health. Whilst this number is similar to other Trusts providing similar services, careful monitoring of sudden spikes in figures or drops in figures will provide a view to CCGs on an improvement/deterioration in safety and quality of services, and is an important measure to understand headline safety issues. In 2015 – 16 we have seen an increase in serious incidents reported in relation to delay in diagnosis / treatment. In 2014-15 CHFT reported 0 Never Events, which are preventable safety incidents that cause significant harm to a patient<sup>4</sup>, and are a specific type of Serious Incident. Maintenance of zero Never Events is a useful proxy measure of the fundamental safety of a service and changes in services need to take account of changing procedures and maintaining safety checks and managing down levels of risks.
- Length of stay, occupied bed days, excess bed days and delayed transfers of care: these four metrics are indicators of the health of the local care economy and the way in which the hospital is best able to use resources to promote recovery, and discharge to patients in a timely and effective manner to aid patient flow within the Trust. Currently CHFT and partners have a Delayed Transfer of Care rate of 4.5% as at November 2015, and a year-average figure to November 2015 of 6.1% against a target of 5% demonstrating room for improvement; much of the latest figure for March 2015 will be linked with flow of patients during winter months and additional pressures on acute trust beds, however, with a year-to-date rate of over target at 6.1% suggests that work with other partner as well as addressing internal patient flow and staffing issues will provide more robust care pathways to patients.

#### **2.2.4 Summary of current position and future positioning**

Whilst the Trust is starting from a solid baseline for performance, including quality and safety, there are services that are not yet at national average, have concerns regarding sustainability or have shown variations that suggest reaching ‘best in class’ remains a challenging ambition.

This raises the fundamental question of what would the case for quality and safety be if the current configuration of services and pathways remained the same. To illustrate this, the measure of mortality would take significant effort in order to make the same reductions as other Trusts have made to reach the 'as expected' level of 100 on HSMR. This would require work on individual pathways and, improved coding of patient care to make some improvements. The Trust have planned to do this work.

However, the current configuration for emergency, acute and planned care for adults and paediatric patients remains across different sites and with variations on the same pathways and a specialist workforce that is quite dispersed. The evidence underpinning Royal College guidance on emergency care, the evidence from the peer review undertaken at CHFT and the safer staffing guidance for planned and emergency care for nursing staff all support a fundamental change in service configuration to make the required gains on quality and safety rather than piecemeal or pathway-work only, such as in mortality, or re-admissions, where again only a small and unsustainable change will be possible while pathways and services are delivered from different areas. The Royal College evidence in particular supports the greater impact that senior medical intervention in the first 48 hours of emergency and urgent care can have on reducing mortality, reducing readmission rates, reducing incidents and reducing harm caused to patients. This is the case for both adult and paediatric care.

In summary, too many people:

- are dying in our hospitals. The hospital Standardised Mortality Rate is higher than the England average.
- are admitted to residential or nursing home care
- stay longer in hospital than is clinically necessary
- are admitted to hospital with a long term condition
- are readmitted within 30 days
- wait over 5 weeks for diagnostic services.
- report they do not have a good experience when they attend A&E
- leave A&E without having been seen.
- CHFT has higher than the national average number of complaints per 1000 inpatient episodes.

### 2.2.5 The Improvement Journey

The CCGs have both articulated a wish to close the gap to the England average and to surpass this, ultimately aiming for 'best in class' outcomes. The following sections provide more detail to describe what this would look like in relation to the Hospital Standards.

- **Acute and Emergency care - moving to meet national standards**  
The picture outlined above is not to suggest that the Trust is providing wholly unsafe services or that these are not subject to careful scrutiny by the Trust and by

commissioners. What these do indicate are that the quality issues are interconnected with the financial and strategic issues also outlined in this document. These are critical issues currently impacting on patients' outcomes and experience of care as evidenced in the Quality and Safety dashboard. In light of the Francis Inquiry and outcomes from the national Keogh reviews, as well as national NHS standards of the current measures of quality and care, it is incumbent on the Trust and commissioners to consider how best to overcome these quality and safety risks and build up to a position of best practice being the norm for patients in Calderdale and Greater Huddersfield.

In the climate outlined above, of increasing demand and financial pressures, the Trust is prioritising what it is able to in order to improve quality. The four quality objectives that CHFT is setting for 2015-16 in its Quality Accounts<sup>3</sup> are:

- Improving sepsis care
- Ensure intravenous antibiotics are given correctly and on time
- Improving the discharge process
- Better food

These priorities will make some inroads to the quality and safety issues detailed above, in particular in emergency and urgent care. These plans are focussed on in-year improvements that, as the review of the 14-15 position shows, are limited when they concern changing some elements of pathways already in place or responding to data as they become available to identify individual actions. Programmes, such as the Trust's Care of the Acutely Ill Patient Programme, will also have an impact on mortality and quality of care, but these all approach the issue from isolated viewpoints rather than enabling Trust-wide sustainable change on a cross-cutting theme, such as mortality, to take place.

These plans do not enable the Trust to overcome the systematic issues that limit the ability to improve quality on a wholesale or sustainable footing, or to move in to a position to meet the full requirements of national staffing guidance in paediatric care or Royal College guidance to have the greatest positive impact on care through earlier intervention and review by senior staff whatever the day and time of presentation. On a local level, these are also unlikely to meet the full scale of the Hospital Standards, such as better deployment of resources to enable more senior input at an earlier stage of patients' pathways, to provide more timely access to key diagnostics or improve staffing ratios and patient pathways.

In numerical terms, and in relation to the CCGs' position and outcomes for the CCGs' patients, it can be anticipated that 2015-16, on the current configuration of services, would deliver:

- A reduction in mortality, based on targeted work on acutely ill patients and earlier interventions in sepsis care and medication administration, but not predicted to be at the 100 national benchmark rate and whether reductions are able to be maintained

- No anticipated progress in improving access to and senior clinician review for emergency and urgent cases
- No anticipated progress in improving pathways of care in paediatrics to bring together better ways of working and more senior input in to paediatric cases, particularly surgical cases, earlier in patients' episodes, as recommended by national guidance
- Some improvement in increasing rates in harm-free due to targeted work on pressure ulcer care and falls, but no articulation as to a rate of improvement to the 95% national benchmark or reducing down all avoidable/new harms to patients
- Maintaining satisfaction/rates of recommending planned and elective care in Friends and Family test but no articulation as to how to improve response rate or level of recommendation for A&E and urgent care

The quality and safety case for change therefore includes:

- A need to reduce current variation in outcomes as measured through the Quality and Safety dashboard and underpinning 26 metrics between different patient population segments by having more robust single pathways and teams within service areas, co-located for more timely access to specialist staff, scans and results – this will improve the quality and safety of services
- A requirement for sustainable compliance with relevant Royal College guidance
- A further opportunity for clinicians to take ownership of patient pathways by working in a single team around the needs of the patient
- Have co-located support services to help with patient flow, better management of the increasing acuity of demand and deteriorating patients

It can be anticipated that the Trust will set targets for improvement for 15-16 as plans are further developed and that the Trust will be able to make some improvements in mortality, reduction in falls and incidents causing harm and other key targets, with which commissioners will support the Trust.

As detailed above, these impacts are limited by current service configurations and staff availability for designed changes to pathways for more senior intervention. The Trust's current service configuration means that there are fundamental staffing issues to address, and having the capacity to change pathways to enable more senior staff input earlier in patient care. These are blockers to being able to move to national averages or to the best in class of the Hospital Standards.

In terms of the future, in order to move towards consistently meeting national benchmarks and standards (staffing, harm-free care, mortality, re-admissions), commissioners and the Trust can expect to see significant improvement in years 1 and 2 post reconfiguration, should this be the agreement, that services and teams are brought together in to new configurations that will allow more robust clinical ownership and managerial oversight of emergency and urgent care.

Without service reconfiguration, there is a clear clinical consensus, backed up by the independent reviews that have been conducted, that have told us that it will not be possible to expect to see the level of year-on-year improvements in mortality, infection control and access targets (which impact on quality), with a stretch to national standards and gold standards, on the current risk-based approach. The short-term risks are those that will put in place stable and safe services prior to transition, with gains that can be better made through a centralised model that has great clinical input and oversight

- **Elective Care**

Linked to position outlined above in relation to the distance to travel for acute and emergency care is the current position on elective care where many of the same outcomes apply. There are service pressures and a growing concern on sustainability of current services. These are seen in the Trust's Integrated Performance Report, shared with Commissioners, which shows variation and lower levels of compliance in areas of patient safety and quality particularly within surgery in relation to:

- Harm-free care (patient safety thermometer), which was not at the 95% national standard in surgery at the end of 2014-15 (also in the Quality and Safety dashboard)
- Access to diagnostics within required timescales
- The numbers of pressure ulcers in medicine and surgical services, including a number of Grade 3 and 4 pressure ulcers
- Pressures in infection control figures (MRSA, c. difficile and MSSA) and hand-washing compliance audits
- Pressures on the number of patients being transferred to another ward or to another site during their inpatient stay
- Pressures caused by the number of incidents causing severe harm
- Staffing levels where recruitment and retention is a particular issue compounded by the current level of frequency and intensity as a result of service configurations.
- Sickness levels
- General elective access issues as staffing models change to ensure core capacity is focussed on highest risk patients

As with acute and emergency Care, there are actions the Trust can take to address these issues and whilst the Trust has plans in place to improve those areas where possible, these plans are working within the restrictions of current configuration of services, including diagnostic and support services, and are unlikely to achieve our ambitions for patients.

The Trust has undertaken a baseline view against the agreed Hospital Standards; in relation to diagnostics and supporting seven day services, the Trust's position is that Emergency provision in place seven days a week but MRI or ultrasound are not



available seven days a week for urgent or elective requirements. There is also no Out of Hours provision to support elective activity

The Trust's aspiration in line with the agreed Hospital Standards is to have a seven day per week service for elective and urgent care. The aim would be to have the majority of inpatient tests completed within 4hours of request and the results available to support early senior decision making and overall patient flow.

A full reconfiguration of all the acute specialities and emergency services could enable even more people to benefit from similar improved safety and reduction in mortality (more lives saved). This would then support better configuration and support to elective care as determined by Commissioners and the Trust and position the Trust to move to meeting the full range of Hospital Standards as a key enabler.

Without reconfiguration of services, these standards could not be met. In elective care, as is the case with emergency and acute care, we believe that reconfiguration will remove much of the duplication, variation and potential for harm. In quality and patient safety terms, the reconfiguration and co-location of services in elective care will enable more robust, single pathways to be put in place that reduce the risk of patient safety issues and increase ownership of care pathways. This is an evidenced-based approach to take in an organisation with a healthy safety culture<sup>1</sup>. This also increases the capacity of teams to improve their services as they will be able to concentrate improvements and resources in to one area, which will in due course impact on the full range of quality and safety metrics.

As with emergency care, the Trust is current in a 'holding pattern' of outcomes for patients and the Trust will not be able to stand still in this position. The CCGs and the Trust can monitor in-year improvement plans that will address some issues each year but wholesale improvement would come post-reconfiguration and post co-location, with targets (agreed by commissioners and the trust against the Hospital Standards) to reduce variation in outcomes between the populations served by the hospital and improve the patient safety and quality picture each year in the way that is not possible at the moment.

Increasingly Royal College guidance recommends the separation of elective and acute capacity, reflecting the requirement to ensure rapid response by the most senior clinician to a patient presenting acutely to the hospital. Increasing pressures of unplanned admissions have impacted on elective care and separation ensures compliance with rapid response time but also secures a positive experience for patients undergoing planned care through dedicated facilities. Our locally agreed Hospital Standards reflect this increasing requirement from Royal Colleges' guidance and recommendations.

- **Maternity and Paediatric services**

As with urgent and emergency care, the Trust can make some progress each year on actions that will make some improvement. At present, there is variation in the quality of care women can access in maternity, and services in paediatrics that are

not configured around the patients' needs. There are also a number of areas of national guidance against which the Trust is not yet compliant.

In maternity care, the Hospital Standards outline the care environment that would achieve a high standard of maternity care and choice across hospital services for women and their families. The standards – of midwifery-led care, co-location of services and 1:1 staffing for women during labour are internationally recognised standards of maternity care; co-location of services and restructuring services around midwifery care and appropriate access to obstetricians creates the right care environment to minimise clinical risk and support women's choices in pregnancy and labour.

In paediatric services, the National Clinical Advisory Team (NCAT) visit to the Trust in 2013 made specific recommendations on paediatric care, which are supported by the Hospital Standards. The NCAT highlighted that the emergency departments of the Trust are currently *non-compliant with many of the standards for Children and Young people in Emergency Care settings . . . a dedicated Paediatric ED, which would then result in compliance with many, (if not all) of these standards; this is highly desirable. It is clear that in terms of providing sufficient numbers of adequately trained and skilled staff, it would be impossible to provide this level of service on both sites. . . In particular, the co-location of Paediatrics and Paediatrics EM will allow for Paediatric emergency medicine (PEM) trained staff to work alongside and support acute Paediatrics which also has significant workforce issues, especially medical staffing.*

Against the agreed Hospital Standards for paediatric care, the Trust's baseline assessment details that the Trust at present does not provide a dedicated Acute Emergency Department (AED) for children due to split site configuration and cannot provide a 24/7 children's AED environment as there is not sufficient critical mass to support 2 x 24/7 AED units.

Due to the current configuration of two accident and emergency departments, the Trust has to retain a Children's Assessment Unit (CAU) on one site with the remaining children's inpatient facilities on the second site. Inpatient facilities are compliant with the Hospital Standards but the CAU does not have Paediatric Consultant cover and is covered by base specialty of the child.

Some adult specialties such as Trauma see and treat children at Huddersfield Royal Infirmary, which means they reside on the CAU site rather than transfer to main inpatient facility.

The bulk of specialties run dedicated children's outpatient clinics but there are still several specialties where children and adult services are mixed.

Patient experience data, also detail that parents are dissatisfied with the impact of current service configuration that requires transfer of children across to different hospital sites to access diagnostic and then paediatric surgical teams and the impact this has on parents to stay with their children, visit them and to maintain their other caring duties.

Implementing a service reconfiguration will more likely put in place services to fully comply with existing and new national standards (at this stage we anticipate that the proposed model be consistent with the requirements of the Cumberledge Review), alongside which commissioners and the Trust will be in a position to put in place trajectories for further improvement to meet and surpass the Hospital Standards to 'best in class'. These would include reductions in harm and increased patient satisfaction that will be measures of how well the standards have been achieved. . Therefore the case for change in this area will secure a reduction in variation in delivery and outcomes, to narrow the differences in dashboard measures between Calderdale and Huddersfield CCGs' populations as currently seen.

### **2.2.6 Case for Change Summary**

The full implementation of the Hospital Standards will bring local standards in line with other acute Trusts and start to reduce variation in patient outcomes, quality and safety as currently seen. Whilst actions planned by the Trust and by commissioners can make a level of improvement in-year, reconfiguration of services around patient needs is the more fundamental change needed in order to consistently meet and where possible surpass national standards. Services split across sites do not enable as timely Consultant input in emergency and urgent care for adults or children. The evidence base for quicker medical intervention in acute and urgent care is detailed in national guidance and would enhance the patient experience as well as reduce key risks faced by the Trust and CCGs. Services are not co-located to reduce the potential for clinical risk in the most effective way possible, both in urgent and elective care.

Without service reconfiguration, the services will not have the capacity and concentration of expertise to maintain current service delivery let alone being able to offer a consistent 7 day a week service and could not accommodate the required wholesale changes in pathways and medical intervention for better outcomes, nor in paediatric and maternity services to improve staffing ratios and surgical availability without co-locations of teams. These will be evidenced over time by: reductions in harms; reductions in mortality within services and against specific conditions; a reduction in incidents and serious incidents; and improvements in patient experience, all of which describe where the right care environment has been created to reduce and manage clinical risk as far as possible.

From a quality perspective, the case for change is a signal of our ambition to develop the capability to meet and surpass good standards of care and create the opportunity to move to 'best in class' standards for services and pathways. This will help to address the inequality of outcomes for patients living in different areas covered by the hospitals trust's services. It will also positively promote patients' right to choose in elective and maternity care, within the configurations that support safe, effective and sustainable services, and satisfaction levels with the new models of care can be measured through existing metrics and feedback mechanisms. The baseline on patient satisfaction has elements that are good, but there is room for improvement, particularly in urgent care. The case for change for patient safety and quality is interconnected with the financial and strategic issues also outlined in this

document; unsustainable services will become more unsafe for patients therefore this business case for hospital care presents a real opportunity to create safe and best practice care environments and pathways whilst supporting services to all patients and offering better and more consistent outcomes.

#### List of References

- 1 National Patient Safety Agency: Organisational Patient Safety Incident Reports
- 2 NRLS quarterly report, CHFT, to September 2014).
- 3 Calderdale and Huddersfield NHS Foundation Trust Draft Quality Accounts 2014-15
- 4 Keogh Mortality Review – Final National Outcomes Report July 2013
- 5 NHS England Serious Incident Framework March 2015

### 2.3 Workforce Challenges

Workforce is one of the key factors driving the need for reconfiguration. The Five Year Strategic Plan and Workforce Plan have been developed in response to a number of specific workforce challenges the Trust is facing in delivering sustainable, resilient and affordable clinical services for its local population. These challenges are highlighted as follows:

- Meeting Royal College of Emergency Medicine’s recommendations / standards: both hospital sites operate an Emergency Department and a Critical Care Unit. The care provided under both of these services is either non-compliant with some of the standards for Children and Young People in Emergency Care settings or not fully compliant with guidance on Critical Care workforce standards. The two sites do not satisfy the College’s recommendation of a minimum of 10 consultants per Emergency Department and for 14 hours a day consultant cover.
- Intense, fragile clinical rotas: the provision of services at two different sites and a significant number of staff vacancies has resulted in the Trust operating a number of high frequency clinical rotas. This places a considerable workload strain on staff and detracts from the resilience of the services as a whole. Examples include the 1 in 5 ED rota, the 1 in 11 Acute Medicine rota (neighbouring Trusts have a 1 in 15 rota) and the 1 in 5 Acute Medicine weekend rota.
- Long term sickness absence: 4.3% of the Trust total workforce is on long term sickness absence, though the rate is higher for a number of particular areas such as the Medicine Directorate which has a rate of 5.3%. Anxiety, stress and depression are by far the most commonly reported causes.
- Recruitment, retention and vacancy challenges: the Trust faces considerable recruitment and retention challenges, arising in vacancies in a number of key clinical staff groups. These reflect both national shortages (Emergency, Paediatric and Radiologist consultants) and a variety of local factors which compound these. Examples include the cross site working, intense rotas, and reduced opportunities for sub-specialisation in ED and Radiology rotas.
- Nursing and Midwifery Staffing: There has been a gradual improvement in shift fill rate over the past 12 months; qualified nurse shifts on both days and nights are currently running at between 85% and 90% fill rate. Unqualified shifts are currently

filled at between at 94% and 109%, the percentage over 100% signifies that qualified nurse shifts are being covered by the unqualified workforce in a bid to ensure that safe care is delivered. The sickness level within nursing and midwifery is currently 5.26% this is above the trust target of 4%. Turnover rate in the previous 12 months is also high at 15.5%. Although the overall picture has improved in the Nursing and Midwifery workforce over the past 12 months the situation remains fragile.

- Heavy reliance of locum staff: due to vacancies and a high sickness absence amongst the workforce, the Trust relies considerably on agency and locum staff to cover gaps in the workforce. This represents a considerable financial pressure for the Trust, with £21.2m agency and locum expenditure forecast for FY16. The Medicine (£12.5m) and the Surgery & Anaesthetics (£4.8m) Directorates account for 82% this expenditure, with junior doctors (£8.2m), nursing (£6.9m) and consultants (£4.3m) accounting for 87% from a staff group perspective.

## 2.4 Financial Case for Change

### 2.4.1 Context of the financial challenge

In addition to the Quality and Safety drivers for change there is a strong financial case for change. Without change we will not be able to deliver a financially stable health economy or provide sufficient resource to deliver the essential improvement in clinical standards that is required to deliver sustainable high quality care consistently.

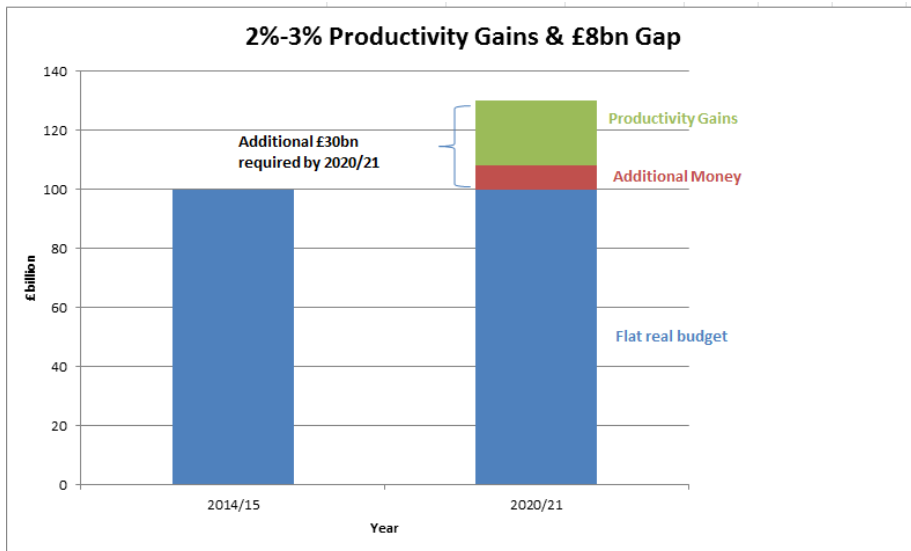
“There are a number of future pressures that threaten to overwhelm the NHS. The population is ageing and we are seeing a significant increase in the number of people with long-term conditions - for example, heart disease, diabetes and hypertension. The resulting increase in demand combined with rising costs threatens the financial stability and sustainability of the NHS.” Source: NHS England. “A Call to Action”

According to the Office of National Statistics, the combined population of the Calderdale and Greater Huddersfield CCG areas was 446,799 in 2013 and is set to rise by 3% by 2018 when it will reach 461,520. The number of over 60s will also rise from 96,672 in 2013 to 105,194 within five years; a 9% growth. These statistics are in line with national trends where both population growth and an ageing population have been widely reported.

The requirement to improve the quality and standard of patient care together with the change in demographics and a budget pegged to inflation is having a significant effect on the cost of healthcare provision. In the Five Year Forward View, NHS England stated:

“In order to provide the comprehensive and high quality care the people of England clearly want, Monitor, NHS England and independent analysts have previously calculated that a combination of growing demand if met by no further annual efficiencies and flat real terms funding would produce a mismatch between resources and patient needs of nearly £30 billion a year by 2020/21. So to sustain a comprehensive high-quality NHS, action will be needed on all three fronts – demand, efficiency and funding.”

The size of the challenge facing the NHS in the coming years is illustrated in the chart below



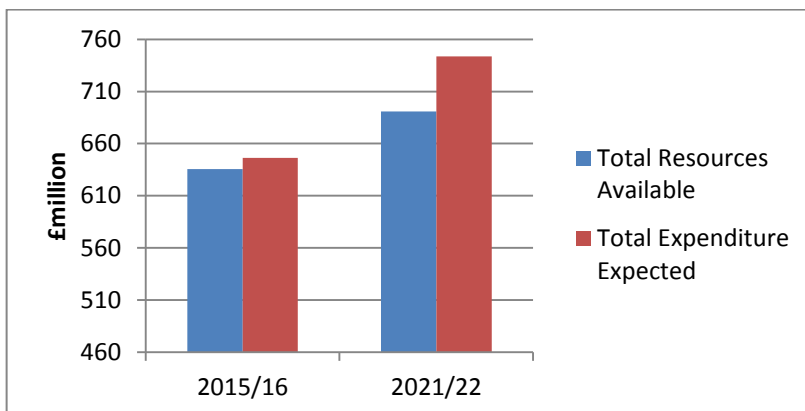
Projected national costs and resources (£billion). Source: NHS England

**2.4.2 Finance challenge for Commissioners**

For the CCGs, the local challenge across both Calderdale and Greater Huddersfield has been quantified as £59.7m between 2015/16 and 2021/22. The funding available to the CCGs will be insufficient to cover the rising demand for health services, the cost of inflation and any other future investments aimed at improving patient outcomes. Despite increasing resources available, growth in expenditure exceeds this.

The £59.7m represents the gap that needs closing with QIPP savings in the next five years up until 2021/22 to achieve the 1% required surplus as stated by NHS England.

In 2015/16 there is a plan to achieve a surplus, but over the five years expenditure is expected to increase at a greater rate than the resources available. This is shown below.



**2.4.3 Finance challenge for Providers.**

Providers are also facing a cumulative challenge of £257m. This is largely driven by the deficit position in CHFT (covered in more detail below) and the efficiency factor of 2% set by NHS England and Monitor that Providers, are expected to deliver, together with the financial pressures related to:

- Increases in quality and other external standards
- Increases in demand from a growing population

- A rise in the number of patients suffering from long term conditions.
- A national shortage of specialist clinical staff
- The rising cost of drugs and devices.

Calderdale & Huddersfield NHS Foundation Trust have two additional and significant financial pressures, which along with those highlighted above, result in the Trust being financially unsustainable. These two factors are:

1. Dual site running (two A&E departments less than 6 miles apart).
2. A legacy, first wave PFI arrangement on the Calderdale site with no negotiable exit route (legally tested).

In financial year 15/16, the Trust will deliver a £20m trading deficit, with a further £1m one off restructuring costs and will require £13m cash support from the Treasury. This is after delivering efficiency savings in excess of £17m.

Looking forward, 16/17 will see the Trust with a £40.5m deficit after delivery of a further £14m savings. Without reconfiguration of our services between the two sites, the forecast is a cumulative I&E deficit of £204m by 2021/22, to support normal business, which generates a funding requirement of £292m with the inclusion of essential backlog (capital) funding. Furthermore, the cash shortfall assumes annual efficiency savings in line with annual tariff expectations as a minimum and commissioner QIPP will be achieved and as such carries significant risk.

#### **2.4.4 The Financial Pressures**

Presented below are the financial positions of the commissioner and provider organisations across the Calderdale and Greater Huddersfield area. The figures are as per the Comprehensive Spending Review and CCG Allocations published in January 2016.

#### **2.4.5 The commissioners' position**

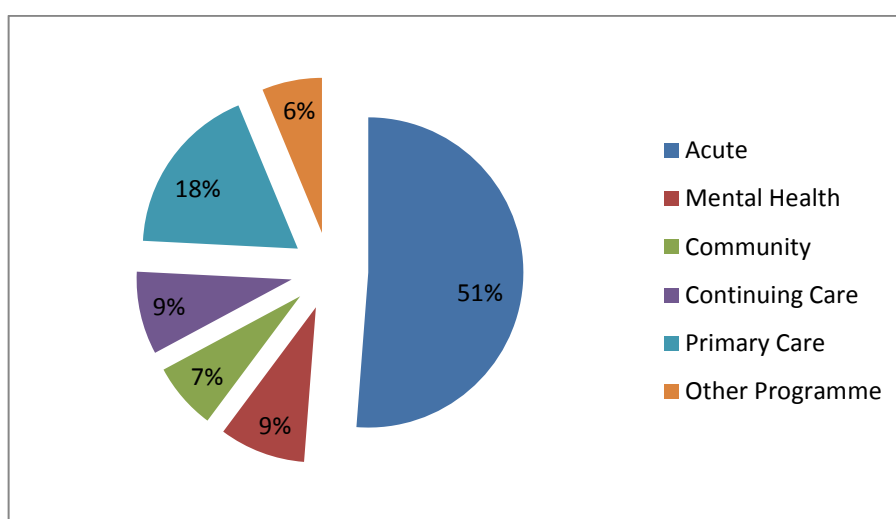
The CCG has used the recently published 5 year allocations for the period 2016/17 to 2020/21 and has assumed a 1% uplift to allocations in 2021/22.

##### **Overview of 2015-2022**

Available resources for the period 2015/17 – 2021/22 are shown in summary below. The allocation that CCGs receive is set by NHS England who consider, age, health status, unmet needs and health inequalities. This is broken down by CCG in the table below.

	CCG Notified and Indicative Allocations	2015/16 £'000	2016/17 £'000 Notified	2017/18 £'000 Notified	2018/19 £'000 Notified	2019/20 £'000 Indicative	2020/21 £'000 Indicative	2021/22 £'000 (1% uplift assumed)
Calderdale CCG	Recurrent	307,960	309,625	314,279	319,341	322,143	325,441	328,695
	Non-Recurrent and returned surplus	7,600	7,933	6,822	5,852	3,693	3,721	3,759
Greater Huddersfield CCG	Recurrent	285,809	325,964	332,373	338,912	345,914	358,514	362,099
	Non-Recurrent and returned surplus	4,295	3,188	3,291	3,304	3,369	3,440	3,474
Total	Recurrent	593,769	635,589	646,652	658,253	668,057	683,955	690,794
	Non-Recurrent and returned surplus	11,895	11,121	10,114	9,156	7,063	7,161	7,233

These available resources are used to fund programme costs and running costs. In 2015/16, the CCGs programme spend is forecast at £580m with Acute expenditure responsible for 51% of spend at £297m. The percentage of programme spends for both CCGs combined is shown below.



The table below predicts that by the end of 2021/22 to achieve the required surplus, there will be a gap of £59.7m at the end of the five years. This is due to the accumulation of recurrent QIPP requirements (brought forward), in year excess of expenditure over resources as a result in increasing programme spend.



Combined CCG Position	2015/16 £'000	2016/17 £'000	2017/18 £'000	2018/19 £'000	2019/20 £'000	2020/21 £'000	2021/22 £'000
Total Resources Available	593,769	635,589	646,652	658,253	668,057	683,955	690,794
Total Expenditure Expected	591,984	637,776	646,397	659,690	669,396	685,133	690,905
Surplus/(Deficit)	10,285	9,614	8,656	6,563	6,661	6,821	6,889
QIPP	(8,500)	(11,800)	(8,400)	(8,000)	(8,000)	(8,000)	(7,000)
Accumulative QIPP Req	(8,500)	(20,300)	(28,700)	(36,700)	(44,700)	(52,700)	(59,700)

### Yearly deficit pressures

Each year the CCG receives an increase in allocation. In 2016/17 Greater Huddersfield CCG's allocation will include primary care allocations so will be comparable to Calderdale CCG's baseline, so comparative growth in allocations and expenditure is best measured from 2016/17.

Combined this is a total increase in allocation of 8.69% over the six years, however this will not cover the expected rise in expenditure which is anticipated to be significantly higher at 15.06%. Both available resources and expected expenditure percentage change is represented below, illustrating the increasing pressure over the next six years.

Combined CCG	2016/17	2021/22	% Change
Total Resources Available	635,589	690,794	8.69%
Total Expenditure Expected	646,276	743,605	15.06%

## 2.4.6 The Providers' position

### Calderdale and Huddersfield NHS Foundation Trust

Calderdale and Huddersfield NHS Foundation Trust has identified that without reconfiguration, it will have an underlying deficit of £29m in 2021/22, despite having made savings of £65m over the same period. These savings are driven by the provider efficiency element of the tariff and commissioner QIPP plans. This is summarised below:

£000's	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22
Efficiency Savings	14	11	9	9	11	11
Forecast (Resulted) Deficit	41	29	28	28	29	29

Of the £65m of required efficiency savings, £53m (query – based on same proportion as previously stated £44/£54m) relates to savings on services commissioned by Calderdale CCG

and Greater Huddersfield CCG. The remainder relates to services provided by other commissioners.

Overall, despite exceeding national expectation on efficiency savings, CHFT is no longer financially viable as it is currently configured. This aligned to the weakness in the current clinical service offered, as viewed by NCAT and others, the status quo can no longer prevail.

### Other providers

In addition to the savings required by Calderdale and Huddersfield NHS Foundation Trust, the efficiency factor of 2.0% has been applied to contacts where Calderdale CCG and Greater Huddersfield CCG apply tariff assumptions.

This amounts to £17.2m of required savings from the other providers from which services are commissioned, shown below.

£000's	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	Total
South West Yorkshire Partnership NHS Foundation Trust	(859)	(852)	(874)	(896)	(920)	(953)	(962)	(6,316)
Locala Community Partnership CIC	(288)	(433)	(438)	(442)	(447)	(452)	(456)	(2,956)
Yorkshire Ambulance Service NHS Trust	(351)	(350)	(349)	(348)	(347)	(346)	(350)	(2,441)
Leeds Teaching Hospitals NHS Trust	(231)	(237)	(243)	(250)	(257)	(264)	(267)	(1,748)
Sheffield Teaching Hospitals NHS Foundation Trust	(99)	(101)	(103)	(105)	(107)	(109)	(110)	(734)
Spire Healthcare LTD	(94)	(96)	(98)	(100)	(102)	(104)	(105)	(699)
BMI Healthcare LTD	(91)	(94)	(98)	(102)	(106)	(110)	(111)	(711)
Barnsley Hospital NHS Foundation Trust	(74)	(77)	(80)	(84)	(87)	(91)	(91)	(584)
Bradford Hospitals NHS Foundation Trust	(55)	(57)	(60)	(62)	(65)	(67)	(68)	(433)
Mid Yorkshire Hospitals NHS Trust	(49)	(50)	(52)	(54)	(56)	(58)	(58)	(376)
Pennine Acute NHS Foundation Trust	(14)	(14)	(14)	(14)	(14)	(15)	(15)	(100)
East Lancashire NHS Trust	(13)	(13)	(13)	(13)	(13)	(13)	(13)	(91)
Yorkshire Clinic	(12)	(12)	(12)	(12)	(12)	(13)	(13)	(86)
Total	(2,229)	(2,386)	(2,433)	(2,482)	(2,532)	(2,593)	(2,619)	(17,275)
Cumulative Total	(2,229)	(4,615)	(7,049)	(9,530)	(12,063)	(14,656)	(17,275)	

### 2.4.7 Combined Challenge

Each organisation is facing its own pressures and when combined, the locality of Calderdale and Greater Huddersfield (health sector only) faces a significant challenge.

Calderdale & Greater Huddersfield Combined	2015/16 £'000	2016/17 £'000	2017/18 £'000	2018/19 £'000	2019/20 £'000	2020/21 £'000	2021/22 £'000	Total £'000
Clinical Commissioning Groups	-8,500	-11,800	-8,400	-8,000	-8,000	-8,000	-7,000	-59,700
Other Providers	-2,229	-2,386	-2,433	-2,482	-2,532	-2,593	-2,619	-17,275
CHFT	-21,100	-40,500	-29,100	-28,400	-27,500	-28,700	-28,700	-204,000
Total (£'000)	-31,829	-54,686	-39,933	-38,882	-38,032	-39,293	-38,319	-280,975

At the end of the seven years in 2021/22 the financial challenge facing the area of Calderdale and Greater Huddersfield (health sector only) amounts to £281m.

There are significant social care financial challenges that are not currently factored into this position but clearly impact on the overall affordability challenge. Work is ongoing across both local authority footprints to understand these challenges and mitigate further risk.

### 3.0 WHAT OUR ENGAGEMENT HAS TOLD US

#### 3.1 Engagement Method and Approaches

Engagement is the informative stage, where we gather information, listen to people's ideas and views and consider the findings to develop the plans.

Our engagement process started in May 2014, however our journey started in September 2012 during this period we directly gathered views from over 4,000 people on both hospital and community services. During this time we have had lots of community conversations and three stakeholder events. In summary we have engaged on:

- Strategic Outline Case (SOC): providers' response to the case for change.
- NHS Calderdale and Greater Huddersfield CCGs - 5 year strategies and commissioner intentions.
- Care Closer to Home: for both Calderdale and Greater Huddersfield
- Hospital Standards and Hospital services: emergency, urgent and planned care, therapies, new technology and more recently maternity and paediatrics

We have tabled in section 3.2 a summary of our journey to date and the engagement process we have followed to ensure the view of local people are captured as part of the development and design stage. The table sets out what people have told us and how we have used the information to develop our plans.

#### 3.2 How people's views have influenced our plans

What we did	What people told us	How we used the information
<p>From <b>November 2012 to February 2013</b> we engaged with people in Calderdale and Greater Huddersfield on:</p> <ul style="list-style-type: none"> <li>• Planned Care</li> <li>• Unplanned care</li> <li>• Children</li> <li>• Long term care</li> </ul>	<p>We received over 2,000 views and people told us you want to see:</p> <ul style="list-style-type: none"> <li>•Timely and consistent access to services</li> <li>•Coordinated and integrated care</li> <li>•Services closer to home</li> <li>•Involve us in decisions about our care and in planning care</li> <li>•Better use of technology.</li> </ul>	<p>We used this information to develop a case for change</p>
<p>In <b>September 2013 – December 2013</b> we engaged with people in Calderdale and Greater Huddersfield on:</p> <ul style="list-style-type: none"> <li>• Call to Action</li> </ul>	<p>We received 487 views people identified 13 themes they wanted us to focus on, in order of importance the themes were:</p> <ul style="list-style-type: none"> <li>•Education and information</li> <li>•Invest in the community</li> <li>•National solutions and campaigns</li> <li>•Self- care</li> <li>•Improve access to health services</li> <li>•Staff and training</li> <li>•Working together</li> <li>•Regular check ups</li> </ul>	<p>The providers used this information and the previous information gathered from November 2012 – February 2013 to develop a 'Strategic Outline Case' (SOC).</p>

What we did	What people told us	How we used the information
	<ul style="list-style-type: none"> <li>• Discharge planning and better hospitals</li> <li>• Manage risk and safeguarding</li> <li>• More services in the community</li> <li>• Invest in technology</li> <li>• Accountability</li> </ul>	The commissioners (CCGs) used this information to inform their commissioning intentions and local strategies.
<p>In <b>May/June 2014 to August 2015</b> we engaged with people in Calderdale and Greater Huddersfield on: The commissioners intentions; and the providers 'Strategic Outline Case' (SOC)</p>	<p>We received over 2,500 views and people told us:</p> <ul style="list-style-type: none"> <li>• People wanted to see more services closer to home and in a variety of community settings</li> <li>• The public in Calderdale do not want to lose their A&amp;E as part of services changing</li> <li>• Travel and transport needed further consideration.</li> <li>• Access to services in the community needed to be 24/7 including bank holidays and there was a strong message that GP access in particular needed to be addressed if the system was to change.</li> <li>• People wanted more focus on prevention and innovative opportunities to keep themselves well or be educated, particularly at a young age</li> <li>• Appropriate staff are needed in the community</li> <li>• There were concerns that the model looked good on paper but would it work in practice,</li> <li>• People did not understand the detail of any of the plans and wanted to understand this further</li> <li>• People wanted the community to be part of the solution including design, delivery and estates</li> <li>• Mental health services were not working and there was a need to look at services further</li> <li>• Hospital services were poor on waiting times and needed to improve</li> <li>• There needs to be more consideration for vulnerable groups, protected groups, carers and those with a disability</li> </ul>	The information was used to inform both NHS Calderdale and Greater Huddersfield CCGs commissioning intentions and the providers Strategic Outline Case (SOC)

What we did	What people told us	How we used the information
<p>In <b>August 2014</b> we shared the findings from our engagement activity at a joint stakeholder event. We also engaged with people from Calderdale and Greater Huddersfield on:</p> <ul style="list-style-type: none"> <li>• Our plans for Care Closer to Home in Both Calderdale and Huddersfield</li> <li>• The appraisal criteria</li> <li>• Hospital Standards</li> </ul>	<p>Over 100 people attended the event and people told us:</p> <ul style="list-style-type: none"> <li>• A need to communicate our plans to the wider public, explain our reasons clearly and in plain language</li> <li>• That Care Closer to Home is the way forward and some progress can be seen</li> <li>• The public want to stay involved in the development of any plan</li> <li>• There was a general consensus that change needs to happen, but the pace of change is slow</li> <li>• Travel and transport need to be considered as part of Care Closer to Home as much as hospital services</li> <li>• Partnerships need to be strengthened</li> <li>• We have a diverse population and we need to consider all our population when designing new services</li> <li>• Workforce skills and capacity, estates and new technology require thorough consideration if models are to be delivered.</li> </ul>	<p>The information from the event was used to inform plans for 'Care Closer to Home' in Calderdale and Huddersfield.</p> <p>NHS Greater Huddersfield CCG used the information to support the procurement process using lay representatives on the panel.</p> <p>NHS Calderdale CCG used the information to develop a specification for 'Care Closer to Home' and delivered a second event in December to share their plans further.</p>
<p>In <b>July 2015</b> we engaged further with targeted audiences on hospital services. This engagement was part of pre-consultation engagement. We wanted to ask more questions on the following:</p> <ul style="list-style-type: none"> <li>• Urgent and emergency care</li> <li>• Planned care</li> <li>• New technology and therapies</li> </ul>	<p>We received 654 views and people told us:</p> <ul style="list-style-type: none"> <li>• Peoples preferred contact in an urgent care situation is the local GP, followed by a chemist then walk in centre. Family, friend or self, featured strongly in the responses</li> <li>• In an emergency care situation people want the right care where ever that is and to see a professional with special knowledge, skills and equipment</li> <li>• People in emergency want to receive care quickly and get the treatment they need and feel safe</li> <li>• For some having transport that can accommodate their needs is a priority – particularly for people with a disability</li> <li>• In a planned care situation people want the person treating me to have access to all the information they need and for services to be joined up and coordinated</li> </ul>	<p>The information gathered during this period has been used to further inform the future clinical model of care.</p>

What we did	What people told us	How we used the information
	<ul style="list-style-type: none"> <li>• Services for planned care should be provided at local treatment centres such as the GP/drop in sessions</li> <li>• Good access in the community for services including follow up appointments and more use of the telephone for contact</li> <li>• Recovery time to be appropriate with services in place to provide aftercare</li> <li>• Poor Wi-Fi connection in a number of local areas needs to be addressed although technology should not take the place of face to face contact</li> <li>• For new technology a lack of equipment or knowledge would need to be supported</li> <li>• 80% of the respondents use a car or taxi – concerns about cost of parking or journey cost</li> <li>• 35% of the respondents use public transport - concerns about getting to early appointment, services not on bus routes, cost</li> <li>• 20% of respondents use supported transport – concerns about access including wheelchair access, long journeys</li> </ul>	
<p>In <b>August 2015</b> we shared the findings from our pre-consultation engagement at two local stakeholder events (event 1a and 1b), one in Calderdale and one in Greater Huddersfield. We asked people to tell us:</p> <ul style="list-style-type: none"> <li>• Where they thought we were with our plans for Care Closer to Home</li> <li>• If there was anything we should now consider as part of the future clinical model of care</li> </ul>	<p>164 people in total attended both events and people told us:</p> <ul style="list-style-type: none"> <li>• We need to communicate our plans to the wider public, explain our reasons clearly and in plain language.</li> <li>• That Care Closer to Home is the way forward and some progress can be seen, more should be done to demonstrate it is working, again more publicity.</li> <li>• The public want to stay involved in the development of any plans and want us to improve our engagement.</li> <li>• There was a general consensus that change needs to happen.</li> <li>• Travel and transport need to be considered as part of Care Closer to Home as much as hospital services.</li> <li>• Partnerships need to be strengthened we need to show we are working with colleagues from the local authority, ambulance service and the voluntary sector to ensure our plans work.</li> <li>• We have a diverse population and we need to consider all our population when designing new services.</li> </ul>	<p>The information gathered during this period again further informed the future clinical model of care.</p>

What we did	What people told us	How we used the information
	<ul style="list-style-type: none"> <li>Workforce skills and capacity, estates and new technology are all highlighted as key areas requiring thorough consideration.</li> </ul>	
<p>In <b>November 2015</b> we engaged further with targeted audiences as part of pre-consultation engagement. We wanted to ask more questions on the following:</p> <ul style="list-style-type: none"> <li>Maternity services</li> <li>Paediatric services</li> </ul>	<p>We received 1,112 views and people told us:</p> <p><b>Maternity services</b></p> <ul style="list-style-type: none"> <li>People want to see staff who are highly skilled, professional, calm, compassionate and confident, not rushed or stressed</li> <li>People want to see the same staff throughout their pregnancy right through to the health visitor contact</li> <li>People want as many services as possible closer to home with improved waiting and appointment times</li> <li>Transport and travel and getting about in the latter stage of pregnancy particularly for those with children and also who don't drive need to be considered. Designated parking spaces with longer waiting allowances for parents</li> <li>More information and support before pregnancy to ensure the right choices for birth are made, including support for dads.</li> <li>More awareness and training for staff on the cultural view of home birth and also how to support different types of family</li> <li>Parents want to have good equipment in the right location with access to services if things go wrong.</li> <li>People want a calm and clean space that is private and comfortable with lots of room and good nourishing food</li> <li>People want more support whilst in hospital including help with feeding and not being discharged too early</li> <li>For families who face complications or loss of a baby they would like separate spaces and entrances</li> </ul>	<p>The information gathered during this period again further informed the future clinical model of care.</p>

What we did	What people told us	How we used the information
	<p><b>Paediatric services</b></p> <ul style="list-style-type: none"> <li>• Most parents want support to self-manage a child's illness or condition.</li> <li>• Parents want services close to home with limited travel time and have described their GP practice as their preferred contact point in an urgent care situation</li> <li>• Parents want access to a paediatrician when they visit hospital</li> <li>• Parents want separate spaces for children, shorter waiting times and children to be seen straight away</li> <li>• Children and young people want reassuring and understanding staff who communicate well in a non-patronising way.</li> <li>• Children young people want reduced waiting times in A&amp;E, an environment with child friendly facilities such as toys and Wifi</li> <li>• Children and young people also prefer the GP as the first point of contact in an urgent care situation and want to be seen straight away in services near to where they live or close to home on good bus routes</li> </ul>	
<p>The most recent joint stakeholder event (event 2) held in December 2015 ensured we could update people on our journey to develop a future clinical model and an update on the two hospitals. We also further engaged with people from Calderdale and Greater Huddersfield on:</p> <ul style="list-style-type: none"> <li>• Their thoughts on what they had just heard</li> <li>• The appraisal criteria and how it has been applied</li> </ul>	<p>The responses from this event are contained in this report. The key themes are:</p> <ul style="list-style-type: none"> <li>• In general people agreed with the appraisal criteria used. Additional considerations were captured that added value to the original description. There were only a few recommended changes.</li> <li>• The ranking of the criteria proved difficult with most tables agreeing that all were equally important. However the highest ranked criteria was 'Quality of Care' followed by either 'Access to Care' or 'Value for Money'.</li> <li>• The feedback received about the event was positive, with most attendees feeling they had been able to follow the journey.</li> <li>• There was a general view that engagement had informed the plans and this was evident in the work that had been presented.</li> <li>• Support for mental health and the services required needs to be considered as part of any transformation plan.</li> </ul>	<p>The information gathered now concludes the end of the pre-consultation engagement process.</p>



In addition to the above, we have worked with the Consultation Institute which has provided assurance in relation to our pre-consultation engagement. The next stage of our journey will be a formal consultation process. Consultation is the formal legal stage and cannot happen without engagement. This will end in a final decision, informed by the public, of how services will be delivered in the future.

### 3.2 Summary of engagement, themes and responses

In summary local people told us they want to see:

- As many services as possible should be close to home in local settings such as a GP practice with improved waiting and appointment times
- Services that are coordinated and wrap around all the persons needs involving a range of partners and agencies
- The right staff. With the right skills that are caring and competent and treat people with dignity and respect
- Services that are properly planned and that are appropriately staffed and resourced, have the right equipment and maintain quality
- More information available about health conditions and more communication about what is available to ensure people can make choices and have support to self-manage health care
- Services that everyone can access including clean comfortable buildings aimed at the right target audience, appropriate information and staff that represent the community they serve.
- Any barriers to parking, travel and transport addressed with a clear plan which takes account of diversity and locality
- Improved communication between all agencies involved in a person's care and treatment including better communication with young people
- Services that are responsive and flexible - particularly in an urgent care situation
- Reduce delays in getting the care and treatment required and improving waiting times
- Technology that people can use to reduce travel times and unnecessary journeys – particularly for young people
- Support for mental health across all services

A full composite report of all our engagement is available on our website.

## 4.0 THE CHANGES WE ARE PROPOSING

### 4.1 Calderdale and Greater Huddersfield health care Vision

We have identified some high level principles regarding the future design and operation of Health and Social Care in Calderdale and Greater Huddersfield:

We will design services which:

1. Deliver care locally and retain services close to home and, where possible, also bring additional services closer to home
2. Deliver services in accordance with best practice standards in relation to standards of Care and Patient Experience.
3. Provide better/improved access to primary care services
4. Build resilient, sustainable services, users and communities
5. Provide a financially sustainable system
6. Are underpinned by high levels of performance and delivering World Class outcomes.
7. Are planned and delivered in a joined up / integrated way across agencies
8. Maximise the use of technology to support local delivery, effective decision making and cross location working
9. Are supported by a sustainable workforce with the right leadership, skills, values and behaviours optimising professionals working at their skill level

These principles apply to all the phases of the Right Care, Right Time, Right Place Programme

### 4.2 Primary Care

- **Calderdale CCG**, has committed to fully delegated commissioning of GP services and is in a strong position to move forward with its Primary Care Strategy. This strategy is at the heart of our CC2H model. This emerging strategy recognises the need for change. Whilst strengthening the role of the GP practice in holding responsibility for the care of its registered patients, it will have a stronger population focus and an expanded workforce. It will bring together general practices and community pharmacies through networks and federations in order to provide a wider range of services, and IT systems will become joined up across providers of primary care. Primary and community care staff will also work closely with secondary care and social services through some of the models outlined in the NHS Five Year Forward View. Premises will be upgraded, making better use of existing community facilities in order to support closer working with hospitals and with social services, and to provide a wider range of diagnostic facilities.

Calderdale CCG's Vision for Primary Care Services is:

- Wherever you go in Calderdale to receive your primary medical services you can be guaranteed that your experience will be excellent and your outcomes from treatment will be as good as the best.
- This will be delivered by a model for general practice that is sustainable and responds to the needs of the system and is regarded as fantastic by the people who work in it and the people who use it.

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**Greater Huddersfield CCG** will have fully delegated commissioning from 1<sup>st</sup> April, 2016. The CCG is currently working with its member practices and others to develop its Primary Care Strategy. Key elements of the Strategy will include:

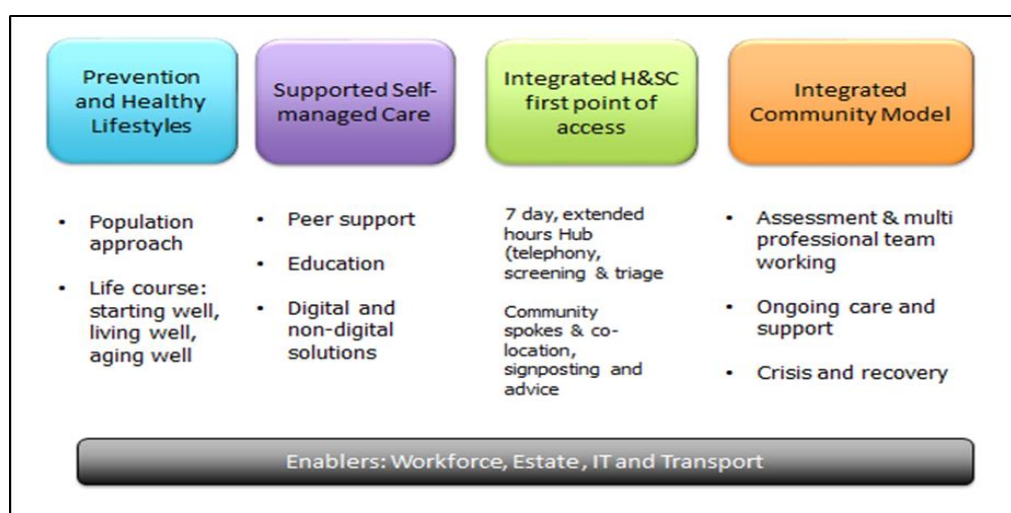
- ensuring that patients are well informed and capable of making responsible decisions relating to their lifestyle, health and wellbeing and access services appropriately
- supporting and developing primary care as the cornerstone of an integrated system of 'out of hospital' care with the patient and their needs at the centre
- Setting out access to a range of services and high standards of care that all Greater Huddersfield patients can expect to receive from every GP practice
- supporting workforce design introducing new clinical roles and disciplines that make fullest use of capacity, expertise, knowledge and experience across teams and practices
- Actively promoting workforce development and education with a focus on upskilling and succession planning and talent management.
- making Greater Huddersfield the place that clinicians choose to work by valuing our existing practitioners and developing new models of care that promote Continuing Professional Development (CPD)
- defining an 'enhanced' level of service accessible to all patients which supports delivery of 'Care Closer to Home'
- using flexibilities within this new contract to encourage and enable practitioners and service providers to innovate and work collaboratively
- being creative in the use of modern technology and newly developed health facilities to deliver a wide range of easily accessible health and social care services, as well as encouraging greater collaboration between patients, practices, multi-disciplinary teams and the voluntary sector

## 4.3 Community Based Care Proposals

### 4.3.1 Calderdale CCG Care Closer to Home

#### What is the model?

The CCG agreed a formal specification for current providers of community services in March 2015. This set out our response to key messages from public and patient engagement, and translated them into a high level service model and outcomes. The model is described below:



The specification was set within contracts for 2015/16 and is being monitored in order to ensure delivery.

#### Calderdale CCG – Phase Two

Phase-two includes identifying services currently provided in hospital which should be provided out in community. The work, done jointly by the CCG and providers used: the output of engagement, national evidence, benchmarking data and clinical insights in order to develop a view of which services should be included.

Using the approach described above, the CCG has looked at where it needed to focus its plans.

The total cost of avoidable emergency admissions conditions in 2014/15 was **£8,800,000**. There are 2 subsets (ACS – Ambulatory Care Sensitive Conditions and CNRA – Conditions not Requiring Admission) – there is a clear national evidence base for the interventions to support these reductions.

- To deliver a reduction in CNRA conditions our focus will be on conditions associated with **'frail elderly'**, Influenza/ pneumonia, UTI, Dehydration/ gastroenteritis – with smaller numbers associated with **children & young people**. Using a review of national evidence we will also focus on developing integrated models of care to support children with complex needs and their families.
- To deliver a reduction in ACS conditions our focus will be on – **Respiratory**: COPD, Asthma reductions and **CVD**: congestive heart failure, atrial fibrillation, Angina.

- In addition we will develop new preventative approaches, strengthen supported self-care, develop an integrated single point of contact, and introduce new integrated models of community working will particularly support those with a wide range of long-term conditions and those at risk due to their frailty – whatever their age.

### **Frail Elderly**

The evidence base suggests a number of interventions, which are closely aligned to the CC2H model agreed locally, particularly;

- Structuring integrated care around frailty, to ensure that those who may benefit most are identified for integrated services, including care home residents
- Developing a clinical contact centre (first point of contact) providing new flexible access channels for stakeholders, clinicians and patients.
- Enabling targeted medication reviews for older people with frailty using evidence-based checklists (e.g. STOPP/START criteria)
- Identifying the presence of frailty to guide more appropriate, shared decision making in secondary care, for example in cancer services for older people
- Identifying those with advanced frailty who may be entering the terminal phase of life for advance care planning discussion
- Strengthening falls prevention pathways and services

Our plans to tackle frailty in 15/16 include the Quest for Quality in Care home. This includes – refresh of the model and roll-out to all remaining care home in Calderdale. We have already invested £1m in a pilot delivered by CHFT and we have planned the future growth of the scheme.

### **Children with Complex Needs and their families**

Vanguard partners involved in the delivery and commissioning of services for children with complex needs are currently developing a view of:

- Case finding – how we can identify the children for whom a more integrated offer would potentially improve their outcomes
- The evidenced-based or innovative interventions which would be delivered locally
- A view of measurement to ensure replicability and learning elsewhere

### **For people accessing community services**

- More support to prevent ill health and reduce in equalities – through the implementation of new preventative strategies for a range of conditions and provide practical support in communities
- More practical support to help people manage their care more effective and receive information
- An integrated first point of contact for health and social care which provides both a vehicle for signposting to services, assessment and arrangements for on-going care
- A new integrated community model bringing together; health care, social care, primary care and third sector support – including new models of community based urgent care, end of life care, planned care (for example MSK, ophthalmology, dermatology and ENT and care provided in care homes. Delivering care out in community wherever possible.

### Strengthening the community infrastructure

- Developing a new view of the future GP and primary care offers
- Developing plans to ensure our workforce is able to deliver new care models
- Developing plans to maximise our use of community estate
- Continue work to develop capacity and capability in the third sector
- Developing an IT/digitisation plans to ensure we maximise the use of new technology
- Developing a plan to ensure that people can access appropriate transport.

### ***What will this mean for shifting care from Hospital to Community?***

We have worked with our provides to create assumptions about the shift of activity into the community – both in terms of both planned and unplanned care as part of our Care Closer to Home model.

A full list of service we are considering as part of this shift is shown below

Population Cohorts	Overview - Service Lines
Children & Young People	Respiratory - captured under LTC respiratory line below
Frailty	e.g. Falls, UTI and Care Homes
Long Term Conditions	Respiratory (Children and Adults)
	CVD
	Diabetes
	MSK
	Ophthalmology
	Dermatology
	Diagnostics – part of Vanguard discussions.
Other CC2H Areas	Ear, Nose and Throat
	EoLC
	First Point of Contact
	Integrated Community Model
	Rehab Bed Days

### 4.3.2 Greater Huddersfield CCG Care Closer to Home

#### What is the model?

The Care Closer to Home vision is for integrated community-based healthcare services for all, from children and young people through to and including the frail, vulnerable and older people and also end of life care. It is crucial that we make lasting changes to our health and social care system to ensure that services are fit for purpose and sustainable in the future. Key characteristics of Care Closer to Home are:

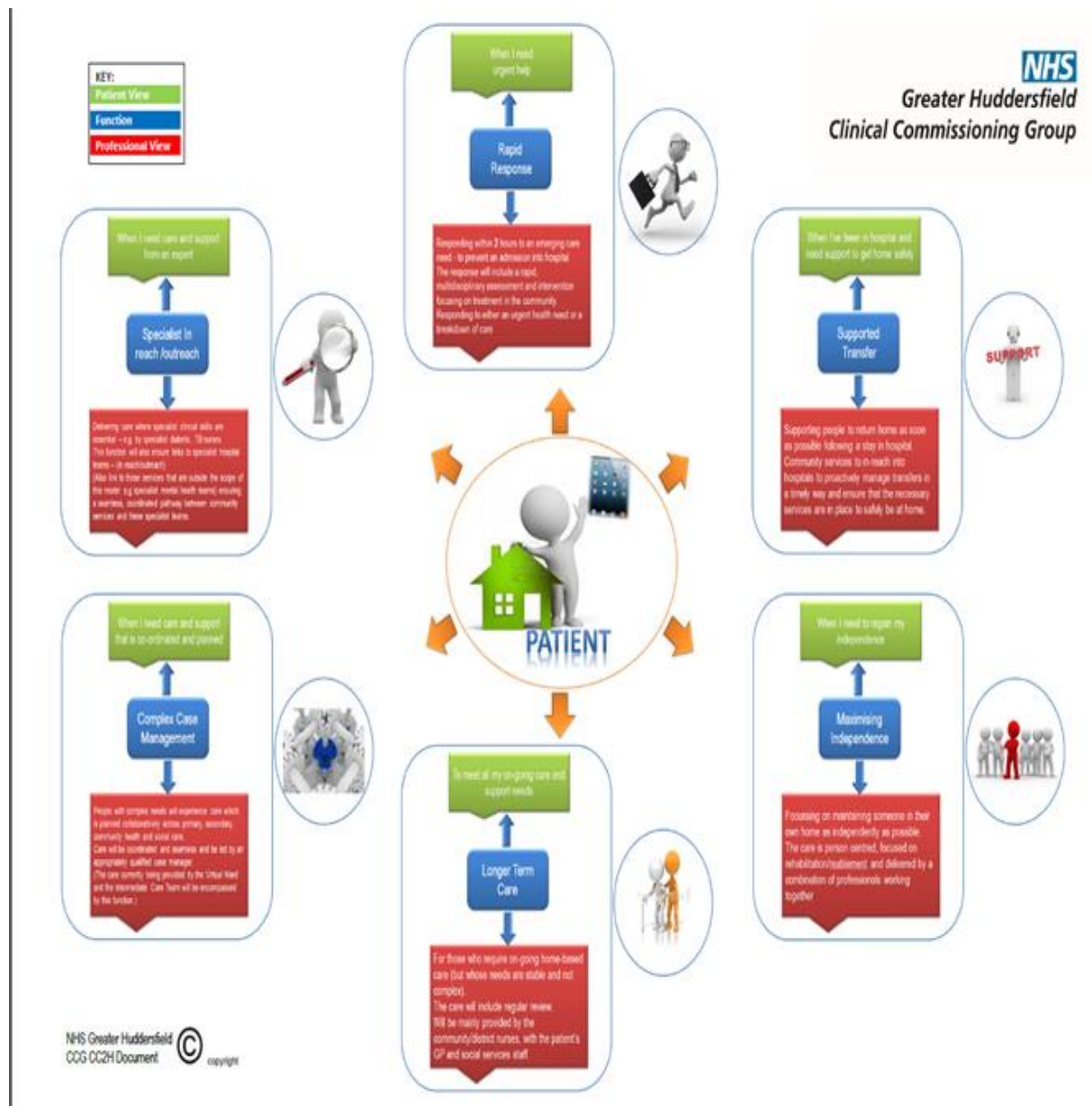
- Improved primary and community care providing the right care at the right time in the right place
- Provision of services in the community that promote independence and wellbeing for patients so they can support themselves by exercising self-management, choice and control
- Integrated high-quality services at times required to meet the needs of the community
- Providing more planned care earlier thereby reducing reactive, unscheduled care
- Care provided as one coherent package, with a focus on individuals and helping people to get better

The main elements of the model are:

- Risk assessment to identify people who are most vulnerable and most likely to be admitted to hospital
- Proactive care management by multi-disciplinary teams
- High quality local information and support to enable people to manage their own condition and access the most appropriate care
- Person centred care delivered through a single assessment process and single care plan 24/7
- Care at or near home wherever possible

The Model includes

- A new Single Point of Contact (SPC) providing one contact point for patients, carers and professionals for Care Closer to Home services
- Integrated multi-professional locality teams working closely with general practice
- Allocated teams working to provide 'urgent' and 'routine' visits ensuring a rapid response within 2 hours where required without disrupting the delivery of routine appointments and visits
- Specialist 'expert' teams for particular interventions e.g. long term conditions management, tissue viability, mental health support
- Delivery of some 'planned' services such as dermatology and musculoskeletal services (MSK), usually through clinics
- Holistic assessment for all patients including a focus on maximising independence, supporting patients to be able to manage their own conditions as far as possible
- Use of technology to support the efficient delivery of the model and improving communication between professionals and with patients.



**What does that mean to patients?**

- I'm seen at the right time by the right person
- More of my care happens nearer to home
- Me and my carers know how to manage my health and wellbeing
- Everyone involved in my care knows my story

The impact of the new model will be monitored through the identified KPIs within the contract and through the service development and improvement plan which identifies planned service developments over the duration of the contract. New contractual and quality management and governance arrangements have been established to monitor the impact of the contract.



The contract was procured to ensure the onus is on the provider to manage activity and demand and therefore create the required level of efficiencies to manage demand and continue to meet the prescribed outcomes for patients and carers.

### **Plans and Phase two**

From our work on shifting services from acute care to communities and closer to patient's homes and the need to best manage quality and value for money, we have developed our QIPP plans.

There are 2 nationally defined indicators for adults that make up this overall indicator (ACS – Ambulatory Care Sensitive Conditions and CNRA – Conditions not Requiring Admission) – there is a clear national evidence base for reductions.

- Plan is £2m cash releasing per annum up to 2020/21
- It would take at least 4 years for this opportunity to materialise fully

### **Long Term Conditions**

The initial focus of the work is those at risk of harm due to their frailty (all adults).

We know from local data that there are a significant number of frail, particularly older people attend hospital for Conditions Not Requiring Admission (CNRA). Greater Huddersfield is ranked in the 3rd quartile nationally and is higher than the national average.

The total cost of emergency admissions for CNRA in 2014/15 was **£1,775,000**. The top two conditions for which people were admitted were UTI's and Dehydration.

We know that emergency admissions for our Older population are increasing (11% compared to the same period last year) and that of this group 56.5% are referred from the hospital to our hospital avoidance team (HAT), analysis shows us that current activity through the HAT team is not as efficient as it could be – 21% of the current activity isn't at the agreed threshold – pathway redesign will free up this capacity to prevent avoidable admissions and support more rapid hospital discharges. This will have a positive impact of the delayed transfers of care, of which 24% are attributed to social care access. We are working on this programme through our integrated service models, which are clearly linked to our CC2H programme and BCF schemes.

Through our agreed targeted approach we believe that there is additional capacity to manage cases out of hospital, in addition there is the potential to deflect a further 50% of people from the formal pathways of care (should all other things remain as is)

In terms of paediatric services, trauma and orthopaedics and respiratory medicine assumptions in the shift of activity to the new community model have been included on the finance sheet – these have also assumed a changed tariff based on the new service model

### **Phase Two**

Phase two builds upon the principles of Phase one. Whilst Phase one established the core model and outcomes for Care Closer to Home, Phase two is designed to further develop the model and bring more services closer to home for patients, moving delivery of some services from a hospital setting to a community-based setting.

For some services this approach has been developed over a period of time and cemented as part of Phase one. For example, for patients with a dermatology need or with diabetes, only very specialist or high-risk services are now delivered in a hospital outpatient setting, the majority of patients will be seen in a community-based service. There may be further scope to bring specialist support from acute consultants out into the community to deliver services in the future.

There are a number of services delivered by the acute trust, either in a hospital or community setting which can be delivered as a partially or fully community focused service. These services in the scope of Phase II for consultation are:

Service Areas	Indication of likely services to be in scope for Phase 2	Potential changes to service model
Therapies	Speech and Language Therapy Occupational Therapy Physiotherapy	Delivery of outpatient therapy in a community based setting
Children's services	Community Nursing Services for Children Community Paediatric services Specialist Nurses  Speech and Language Therapy Occupational Therapy Physiotherapy	Delivery of community children's services as primary / community based service rather than an acute-led service. Therapy – delivery of outpatient therapy in a community based setting
Other services	Rehab Bed Days	Delivery of rehabilitation beds in a community setting rather than an acute setting.

### Strengthening the community and primary care infrastructure

- Developing a Primary Care Strategy as the third key pillar of care alongside hospital services and care closer to home
- Developing plans to ensure our workforce is able to deliver new and re-designed services
- Continue to work with, develop and support social care and the third sector
- Continue to develop the infrastructure around IT, technology and digitisation.

## 4.4 In- Hospital Future Model of Care

### 4.4.1 Scope of the In Hospital Services Programme

We have agreed the scope of our In Hospital Services as follows:

- Urgent Care
- Emergency Surgery and Accident and Emergency
- Emergency Medicine
- Planned Care, Day Case and Diagnostics
- Maternity Services
- Paediatric Services

### 4.4.2 Future Model of Care Summary

Our overall aim is to deliver services in line with the high level principles as outlined above.

In summary, **the proposed model of care**, described in more detail below, is

- Deliver care locally for the majority of patients, and where possible bring more services closer to Home.
- Continue to provide an NHS non-emergency number for those patients who need urgent medical help or advice which will, where appropriate, direct patients to the local service that is best placed to help them.
- For those people with Urgent care needs provide a highly responsive service that delivers care as close to home as possible, minimising disruption and inconvenience for patients and their families.
- Care for the smaller number of patients with 'once in a lifetime' life threatening illnesses and injuries in a single emergency centre or a specialist emergency centre with the very best expertise and facilities in order to maximise the chances of survival and a good recovery.
- For those elements of Planned Care where Hospital facilities are required, deliver that care as part of a broader integrated system, working across services, to keep people healthy and improve health at a population level.
- Deliver Maternity care that is integrated with specialist services and provides choice for mothers.
- Deliver Paediatric care that is integrated with specialist services and provides effective transition for children to adult services
- Deliver all in-hospital services in line with our Hospital Quality and Safety standards
- Work with the ambulance service to direct patients to the right place at the right time, including to Community and Primary Care if appropriate as well as to local and specialist services

#### 4.4.3 Future Model of Care – Care Closer to Home

**Deliver care locally for the majority of patients, and where possible bring more services closer to Home.**

Through our Care Closer to Home Programmes and emerging Primary Care Strategies we are working to strengthen and enhance the services we provide in communities.

The aim for the first phase of Care Closer to Home is to transform community services in Calderdale and Kirklees by strengthening, improving and embedding the current services provided in the community so that they become more integrated and joined-up.

The Care Closer to Home Programme will continue to transform services locally by expanding and enhancing community services to (where possible) enable a shift in services that are being delivered in a hospital setting closer to home. The aim is to allow people to remain independent in their own home for longer, or be discharged from hospital at an earlier stage in their recovery with the appropriate care and services available at home or an appropriate community setting.

By offering integrated high quality services at times required to meet the needs of the community we will reduce reactive, unscheduled care and do more planned care earlier. People will receive care which is more timely and organised to meet their specific needs.

Our intentions in relation to Care Closer to Home are described in the section 4.4 Community Based Care Proposals. Our intentions in relation to providing Hospital Services closer to home are described in the following sections.

#### 4.4.4 Future Model of Care – Urgent Care

**For those people with Urgent care needs provide a highly responsive service that delivers care as close to home as possible, minimising disruption and inconvenience for patients and their families**

**Continue to provide an NHS non-emergency number for those patients who need urgent medical help or advice which will, where appropriate, direct patients to the local service that is best placed to help them.**

A key aim of the Health and Social Care transformation is to bring services closer to home, where appropriate. Each local hospital in Calderdale and Greater Huddersfield will provide Urgent Care services for patients with non-life threatening illnesses and injuries with facilities and resources for treating this group of patients.

These 'Urgent Care Centres' will provide access to walk in minor illness and minor injury services<sup>6</sup> including GP Out of Hours, and will be part of wider community primary care services. We will encourage patients to ring the NHS non-emergency number (NHS 111) to

<sup>6</sup> An urgent health care need is not life threatening and can be a minor illness or injury such as a suspected broken bone, a cut, suspected sprain, upset stomach or perhaps a child who is generally unwell and now has a persistently high temperature .

receive medical help or advice and be signposted to the appropriate service to meet their needs. If this is an Urgent Care Centre, appointments will be made directly into the Urgent Care Centres. They will also incorporate the current out of hours GP services. This means that the services people use most frequently will continue to be available at both hospitals or in a local community setting.

This work is closely linked to the development of our out of hospital urgent care models being created through our Care Closer to Home Programmes. This will ensure a whole system approach to emergency and urgent care.

We may wish to consider a face to face “Pathways triage” for walk-in patients in the new model ensuring consistency of service for all urgent patients.

Using national evidence it is estimated that 40% of patients who currently use accident and emergency are related to minor injuries and therefore an Urgent Care Centre will be able to provide the right care, in the right place at the right time for this group of patients.

#### **The proposed Urgent Care model would include:**

- Consistency in the core Urgent Care Centre offer across both Calderdale and Greater Huddersfield
- 2 Urgent Care Centres (HRI and CRH).
- All Patients will be encouraged to use existing Primary Care Access and 111 for initial access to Urgent Care
- The UCC will provide clinical triage for all “walk-in” patients and redirection if appropriate. Patients will be encouraged to have phoned 111 and have an appointment booked in the UCC.
- Patients with life-threatening illness and injury will be taken by ambulance directly to the Emergency Care Centre or Specialist Emergency Care Centre
- The centres will be medically-led by a clinician with the knowledge and skills to undertake triage and autonomous decision making regarding the next steps in an individual’s care.
- Diagnostic facilities (including Point of Care and X-Ray) to support triage and decision making
- The Urgent care centres will operate 24 hours per day, seven days a week.
- Access to the Emergency Care Centre will be via triage or via the ambulance service. All patients will have had clinical triage.
- Direct access to specialist support from the Emergency Care centre will be available to all Urgent Care Centres via technology.
- Urgent Care Centres would not carry the emergency red sign, nor be considered the right place to go in a medical emergency (when 999 should be used), but would have protocols in place with the ambulance service if such events occurred.
- We may want to consider a face to face “Pathways triage” for walk-in patients to ensure consistency of service for all urgent patients.

#### **Specific requirements in relation to Children**

- All children will have clinical triage within 15 minutes to ensure a child is in the correct place to receive treatment.
- The UCC will comply with the RCPCH ‘Standards for Children and Young People in Emergency Care settings’

- Refreshed protocols in place for 111 and the Ambulance service to ensure that any children with injury or illness requiring emergency care are directed to the specialist Paediatric Emergency Centre. Children of any age who have been triaged and referred for Primary Care treatment may be treated in the UCC by a primary care practitioner.
- Paediatric Surgery and Acute inpatient medical care will be co-located with the Emergency Care Centre
- The Urgent Care Centre(s) will manage children 5 years and older with minor injuries and those children considered to have minor illness after triage by 111. All other children will be redirected to the Paediatric Emergency Centre..
- Facilities to provide care to children with minor injuries over 5 years old; children under 5 years old would automatically be directed to the Paediatric Emergency Centre.
- In instances where children who are ill, have serious injury or are under five years old present at an UCC they will be quickly triaged, stabilised and transported to the PEC.

#### 4.4.5 Future Model of Care – Emergency and Specialist Emergency Care

**Care for the smaller number of patients with Emergency Care needs in a single emergency centre or a specialist emergency centre with the very best expertise and facilities in order to maximise the chances of survival and a good recovery**

For patients with more serious or life threatening conditions, it is much safer for them to be treated by clinical teams that specialise in emergency care, with the right equipment and facilities to support them<sup>7</sup>. Additionally, there is a wealth of evidence that centralising some services can save lives: lives have already been saved as a result of centralising stroke and major trauma services on a West Yorkshire basis. To reflect this evidence we have two levels of hospital based emergency care. For the purposes of this document we have called these Emergency Care and Specialist Emergency Care.

The proposed Emergency and Specialist Emergency Care model would include:

- A single unified Emergency Care centre for Calderdale and Greater Huddersfield providing Emergency/Acute medicine and Accident and Emergency services
- A Paediatric Emergency Department for Calderdale and Greater Huddersfield which would have facilities which comply with the standards for Children and Young People in Emergency Care Settings.
- Access to emergency care via triage, urgent care centre or via an ambulance
- Specialist Emergency care will continue to be provided on West Yorkshire basis. This means that, as happens now, certain specialisms, such as severe trauma, would be provided at the Specialist Emergency Care centre best skilled and equipped to deal with them.
- Networking of Emergency services and Specialist Emergency services which, with technology support, could bring elements of Emergency Care and Specialist Emergency Care closer to home is also being discussed.

<sup>7</sup> 'Transforming urgent and emergency care services in England - Update on the Urgent and Emergency Care Review', NHS England, August 2014.

The single unified Emergency Care centre would specialise in providing treatment for people who have serious or life threatening emergency care needs and would provide Emergency/Acute medicine and Accident and Emergency services. The centre will bring together on one site all the necessary acute facilities and expertise 24/7 to maximise people's likelihood of survival and a good recovery. This will reduce or eliminate the need for people to transfer between sites.

There are key clinical interdependencies and relationships between A&E, acute medical services and surgical services, and critical care. The on-site support specialties required by *any one* of these four services define the clinically recommended minimum range of services required for any 'emergency centre'. Therefore, in the proposed model for emergency care we would propose to co-locate the following services:

- Acute / general / elderly medicine
- Respiratory (including bronchoscopy)
- Obstetrics / Gynaecology
- Neonatology (SCBU) / paediatrics (including surgery)
- Upper and Lower GI surgery (including acute endoscopy)
- Trauma & Orthopaedics
- ICU / 24hr anaesthetics
- Urology
- Gastroenterology
- ENT
- Acute Mental health
- Cardiology (including CCU)
- Hyper acute stroke services
- X-ray, USS, MRI, CT, other diagnostics 24/7
- Microbiology / Haematology / biochemistry
- Occupational Therapy
- Physiotherapy

#### 4.4.6 Future Model of Care –Planned Care

**For those elements of Planned Care where Hospital facilities are required, deliver that care as part of a broader integrated system, working across services, to keep people healthy and improve health at a population level.**

For those patients with planned care needs<sup>8</sup>, care will be delivered as part of an integrated care model that places Hospitals as part of a broader health system<sup>9</sup> with a responsibility to improve the health of the population they serve.

The proposed Planned Care model would include:

<sup>8</sup> Elective procedure or treatment that is chosen (elected) by the patient or physician that is advantageous to the patient but is not urgent. **Elective** surgery is decided by the patient or their doctor. The procedure is seen as beneficial but not absolutely essential at that time.

<sup>9</sup> The Kings Fund – Population Health Systems - Going Beyond Integrated Care, February 2015.

- Care only being delivered in Hospital when it cannot be delivered elsewhere.
- A new approach to Outpatient care providing better offers to patients, in community wherever possible, and focusing on a significant reduction in out-patient follow-ups.
- Continuing the work to move appropriate elective activity to day cases, and to move appropriate day case activity to out-patient procedures – in line with the evidence base and with specifications for services that would support the new model, e.g. District Nursing.
- The co-location of services on only one site where there is a clinical need due to the interrelationships with other clinical services.
- The co-location of services on the emergency care centre site where there is a clinical dependency on services provided as part of our emergency care offer (e.g. HDU, ICU).
- Consultant led Obstetrics and Neo-natal care co- located with the Emergency Care centre (see Maternity below)
- The co-location of specialist Paediatric services with the Emergency Care Centre (see Paediatrics below).
- The location(s) of delivery for individual specialties to be generated on a case by case basis, with consideration given to: safety; quality; patient experience; and proportionality (particularly in small specialties)
- Any split of activity across sites being aligned to quality and the infrastructure requirements needed to deliver safe and effective services.

**Planned, Day Case/Elective Care Services include:**

- Outpatient care for adults and children
- Specialist Psychiatric liaison services
- Day Case Surgery
- Therapy services (Physiotherapy, Occupational Therapy, Speech Therapy and Dietetics)
- Endoscopy
- Other specialist services such as specific cancer or chemotherapy treatments and diagnostic tests
- We are also considering whether other elements of specialist services could be provided at each site, and the provision of outpatient appointments in a local hospital or community setting.

**4.4.7 Future Model of Care – Maternity Services**

**Deliver Maternity care that is integrated with specialist services, provides choice for mothers.**

Maternity services will be delivered in a way that reflects the critical interdependencies between Paediatric and Maternity services and Emergency Care and Urgent Care (and the key clinical interdependencies outlined in those sections) and Community Care, with an emphasis on provision of care in the community wherever possible.

The proposed model for Maternity care would include:



- Extended ante-natal, intra partum and post-natal care provided in the community where possible
- Choice in relation to where the birth takes place.
- Midwifery led maternity on both Hospital sites.
- Consultant led Obstetrics and Neo-natal care co- located with the Emergency Care centre

**Maternity Services include:**

- Midwife led birthing service
- Consultant led Obstetrics
- Ante natal, intra partum and post-natal care
- Early Pregnancy Assessment Units

**4.4.8 Future Model of Care – Paediatric Services**

**Deliver Paediatric care that is integrated with specialist services and provides effective transition for children to adult services**

Paediatric services will be delivered in a way that reflects the critical interdependencies between Paediatric and Maternity services and Emergency Care and Urgent Care (and the key clinical interdependencies outlined in those sections) and Community Care, with an emphasis on provision of care in the community wherever possible.

We will encourage all parents to call 111 for advice on urgent health needs for their child; they will be able to direct them to the best place for assessment/treatment.

We will refresh the protocols in place for 111 and the Ambulance service to ensure that any children with injury or illness requiring emergency care are directed to the specialist Paediatric Emergency Centre that will be co-located with the Emergency Care Centre.

The proposed model for Paediatric care would include:

- Enhanced community Paediatric services - provided in community where possible, including hot clinics to support GPs in-hours
- Support from and inter-working with Child and Adolescent Mental Health Services (CAMHS)
- Paediatric outpatient facilities on both Hospital sites
- Specialist Paediatric Emergency Centre – co-located within the Emergency Care Centre.
- Specialist Paediatric advice available to the Urgent Care Centres via a technology link.
- Paediatric Surgery and Acute inpatient medical Care co-located with the Emergency Care Centre
- Transition from paediatric to adult services on a case by case basis.
- We are also considering the effectiveness of current arrangements for 6 and 12 month paediatric follow ups.

**Paediatric Services include:**

- Paediatric out patients

- Paediatric surgery
- Paediatric Acute/ Emergency care

#### 4.4.9 Future Model of Care – Quality and Safety Standards

**Deliver all in-hospital services in line with our Hospital Quality and Safety Standards**

We have agreed the Quality and Safety standards<sup>10</sup> that we want to apply to our Hospital Services together with the outputs and outcomes that we expect these standards to achieve.

These are summarised in section 4.3 and cover the following areas:

- Urgent Care
- Emergency Surgery and Accident and Emergency
- Emergency Medicine
- Planned Care, Day Case and Diagnostics
- Maternity Services
- Paediatric Services

The full set of Hospital Standards is available as a separate document. On the basis that the standards are likely to be updated on a regular basis as new guidance is published it is considered appropriate to retain them as a separate document subject to separate governance. At the time of writing the current version of the standards is Version 2.1.

#### 4.4.10 Future Model of Care – Yorkshire Ambulance Service

**Work with the ambulance service to direct patients to the right place at the right time, including to Community and Primary Care if appropriate as well as to local and specialist services**

The Ambulance Service play a vital role in the future model of care as they will assist in directing patients to the most appropriate service to meet their care needs.

We will work with the Ambulance Service so that patients are taken to the most appropriate service.

We will work with Community Services and the Ambulance Service to establish protocols which enable the decisions around which is the most appropriate service for people to be informed by availability of that service.

Whilst Pathfinder will be used to direct patients to the most appropriate service, some patients may present at a local site with an emergency or specialist emergency care need. There will be pathways put in place for the stabilisation of these patients and transfer to the Emergency Centre or Specialist Emergency Centre. We will work with the Ambulance service and local Community Patient Transport Services to develop local protocols around intra-site transfers.

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<sup>10</sup> These standards are additional to and do not replace existing CQC, NICE, CQUIN and Standard contract targets

#### 4.4.11 Current and proposed location of services – summary

Current Services Provided at Both Hospitals:

- Outpatient and day case services
- A&E services
- Acute medical services
- Rehab older people
- Complete range of diagnostics
- Endoscopy
- Therapy services
- Level 3 intensive care therapy

Acute service provision at Calderdale Royal Hospital

- Stroke Services
- Inpatient Paediatrics
- Midwife/Consultant led maternity
- Special Care Baby Unit and neonatal level 2
- Interventional cardiology services

Acute service provision at Huddersfield Royal Infirmary

- Trauma Unit
- Unplanned surgery
- Paediatric surgery
- Midwife led unit

#### Proposed location of Services

##### Hospital A

- Urgent Care Centre (Minor injury unit / medically led minor illness unit inc' diagnostics)
- Emergency centre
- Paediatric Emergency Centre
- 24 hr Obstetrics
- Inpatient Paediatrics
- Acute Endoscopy
- Intensive Care Unit
- Complex and unplanned Surgery

##### Hospital B

- Urgent Care Centre (Minor injury unit / medically led minor illness unit inc' diagnostics)
- Medical day case
- Endoscopy
- Planned Inpatient Surgery

##### Service Provision on both hospital sites:

- Outpatient services
- Therapies
- Day Case Surgery
- Mid-Wife led Maternity unit
- Diagnostics

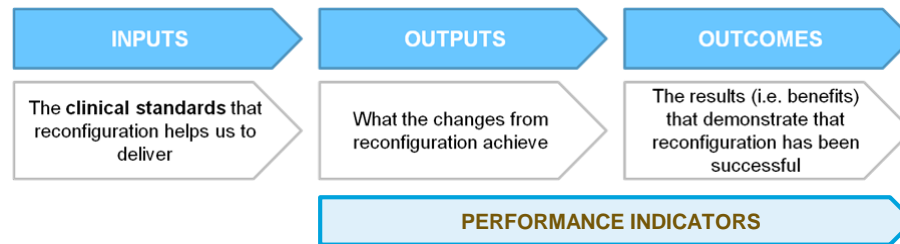
#### 4.5 Future Model of Care – Outcomes for Patients

The Hospital Standards outlined below show at a summary level, the outputs that we expect to achieve from our future model of care in summary, these are:

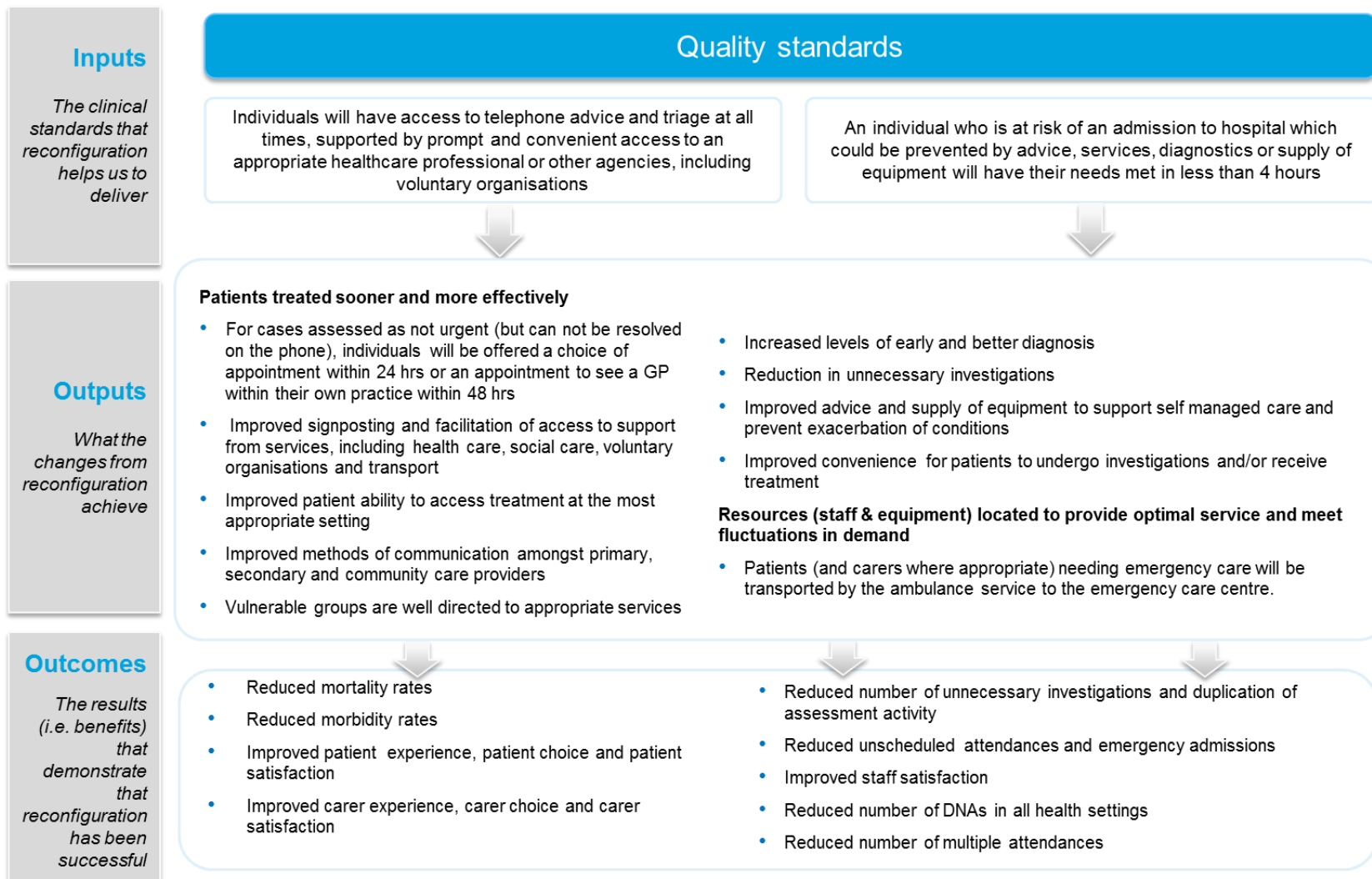
- Patients treated sooner and more effectively
- Improved management of patient flow
- Resources (staff and equipment) located to provide optimal service and meet fluctuations in demand
- Decisions about treatment are made earlier
- Reductions in average Length of Stay

As a result of achieving these outputs, we expect to deliver the following benefits:

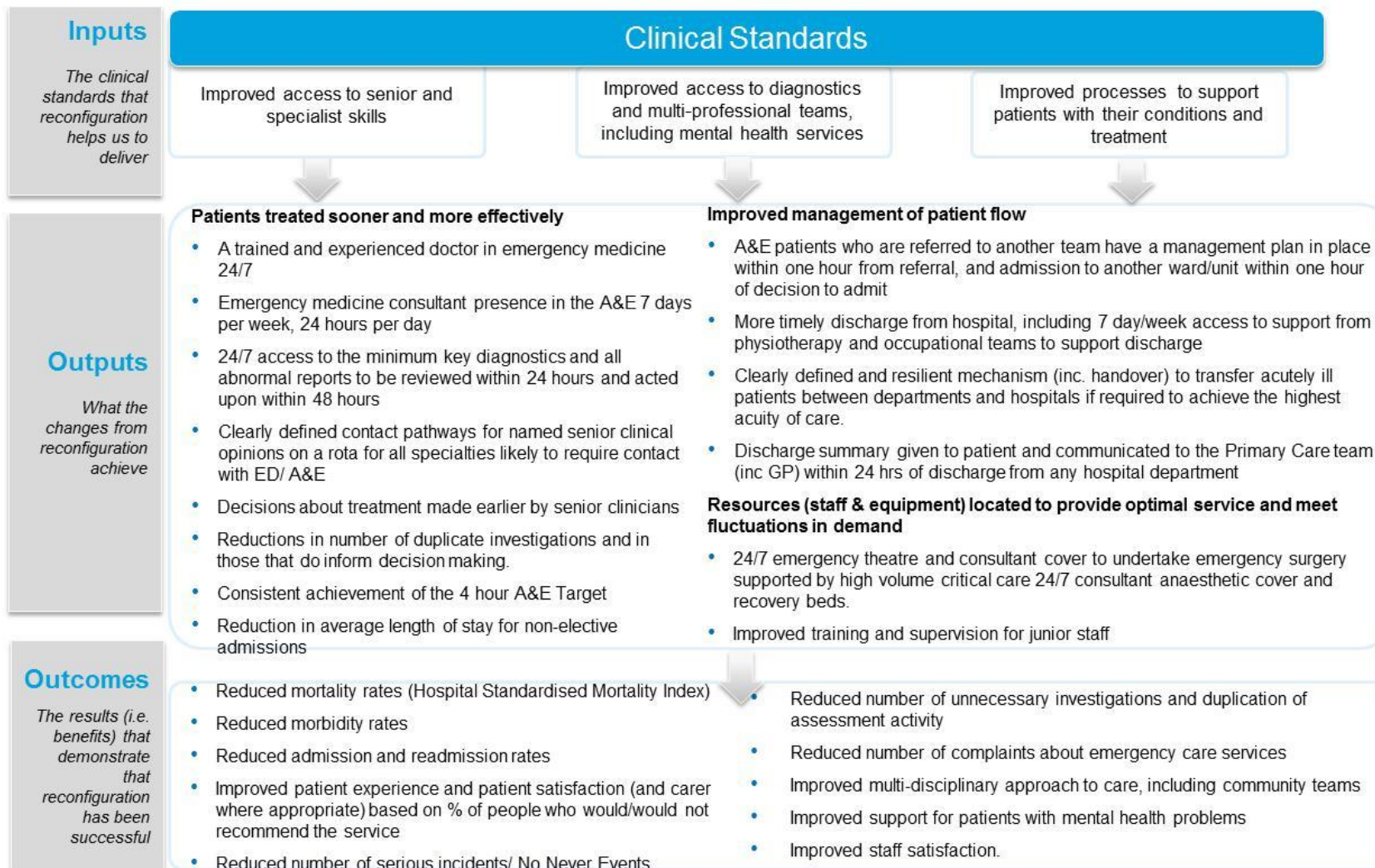
- Improved Outcomes for Patients
- Improved levels of Quality and Safety
- Better Use of Resources



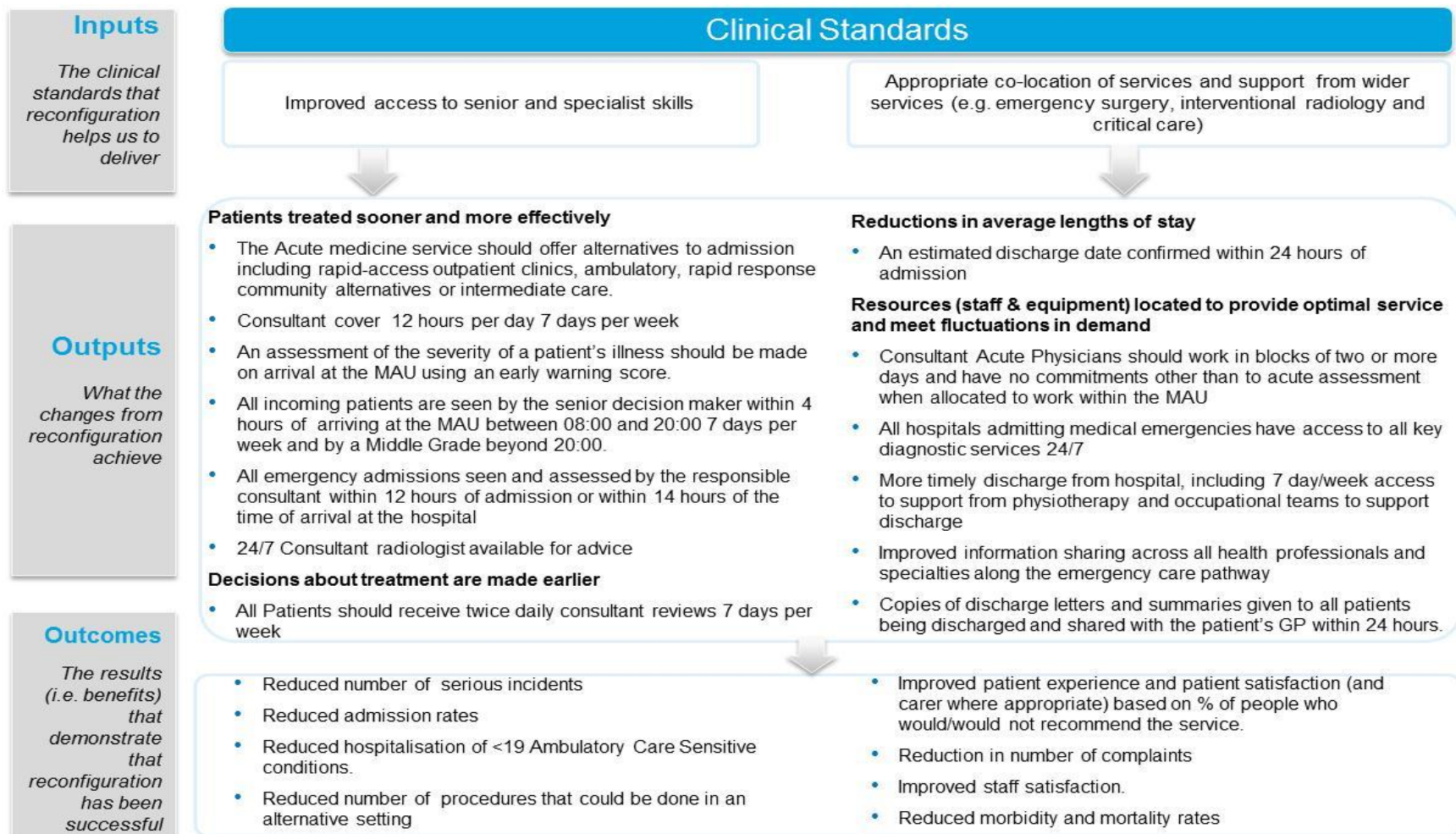
## Patient & Clinical benefits – Urgent Care



## Patient & Clinical benefits - Emergency Surgery and A&E

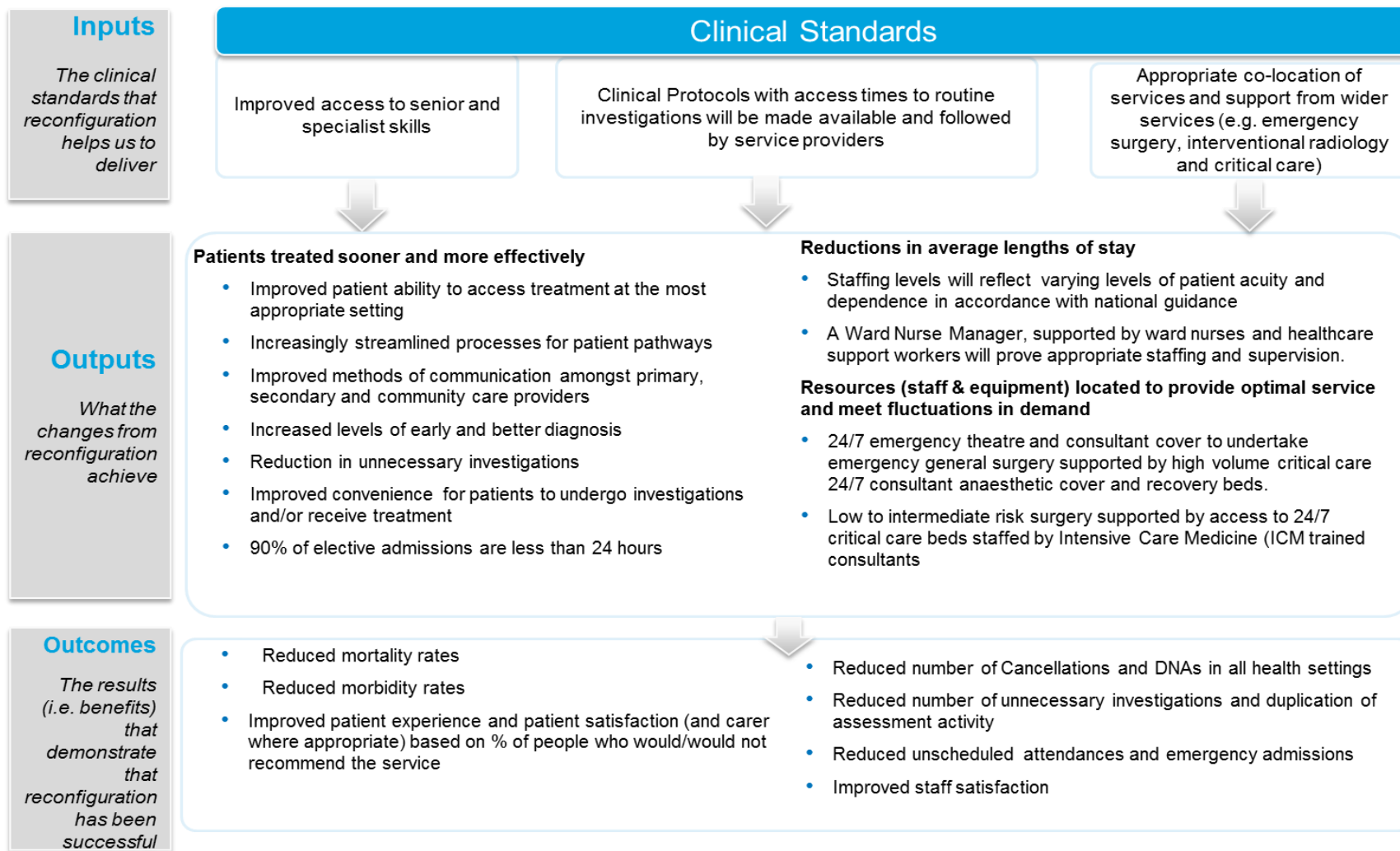


# Patient & Clinical benefits – Emergency Medicine

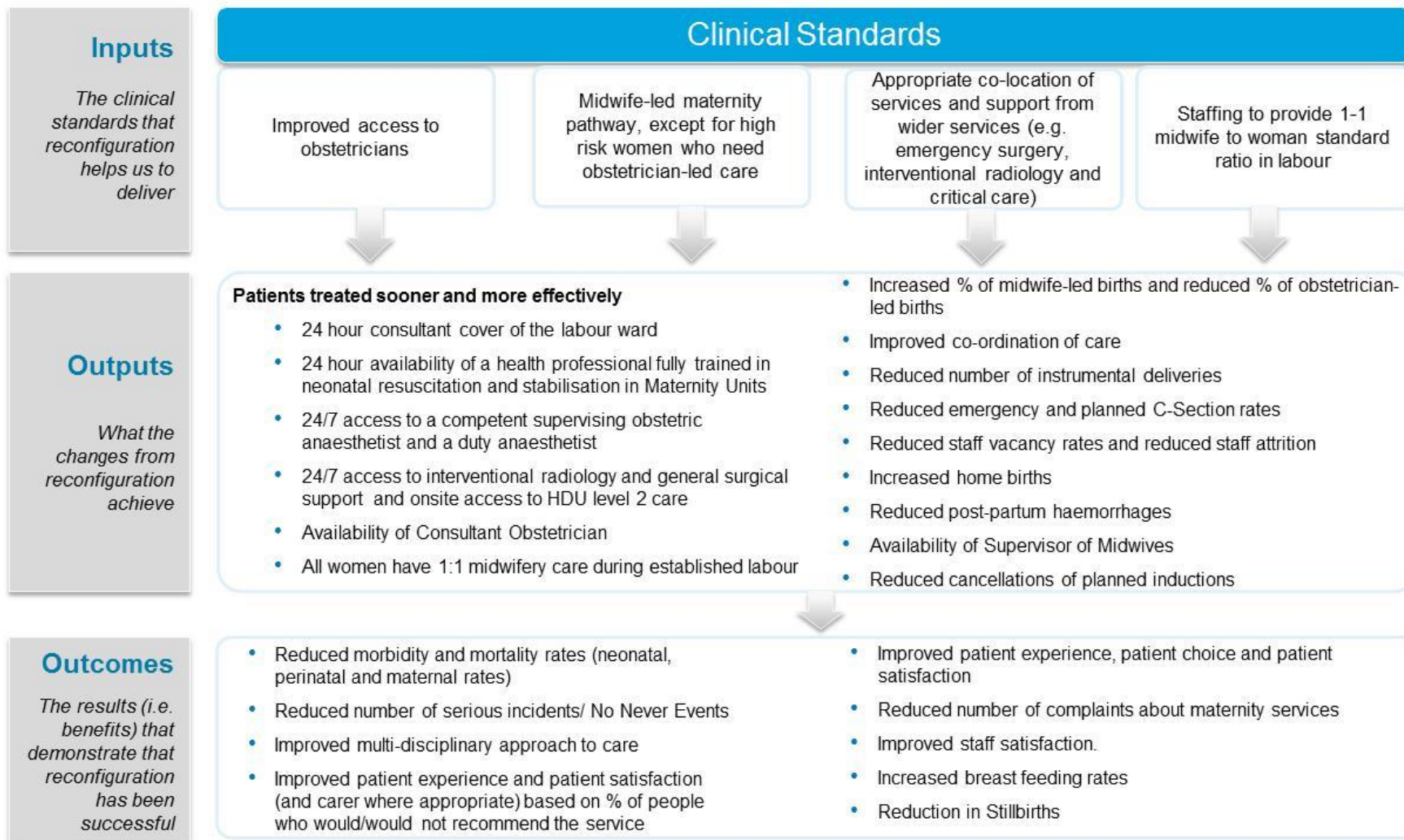




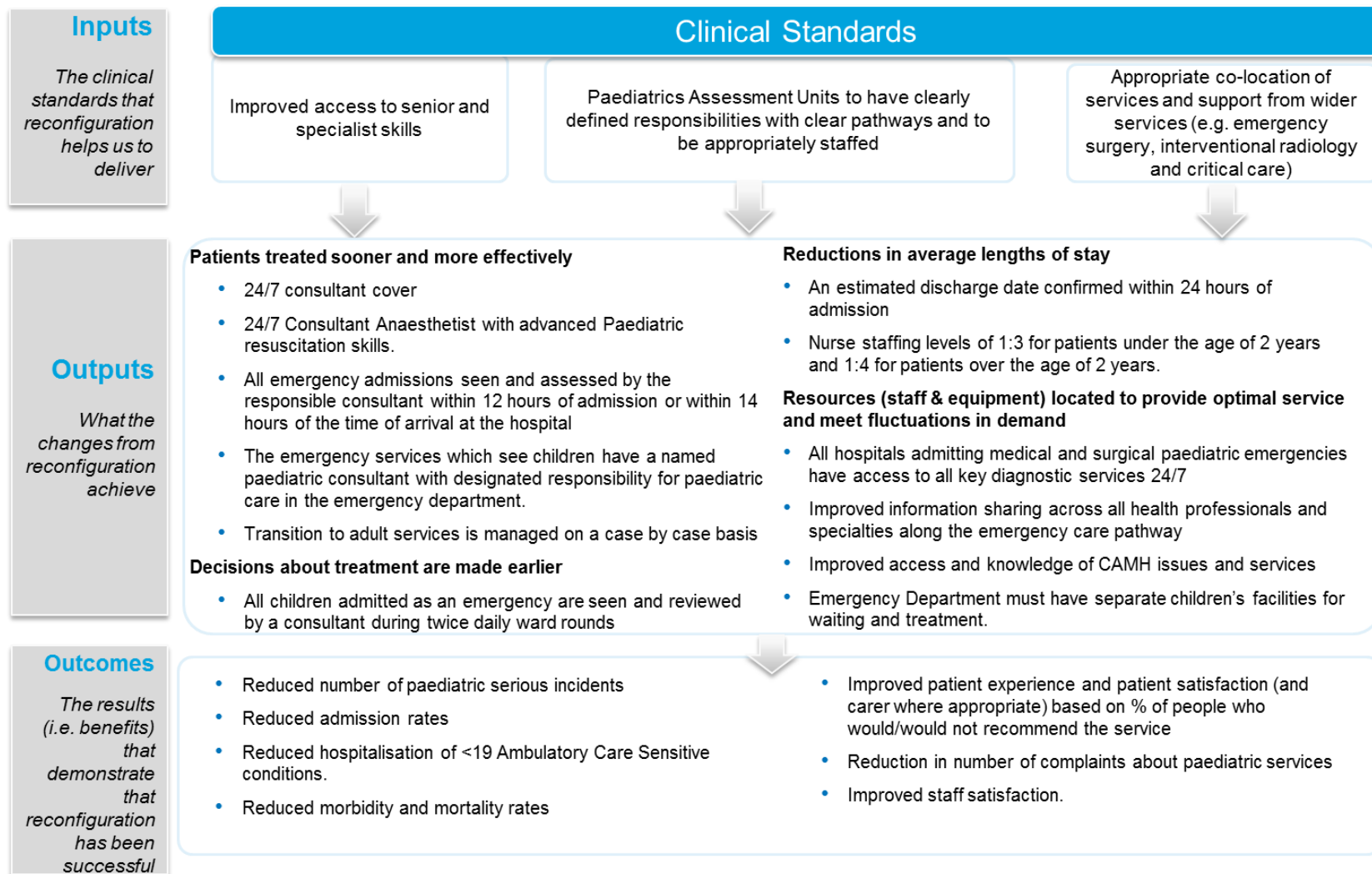
## Patient & Clinical benefits – Planned Care, Day Case & Diagnostics



## Patient & Clinical benefits - Maternity services



## Patient & Clinical benefits - Paediatric services



## 5.0 THE IMPACT OF THE PROPOSED CHANGES

### 5.1 Quality Impact Assessment

The quality assessment describes the impact of service changes as a result of implementation of the potential future outline model of care for hospital services (the Clinical Model), on the Trust's ability to provide high quality patient care. Specifically the Quality Impact Assessment (QIA) of the proposed future model of care has been developed to provide assurance that the proposed reconfiguration of CHFT acute services will have a positive impact and not adversely affect the quality of patient care. This is defined by NHS England as care that is clinically effective, safe and that provides as positive an experience for patients as possible.

The QIA describes the service changes as a result of implementation of the potential outline model of care for hospital services but does not assess the impact of any changes in service delivery location as site specific changes are yet to be decided. Travel times and ease of access are areas for review in the equality impact assessment, which is in section 5.3 below.

The following sections provide a summary of the QIA. The full assessment is included at Appendix D.

#### 5.1.1 Benefits to be realised from the proposed clinical model

The proposed clinical model will enable the Trust to better respond to the above challenges in the following ways:

- **Split service provision:** Ensuring that paediatric medicine and surgery are located on one site would ensure that consultants can oversight and input into both specialties thus facilitating the provision of shared senior paediatric and surgical care for patients. This would enable the delivery of more streamlined care for patients and ensure a more efficient use of paediatric workforce.

Additionally, co-location of paediatrics with the paediatrics Emergency Department will allow for paediatric emergency medicine (PEM) trained staff to work alongside and support acute paediatrics which has significant workforce issues, especially medical staffing.

- **Meeting Royal College recommendations / clinical standards:** Co-location of paediatrics with paediatrics emergency care will support conformity with the standards for Children and Young people in Emergency Care settings. Furthermore, the co-location of paediatric medicine and surgery would ensure that the Trust is better able to conform with the Royal College of Paediatrics and Child Health (RCPCH) guidance to provide consultant delivered care at peak times within the next 5 years

A single point of access for critical care beds will result in the Trust being better able to respond to critical care workforce standards thus supporting the delivery of improved patient outcomes for critical care and complex patients.

- **Patient safety:** Consolidation of acute services onto one site will facilitate the design, development and implementation of patient pathways across the patient's full acute journey, thereby strengthening safety mechanisms and minimising the opportunity for harm. Access to acute specialties in one place will ensure that complex patients are able to access the best breadth and depth of care appropriate to their needs and in a timely fashion.
- **Inter-hospital transfers:** The reconfiguration of acute medicine onto one site, to support the activity of the single ED, would have the advantage of reducing inter-hospital transfers which currently take place frequently for acute medical admissions, when one or other site has reached its maximum medical bed capacity. Eliminating transfers of medical patients will improve safety, optimise patient flow in ED, shorten waits to definitive care, reduce ED breaches of the four-hour target, and reduce the workload on the ambulance service which is currently responsible for providing these transfers.
- **Patient experience:** Providing planned services, including surgery, in a dedicated site ensures that access to treatment, surgery or therapy input can be structured and planned without risk of disruption from emergency cases.
- **Medical workforce / senior medical cover:** The changes in service and workforce model through consolidation into a single emergency department will ensure that the Trust will be in a position to meet the College of Emergency Medicine recommendation for a minimum of 10 Consultants in Emergency Medicine per emergency department. This will improve the likelihood of survival and a good recovery for patients.

A single emergency department, and separation into unplanned and planned services, will enable the Trust to leverage its workforce more efficiently and leave the Trust in a better position to meet standards around 7 day working in the future.

### 5.1.2 Summary of issues and benefits

A summary of the issues pertaining to each clinical division are listed below. Details of the proposed future model and how this will yield actual benefits and address current problems are also described.

Division / Directorate	Current model / problems	Proposed Model	Benefits
<b>Medicine - Emergency Department</b>	<p>It is difficult to recruit sufficient numbers and seniority of staff to provide full senior medical oversight across both emergency departments.</p> <p>The two sites do not provide the same breadth of acute services and there is often a need for inter hospital transfer of patients as there is not a co-location of all the expertise needed on both sites</p>	<ul style="list-style-type: none"> <li>• A single unified Emergency Care centre for providing Emergency/Acute medicine and Accident and Emergency services will be located at the unplanned site. This will include access to MAU, SAU and ITU</li> <li>• Access to paediatric emergency care will also be provided at the unplanned site</li> <li>• There will be urgent care centres (UCC) at each hospital and in one further location for the treatment of adults with minor illnesses and minor injuries</li> <li>• Any child aged 5 years or younger will be referred to the Paediatric Emergency Department. Children between the ages of 5-16 with minor injuries can be seen at one of the UCCs</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Patients:</b> Improved patient safety and quality of care due to the shift to an operationally sustainable model and ability to provide longer periods of on-site consultant cover</li> <li>• <b>Patients:</b> Patients seen at appropriate site based on acuity with access to a wider range of services for patients requiring more complex care</li> <li>• <b>Staff:</b> A single ED will ensure that the workforce will not be stretched across two departments as is the case currently. The changes in service and workforce model will enable the College of Emergency Medicine recommendation of a minimum of 10 consultants in Emergency Medicine per ED to be achieved</li> </ul> <p>Recruitment and retention will improve as at present it is difficult to attract staff due to the 2 site model and frequency of on call shifts</p> <ul style="list-style-type: none"> <li>• <b>Patients:</b> Access to a wider range of services for patients requiring more complex care</li> </ul>
<b>Medicine - Acute Medical Directorate</b>	<p>Acute medical services are currently provided at both sites. Due to the clinical</p>	<ul style="list-style-type: none"> <li>• Acute medical services (cardiology, respiratory, gastroenterology, acute stroke, elderly complex care and orthogeriatric care) will be provided at</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Patients:</b> Access to a wider range of services for patients requiring more</li> </ul>

	<p>adjacencies required, if there is a single ED on the unplanned site then all acute medical services will need to be located</p> <p>Due to difficulties recruiting and retaining sufficient numbers of senior medical staff, the Trust is unable to deliver specialty rotas at present meaning patients do not always have immediate access to the level of specialist care they may require</p>	<p>the unplanned site</p> <ul style="list-style-type: none"> <li>• The following services will integrate with ED: acute medicine, acute elderly + frailty, Comprehensive Geriatric Assessment, respiratory care, stroke and community hub (e.g. crisis intervention, RAID)</li> <li>• Patients will be supported with early care plans so that people that do not need acute hospital care are able to return to their usual place of residence without delay</li> <li>• Enhanced level of ambulatory assessment and treatment with focus on keeping people at home</li> <li>• Early rehabilitation will be available on the unplanned site</li> <li>• Diabetes and endocrinology can be principally delivered in the community</li> </ul>	<p>complex care</p> <ul style="list-style-type: none"> <li>• <b>Patients:</b> There will be reduction in the need for intra and inter-hospital transfers for people who have more than one clinical need</li> <li>• <b>Staff / Trust:</b> The enlarged organisation will be a more attractive proposition to potential recruits, with a greater level of stability, more sustainable rotas, and the opportunity for sub-specialisation. Fewer Consultant vacancies will mean better continuity of care for patients.</li> <li>• <b>Patients:</b> Improving quality of care by providing comprehensive geriatric care for this Elderly Care patients</li> </ul>
<b>Medicine - Integrated Specialty</b>		<ul style="list-style-type: none"> <li>• Acute oncology and haematology services will be located on the unplanned site</li> <li>• Dermatology will be principally delivered in an outpatient and community clinic setting</li> <li>• Rheumatology will be principally based on the planned site as most services are delivered in a day case / clinic setting</li> <li>• Neurology will be predominantly outpatient based</li> <li>• Palliative care will be principally delivered in the community</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Patients:</b> Access to less acute medical input will be easier and faster in the dedicated planned site</li> <li>• <b>Patients:</b> Patients seen at appropriate site based on acuity</li> </ul>
<b>Surgery &amp; Anaesthetics</b>		No change	<ul style="list-style-type: none"> <li>• <b>Patients:</b> Continued improvement in</li> </ul>

<p><b>- Trauma &amp; Orthopaedic Services</b></p>		<ul style="list-style-type: none"> <li>• Acute trauma will continue to be located on the unplanned site</li> <li>• Unplanned orthopaedic surgery will continue to be undertaken at the unplanned site</li> <li>• Planned surgery to take place on the planned site routinely - transfers to critical care to take place if required and patients would only stay on the unplanned site for the duration of their acute/ critical care stay before transferring back to the planned site</li> <li>• Complex elective patients (hip revisions) to take place on the unplanned site as there will likely be a requirement for access to a high dependency unit</li> <li>• Other elective patients who are likely to require critical care support will be identified at the pre-assessment clinic</li> <li>• There is already a split of elective and non-elective activity (majority of acute work takes place at HRI, majority of elective work is at CRH)</li> <li>• There will be a single fracture clinic on the unplanned site</li> <li>• Majority of daycase work to take place on the planned site</li> </ul>	<p>safety and mortality rates, already demonstrated by a partial reconfiguration of acute surgery onto HRI in 2005/6</p> <ul style="list-style-type: none"> <li>• <b>Staff:</b> Consolidating non-electives and electives on single sites will ensure that rotas can be strengthened, staff will not be spread thinly and there will be less of a dependence on locums</li> <li>• <b>Patients:</b> There will be a greater opportunity to review and redesign patient pathways thus improving patient outcomes and the patient experience</li> <li>• <b>Staff:</b> Centralising the 'unplanned' work will ensure that there is greater flex in the team and a better place to work therefore improving recruitment and retention</li> </ul>
<p><b>Surgery &amp; Anaesthetics - Operating Services, Theatres, Anaesthetics, Critical Care and Pain</b></p>	<p>The provision of a critical care unit at each site means that the Trust is not currently in a position to fully comply with D16 guidance on critical care workforce standards.</p>	<ul style="list-style-type: none"> <li>• Level 2 and Level 3 ITU / Critical Care to be based on the unplanned site (currently Trust does not separate ITU and HDU, beds can be upgraded or downgraded as necessary)</li> <li>• Patients requiring critical care will be transferred from planned site or identified in advance at the</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Patients:</b> Improvement in safety and patient outcomes when critical care workforce standards are met</li> </ul>



		<p>pre-assessment stage</p> <ul style="list-style-type: none"> <li>• Full day case theatre suite needed at planned site including recovery beds / trolleys</li> <li>• Pain services will be centralised at the planned site</li> <li>• Endoscopy services will be available on both sites</li> </ul>	
<b>Surgery &amp; Anaesthetics - General Specialist Surgical Services</b>		<ul style="list-style-type: none"> <li>• No change</li> </ul> <p>Acute surgery will continue to be carried out on the unplanned site</p> <ul style="list-style-type: none"> <li>• Most inpatient planned surgery to be undertaken on the planned site</li> <li>• All vascular and urology surgery (including day case) to be undertaken on the unplanned site</li> <li>• Endoscopy units needed on both sites - GI bleeds will be managed on the unplanned site</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Staff:</b> Reconfiguration will improve resilience within the staff rota due to separation of planned and unplanned surgery</li> <li>• <b>Patients:</b> Better patient outcomes as more complex procedures will be centralised</li> </ul>
<b>Surgery &amp; Anaesthetics- Head &amp; Neck</b>		<ul style="list-style-type: none"> <li>• All ENT surgery (elective and non-elective) to be centralised onto the unplanned site</li> <li>• Ophthalmology to be undertaken on the planned site</li> <li>• Max fax day unit to be moved to the planned site</li> </ul>	
<b>Families &amp; Specialist services - Children's Services</b>	Paediatrics is split between the two sites – paediatric medicine at CRH and most paediatric surgery at HRI. This means that there is sub-optimal paediatric	<ul style="list-style-type: none"> <li>• Specialist paediatric services will be co-located with the Emergency Care Centre - this will cover neonates, paediatric surgery and paediatric medicine</li> <li>• Neonates will be co-located with Consultant led</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Patients:</b> Co-locating neonates with all acute paediatrics and obstetrics / gynaecology will mitigate against any possible risks from having these separate at present</li> </ul>

	<p>senior medical doctor oversight at HRI. At present consultants have little time to cover HRI but there is already a single consultant on call rota at present.</p>	<p>Maternity care.</p> <ul style="list-style-type: none"> <li>• All paediatric surgery (including daycase) and paediatric medical care to be co-located at the unplanned site</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Staff:</b> Co-location of paediatric medicine and surgery will ensure that consultants can have oversight of both. The current model of having them separate is safe but not optimal.</li> <li>• <b>Staff:</b> Co-location of Paediatrics and Paediatrics EM will allow for Paediatric emergency medicine (PEM) trained staff to work alongside and support acute Paediatrics which also has significant workforce issues, especially medical staffing</li> <li>• <b>Trust:</b> Better conformity with the standards for Children and Young people in Emergency Care settings and Royal College of Paediatrics and Child Health (RCPCH) guidance to provide consultant delivered care at peak times within the next 5 years</li> </ul>
<p><b>Families &amp; Specialist Support Services - Women's Services</b></p>		<ul style="list-style-type: none"> <li>• Consultant - led obstetrics and neonatal care (currently at CRH) to be co-located on the unplanned site</li> <li>• Midwife - led maternity will be available on both hospital sites</li> <li>• Acute and inpatient gynaecology services will be provided at the unplanned site</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Patients:</b> Patients can access a wider range of maternity care closer to home</li> <li>• <b>Patients:</b> Improved safety by ensuring only appropriate patients are cared for by the MLU and patients that may require obstetric care are seen at the specialist centre</li> <li>• <b>Patients:</b> Patients with complex obstetrics will be cared for in the centre where other specialist services ( ITU/ Surgery/ Interventional radiology) are</li> </ul>

			<p>available</p> <ul style="list-style-type: none"> <li>• <b>Patients:</b> There will be 24 hour consultant cover of the labour ward and 24/7 access to a competent supervising anaesthetist</li> <li>• <b>Staff / Trust:</b> The trust will be a more attractive proposition to potential recruits, with a greater level of stability, more sustainable rotas, and the opportunity for sub-specialisation</li> </ul>
<b>Community Services</b>	<p>The Trust faces a key capacity issue over the next 10 years due to a growth in demand for hospital services from the increasing population.</p>	<ul style="list-style-type: none"> <li>• Early rehabilitation and reablement will be provided on the unplanned site with some rehabilitation provision at the planned site (TBC)</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Patients:</b> The provision of rehabilitation and reablement provision on the unplanned site will ensure that rehabilitation can begin as early as appropriate in the patient’s journey. This will facilitate quicker and more assured discharge back to the patient’s own home or into the community</li> </ul>

## 5.2 Travel Analysis

### 5.2.1 Impact on Patients

The geographic area of Calderdale and Greater Huddersfield covers 395 square miles. Calderdale CCG and Greater Huddersfield CCG commission services for their residents within this area and the current hospital service profile requires a degree of cross-district travel for patients to access the appropriate services for their needs.

In order to understand the impact for patients a detailed travel analysis has been undertaken by Jacobs Engineering. In summary this demonstrates that:

- The majority of residents within Calderdale and Huddersfield attend their most local hospital to receive their care
- All emergency ambulance journeys across the locality are less than 45 minutes with the majority being less than 30 minutes
- The key areas of deprivation are located around the main towns of Halifax and Huddersfield with a greater proportion in and around Huddersfield
- The elderly are mostly located in the suburbs of the main towns of Halifax and Huddersfield, which results in slightly longer travel times to either hospital site.

The potential impact of the hospital and community service reconfiguration has been assessed by Yorkshire Ambulance Service and by Jacobs Engineering.

The analysis has assessed the travel implications for car and public transport journeys to hospital. Specific analysis in relation to the population impact relative to deprivation, age, and race has been included.

The calculations are based on the average times across the day to avoid the complexity of repeating every analysis for multiple times during the day (this highlights any disproportionate impacts requiring further analysis without introducing undue complexity).

Jacobs Engineering has calculated times for car journeys and public transport weighted by the number of patient journeys typically arising in each area (this ensures the analysis is not unduly influenced by the small numbers of patients who attend from peripheral areas).

The journey time analysis has been carried out using industry-standard Geographical Information Systems (GIS) software at the Lower layer Super Output Area (LSOA) level of detail (the most detailed available). LSOAs are built up from groups of output areas. LSOAs are defined as having a population of between 1000 and 3000 people, and between 400 and 1200 households. Within Kirklees and Calderdale there are 387 LSOAs. It is these LSOA boundaries that have been used to build the journey time maps.

The conclusions of the analysis are that there are no disproportionate impacts of the change in travel time related to whether HRI or CRH is the planned or unplanned hospital care site.

Currently 76% of patients and 60% of the whole population are within a 15 minute drive of Calderdale Royal Hospital or Huddersfield Royal Infirmary. With 96% of both patients and the population being within a 30 minute drive of Calderdale Royal Hospital or Huddersfield Royal Infirmary.

## 5.2.2 Impact on Yorkshire Ambulance Service

In order to understand the implications for the Yorkshire Ambulance Service a detailed analysis has been undertaken by North of England Commissioning Support (NECS). Having established the baseline they modelled two Scenarios: CRH being the Unplanned Site and HRI being the unplanned site and; HRI being the Unplanned site and CRH being the Planned site.

Their findings are summarised in the tables below and show that there is no disproportionate impact on Yorkshire Ambulance Service as a result of choice of site.

**Baseline results, based on 12 months data were established as follows:**

Destination Sites	Sum of Total Journey Time (mins)	Average Journey Time (mins)	Number of Journeys	% of Total Journeys
BARNSELY DISTRICT GENERAL	12366.10	36.05	343	0.4%
BRADFORD ROYAL INFIRMARY	13400.61	19.42	690	0.8%
CALDERDALE ROYAL HOSPITAL	534579.58	14.09	37930	41.2%
DEWSBURY DISTRICT HOSPITAL	37394.56	21.86	1711	1.9%
HUDDERSFIELD ROYAL INFIRMARY	758768.13	15.71	48299	52.5%
LEEDS GENERAL INFIRMARY	32824.68	28.30	1160	1.3%
NORTHERN GENERAL HOSPITAL	182.68	1.59	115	0.1%
PINDERFIELDS GENERAL HOSPITAL	38438.67	34.57	1112	1.2%
ROYAL BLACKBURN HOSPITAL	16958.82	53.00	320	0.3%
ST JAMES UNIVERSITY HOSPITAL	12733.67	42.03	303	0.3%
<b>Grand Total</b>	<b>1457647.51</b>	<b>15.85</b>	<b>91983</b>	<b>100.0%</b>

### Option 1 – A single Emergency Site at CRH. Modelling without HRI

Destination Sites	Sum of Total Journey Time (mins)	Average Journey Time (mins)	Number of Journeys	% of Total Journeys
BARNSELY DISTRICT GENERAL	66150.50	36.87	1794	2.0%
BRADFORD ROYAL INFIRMARY	10644.66	18.97	561	0.6%
CALDERDALE ROYAL HOSPITAL	1731721.22	21.28	81370	88.5%
DEWSBURY DISTRICT HOSPITAL	152920.85	25.06	6101	6.6%
HUDDERSFIELD ROYAL INFIRMARY	0.00	0.00	0	0.0%
LEEDS GENERAL INFIRMARY	32419.61	28.36	1143	1.2%
NORTHERN GENERAL HOSPITAL	395.04	3.29	120	0.1%
PINDERFIELDS GENERAL HOSPITAL	3221.14	28.26	114	0.1%
ROYAL BLACKBURN HOSPITAL	25198.15	54.31	464	0.5%
ST JAMES UNIVERSITY HOSPITAL	13157.78	41.64	316	0.3%
<b>Grand Total</b>	<b>2035828.94</b>	<b>22.13</b>	<b>91983</b>	<b>100.0%</b>

The total journey time in hours is 33,930.48 hours. An increase over baseline of 9,636.36 hours.

### Option 2 – A single Emergency Site at HRI. Modelling without CRH

Destination Sites	Sum of Total Journey Time (mins)	Average Journey Time (mins)	Number of Journeys	% of Total Journeys
BARNSELY DISTRICT GENERAL	52399.79	34.66	1512	1.6%
BRADFORD ROYAL INFIRMARY	112883.22	27.12	4163	4.5%
CALDERDALE ROYAL HOSPITAL	0.00	0.00	0	0.0%
DEWSBURY DISTRICT HOSPITAL	42386.23	22.73	1865	2.0%
HUDDERSFIELD ROYAL INFIRMARY	1647985.72	20.20	81570	88.7%
LEEDS GENERAL INFIRMARY	32600.67	28.25	1154	1.3%
NORTHERN GENERAL HOSPITAL	395.04	3.29	120	0.1%
PINDERFIELDS GENERAL HOSPITAL	746.29	12.87	58	0.1%
ROYAL BLACKBURN HOSPITAL	75740.28	61.83	1225	1.3%
ST JAMES UNIVERSITY HOSPITAL	13157.78	41.64	316	0.3%
<b>Grand Total</b>	<b>1978295.01</b>	<b>21.51</b>	<b>91983</b>	<b>100.0%</b>

The total journey time in hours is 32,971.58 hours. An increase over baseline of 8,677.46 hours.

In addition North of England Commissioning Support (NECS) also looked at the impact on PTS for the transport of A & E patients and concluded that The impact on the PTS service for the transport of patients home from A&E is negligible. There were only 159 journeys (116 from CRH and 43 from HRI) in total during the year, totalling 728 miles (568 miles for journeys from CRH and 160 from HRI)

### 5.3 Equality Impact Assessment

A detailed Equality Impact Assessment has been undertaken by North of England Commissioning Support (NECS). The full report is included at Appendix E.

The report concluded that there are no protected groups who are likely to be highly impacted by the proposed changes to hospital services. The most likely areas for negative impact is to those groups who are high users of Accident & Emergency services, such as younger, older people and some ethnic groups.

There are certain groups where we found limited evidence; however we believe that all groups have been considered sufficiently for this proposal to be taken to formal Public Consultation, where further work can be undertaken. There is a Maternity and Paediatric Services engagement underway, and the results of this will address some gaps outlined in the EQIA.

The report recommends the following:

- Actively consult older people around emergency and urgent care services as they are frequent users.
- Through the public consultation gather further information and views from Asian/Asian British and White Other groups which are over or under-represented in relation to the local population in service use so their views can be considered.
- Reach out to impairment groups that could be significant users of the services where changes are proposed to enable potential negative impacts to be identified and mitigated.
- Once the information from the Maternity and Paediatric Engagement has been collated and analysed review to identify any particular groups that need further consideration.
- Carers should be reached in the consultation to identify if any proposed changes would be experienced more by carers.
- Equality Impact Assessments should be completed for all services as they are redefined/relocated this should be an iterative process every time there is significant change.
- The Trust should work towards improved equality monitoring data; collected, analysed and addressed for protected characteristics not currently routinely collected.
- Actively consult children and young people and children during the public consultation.

## 6.0 ESTABLISHING A SHORT LIST OF OPTIONS

### 6.1 Long list to short list

The table below shows the 11 options that were considered together with the rationale for their being included or discounted as part of the short list of possible estate configuration options.

This initial shortlisting of options resulted in the following five options being taken forward to the next stage of the options appraisal process:

1. **The Base Case**  
Minimum change in hospital configuration across two sites but incorporates known changes that will occur in next 5 years (e.g. demographic, tariff impacts, initiatives unrelated to hospital reconfiguration ).
2. **Emergency and Acute Care Centre and high risk planned care delivered at CRH.**  
CRH provides all acute and emergency care and clinically high risk planned care. Elective services are provided at HRI site on main site (dispose of Acre Mill).
3. **Emergency and Acute Care Centre and high risk planned care delivered at CRH.**  
CRH provides all acute and emergency care and clinically high risk planned care. Elective services are provided at HRI site on Acre Mill site (dispose of main site).
4. **Emergency and Acute Care Centre and high risk planned care delivered at HRI.**  
HRI provides all acute and emergency care and clinically high risk planned care. Elective services are provided at CRH site.
5. **Emergency and Acute Care Centre and high risk planned care delivered at HRI.**  
HRI provides all acute and emergency care and clinically high risk planned care. Elective services are provided at CRH site and alternate use of some of CRH estate is explored to optimise PFI utilisation.

It is important to note that the estate configuration options described above and in the table below relate solely to the existing hospital services provided by CHFT. For all the estate configuration options we also overlaid the requirement for the provision of a medically led 24x7 Urgent Care Centre at both Hospital sites in Halifax and Huddersfield.

Option	Configuration	Description of Assessment	Shortlist
1	<b>The Base Case</b> Minimum change in hospital configuration across two sites but incorporates known changes that will occur in next 5 years (e.g. demographic, tariff impacts, initiatives unrelated to hospital reconfig).	The base case must be included in the strategy to understand the impact of the reconfiguration options.	YES
2	<b>All current Hospital Services provided at CRH</b> All existing hospital services provided at CRH i.e. a single hospital site proposal. Dispose of HRI and Acre Mill sites.	Not in line with Clinical Model No guarantee that capacity will be sufficient to service the local community Requires extensive reconfiguration and capital investment.	NO - Discount
2a	<b>All Hospital Services provided at CRH enabled by a retracted range of services provided by CHFT</b> The trust reduces market share to ensure all services can be delivered from CRH site only i.e. single hospital site proposal. Dispose of HRI and Acre Mill site	Not in line with Clinical Model No guarantee that capacity will be sufficient to service the local community Requires extensive reconfiguration and capital investment.	NO - Discount
3a	<b>All Hospital Services at HRI – Use Break Clause for PFI</b> All hospital services provided at HRI i.e. a single hospital site proposal. Exit CRH site through use of PFI break clause.	Not in line with Clinical Model No guarantee that capacity will be sufficient to service the local community Requires extensive reconfiguration and capital investment. PFI break clause expected to be £200m and not available for 30 years.	NO - Discount
3b	<b>All Hospital Services at HRI –Trust sublets / finds alternate use of CRH</b> All hospital services provided at HRI i.e. a single hospital site proposal. Alternate use of CRH secured.	Not in line with Clinical Model No guarantee that capacity will be sufficient to service the local community Requires extensive reconfiguration and capital investment. Likelihood of securing alternate use that would cover PFI cost is low	NO - Discount
4(a)	<b>Emergency and Acute Care Centre and high risk planned care delivered at CRH.</b> CRH provides all acute and emergency care and clinically high risk planned care. Elective services are provided at HRI site on main site (dispose of Acre Mill).	In line with Clinical Model Safer / higher quality services, 24hr consultant led care Undisturbed planned care More resilient workforce model Capital receipt from sale of Acre Mill	YES



Option	Configuration	Description of Assessment	Shortlist
4(b)	<b>Emergency and Acute Care Centre and high risk planned care delivered at CRH.</b> CRH provides all acute and emergency care and clinically high risk planned care. Elective services are provided at HRI site on Acre Mill site (dispose of main site).	In line with Clinical Model Safer / higher quality services 24hr consultant led care Undisturbed planned care More resilient workforce model Capital receipt from sale of HRI	YES
5(a)	<b>Emergency and Acute Care Centre and high risk planned care delivered at HRI.</b> HRI provides all acute and emergency care and clinically high risk planned care. Elective services are provided at CRH site.	In line with Clinical Model Safer / higher quality services 24hr consultant led care Undisturbed planned care More resilient workforce model	YES
5(b)	<b>Emergency and Acute Care Centre and high risk planned care delivered at HRI.</b> HRI provides all acute and emergency care and clinically high risk planned care. Elective services are provided at CRH site and alternate use of some of CRH estate is explored to optimise PFI utilisation.	In line with Clinical Model Safer / higher quality services 24hr consultant led care Undisturbed planned care More resilient workforce model	YES
6	<b>New build</b> Exit both CRH and HRI sites and build new hospital delivering all services on alternate site.	In line with Clinical Model Safer / higher quality services 24hr consultant led care Undisturbed planned care More resilient workforce model Requires extensive capital investment. Funding highly unlikely to be provided PFI break clause expected to be £200m & not available for 30 years Likelihood of securing alternate use that would cover PFI cost is low.	NO - Discount
7	<b>Growth of activity and income on both sites to improve financial &amp; clinical viability negating need for reconfiguration</b> Maximise income from both sites via increased market share to enable improved income and viability.	Not in line with Clinical model Unlikely to be able to secure sufficient market share / growth to enable improvement in financial and clinical viability.	NO - Discount

## 6.2 Appraisal Criteria

In order to arrive at our options for consultation we have undertaken an options appraisal process. This is described in more detail in Section 8. The options appraisal process considers a number of factors that would influence the configuration of the potential future model and produces a recommended configuration based on the optimisation of these criteria. Both Commissioners and CHFT have independently produced criteria and conducted engagement with stakeholders during 2014-2015 in relation to them. These have been consolidated into a single set and subject to further engagement at a stakeholder event in December 2015. The feedback from that event was that stakeholders were supportive of the criteria we were using and thought that Quality of Care was the most important criteria. The table below shows the appraisal criteria that we have agreed.

	Criterion	Description
1	<b>Quality of Care</b>	Deliver improvements to our clinical quality and safety whilst giving best chance of achieving our hospital standards
		Provides a better experience for patients
		Provides a better experience for staff
		Enables supportive self management
2	<b>Access to Care</b>	Quality and equality impact assessment for both adults and children. This covers 4 areas: 1. Improved patient ability to access the right treatment in the most appropriate setting. 2. Minimising the average and/or total time it takes people to get to hospital by ambulance, public transport and car (off-peak& peak) 3. Car parking facilities 4. Minimise delays in care pathways, once in receipt of care.
3	<b>Value for Money</b>	Most likely to return the Trust to sustainable financial position within the context of a balanced Health and Social Care System
		Provides the most positive net present value (NPV) over 30 years, return on capital and other financial requirements
		Delivers improvement of headline profitability ratios (e.g. Carter)
		Improves income / cost balance of individual service lines
4	<b>Deliverability &amp; Sustainability</b>	Minimises avoidable harm during transition
		Provides the most cost effective reconfiguration of services
		Minimises the time taken to deliver the proposed changes
		Delivers robustness over a 20 year time horizon
		Supports attraction and retention of staff
5	<b>Co-dependencies with other strategies</b>	Demonstrates sufficient flexibility to integrate/improve partnership working with, for example, the Local Authority/ Social Care/ GPs and Third Sector.
		Alignment with Joint Strategic Needs Assessments (JSNA's)
		Maximise resilience to wider system/organisational failure

## 7.0 DETERMINING OPTIONS FOR IMPLEMENTATION

### 7.1 Activity and Capacity Modelling

An assessment of the impact of the Clinical Model on future activity, based on the proposed service and patient flow changes, has been completed. This modelling was run separately for the two main site options:

- CRH being the unplanned care site and HRI being the planned care site
- HRI being the unplanned care site and CRH being the planned care site

Additionally, a number of key assumptions were included as outlined in the following section.

#### 7.1.1 Key Assumptions

Key overarching assumptions that were applied to the model were:

- All modelling has been based on the forecast activity for FY16 (as at month 6)
- Growth has been modelled in accordance with the Trust financial assumptions
- The bed baseline has been adjusted to match the Trust's FY17 plan
- All movements will occur in year 5 on the basis that reconfiguration will require consultation and a capital build
- Patients not appropriate to be seen at the UCC are diverted to the next nearest ECC department based on travel time
- Walk-ins are assumed to continue to attend the ECC they currently attend
- Patients attending the UCC that require admission or more acute treatment are transferred to the ECC
- Inpatient spells arising from an ECC attendances will move with the ECC attendances
- An additional 30 winter pressure beds have been included to provide resilience to manage seasonality variations. This is in line with the seasonal swing identified by the Medicine division.
- Significant delivery of commissioner QIPP will be realised (resulting in a 6% reduction in non-elective medical admissions per annum)
- Length of stay (LOS) reductions as follows:
  - Medicine: 6% LOS reduction
  - Surgery: Bring average LOS for non-complex hips and knees to 4 days
  - FSS: 10% reduction in paediatrics, 5% reduction in gynaecology
- Bed occupancy to be applied as follows:
  - Medicine: 90%
  - Surgery: Utilise current occupancy level – 86.4%
  - FSS: 60% for paediatrics and maternity, 90% for gynaecology
- Current average theatre utilisation (i.e. reflecting current usage of theatres) and a move to 4 hours sessions
- Expansion of ambulatory care pathways
- Reconfiguration is anticipated to have a modest, but material, impact on neighbouring providers

- If HRI is the unplanned care site there could be an estimated 1,129 additional attendances annually at The Royal Oldham Hospital, with an incremental capacity requirement equivalent to 10 beds.
- If CRH is chosen as the unplanned care site there could be an estimated 1,089 additional attendances at Pinderfields General Hospital, with an incremental capacity requirement equivalent to 8 beds.
- No growth in elective market share
- 3% increase in home births
- 18 critical care beds in total (an increase of 6 beds from current provision)

**Key service by service assumptions applied to the model were:**

Service	Assumptions
Emergency Department	<ul style="list-style-type: none"> <li>• Planned care site no longer to have an ECC, but to become an Urgent Care Centre</li> <li>• All ambulances diverted to other ECCs</li> <li>• Adult walk-ins matching the Trust minor injuries and minor illness UCC criteria to remain at the planned care site(if attending there)</li> <li>• 5-16 year olds with minor injuries matching the Trust UCC criteria to remain at the planned care site (if attending there)</li> <li>• All under 5s to divert to nearest paediatric ECC</li> <li>• Increase in ED activity due to potential Dewsbury service changes (Trust estimate of 7 ED attendances per week with 38% conversion)</li> <li>• UCCs will likely be GP-led</li> </ul>
Acute Medicine	<ul style="list-style-type: none"> <li>• All cardiology, respiratory, gastroenterology, acute stroke, elderly complex care and orthogeriatric care to move to the unplanned care site</li> </ul>
Medicine – Integrated Speciality	<ul style="list-style-type: none"> <li>• Rheumatology and dermatology to move to the planned care site. Nephrology to move to the unplanned care site (Leeds service) (N.B: alternatively nephrology could be based on the planned care site with consultants providing in-reach to both the unplanned care site and the community)</li> </ul>
Surgery – General Specialist Surgical Services	<ul style="list-style-type: none"> <li>• All urology (elective, non-elective and day case) on the unplanned care site</li> <li>• All inpatient vascular surgery (elective and non-elective) on the unplanned care site</li> <li>• All GI bleeds on the unplanned care site</li> <li>• Increase in day cases (defined based on review of current 1 day LOS list)</li> <li>• Shift all T&amp;O, general surgical and urology inpatients from the unplanned care site to the planned care site if they have a LOS greater than 10 days (in practice will only be undertaken if clinically appropriate)</li> </ul>

Service	Assumptions
	<ul style="list-style-type: none"> <li>Shift all vascular inpatients from the unplanned care site to the planned care site if they have a LOS greater than 14 days (in practice will only be undertaken if clinically appropriate)</li> </ul>
Surgery – Trauma and Orthopaedics	<ul style="list-style-type: none"> <li>All emergency and non-elective trauma and orthopaedics to be on the unplanned care site</li> <li>Elective orthopaedics (with the exception of hip revisions/ other complex patients) to be on the planned care site</li> <li>90% of hand trauma on the planned care site (to be developed further)</li> </ul>
Surgery – Head & Neck	<ul style="list-style-type: none"> <li>All ENT emergency, elective and non-elective inpatient work to be moved to the unplanned care site</li> <li>All maxillo-facial and ophthalmology work to be moved to the planned care site</li> </ul>
Surgery – Operating Services, Theatres, Anaesthetics, Critical Care and Pain	<ul style="list-style-type: none"> <li>Critical Care to be based on the unplanned care site</li> <li>Patients requiring critical care will be transferred from the planned care site or identified in advance at the pre-assessment stage</li> </ul>
Paediatrics	<ul style="list-style-type: none"> <li>All paediatric medicine and surgery at the unplanned care site</li> </ul>
Gynaecology	<ul style="list-style-type: none"> <li>All gynaecology at the unplanned care site (with the exception of day case hysteroscopies which may take place at the planned care site)</li> <li>Midwife-led units on unplanned care and planned care sites</li> <li>All consultant led obstetric activity at the unplanned care site</li> </ul>

### 7.1.2 Modelling Outputs

The modelling was designed to provide the following outputs:

- Bed capacity requirements
- Number of theatre sessions required in order to inform theatre requirements
- The number of consultant vs midwife-led births at each site
- Breakdown of ECC vs UCC attendances (based on the minor injuries/ minor illnesses criteria)
- Prediction of the impact on other providers

The above outputs were utilised to prepare the cost model which identifies the total cost (revenue, capital, requirements and income) for each of the site options referred to earlier in this document.

### 7.1.3 Bed Capacity Requirements

At present, there are over 400 beds located at each site. Modelling indicates that the Trust would require a total bed base of 734 beds, irrespective of which site is the unplanned care site. Figure 26 starts from the agreed average bed base included in the Trust's FY 17 plan (811).

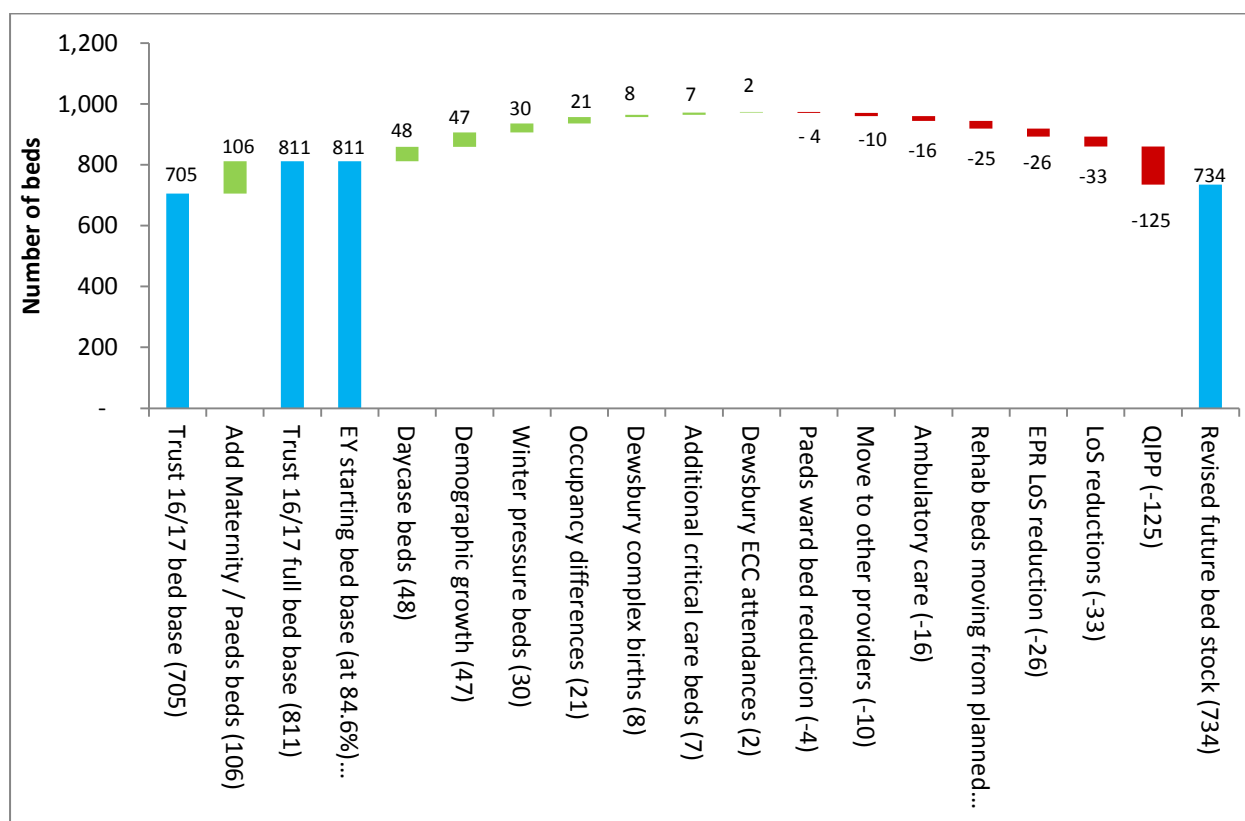


Figure 25: Changes in CHFT bed numbers over the 5 year time horizon

Table 1 and Table 2 below highlight that there are small differences in divisional-bed numbers for each of the site options as a result of changes to geography and the impact on patient flow.

Division	CRH	HRI	Total
Surgical (excluding critical care)	124	113	237
Critical care	18	0	18
Medical	307	4	311
Paediatrics (includes NICU)	63	0	63
Gynaecology	10	0	10
Maternity	63	2	65
Other (winter pressure beds)	30	0	30
	<b>615</b>	<b>119</b>	<b>734</b>

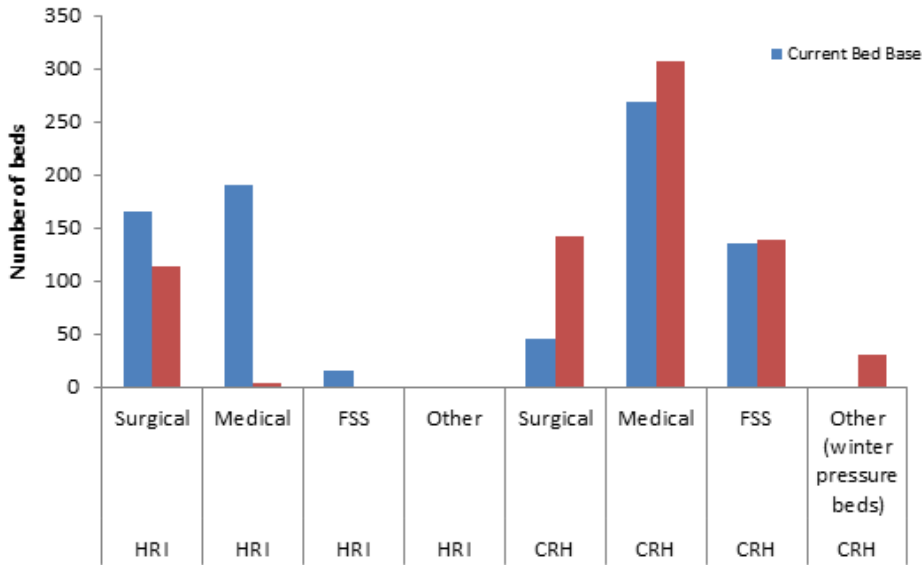
Table 1: Divisional – level beds required at each site if CHR is the unplanned care site

Division	CRH	HRI	Total
Surgical (excluding critical care)	115	127	242
Critical care	0	18	18
Medical	3	302	305
Paediatrics	0	63	63

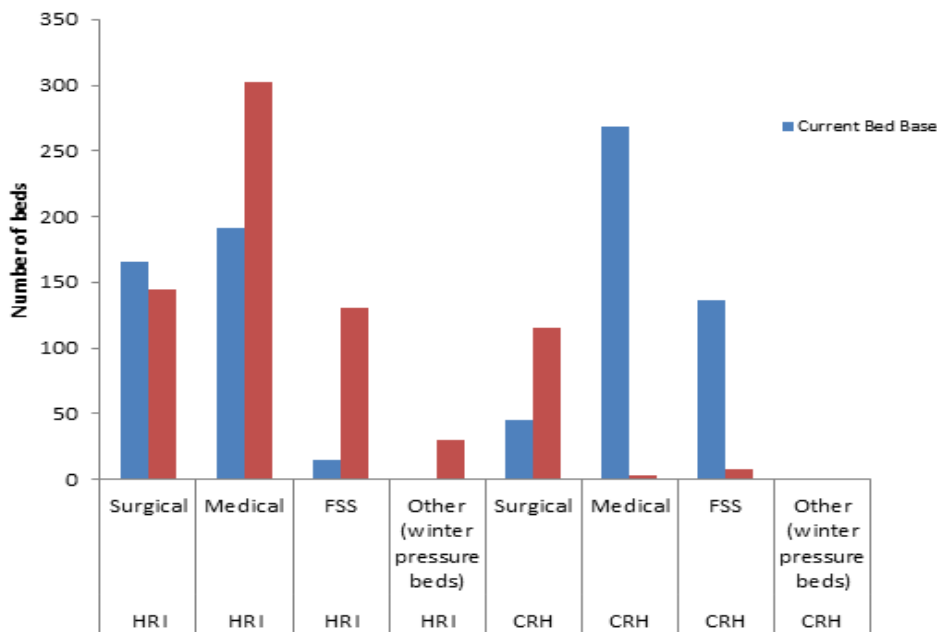
Gynaecology	0	10	10
Maternity	8	58	66
Other (winter pressure beds)	0	30	30
<b>Total</b>	<b>126</b>	<b>608</b>	<b>734</b>

**Table 2: Divisional-level beds required at each site if HRI is the unplanned care site**

Figure 1 and Figure 2 show the current versus projected number of divisional-level beds for both site options. (Note: ‘Other’ category of beds contains winter pressure beds).



**Figure 1: Number of beds required at both sites, by division, if CRH is the unplanned care site**



**Figure 2: Number of beds required at both sites, by division, if HRI is the unplanned care site**

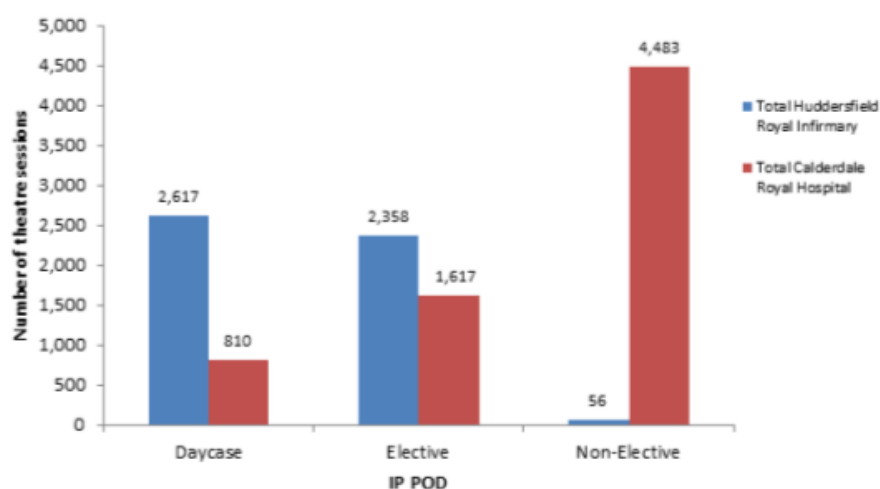
### 7.1.4 Theatre requirements

The total number of theatre sessions in 5 years’ time will be nearly 12,000 theatre sessions per annum for both site options as shown in Table 20. These figures include all day case, elective and non-elective activity.

Option	Huddersfield theatre sessions	Calderdale theatre sessions	Total
HRI unplanned, CRH planned	6,942	5,031	11,973
CRH unplanned, HRI planned	5,031	6,805	11,836

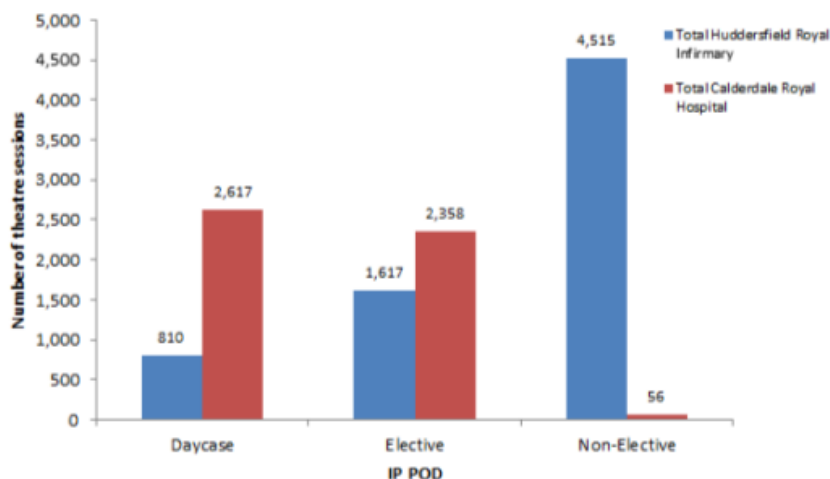
**Table 3: Number of predicted theatre sessions at both sites in 5 years’ time. Note, the difference between the two sites is as a result of activity drift to other providers.**

The breakdown of theatre sessions by type for each of the site options are summarised in Figure 3



and Figure 4.

**Figure 3: Predicted theatre session breakdown if CRH is the unplanned care site**



**Figure 4: Predicted theatre session breakdown if HRI is the unplanned care site**

Assuming that elective theatres will operate two four sessions per day over 49 weeks, for both site options (CRH or HRI unplanned) the activity modelling shows that 8 theatres will be required on the



unplanned care site and 10 theatres on the planned care site. This includes one 24 hour emergency theatre ('CEPOD'), one trauma theatre and one emergency obstetrics and gynaecology theatre.

Estate option	Non-elective theatres	Elective (other)	Day case theatres	Procedure room	Total
HRI unplanned	3 (CEPOD*, trauma, obs/gynae)	5	0	0	8
CRH planned	0	6	3	1	10

CRH unplanned	3 (CEPOD*, trauma, obs/gynae)	5	0	0	8
HRI planned	0	6	3	1	10

**Table 4: Predicted future theatre breakdown as informed by the modelling**

Note: \* The Trust's CEPOD theatre refers to a dedicated 24 hour emergency theatre established in response to the National Confidential Enquiry into Patient Outcome and Death.

#### 1.1.1.1 Emergency attendances

The Clinical Consensus Model proposes a model whereby there will be an urgent care centre co-located at each hospital site. These urgent care centres will operate 24 hours a day and be available to care for adults with minor injuries and illnesses and children over the age of 5 years with minor injuries only.

The modelling indicates that total emergency attendances will not vary significantly under reconfiguration, even with the provision of the urgent care centres.

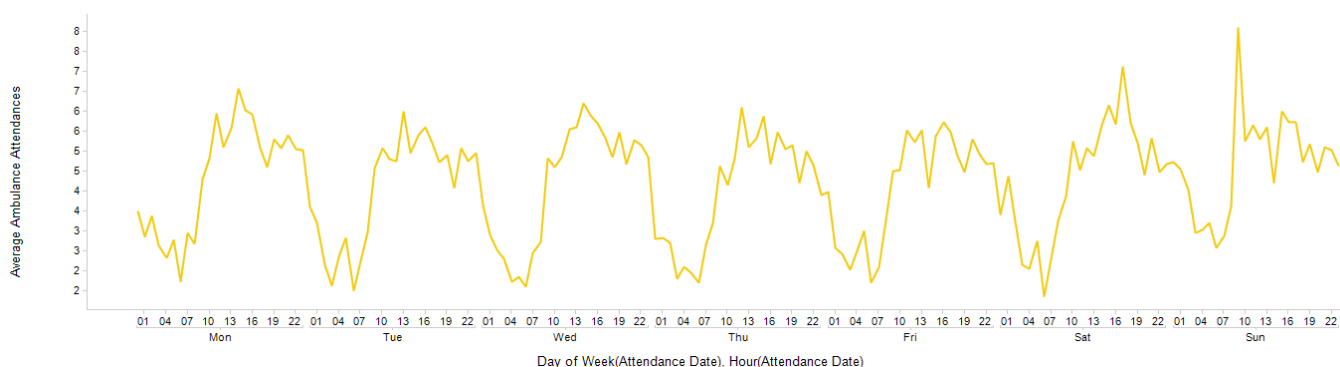
Site	Age Group	ECC Attendances	UCC Attendances	Total	FY17 ECC
Huddersfield Royal Infirmary	Paediatrics		13,746	13,746	
	Adults		42,069	42,069	
<b>Total Huddersfield Royal Infirmary</b>		<b>0</b>	<b>55,815</b>	<b>55,815</b>	<b>72,217</b>
Calderdale Royal Hospital	Paediatrics	19,440	6,999	26,439	
	Adults	58,775	30,350	89,125	
<b>Total Calderdale Royal Hospital</b>		<b>78,215</b>	<b>37,349</b>	<b>115,564</b>	<b>73,207</b>

**Table 5: Predicted emergency / urgent care activity if CRH is the unplanned care site**

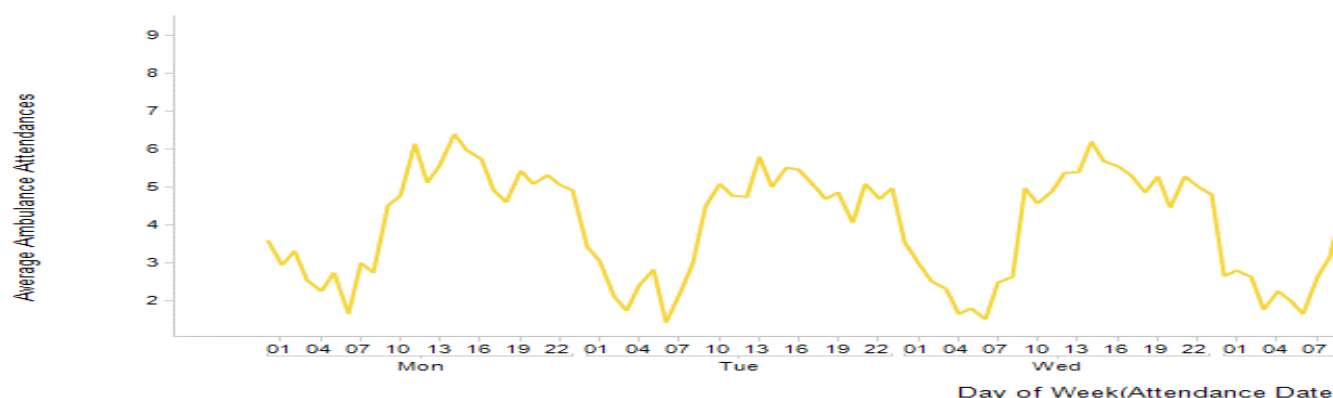
Site	Age Group	ECC Attendances	UCC Attendances	Total	FY17 ECC
Huddersfield Royal Infirmary	Paediatrics	19,323	6,509	25,832	
	Adults	58,942	31,069	90,011	
<b>Total Huddersfield Royal Infirmary</b>		<b>78,265</b>	<b>37,578</b>	<b>115,843</b>	<b>72,217</b>
Calderdale Royal Hospital	Paediatrics		15,636	15,636	
	Adults		41,358	41,358	
<b>Total Calderdale Royal Hospital</b>		<b>0</b>	<b>56,994</b>	<b>56,994</b>	<b>73,207</b>

**Table 6: Predicted emergency / urgent care activity if HRI is the unplanned care site**

The following charts display the average number of ambulance arrivals by hour and day of the week. The charts show that between midday and 11pm each day, the number of ambulance arrivals are fairly consistent and then considerably drop in the early hours of the morning. It is clear to see that there are increases in the number of arrivals over the weekend.



**Figure 5: Predicted ambulance arrivals per hour if CRH is the unplanned care site**

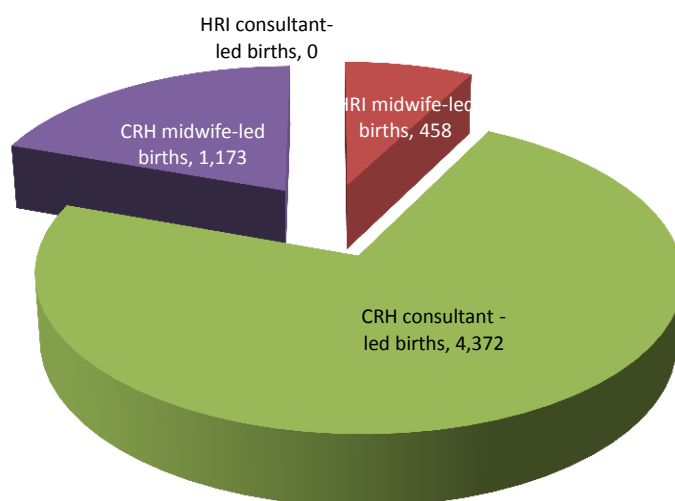


**Figure 6: Predicted ambulance arrivals per hour if HRI is the unplanned care site**

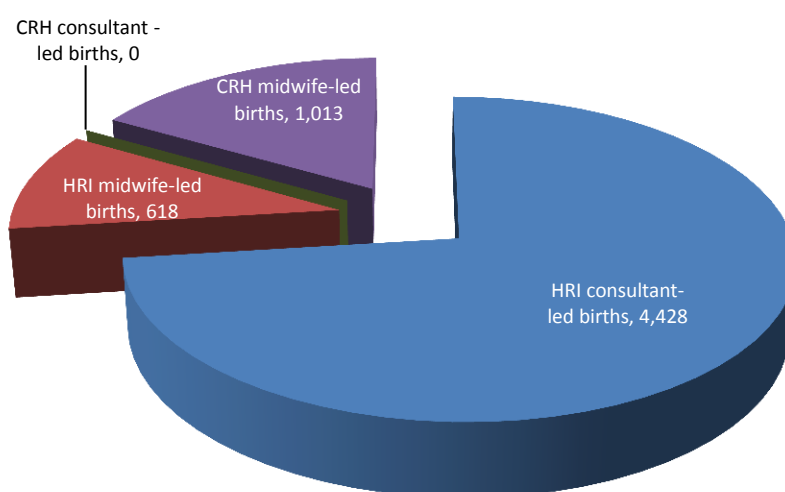
### 7.1.5 Births

In the outline model of care for hospital services, each site will continue to have a midwife-led birthing unit. Complex obstetrics will be cared for on the unplanned care site.

The model indicates that there will be a small increase in births at the Trust due to anticipated service changes at neighbouring Dewsbury Hospital. The effect of changes at Dewsbury Hospital have a greater impact if HRI is the unplanned care site due to geography and the likelihood of more patients in the HRI catchment area coming to HRI for their obstetrics needs.



**Figure 7: Breakdown of births if CRH is the unplanned care site**



**Figure 8: Breakdown of births if HRI is the unplanned care site**

#### 7.1.6 The impact on other providers

By using the Geographical Information System (GIS) software MapInfo, travel times of patients were calculated to both the Calderdale and Huddersfield sites, along with other local emergency care providers<sup>11</sup> based on patient postcodes from FY16 data. To note,

<sup>11</sup> The agreed providers to be considered were: Royal Blackburn Hospital; Fairfield General Hospital; Leeds General Infirmary

Dewsbury has been excluded from the analysis due to plans to downgrade this site to an Urgent Care Centre.

For all patients that arrived in an ambulance, the travel times were used to determine the closest Emergency Care Centre and it was assumed that patients currently being treated at the planned care site, would be treated at the nearest Emergency Care Centre in the future. These patients are also assumed to have their inpatient care (if required) at the same provider.

The tables below show that the impact of reconfiguration at CHFT will result in activity shifts to neighbouring providers, leading to an increased total bed requirement across neighbouring trusts of 10 beds, irrespective of which site option is selected.

#### Option 1: HRI is unplanned, CRH is planned

Final Location	Attendances
Fairfield General Hospital	6
Leeds General Infirmary	78
Manchester Royal Infirmary	8
North Manchester	2
Pinderfields General Hospital	81
Pontefract General Infirmary	15
Royal Blackburn Hospital	244
St James's University Hospital	8
The Royal Oldham Hospital	1129
Trafford General Hospital	19
<b>Total</b>	<b>1589</b>

**Table 7: Increase in attendance rates at neighbouring trusts as a result of activity drift**

Trafford General Hospital; Bradford Royal Infirmary; Pontefract General Infirmary; Pinderfields General Hospital; St James's University Hospital; Manchester Royal Infirmary; North Manchester; The Royal Oldham Hospital

Final Location	Beds
The Royal Oldham Hospital	8
Royal Blackburn Hospital	1
Pinderfields General Hospital	0
Leeds General Infirmary	0
Manchester Royal Infirmary	0
Fairfield General Hospital	0
St James's University Hospital	0
Pontefract General Infirmary	0
Trafford General Hospital	0
North Manchester	0
<b>Total</b>	<b>10</b>

**Table 8: Bed requirements at neighbouring trusts as a result of activity drift**

**Option 2: CRH is unplanned, HRI is planned**

Final Location	Attendances
Fairfield General Hospital	8
Leeds General Infirmary	82
Manchester Royal Infirmary	8
North Manchester	8
Pinderfields General Hospital	1082
Pontefract General Infirmary	27
Royal Blackburn Hospital	19
St James's University Hospital	29
The Royal Oldham Hospital	330
Trafford General Hospital	47
<b>Total</b>	<b>1640</b>

**Table 9: Increase in attendance rates at neighbouring trusts as a result of activity drift**

Final Location	Beds
Pinderfields General Hospital	7
The Royal Oldham Hospital	2
Leeds General Infirmary	0
Trafford General Hospital	0
Pontefract General Infirmary	0
Royal Blackburn Hospital	0
St James's University Hospital	0
Fairfield General Hospital	0
<b>Total</b>	<b>10</b>

**Table 10: Bed requirements at neighbouring trusts as a result of activity drift**

A mapping of the sources of this activity drift, together with choice of alternative provider (based on travel time) is shown below:

The map chart displays the locations of patients that are currently arriving by ambulance at the cold site and is colour coded (see the legend on the chart) by the location of where they will be diverted to in the future. Due to the close proximity of Calderdale Royal Hospital and Huddersfield Royal Infirmary the majority of patients will remain within the Trust.

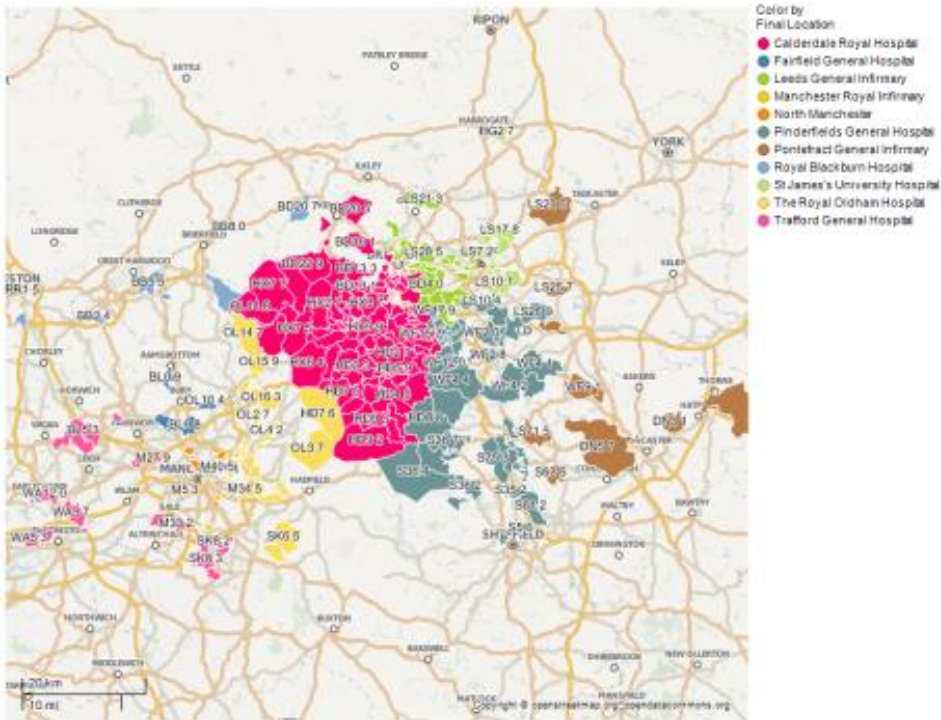


Figure 9: Mapping of forecast change in attendances if CRH is the unplanned care site

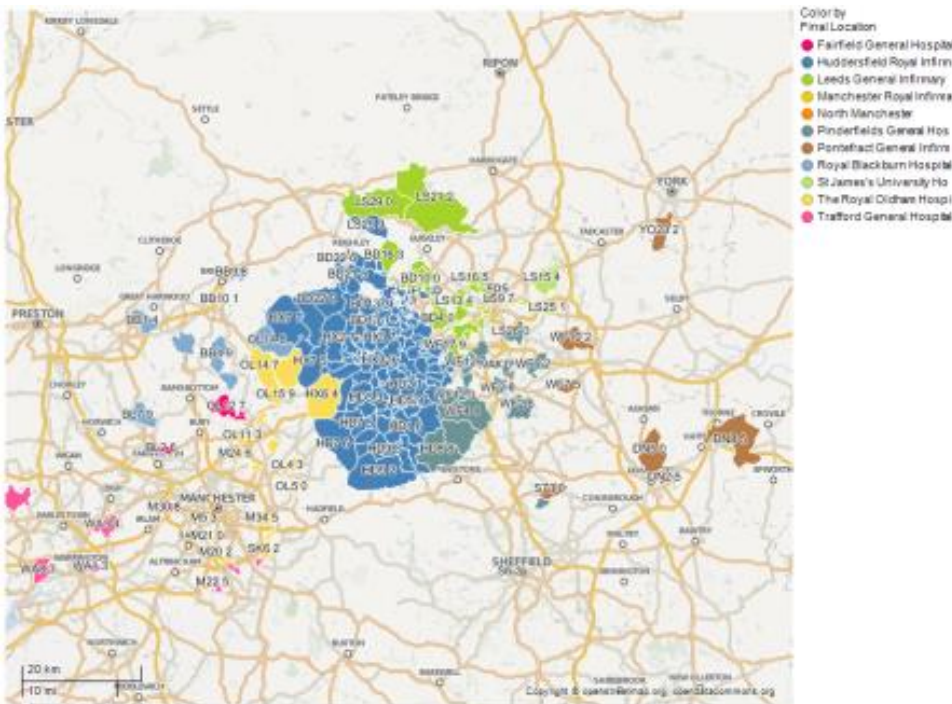


Figure 10: Mapping of forecast change in attendances if HRI is the unplanned care site.

## 7.2 Financial Analysis

### 7.2.1 Summary of options

In terms of how the options have been incorporated into the financial assessment, the following descriptions are relevant:

- Do Nothing – Do Nothing refers to the rolling forward of the 2016/17 Plan position. In each year, the Trust is assumed to meet its efficiency requirement via CIP. This is an average of £9.1m per annum between 2016/17 and 2021/22. In addition to achieving CIPs, the Trust delivers additional savings from the Strategic Initiatives;
- HRI as the site for delivering unplanned care – this option assumes services are reconfigured so that unplanned care is delivered from Huddersfield Royal Infirmary. Planned care is thus delivered from Calderdale Royal Hospital. This reconfiguration generates savings that are in addition to CIP and savings from the Strategic Initiatives;
- CRH as the site for delivering unplanned care – this is as above, but with unplanned care being delivered from CRH and planned care from HRI. This generates its own set of reconfiguration savings.

The table below summarises the I&E position in 2021/22 and the cumulative cash position and funding requirement for the years 2016/17-2021/22. The surplus/(deficit) position is a recurrent position for the Trust and includes the full impact of all savings identified under each option.

£000 (Nominal)	Do nothing	HRI as site for unplanned care	CRH as site for unplanned care
<b>EBITDA</b>	12,700	27,300	30,500
<b>Surplus/(deficit)</b>	-28,700	-22,800	-10,700
<b>Strategic savings</b>	7,400	7,400	7,400
<b>Reconfiguration savings</b>		14,600	17,800
<b>Made up of:</b>			
- <i>Net cost savings</i>		14,800	18,000
- <i>Loss of contribution as a result of activity displacement</i>		-200	-200
<b>Cumulative I&amp;E position</b>	-204,000	-237,300	-292,300
<b>Cumulative cash position - I&amp;E driven</b>	-199,700	-211,800	-190,100
<b>I&amp;E driven cash funding requirement</b>	199,700	211,800	190,100
<b>Capital funding requirement</b>	92,400	308,900	300,300
<b>Total funding requirement</b>	292,100	520,700	490,400

The cumulative deficit shown under the reconfigured site options is inclusive of non-trading related capital charges such as increased depreciation and losses on asset disposals. The trading position as accounted at EBITDA is mirrored by the cash position.

The lowest cash deficit arises from CRH being the site delivering unplanned care due to its lower capital requirement than for HRI. This is coupled with the more favourable I&E position generating more cash for the Trust.

The least favourable option is the Do Nothing option – this option assumes CIP savings the Trust generates are sufficient to meet its efficiency requirement. Operationally, clinically, this option is not considered viable.

All of the options leave the Trust with a Continuity of Services Risk Rating (CoSRR) of 1 due to its debt profile and cash shortage.

### 7.2.2 Conclusion to the financial analysis

The preferred financial option is that unplanned services be delivered from the CRH site, with HRI delivering planned care. This is the option that results in the most favourable I and E position by FY22, as well as the most favourable cash position.

### 7.2.3 External Funding Support

The preferred option is dependent upon securing external funding support of £490.4m.

### 7.2.4 Economic Assumptions

The Trust has also made a number of economic assumptions governing cost inflation and tariff deflation.

These are presented below.

CRH unplanned site	2016/17 £'000	2017/18 £'000	2018/19 £'000	2019/20 £'000	2020/21 £'000	2021/22 £'000
Income	1.10%	-1.00%	-0.60%	-0.60%	-0.60%	-0.60%
Pay	1.00%	1.00%	1.00%	1.00%	2.00%	2.00%
Incremental drift	1.00%	0.75%	0.00%	0.00%	0.00%	0.00%
Drugs	2.00%	1.00%	1.00%	1.00%	1.00%	1.00%
Clinical Supplies & Other non-pay	2.00%	3.00%	3.00%	3.00%	3.00%	3.00%

These assumptions do not impact the financial option appraisal since changes to such assumptions will impact all options equally.

It should be noted that the financial modelling has been updated from the figures in the five year strategic plan approved by CHFT Trust Board at its meeting on 29<sup>th</sup> December 2015 and submitted to Monitor and Treasury. The detail of the changes are :-

Update of tariff in line with national planning guidance issued in January 2016 – change in the income assumption from -1.8% to +1.1% in 2016/17

Recognition of £3m additional costs in respect of CNST contributions notified to CHFT from the NHSLA following completion of the five year plan. Future year contributions potential increases have been assumed at zero change.

Inclusion of £5m non recurrent variability in the delivery of CHFTs ability to deliver contracted activity levels due to the implementation of EPR in 2016/17.



## 7.2.5 Key assumptions and findings relating to the preferred options

These include:

**Growth** - 1-2% annual activity growth. Non-elective growth has been assumed at c. 1%. Any variation from this will need to be managed at a health economy level through additional Commissioner QIPP.

**Delivery of CIP targets** that offset the annual efficiency requirement, equivalent to £54.4m between 2016/17 and 2021/22.

**Additional savings over and above CIP** - Successful delivery of £17.8m in recurrent annual savings from the reconfiguration, with a further £7.4m independent of the reconfiguration (in nominal terms).

**Local health economy requirement** - Successful delivery of a 6% annual reduction in Non Elective Medical Admissions over each of the 5 years – a significant target. This has been assumed to be offset by an equal level of cost reduction within the Trust and equates to a real term reduction of c.£2.5m per annum.

**Securing external funding support** of £490.4m made up of:

- loan funding to support the capital requirement.
- non-recurrent reconfiguration revenue costs funding.
- non-recurrent deficit support funding.

Subject to securing the external funding support as above, the Trust's income and expenditure and cash position are forecast to be sufficient to support the Trust's interest and repayment obligations.

## 7.3 Workforce Analysis

Workforce is one of the key factors driving the need for change, particularly in relation to challenges faced by a number of the clinical services currently provided by the Trust. This section sets out a short summary of the workforce benefits arising from the clinical reconfiguration, followed by the specific challenges and benefits detailed by clinical service area.

### 7.3.1 Workforce benefits

- **Royal College of Emergency Medicine's recommendations / standards:** the standards for Children and Young People in Emergency Care settings, Critical Care workforce standards and Emergency Department consultant cover recommendations will be satisfied through the consolidation of the unplanned service workforce on to one site.
- **Clinical rota resilience:** rota frequency will reduce immediately with the consolidation of unplanned services and workforce on to one site, thereby reducing the workload strain on staff and improving the resilience of services. Relevant services include ED, Acute Medicine, Critical Care, Paediatrics and Radiology.
- **Sub-specialisation of clinical services:** the critical mass achieved through consolidating of unplanned patients and workforce onto one site will allow greater

opportunities for sub-specialisation of the workforce, improving the attractiveness of employment at the Trust and enhanced clinical services for patients. Relevant services include Paediatrics and Trauma sub-specialisation in ED, and Acute Medicine.

- **Skill mix / role improvements:** the Advanced Practitioner role will be further refined and deployed in the Trust to reduce the burden on the ED middle grade doctor workforce. There would be an opportunity for Radiography staff to be trained to work across a number of areas such as plain X-Ray and acute head scanning, which would provide broader development opportunities.
- **Improving junior doctor training, oversight and supervision:** junior doctor training and supervision is anticipated to improve for all clinical services being consolidated on to one site given the increased throughput of activity and the increased non-locum consultant presence on site.
- **Recruitment, retention and locum reliance:** it is anticipated that improvements in the key areas already described, such as rotas and extended roles, will improve the attractiveness of the Trust to future and existing staff and thereby increase recruitment opportunities and reduce staff turnover. In turn this will reduce the Trust's considerable reliance on locum and agency staff.
- **Long term sickness absence:** the factors above allow for more effective service planning, thereby reducing stress for staff and mitigating the Trust's long term sickness absence challenge.

### 7.3.2 Workforce Challenges and benefits

This section details the specific workforce challenges facing the relevant clinical services, and the benefits arising from the clinical reconfiguration.

#### Medicine – ED services Challenges

- ED faces considerable recruitment challenges at both consultant and middle grade doctor levels. At present there is a shortfall of six ED consultants compared with an establishment of 15, and a shortfall of six middle grade doctors compared with an establishment of 10. The College of Emergency Medicine recommends a minimum of 10 consultants in Emergency Medicine per emergency department, whilst just nine are covering both the Calderdale and Huddersfield ED departments.
- Recruitment difficulties reflect both national shortages of emergency doctors (nearly one fifth of consultant posts in ED departments are either vacant or filled by locums) and local factors, such as the lack of ED sub specialisation (e.g. paediatrics and trauma) and the intense frequency of rotas (1 in 5) which are both unattractive propositions for the workforce.
- Both these local factors are driven primarily by the two site ED clinical model. This scenario has led to a considerable reliance on locum cover, particularly overnight during week days and during the weekends.
- Based on current consultant capacity, the Trust is unable to meet the 14 hours a day consultant on site requirement as per the Royal College of Emergency Medicine, with consultant cover 8am - 5pm Monday - Friday with six vacancies.

### **Medicine – ED services benefits**

- Under the proposed clinical model, the emergency department will be consolidated onto a single site. The clinical workforce would no longer be stretched across two departments and the College of Emergency Medicine recommendation of a minimum of 10 consultants in Emergency Medicine would be satisfied. Recruitment and retention are anticipated to improve with the considerable reduction in frequency of rotas.
- Under the proposed service model, the Trust will be able to meet the 14 hours a day consultant on site requirement as per the Royal College of Emergency Medicine, with consultant cover improving from 8am - 5pm Monday - Friday to 8am - 12pm Monday - Friday, and 9am - 5pm Saturdays and Sundays.
- The consolidation of patients and workforce onto one site is anticipated to improve training and supervision for junior staff (with increased on site consultant presence), optimise the use of middle-grade staff and increase the opportunity for subspecialisation noted as highly attractive to the workforce. Further to this, it is anticipated to and considerably reduce the Trust's reliance on locum staff, enabling both improved service planning as well as delivering a more cost effective service.
- It is anticipated that under the proposed clinical model, the Advanced Nurse Practitioner role will be further refined and deployed to reduce the burden on the stretched middle grade doctor workforce. In addition to promoting an attractive role for nurses, this is anticipated to reduce the reliance and workload burden on middle grade doctors and thereby improve recruitment and retention, as well as further reducing the Trust's reliance on locum workforce.

The reconfiguration on to one site also provides an opportunity to reduce the amount of administrative support time required (currently 18 WTE in budget, including 8 receptionists per site), which could yield some efficiency savings in the number of admin staff required.

### **Medicine – Acute Medical Directorate Challenges**

- Acute Medical services face similar challenges to ED services both in the recruitment and retention of workforce, with the retention of consultants particularly relevant in recent times.
- Rota frequency is particularly intense, with a 1 in 11 week day rota (neighbouring Trusts' have a 1 in 15 week day rota) and a 1 in 5 weekend rota. Subspecialisation of the rota is limited to Stroke, Cardiology, Haematology and Oncology, whereas a greater critical mass of patients and staff would enable further specialisation into specialties such as Respiratory, Gastroenterology and Geriatrics. These factors contribute considerable to the recruitment and retention challenges, and are primarily features of managing unplanned services across two sites.

Other specific workforce challenges include:

- 50% or greater vacancies in consultant posts in Gastroenterology (2.5 WTEs in post compared with an establishment of 6), Geriatrics and in Dermatology, resulting in heavy reliance on locum and agency staff to deliver the service.

- Haematology operates an intense 1 in 4 rota during weekdays and over the weekend causing considerable strain on workforce and challenging the resilience and sustainability of service provision.
- Two of five Respiratory consultants are due to leave the Trust in December 2015 which will lead to considerable reliance on locum cover to provide services over the two sites.
- With regards to senior decision making such as patient referrals and discharges, the Trust is reliant on one Medical Registrar per site to cover the out of hours service between 8pm and 8am. On occasions where the registrar is called to ED or one of the wards, there are no further senior decisions makers on site to cover. This represents a challenging workload for Registrars and represents a risk to the future pipeline of consultants as registrars progress their careers.

#### **Medicine – Acute Medical Directorate benefits**

- Under the proposed clinical model, all acute medical services will need to be located on the unplanned care site with the single ED for clinical adjacency purposes. Operating rotas over one site instead of two will reduce rota frequency for the medical workforce and thereby improve the Trust's ability to recruit and retain staff key to resilient service delivery, reducing reliance on locum staff.
- Additionally, this consolidation on to one site is anticipated to improve training, supervision and oversight of junior doctors, increase the scope for subspecialisation of rotas supporting recruitment and retention, and to deploy staff more productively across a pooled activity base.

#### **Surgery & anaesthetics – Operating Services, Theatres, Anaesthetics, Critical Care and Pain Challenges**

- Critical care units are operated both at HRI and at CRH. Under this configuration of services, the Trust is unable to fully comply with D16 guidance on Critical Care workforce standards.
- The service faces considerable recruitment and retention challenges especially with regards to ICU nursing. This has been attributed to the high frequency of overnight work required by ICU nurses at CHFT, and also to the situation whereby the ICU nurses are often redirected away from their ICU role to cover gaps in nursing workforce elsewhere in the Trust at short notice (since the ICU is relatively nurse rich, with 1:1 or 1:2 staffing ratios. These factors are often unattractive to nurses.
- Nurses are brought into the Trust through a general nursing recruitment programme and are subsequently posted to ICU, as compared with having a specific ICU nurse recruitment programme. This often results in a nurse working in ICU when they had intended to work as an outpatient nurse – compounded with the night work factors above this contributes to the retention challenges.

#### **Surgery & anaesthetics – Operating Services, Theatres, Anaesthetics, Critical Care and Pain benefits**

- Under the proposed clinical model, Level 2 and Level 3 ITU / Critical Care will be located on the unplanned care site (currently the Trust does not separate ITU and

HDU, with beds being upgraded or downgraded as necessary). Patients requiring critical care will be transferred from the planned care site or identified in advance at the pre-assessment stage and Pain Services will be centralised at the planned care site.

- This consolidation of activity would better enable the Trust to comply with D16 guidance on critical care workforce standards, improve training, supervision and oversight of junior doctors and improve resilience of the staff rota and thereby improve recruitment and retention.

#### **Surgery & anaesthetics – Ophthalmology and ENT**

- Ophthalmology and ENT are currently provided at both HRI and CRH. Whilst these services do not face the same scale of challenges as other services highlighted above, the consolidation of these services on to one site is anticipated to improve training, supervision and oversight of junior doctors.

#### **Children's services / Paediatrics Challenges**

- The Paediatrics service is currently split between the both the HRI and CRH sites, with paediatric medicine provided at CRH and most of paediatric surgery at HRI. This has resulted in sub-optimal paediatric senior medical doctor oversight at HRI. Currently the EDs of CHFT are non-compliant with a number of the standards for Children and Young people in Emergency Care settings.
- The service currently has a shortfall of 3.5 WTEs, with 7.5 Tier 2 doctors in place compared with an establishment of 11, the service deemed to require 10 WTEs to operate effectively. 11 speciality paediatric doctors are needed to cover existing rotas. The Trust has however developed the Advanced Paediatric Nurse Practitioner (APNP) role (Band 8A), and a similar role in NICU, the Advanced Neonatal Nurse Practitioner (Band 7), both of which can contribute to the medical or nursing workforce rotas. Whilst further work is ongoing in refining these roles, these mitigate pressure associated with the workforce shortage.
- Paediatric recruiting challenges reflect both national and local shortages, and across the region there is a significant shortage in the number of paediatric specialist doctors in training starting in 2015.

#### **Children's services / Paediatrics Benefits**

- Under the proposed clinical model, specialist paediatric services will be co-located with the Emergency Care Centre. This will cover neonates, all paediatric surgery and paediatric medical care, with Neonates co-located with consultant led Maternity care.
- Concentration of all emergency, acute medical and surgical paediatric services would enable optimal use of the medical workforce, crucial in the context of workforce shortfalls, and enable consultant oversight of across these services. It is anticipated that this will be a more attractive proposition to potential recruits, with a greater level of service stability, more sustainable rotas, and the potential for sub-specialisation.

- Additionally, co-location of Paediatrics and Paediatrics EM will allow for Paediatric emergency medicine (PEM) trained staff to work alongside and support acute Paediatrics which also has significant workforce issues, especially in medical staffing.

#### **Radiology Challenges**

- At present there is a shortfall of four Radiology consultants against the establishment of 17, reflecting the national workforce shortage.
- Sub specialty workforce challenges include the following:
- Breast Radiology has one consultant in post against the requirement of two to run a resilient service. Currently the Trust relies on external agreements and makes seasonal use of locums to strengthen the service.
- Interventional Radiology has a shortfall of one consultant against the establishment of four.
- Upper GI Radiology has no consultants in post against the establishment of one, the consultant having left recently and the Trust struggling to attract any interest in the post having advertised it.

#### **Radiology Benefits**

- Under the proposed clinical model, it is anticipated that the majority of radiologists will work from the unplanned care site and report on the planned care site remotely. This would enable the merging of the current two site-based rotas into one, improving the resilience of the service and the attractiveness of the post to potential new recruits. Additionally, there may be no need for an on-call CT radiographer service on the planned care site, which would alleviate some of the pressure of competition from private providers for this workforce group.
- This service model would give rise to the opportunity for staff to be trained to work across a number of areas such as plain X-Ray and acute head scanning, which would provide broader development opportunities for staff and thereby improve recruitment and retention.

### **7.3.3 Workforce Initiatives**

In addition to the reconfiguration changes described above, significant changes to workforce have been identified within CHFT's five year strategic plan. A significant driver for the changes is planned QIPP and a move to out of hospital care, and no assumption has been made as to whether the Trust will be the provider of choice for community services going forward.

Over the life of the five year strategic plan, the Trust is planning to redesign the workforce, supported by the workforce initiatives below. This will improve the quality and resilience of clinical services, improve opportunities for the workforce, and to respond to the financial challenges facing the Trust.

- **Workforce skill mix changes:** an example includes exploring the benefits and opportunities for improvements in quality of care through the use of Physician Associates and Advanced Practitioners, and multi-skilling of staff.

- **Shared provision of pathology service:** exploring opportunities to increase collaboration across the local pathology network to improve effective deployment of resources across the local area.
- **Primary care collaboration and integration:** enhancing generalist and collaborative skills for the Trust's workforce across primary and secondary care to support delivery of Commissioner QIPP requirements, and effective, efficient delivery of care closer to home for patients.
- **Service delivery methods:** exploring new methods of delivering patient services, for example the potential using group clinics for appropriate services where this is anticipated to improve the effectiveness of resource deployment whilst maintaining or improving service quality.
- **Sickness absence:** employing initiatives to better manage long and short term sickness absence across the Trust.
- **Use of technology:** employment of IT solutions to improve patient care and better enable self-management of care for patients, whilst reducing clinics and travel time for the Trust's workforce, for example Telehealth and virtual clinics. Telehealth for patients with long-term conditions, for example, could improve regularity of monitoring conditions allowing prompt detection of any deterioration and thus a swifter response by clinicians. Another example is the use of Telehealth to link services between different care settings, or to bringing specialist care closer to the community.
- **Pennine GP Alliance:** exploring new initiatives for the delivery of community services in collaboration with Pennine GP Alliance.
- **West Yorkshire's Association of Acute Trusts:** exploring pooling / sharing Radiology on call with West Yorkshire's Association of Acute Trusts to improve service delivery resilience, provide more efficient deployment of limited resources and mitigate recruitment challenges in the face of national shortages of Radiologists.

#### 7.3.4 Impact of Workforce Initiatives

Workforce numbers are due to reduce by 755, from 5,570 in 2016/17 to 4,815 at the end of 2021/22. This equates to an average annual reduction of in headcount of 3.0 and reflects a shift of activity from an acute setting to a community setting – no assumption has been made as to whether the Trust will be the provider of choice for community services going forwards

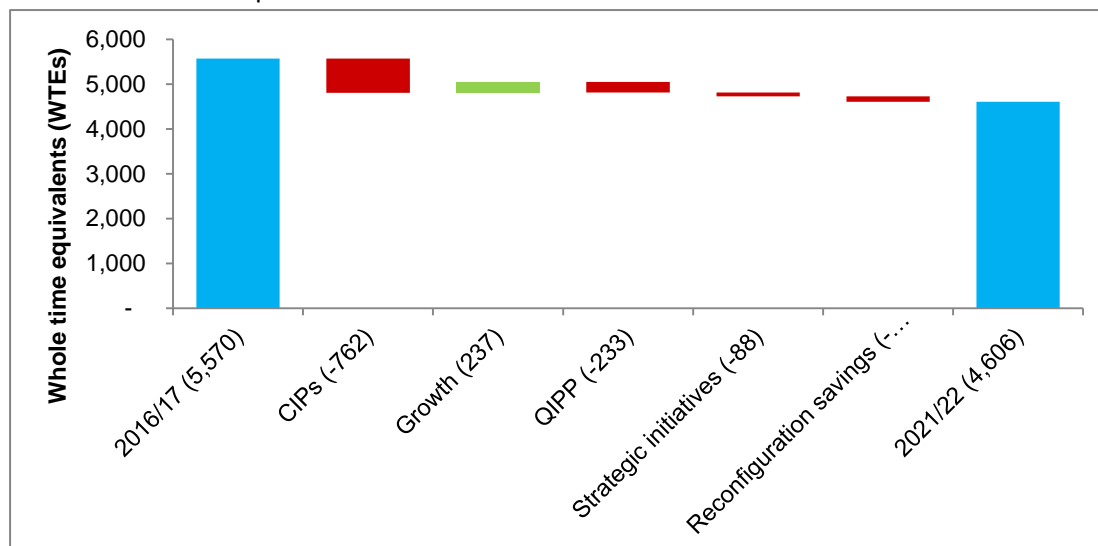
The proposed strategic initiatives together with delivery of the annual CIP and the clinical reconfiguration account for the vast majority of the reduction in workforce.

Of the 964 reduction in WTEs (from 5,570 to 4,606) over the five year period:

- a 567 (74%) WTE reduction relates to a reduction to delivering the annual efficiency requirement
- a 234 (26%) WTE reduction relates to delivering strategic initiatives and clinical reconfiguration savings
- activity growth and Commissioner QIPP roughly match one another in WTE terms

Reconfiguration cost WTEs (e.g. double running) of 35 are non recurrent, as such do not contribute to the overall movement in WTEs between 2016/17 and 2021/22.

The table below highlights the main factors contributing towards the overall movement in headcount over this period.



No redundancy costs have been included in reconfiguration costs in the financial case, despite the projected reduction in WTEs arising from the reconfiguration. Instead it is assumed that business as usual turnover of staff, currently at 15.4%, will be sufficient to achieve the necessary reduction in WTEs without the need for redundancies.

#### 7.4 Technology Analysis

One of the key strategic initiatives for CHFT is the implementation of EPR. Within the EPR business case are the specific benefits outlined below:

High Level Benefit	Details of Associated Benefits
Improves patient care and safety	<ul style="list-style-type: none"> <li>Systems and information will be accessible for out of hospital care</li> <li>Enables real-time clinical decision support</li> </ul>
Improves working with other care providers	<ul style="list-style-type: none"> <li>Allows community pharmacists to view a patient's TTO prescription and proactively make updates</li> <li>Provides treatment pathways which include care to be provided in the community</li> <li>Facilitates electronic communication with GPs and improves quality and timeliness of clinical correspondence, including discharge information</li> <li>Delivers quicker patient discharge through co-ordination with transport services, community staff and social services.</li> </ul>
Improves patient communications	<ul style="list-style-type: none"> <li>Improves information and education about condition and treatments to patients electronically</li> <li>Improves the configurability of patient letters to include information about timescales etc.</li> </ul>



High Level Benefit	Details of Associated Benefits
	<ul style="list-style-type: none"> <li>• Offers patients access to a Patient Portal of their own health record, which they will be able to share with other health professionals involved in their care</li> </ul>
Improves working practices	<ul style="list-style-type: none"> <li>• Improves data quality to support coding and costing (e.g. less duplication, more clinical involvement in data capture)</li> <li>• Improves patient tracking to enable real-time bed management, improving bed utilisation</li> <li>• Facilitates timely discharge leading to a reduction in length of stay</li> <li>• Allows the Trust to actively manage breach dates including RTT, cancer wait times and 28 day rule</li> <li>• Improves communication within the hospital and across organisational boundaries</li> </ul>
Improves management reporting	<ul style="list-style-type: none"> <li>• Better management information allows the Trust to monitor and identify areas for improvement in quality and outcomes</li> <li>• Releases Information Department staff time by enabling managers to undertake simple queries for themselves</li> <li>• Data capture and reporting capabilities better support national CQUIN payments</li> </ul>
Improves efficiency	<ul style="list-style-type: none"> <li>• Optimises Trust wide scheduling to reduce waiting times for appointments and admissions</li> <li>• Improves bed scheduling increasing bed utilisation and patient throughput</li> <li>• Optimised production and streamlining of clinical correspondence</li> <li>• Provides more efficient records management/electronic filing of results</li> </ul>
Improves patient convenience	<ul style="list-style-type: none"> <li>• Improves patient convenience by providing support for scheduling and running 'one stop shop' clinics</li> </ul>

## **8.0 OPTIONS APPRAISAL**

### **8.1 Overview of the appraisal process**

There are three parts to the options appraisal process: Establishing a short list of options; agreeing the appraisal criteria we will use; and applying the criteria to the short list to establish the preferred option. Earlier in this report we have outlined our approach to establishing a shortlist of options and agreeing our appraisal criteria. This section of the report, describes how we have applied our criteria in relation to the information provided in this report in order to establish the preferred option.

### **8.2 Quality of Care**

In order to understand the implications for Quality of Care, we have completed a Quality Impact Assessment and we have submitted our proposals to the Yorkshire and Humber Clinical Senate. Our findings in relation to Quality Care are that the proposed model of care will:

- Support CHFT in meeting the agreed clinical standards
- Support redesigned care pathways to enhance quality and provide a better experience for patients
- Improve CHFT's ability to provide emergency and other clinical leadership and provide a better experience for staff
- Support reductions in avoidable admissions by enabling supportive self-management and enhancing care closer to home.

### **8.3 Access to Care**

In order to understand the implications for Access to Care, we have completed a travel analysis and an Equality Impact Assessment. Our findings in relation to Access to Care are that:

- The proposed model of care will improve patient ability to access the right care in the right setting
- There are no protected groups who are likely to be impacted disproportionately by the proposed changes
- There is no material difference in average travel time impact between the two unplanned care site options
- An increase in car parking has been included in the capital estimates
- Co-location is expected to improve levels of safety and efficiency and allow staff to spend more time on patient care which will minimise delays in care pathways, once in receipt of care.

### **8.4 Value for money and Closing the Gap**

We have undertaken a joint comparison of financial assumptions which has considered: income and activity adjustments over a five year period, including CCG QIPP and commissioning intentions. We have used this information to construct the position over the next five years.

### 8.4.1 Providers Response

Although the clinical model is the same under both options, it is the site specific differences that result in the differing deficits and cash support.

Using the assumptions highlighted in this report, the improved recurrent financial position (£10.7m deficit compared to £28.7m deficit under Do Nothing by 2021/22), as well as the most favourable cash deficit position results in the option of CRH as the unplanned site being the preferred option from a financial perspective.

CRH unplanned site	2015/16 £'000	2016/17 £'000	2017/18 £'000	2018/19 £'000	2019/20 £'000	2020/21 £'000	2021/22 £'000
I&E Surplus/(Deficit)	-21,100	-45,000	-35,800	-31,100	-67,600	-81,000	-10,700
Cumulative cash position - I&E driven	-11,000	-54,700	-84,700	-108,500	-141,900	-168,500	-190,100
Cash support assumed via loan funding	11,000	54,700	84,700	108,500	141,900	168,500	190,100
<b>Cash Surplus / (Shortfall)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>

**\*\*In addition to the above cash support a further £300m is required for capital investment to support the preferred option**

### 8.4.2 The CCGs' Response

Aware of the existing and growing pressures discussed in the previous section, CCGs have, since their inception, worked on developing and delivering robust QIPP plans and transformational initiatives that deliver cost savings while increasing efficiencies in the delivery and commissioning of healthcare services.

QIPP (Quality, Innovation, Productivity and Prevention) initiatives were introduced by the Department of Health in 2010 and are a means of improving the quality and efficiency of healthcare services and the commissioning of those services resulting in reduced costs.

Additionally CCG's are also expected to deliver savings by tackling unwarranted variation in demand through implementing the Right Care programme. Both Calderdale CCG and Greater Huddersfield CCG have signed up to be early implementers of the Right Care programme.

CCG QIPP Vision		2015/16 £'000	2016/17 £'000	2017/18 £'000	2018/19 £'000	2019/20 £'000	2020/21 £'000	2021/22 £'000	Total £'000	
Calderdale CCG	Hospital Based QIPP	Base Case	750	1,377	1,377	1,307	1,241	1,178	1,118	8,348
		Best Case	2,230	2,800	2,800	2,800	2,800	2,800	2,000	18,230
	Non-Hospital Based QIPP	Base Case	800	700	700	700	700	700	700	5,000
		Best Case	1,770	1,200	1,200	1,200	1,200	1,200	1,500	9,270
	Total QIPP	Base Case	1,550	2,077	2,077	2,007	1,941	1,878	1,818	13,348
		Best Case	4,000	4,000	4,000	4,000	4,000	3,500	27,500	
Greater Huddersfield CCG	Hospital Based QIPP	Base Case	750	1,377	1,377	1,307	1,241	1,178	1,118	8,348
		Best Case	2,005	2,800	2,800	2,800	2,800	2,800	2,000	18,005
	Non-Hospital Based QIPP	Base Case	1,750	1,500	1,500	1,000	1,000	1,000	700	8,450
		Best Case	2,495	5,000	1,600	1,200	1,200	1,200	1,500	14,195
	Total QIPP	Base Case	2,500	2,877	2,877	2,307	2,241	2,178	1,818	16,798
		Best Case	4,500	7,800	4,400	4,000	4,000	3,500	32,200	
Combined CCG	Hospital Based QIPP	Base Case	1,500	2,754	2,754	2,614	2,482	2,356	2,236	16,696
		Best Case	4,235	5,600	5,600	5,600	5,600	5,600	4,000	36,235
	Non-Hospital Based QIPP	Base Case	2,550	2,200	2,200	1,700	1,700	1,700	1,400	13,450
		Best Case	4,265	6,200	2,800	2,400	2,400	2,400	3,000	23,465
	Total QIPP	Base Case	4,050	4,954	4,954	4,314	4,182	4,056	3,636	30,146
		Best Case	8,500	11,800	8,400	8,000	8,000	8,000	7,000	59,700

### 8.4.3 Greater Huddersfield CCG's transformational plan (QIPP)

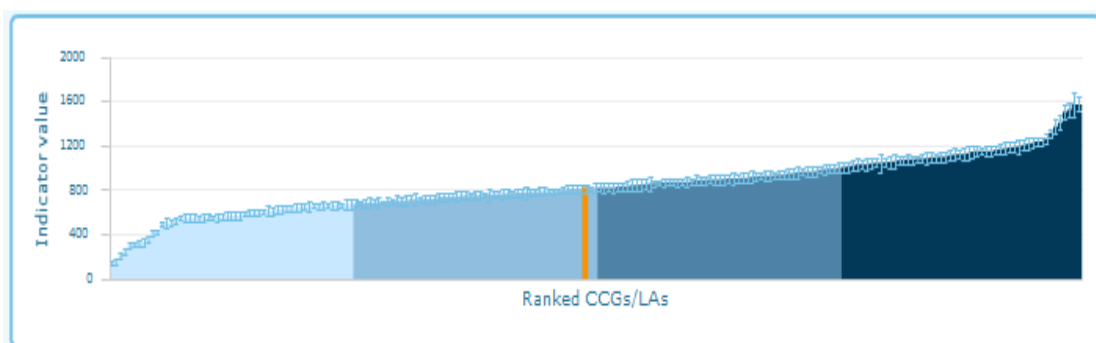
Greater Huddersfield CCG's transformational plans are based on delivery of the Care Closer to Home strategy as set out in section one of this document.

The basis for our QIPP is the benchmarked information for Greater Huddersfield CCG. The total cost of emergency admissions in 2014/15 was in excess of £37m, the total cost of avoidable emergency admissions was £8.1m.

There are 2 nationally defined indicators for adults that make up this overall indicator (ACS – Ambulatory Care Sensitive Conditions and CNRA – Conditions not Requiring Admission) – there is a clear national evidence base for reductions.

- Plan is £2m cash releasing per annum up to 2020/21
- It would take at least 4 years for this opportunity to materialise fully
- For ACS – HRGs are **Respiratory**: COPD, Asthma reductions and **CVD**: congestive heart failure, atrial fibrillation, Angina.
- For CNRA – HRGs are; conditions associated with ‘**frail elderly**’, Influenza/ pneumonia, UTI, Dehydration/ gastroenteritis and **Other** admissions in relation to ENT infections and cellulitis.

The chart below ranks the rate of emergency admission for chronic ambulatory care sensitive conditions for all CCG’s in England. Greater Huddersfield is ranked in the upper 2<sup>nd</sup> quartile nationally and is higher than the national average for England.



In addition to targeting the avoidable admissions indicator, the CCG is aiming to achieve a further saving of £0.8m per annum through the Right Care programme. This along with the avoidable admissions QIPP plan give a hospital based QIPP target of £2.8m per annum. The provider trust has used lower QIPP expectations of between £1.1m and £1.4m in its planning assumptions which are shown in the “base case” QIPP summary table below.

The CCG has non-hospital based QIPP plans to make savings in Continuing Healthcare, Prescribing, Community Services totalling £1.2m per annum. The CCG has a significant QIPP challenge for 2016/17 of £7.8m for which additional plans are still being developed.

CCG QIPP Vision		2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	Total	
		£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	
Greater Huddersfield CCG	Hospital Based QIPP	Base Case	750	1,377	1,377	1,307	1,241	1,178	1,118	8,348
		Best Case	2,005	2,800	2,800	2,800	2,800	2,800	2,000	18,005
	Non-Hospital Based QIPP	Base Case	1,750	1,500	1,500	1,000	1,000	1,000	700	8,450
		Best Case	2,495	5,000	1,600	1,200	1,200	1,200	1,500	14,195
	Total QIPP	Base Case	2,500	2,877	2,877	2,307	2,241	2,178	1,818	16,798
		Best Case	4,500	7,800	4,400	4,000	4,000	4,000	3,500	32,200

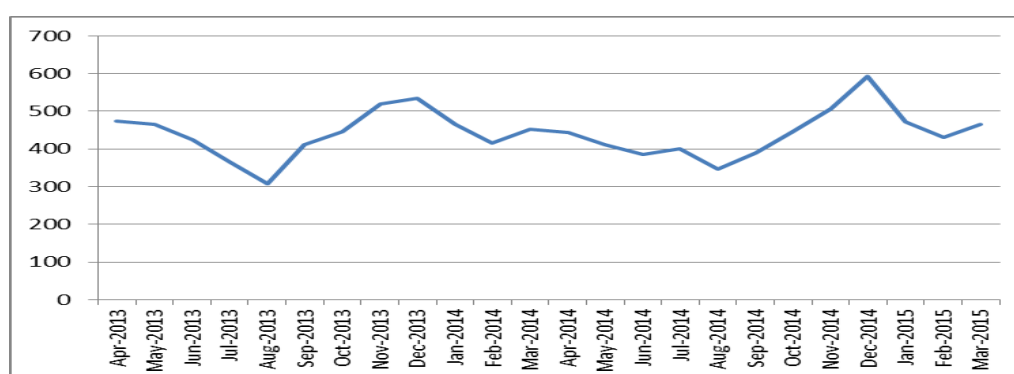
#### 8.4.4 Calderdale CCG's QIPP transformational plan (QIPP)

Calderdale CCG's transformational plans are based on delivery of the Care Closer to Home strategy as set out in section one of this document.

The basis for our QIPP is the benchmarked information for Calderdale CCG. The chart below ranks the rate of avoidable emergency admissions for all CCG's in England. Calderdale is ranked in the 4<sup>th</sup> quartile nationally and is higher than the national average.



The chart below illustrates the monthly variation in the volume of avoidable emergency admissions in Calderdale from 2013/14 to 2014/15.



The total cost of avoidable emergency admissions conditions in 2014/15 was **£8,800,000**. There are 2 subsets (ACS – Ambulatory Care Sensitive Conditions and CNRA – Conditions not Requiring Admission) – there is a clear national evidence base for reductions. We have a clear approach through Vanguard to a collaboration to deliver the change programme.

- Plan is £2m cash releasing per annum up to 2020/21
- It would take at least 4 years for this opportunity to materialise fully
- For ACS – HRGs are **Respiratory**: COPD, Asthma reductions and **CVD**: congestive heart failure, atrial fibrillation, Angina
- For CNRA – HRGs are; conditions associated with '**frail elderly**', Influenza/pneumonia, UTI, Dehydration/ gastroenteritis – with smaller numbers associated with **children & young people**.

In addition to targeting the avoidable admissions indicator, the CCG is aiming to achieve a further saving of £0.5m per annum through the CCGs Quest for Quality in Care Homes programme, and £0.3m from its End of Life Care programme. This along with the avoidable admissions QIPP plan give a hospital based QIPP target of £2.8m per annum. The provider trust has used lower QIPP expectations of £1.4m in its planning assumptions which are shown in the “base case” QIPP summary table below.

The CCG has non-hospital based QIPP plans to make savings in Continuing Healthcare, Prescribing, Community Services, and seamless home from hospital services, totalling £1.2m per annum.

CCG QIPP Vision			2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	Total
			£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Calderdale CCG	Hospital Based QIPP	Base Case	750	1,377	1,377	1,307	1,241	1,178	1,118	8,348
		Best Case	2,230	2,800	2,800	2,800	2,800	2,800	2,000	18,230
	Non-Hospital Based QIPP	Base Case	800	700	700	700	700	700	700	5,000
		Best Case	1,770	1,200	1,200	1,200	1,200	1,200	1,500	9,270
	Total QIPP	Base Case	1,550	2,077	2,077	2,007	1,941	1,878	1,818	13,348
		Best Case	4,000	4,000	4,000	4,000	4,000	4,000	3,500	27,500

#### 8.4.5 Systems Response to Closing the Gap

Calderdale & Greater Huddersfield Combined System Response	2021/22 Gap £'000	Residual Gap Base Case £'000	Residual Gap Best Case £'000
Clinical Commissioning Groups	-59,700	-30,146	0
Other Providers	-17,275	0	0
CHFT	-204,000	-10,700	-10,700
Total (£'000)	-280,975	-40,846	-10,700

The CCGs challenge is £59.7 and has QIPP plans which range between £30m as the base case and £59.7m in the best case. The CCGs will therefore have to meet their best case QIPP plans in order to close the financial gap.

The providers challenge will be reduced to a deficit of £10.7m in year 2021/22.

The Gap will therefore range between £10.7m and £40.7m. The system is committed to working together to achieve the transformational plans to close the financial gap.

#### 8.4.6 Value for Money

We have undertaken a joint comparison of financial assumptions which has considered: income and activity adjustments over a five year period, including CCG QIPP and commissioning intentions. We have used this information to construct the position over the next five years. Our findings in relation to Value for money are that the proposed model of care will for CHFT:

- Yield a positive movement in forecast income and expenditure relative to the base case.

- Forecast the most positive recurrent revenue and cash flow position.
- Improve the income and/or decrease the cost for individual service lines through facilitating the efficient delivery of Care Closer to Home.
- Allows access to a number of possible funding sources.

In addition to this the model supports delivery of CCG QIPP savings over the next 5 years.

### **8.5 Deliverability and Sustainability**

We have completed work to understand the impact of technology and undertaken activity and patient flow modelling (comprising: the expected activity by site; the expected beds, theatres and outpatient clinic requirements by site; and the workforce requirements by site) to identify the implications for estate and workforce. Our findings in relation to deliverability and sustainability are that the proposed model of care will:

- Require a plan to maintain services during transition and minimise avoidable harm.
- Have no material difference in one-off reconfiguration costs between the two unplanned care site options.
- Realise benefits within a five year time frame.
- Support improvements in staffing resilience and flexibility

### **8.6 Co-dependencies with other strategies.**

The proposals are part of the CCGs' long term plans and provide direct alignment with other work in the local health economy in relation to Care Closer to Home. We have also considered the Joint Strategic Needs Assessment (JSNA) and Joint Health and Wellbeing Strategy (JHWS) for both Kirklees and Calderdale and the implications of the changed forecast bed occupancy. Our findings in relation to Co-dependencies with other strategies are the proposed model of care will:

- Be directly aligned with the plans for the local Health Economy
- Support delivery of the JSNA and JHWS priorities
- Improve resilience through a reduction in forecast bed occupancy and improving recruitment and retention of workforce.

### **8.7 Options for Consultation**

From the work completed it is clear that the main difference between the five shortlisted options is finance. This is summarised in the table below and means that the Commissioners support the preferred option, as identified in CHFT's 5year Strategic Plan, that Calderdale Royal Hospital should be the unplanned hospital site and that Acre Mill should be the planned hospital site.

### Summary Evaluation

Criterion	Summary evaluation	Base case	CRH 'hot'	HRI 'hot'
Quality of Care	<p><b>The proposed model of care will:</b></p> <ul style="list-style-type: none"> <li>▶ <b>Support CHFT in meeting clinical standards</b>, irrespective of the choice of planned care site</li> <li>▶ Support redesigned care pathways to enhance quality</li> <li>▶ Improve the Trust's ability to provide emergency and other clinical cover</li> <li>▶ Support cuts in avoidable admissions</li> </ul>			
Access to Care	<ul style="list-style-type: none"> <li>▶ <b>Service reconfiguration will improve patient ability to access the right treatment in the right setting</b></li> <li>▶ There are no protected groups who are likely to be highly impacted by the proposed changes</li> <li>▶ There is no material difference in average travel time impact between the two unplanned site options</li> <li>▶ Car parking in accordance with benchmark norms has been included in the capital estimates</li> <li>▶ The proposed model of care is anticipated to improve patient productive time through co-location</li> </ul>			
Value for Money	<ul style="list-style-type: none"> <li>▶ <b>CRH as the unplanned site provides the most positive movement in forecast income and expenditure</b></li> <li>▶ CRH as the unplanned site provides the most positive I&amp;E and cash position from the investment (reflecting the return on capital invested)</li> <li>▶ CRH as the planned site delivers the greatest improvement to net margin</li> <li>▶ All options can increase income and / or decreases in cost for individual service lines</li> <li>▶ All options are forecast to need a mix of central and local funding sources</li> </ul>			
Deliverability & Sustainability	<ul style="list-style-type: none"> <li>▶ All options will require a plan to maintain high quality services</li> <li>▶ Both reconfiguration options are estimated to have the same one-off reconfiguration cost</li> <li>▶ All options will realise benefits of within a 5 year time horizon</li> <li>▶ <b>Delivery of the new model of care will support sustainability over the medium term</b></li> <li>▶ Both reconfiguration options will support improvements in staffing resilience and flexibility</li> </ul>			
Co-dependencies with other strategies	<ul style="list-style-type: none"> <li>▶ <b>Both reconfiguration options are directly aligned with local health economy plans</b></li> <li>▶ Both reconfiguration options will support delivery against priorities identified in the Joint Strategic Needs Assessment (JSNA) and Joint Health and Wellbeing Strategy (JHWS)</li> <li>▶ Both reconfiguration options will improve resilience through a reduction in forecast bed occupancy, and will improve recruitment and retention of workforce</li> </ul>			



APPENDICES

Appendix A	NCAT Report, 2013
Appendix B	Yorkshire and the Humber Clinical Senate report on Community Services
Appendix C	Yorkshire and the Humber Clinical Senate report on Hospital Services
Appendix D	Quality Impact Assessment
Appendix E	Equality Impact Assessment

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### Calderdale and Huddersfield NHS Foundation Trust

#### Accident and Emergency services.

Date of Visit: 14 June 2013

The NCAT panel:

Dr David Colin-Thomé NCAT panel chair.

Independent Healthcare consultant.

Former GP and former National Clinical Director  
for Primary Care, Department of Health.

Dr Carol Ewing Paediatric Consultant

Central Manchester University Hospitals NHS  
Foundation Trust

RCPCH Workforce Officer

Dr Berni Garrihy, Emergency Medicine Consultant

The Dudley Group of Hospitals NHS Trust

Regional representative College of Emergency  
Medicine

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King's College Hospital

Denmark Hill

London

SE5 9RS

Administrator – Judy Grimshaw

Tel: 020 3299 5172

Email: [Judy.grimshaw@nhs.net](mailto:Judy.grimshaw@nhs.net)

**Chair: Dr Chris Clough**

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### Introduction

The National Clinical Advisory Team was invited to visit Calderdale and Huddersfield NHS Foundation Trust (CHFT) to review their Accident and Emergency services.

See Appendix 1 for Papers received prior to the visit, and Appendix 2 for the agenda

Purpose of the Review defined by CFHT

- External expert consideration and rigorous analysis of the three options identified for the future provision of A&E services in Calderdale and Huddersfield. These options are:
  - Maintain 2 A&E departments
  - Maintain 2 A&E departments during the day, but only one at night
  - Have an acute centre on one site, and a Minor Injuries Unit on the other site.
- The development of a preferred option for future provision of A&E services.

- Identification of clear, identifiable reasons for the preferred option that can be easily understood and discussed.

#### Scope of the Review

The review is to identify a preferred option for the future delivery of A&E services.

The review should take into account:

- All of the options presented today will require very substantial investment either in additional staff and / or capital investment
- Maintaining two sites is extremely challenging. There are workforce constraints, which necessitate the permanent use of locums. Acute surgery, orthopaedics, urology and the trauma unit is already provided on a single site
- Developing a centre of excellence will require a significant capital investment and will require the trust to commit to financing capital borrowing estimated to be in the region of at least £5 million per year
- Providing reduced cover at either site also presents significant challenges over workforce, opening hours, clinical dependencies, handovers and public perceptions
- All of the options need to assess the impact they will have on other services and proposals for change e.g. Community based care and "acute primary care"
- All of the options need to assess the impact they have on clinical adjacencies.
- The local context and uncertainty over the Mid Yorkshire review means it is extremely important that any proposals need to be supported by robust evidence that demonstrates that proposed changes at Mid Yorks have been considered and factored in
- Given all of the current unknowns CHFT is presently unable to identify its preferred option for the future of A&E services

This analysis will include consideration of the impact on:

- Clinical standards

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- Use of the estate
- Dependencies with other services
- Staffing
- Fit with future funding
- The implications of the Mid Yorkshire consultation
- New models of care provision including how primary care and other services can help to reduce the workload of the A&E service

#### **Background**

##### The Trust

- Calderdale and Huddersfield NHS Trust operate 2 A&E departments, both in the region of 70,000 attendances pa.
- The Trust provides services to a population of 420,000.
- The departments are in the two district general hospitals, Huddersfield Royal Infirmary and Calderdale Royal Hospital (Halifax).
- The two hospitals are located respectively south and north of junction 24 of the M62.
- There is approximately 15 minutes drive time between the two hospitals.
- Huddersfield Royal Infirmary (HRI) is a trauma unit and all acute surgery and trauma surgery is undertaken there.

- Calderdale Royal Hospital (CRH) is the centre for paediatrics, maternity services including consultant delivered obstetric care and Gynaecology and also other specialities such as elective orthopaedics and stroke.
- Acute medicine is provided on both sites, Cardiology and Respiratory are both currently provided on both sites.

Wider economy

CHFT have been in a programme conducting a wider review of health and social care services in partnership with:

- Calderdale Council
- Calderdale CCG
- Kirklees Council
- Greater Huddersfield CCG
- Locala (the community provider for the whole of the Kirklees area, including Huddersfield).

CFHT is the integrated provider for secondary and community services for Calderdale. South West Yorkshire Partnership Foundation Trust is the local mental health service provider.

There is a similar review going on in the neighbouring area served by Mid Yorkshire NHS Trust. Mid Yorkshire Trust is currently out to public consultation to reorganise emergency care services. The impact of that could be a change in the provision of A&E facilities at Dewsbury which may result in an additional 20,000 attendances per annum to HRI.

Strategic Review

CHFT is part of a strategic review of services with partners.

CHFT instigated this review due to concerns regarding:

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- The forecast demographic change in the population – an aging population living with more years of ‘unwellness’ and increased dependency
- Difficulty maintaining existing service models due to national workforce shortages. For example the two A&Es require a middle grade rota of 12 doctors, in the last 5 years there has been only had a maximum of 7 doctors on the rota at any one time, gaps being filled by locums
- Meeting external standards, such as shared care of children by paediatrics and surgery, and separating children out audio and visually in A&E
- Sustainable financial model CHFT continues to be in a stable financial position but recognises the existing services models are not affordable in the face of increasing demand.

### **Summary of Presentations and discussions**

Executive welcome and briefing

Summary of presentation

- We cannot continue to run two A&E departments with the medical workforce we currently have
- We have increasing A&E attendances
- Mid Yorkshire Hospitals NHS Trust reconfiguration will increase our acute activity
- We have two sites- one in good condition/one poor
- We are running two medical services
- Paediatrics and maternity are based at CRH; surgery at HRI
- GPs/community/social care currently are busy but not reducing demand for secondary care

- There is no clinical information sharing
  - Discussion;
  - Local the community services provider for Kirklees has a good relationship with Social Services
  - Patient information can be shared between A&E and GPs who use System 1 Technology. Intra trust information sharing is patchy
  - Currently there are Walk-in Centres at Todmorden and Halifax and the respective General Practice Out of Hours services are situated on both HRI and CRH
- A&E and Surgery  
Summary of presentation  
Ambition
- Safe, High Quality services with minimum risk
  - Efficient, cost effective services
  - Ensure the services are sustainable
  - Ensure the integrity of the whole system
- The only way we can provide a safe, high quality, sustainable and efficient acute service
- Single Centre for Acute Care

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Medicine

Summary of presentation

Benefits of Single A&E with Adjacent Site Based Medical and Acute Oncology Services

- Economies of scale and job planning opportunities to deliver emergency medical services till 8pm at night.
- Economies of scale by merging speciality medical services and more opportunities for job planning reviews to increase productivity.
- Potential safety and quality improvement opportunities.
- Reduced risk of ambulance transfer breaches (impact on 4 hour performance).
- Potential for reducing frequency of weekend on call rotas for some teams or for providing more cover where required OOH.
- Potential to find financial savings with single site provision and reduce overall service running costs.
- Opportunities for streamlining ways of working re pathways improving quality and removing variation quality LOS HSMR etc.

Issues relating to split site medical services with single A&E

- Impact on division's ability to deliver all of the above.

In the ensuing discussion following a direct question both clinical and managerial leaders of this clinical division would recommend a single site for acute care

Hospital Standardised Mortality Ratio- CRH had 24 more pneumonia deaths than the model predicts; this is more than the calculated "excess" deaths for the Trust as a whole for this period, in the 56 diagnostic groups of HSMR. The HSMR difference between CRH and HRI is not just confined to pneumonia. On review there appears to be a failure of systems not of individual care GPs and commissioners, urgent care in primary care

Summary of presentation

Primary Care views

- Primary care models need to change
- Hard for GPs to get 'urgent' referrals into specialties, but easy to refer to A&E & assessment units (orthopaedics/back-pain, gynaecology).

- Senior decision makers needed at front door – not sustainable with current model.
- Too many handoffs (A&E-MAU-SS bed-LS bed) – only feedback to GP is from last destination
- Multiple assessments – but lack social and MH input (CRH)
- MAU – good care/pathway – but lack personalised care
- Social care only considered when planning discharge/not at point of admission (CRH)
- Need new models that provide different offers for majors and minors
- Primary care/LMCs regularly unaware of new changes to services and pathways

#### Commissioning intentions

- Best in class urgent and critical care
- Acute provision for Calderdale and Huddersfield
- Integrated paediatric care

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- Community-based urgent care services
- Integrated medical and surgical assessment
- Best in class care management
- Cost effective and efficient urgent care system

In the ensuing discussion following a direct question both CCG GP and managerial leaders would recommend a single site for acute care

Local the community provider for Kirklees and part of Huddersfield works well with the GPs of the area. They have been using a risk stratification methodology for three years for patients with long term conditions

#### Women and Children

##### Summary of presentation

- Previous Reconfiguration (2008)
  - Calderdale Royal Hospital (CRH)
- Centralisation of Consultant led Maternity Services
- Centralisation of Neonatal & Inpatient Paediatrics
- All Inpatient Gynaecology services
- Development of Birth Centre
- Day case and Outpatients
  - Huddersfield Royal Infirmary (HRI)
- Huddersfield Family Birth Centre
- Paediatric Assessment & Observation Unit (Acute Surgery Inpatients)

- Day case and Outpatients

##### Paediatric medical Future Challenges

- Approximately 33% attrition rate in Paediatrics e.g. 28 ST1s appointed in 2007 and only 19 remain at ST6 level
- Drastic reduction in Specialist Training in Paediatrics starting August 2014 (15 ST1)
- Regionally 41 ST1-3 (SHO level) compared to 136 currently
- 55 ST4-8 will be in post ~204 currently) - not equally distributed across region depending on training needs etc
- CHFT 11 ST4-8 are needed for middle grade cover – 75% reduction in middle grades. At best only 2-3 in post at CHFT.

Therefore:

Separate site or status quo model (General Paeds and Level 2 Neonates) will not be safe and/or sustainable

#### Conclusions

- Child centred care
- Medical workforce is the big issue that Paediatrics will face.
- Options-
  - 1. Status quo,
  - 2. One A&E at HRI (Adults and Paediatrics). Minor Injuries CRH. All Paediatric medicine and surgery at HRI.
  - 3. One A&E at HRI (Adults and Paediatrics). Minor Injuries CRH. All Inpatient Paediatrics to remain as now with strengthened services at HRI (Maternity services to remain at CRH).

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- 4. Adult A&E HRI. Paediatric A&E CRH. Adult Minor Injuries at CRH & HRI. All Paediatric medicine and surgery at CRH
- Options 1-3 are **unsafe** and **not sustainable**.
- Option 4 presents the most viable model with the option to close after 10pm.

In the ensuing discussion the divisional representatives stated that they were working under the assumption that obstetric care had to remain at CRH. Their preferred option was clearly and unanimously that obstetrics and neonatal care also should be on a one site acute hospital service

#### Mid Yorkshire Hospitals reconfiguration

A presentation of the proposed reconfiguration that has been out to public consultation

#### DATS (Diagnostics and Therapeutic Services)

A verbal presentation covering hospital imaging, pathology and pharmacy services. Pathology services were reconfigured across both sites one year ago. There has been early discussion about a wider pathology network with other trusts sited in a coherent geographical area which could lead to a wider 'hub and spoke' service.

Imaging has cross over staffing for both sites of Calderdale and Huddersfield NHS trust. Vascular interventions undertaken at HRI, stroke thrombolysis and only planned percutaneous coronary intervention (PCI) undertaken at CRH (emergency PCI go to the regional centre). There is an on call collaboration with Bradford hospital trust

For all DATS whatever future service reconfiguration plans are adopted both sites will need to be serviced. But they will need to only provide one emergency service rather than the current two site emergency service if a one site acute care option is chosen. **The latter is their preferred service option for a safe, high quality, high value and sustainable future for DATS.**

#### Yorkshire Ambulance Service (YAS)

A verbal presentation. **YAS also would prefer a single site for acute care for safety reasons** as there will be less acute care transfers between the two hospital sites. Furthermore many such journeys need a doctor on board as this is not a role for a paramedic.

Incidentally the YAS assessment is that the new 111 phone service is working well after initial problems. A successful 111 service would enhance a sustainable local whole health urgent and emergency system

#### Comments from Dr Berni Garrihy

- It is clear from an Emergency Medicine (EM) perspective that quality, safety and sustainability of service would be best served by reconfiguring EM services, both adult and Paediatric, onto one site, with provision of a Minor Injuries Unit on the other site. Reconfiguration of services to have all Emergency Department (ED) services provided on one site, with a Minor Injuries Unit on the other site would have the following

advantages:

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- Provision of all ED care on one site (with a Minor Injuries Unit on the other site) will allow EM consultant shop floor presence 16 hours a day, seven days a week, in line with College of Emergency Medicine guidance, as opposed to the current arrangement where there is no consultant shop floor presence beyond 10pm on weekdays and no consultant shop-floor presence at all at weekends. Recent studies have highlighted increased mortality in patients admitted to hospital out of hours, which is undoubtedly linked to lack of senior clinical input at these times. A reconfiguration which augments senior clinical presence in ED to recommended CEM levels is highly desirable, and the principal advantage of this reconfiguration model.
- Amalgamation of the two EDs will also have a positive impact on middlegrade staffing levels; staffing both EDs currently requires a high level of locum cover. As there is currently a national shortage of Higher Specialist Trainees in Emergency Medicine, and this situation is not expected to improve in the short or medium term, a reconfiguration which optimises use of middle- grade staff and minimises locum requirements is also desirable; this will enhance service delivery and will improve the training experience, due to increased consultant presence. Again, studies show that clinical incidents in ED increase when there is overreliance on locum staff; the EM team at CHFT have provided clear evidence of this by analysis of their own recent red risk clinical incidents. Reconfiguration of ED services to one site should result in increased safety and reduction in clinical incidents, improved quality of service, as well as the economic benefit of reducing very significant locum costs.
- Currently the EDs of CHFT are non-compliant with many of the standards for Children and Young people in Emergency Care settings. Provision of all ED care on one site (with a Minor Injuries Unit on the other site) could allow for the provision of a dedicated Paediatric ED, which would then result in compliance with many, (if not all) of these standards; this is highly desirable. It is clear that in terms of providing sufficient numbers of adequately trained and skilled staff, it would be impossible to provide this level of service on both sites. However, if a Paediatric ED is established on one site, then it is obvious that this site must also be where acute Paediatric services are located, in order to support the activity of the Paeds ED. The co-location of Paediatrics ED and acute Paediatrics on one site would however have the benefit of integration of the two services and a more efficient use of resources. In particular, the co-location of Paediatrics and Paediatrics EM will allow for Paediatric emergency medicine (PEM) trained staff to work alongside and support acute Paediatrics which also has significant workforce issues, especially middle grade medical staffing. Also, the provision of all ED service on one site, (with a Minor Injuries Unit on the other site) will require a significant expansion of the footprint of one of the EDs, to allow adequate space for extra adult numbers and to provide a dedicated Paediatrics ED. This will obviously result in a significant capital cost and the NCAT team were also given to understand that expansion on one of the CHFT sites would be problematic due to lack of space.
- Reconfiguring of all EM services to one site (with a Minor Injury Unit on the other site) will mandate that all acute specialties required to support



that EM, and its role as a Trauma Unit, will need to be co-located on that **National Clinical Advisory Team - NCAT**

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site. This includes Acute Medicine (whose capacity and workforce is currently spread over the two sites) and surgical specialties such as General Surgery and Trauma and Orthopaedics. This obviously has implications for use of beds within CHFT, and is likely to involve capital spending. However, the NCAT team were given to understand that outpatient services were shortly moving from the Huddersfield main hospital site and thus space for any required expansion could potentially come from this move. The reconfiguration of acute medicine onto one site, to support the activity of the single ED, would also have the advantage of reducing inter-hospital transfers which currently take place frequently for acute medical admissions, when one or other site has reached its maximum medical bed capacity. Eliminating transfers of medical patients will improve safety, optimise patient flow in ED, shorten waits to definitive care, reduce ED breaches of the four-hour target, and reduce the workload on the ambulance service which is currently responsible for providing these transfers.

#### **Comments from Dr Carol Ewing.**

The key objective of the visit was to review the 3 options which have been generated for the future provision of A&E services in Calderdale and Huddersfield. These were:

- To maintain 2 A&E departments
- To maintain 2 A&E departments during the day, but only one at night
- To have an acute centre on one site and a minor injuries on the other site

CHFT operates 2 A&E departments with 69359 (18540 26.7% are children) attendances on the CRH site and 67984 (15489 22.8% are children) attendances on the HRI site. There are co-located GP out-of-hours centres on both hospital sites.

The key driver for change is that it is not possible to maintain A&E sites at both CRH and HRI on a 24/7 7 day a week basis. Expected standards of consultant delivered care cannot be met and the 2 A&E services are already under pressure to function due to rota vacancies particularly at middle grade. There is a significant reliance on locums.

Any change to the operational arrangements for the 2 A&E departments, and in the context of the wider provision of urgent care for the community will have an impact on women's and children's services.

The CHFT future proposed provision for paediatric care is to move to a community based model across the geographical footprint, to maintain paediatric inpatient services at CRH and to support children who attend A&E at HRI or HRI for surgery by providing consultant and nurse practitioner support, and to establish shared paediatric and surgical care of surgical patients.

In the context of the wider geographical footprint, seven organisations who commission and deliver most of the health and social care services in Halifax and Huddersfield are working together to undertake a strategic review of Health and Social Care called *Right Care, Right time, Right place*. The proposals will have an impact on women and children's services. There is a children's care

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stream which has been meeting for 9 months, and this care stream also links to

the unplanned care stream. The population of Hebden Bridge and Todmorden are reliant on the CRH A&E for urgent care.

The Unplanned care stream is proposing to develop an integrated urgent care centre that would provide access to a full range of minor injury services in Todmorden health centre. The impact of the proposed service changes to Mid Yorkshire NHS Trust have also to be taken into account. There are 4 work streams within the children's care stream address the changing morbidities for Children and Young Persons (CYP), which are as follows:

- Shared care planning
- Increasing resilience in the community
- Integrating primary and secondary care, with the development of multidisciplinary teams in the community
- Transition to adult services

#### *National Context*

The Children's Health Outcomes Forum report published in 2012 and the System response to the Forum's recommendations, published in 2013, summarise a number of recommendations, based on the NHS and Public Health Outcomes frameworks for provider services.

There are also a number of clinical standards documents which set out recommendations for a safe and sustainable high quality service for children and young people (CYP). A key document for CYP is the RCPCH publication entitled *Facing the Future: Standards for Paediatric Services*. There are 10 acute service standards for general paediatrics, the principles of which ensure that CYP receive a senior and timely paediatric opinion. *Facing the Future* also describes 4 interlocking recommendations which are integrally linked to the delivery of the 10 standards, namely:

- A reconfiguration of acute services with a reduction in approximately 50 small proximal units
- An expansion in the number of consultants, with more consultants working acute resident shifts
- A reduction in the number of paediatric training grade doctors
- An increase in GP training grade doctors
- An increase in the numbers of nurses with advanced or extended skills.

There are a number of other service standards documents which are as follows:

- Safer Childbirth, Minimum standards for the organisation and delivery of care in labour, RCOG, RCM, RCA, RCPCH; RCOG 2007
- You're welcome quality criteria, making health services young people friendly DH 2007
- Intercollegiate Committee Standards for Children and Young People in Emergency care settings, 2012
- Toolkit for High Quality Neonatal Services, DH, 2009
- Neonatal National Quality Dashboards 2012
- NICE Quality Standards - Specialist Neonatal Care, NICE 2010
- RCSE 2010 General Paediatric surgery :survey of service provision in district general hospitals in England
- RCSE 2013 Standards for Children's surgery
- RCOA 2013 Guidance on the Provision of Anaesthetic Services, Paediatric Anaesthesia

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#### *Local context*

From a women's and children's perspective, as a result of the previous

CRH/HRI reconfiguration in 2008, the main objective of which was to separate acute and non- acute surgery on 2 sites, women's and children's services and acute stroke services have remained on the CRH site whilst all other acute services including surgery and medicine moved to HRI. A&E has continued to be provided on 2 sites. At CRH there is centralisation of consultant led maternity services and neonatal & inpatient paediatrics, all inpatient gynaecology services, a birth centre in development, day case and outpatient services.

At Huddersfield Royal Infirmary there is a family birth centre, a paediatric assessment & observation unit, inpatient paediatric surgery and also day case and outpatient services.

There are 6000 deliveries/year and CRH (600 at Huddersfield Birth Centre, 800 at Calderdale Birth Centre and 4600 consultant led deliveries at CRH). CRH is the 2nd largest maternity unit in the region, the largest unit being at Bradford. The unit at CRH currently provide 76 hours of consultant presence on the labour ward. CFHT have recruited an additional consultant and aim to recruit a further consultant, both to start in September/October this year. Once these are in post we will be able to provide 98 hours of consultant presence.

The current position for paediatric services is that the Facing the Future standards are currently met except for being able to provide consultant delivered care at peak times of the service.

There are children's community nursing teams which link well to the paediatric services on both sites and the CCNTs can also provide on- going care for surgical patients who are discharged.

The Level 3 neonatal unit at CRH has now been designated as a level 2 unit, but in reality is taking a number of babies of 'level 3 status' e.g. to enable cooling. The unit links to the regional neonatal network arrangements. There are 3 other Level 3 neonatal units at Bradford, Hull and Leeds.

Children who require paediatric surgery are initially assessed at either A&E/POAU facility/inpatient ward at CRH and if surgery is required, they are admitted, following transfer if at CRH, to HRI. The surgeon performing the operation is the lead clinician. Day to day management is provided by a cohort of advanced paediatric nurse practitioners (APNPs). The APNPs also support the POAU service at HRI. A paediatric opinion during daytime hours can be provided by paediatricians on site who are also providing outpatient services. There is a regional general paediatric surgical network and young children are likely to be transferred to Leeds for operations. Pathways of care are being developed by the regional surgical network.

There are a number of factors which affect the safety and sustainability of the service if the status quo is maintained, and if paediatrics, neonatal and maternity services continue to be provided on a different site to the rest of the acute services.

There will be a significant reduction in specialist training numbers starting in August 2014. On a regional basis, there will be 41 ST1-3 trainees compared to

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136; there will be 55 ST4-8 compared to 204 and who will be distributed across the region depending on their training needs. The impact on the Trust is that 11 ST4-8 are needed for middle grade cover and there is going to be a 75% reduction in the availability of middle grades so at best that there will only be 2-3 in post . Across the region, there is an approximate 33% attrition rate in Paediatrics eg . 28 ST1s were appointed in 2007 and 19 remain at ST6 level. Urgent general paediatric surgical and anaesthetic support is patchy at HRI and is dependent on who is on call. Most planned paediatric surgery is carried out at

HRI. Paediatric ENT surgery and ophthalmology is provided at CRH. Patients at HRI do not have shared care from a consultant surgeon and paediatrician, and if an urgent consultant paediatric opinion is required out of hours, a consultant paediatrician on call for CRH would have to attend, whilst also being on call for acute paediatrics and neonatology at CRH. If the paediatric service was consolidated one site, then it would be possible to provide shared senior paediatric and surgical care for patients.

If an obstetric emergency presents by chance at HRI, one of 2 midwives who run the HRI birth centre can provide support, but there is no formal service arrangement.

Acute surgery is provided at HRI whilst obstetrics/gynaecology is on the CRH site and if an urgent surgical opinion is required, travel time has to be factored in as part of the potential clinical risk to patients.

In discussion with the clinical groups throughout the day, there was unanimous agreement from the A&E leads, the acute medical and surgical leads, ambulance leads and the commissioning leads that the 'acute' service for the population should be on a single site.

The representatives from the Women's and Children's division, also agreed that a single site acute model for maternity and paediatric services with co-located A&E, surgical and medical services would be the safest and most sustainable option. The women's and children's team presented 4 alternative models but they made it clear that they had to present options in the context of children's and maternity services remaining at CRH:

Option 1: Status Quo

Option 2: One A&E at HRI (adults and paediatrics), Minor injuries CRH, all paediatric medicine and surgery at HRI (maternity services remain at CRH)

Option 3: One A&E at HRI (Adults and Paediatrics), minor injuries CRH, all inpatients to remain at CRH with strengthened services at HRI

Option 4: Adult A&E HRI, paediatric A&E CRH, Adult minor injuries at CRH & HRI, all paediatric medicine and surgery at CRH

Given this constraint, their conclusion was that the only solution would be to have a dedicated paediatric A&E 24/7 7 days a week at CRH, minor injuries units at both sites, adult A&E at HRI, to move paediatric surgery to CRH, to continue to provide consultant led obstetric services at CRH, and to continue to have birth centres at both sites.

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#### *Conclusion*

A single site model for all acute services and a single site model for planned services is the safest, most sustainable option. Due to the estates constraints, this would mean locating all acute services including consultant delivered obstetric care, paediatric medical and surgical and neonatal services on one site and planned care on the other site. This will

- Ensure that paediatric medical and surgical, neonatal, emergency and consultant delivered obstetric services will meet the required standards
- Ensure that there will be a sustainable workforce for both paediatrics and neonatology.
- Allow for shared care of paediatric surgical patients by surgeons and paediatricians
- Co-locate paediatric, neonatal and consultant delivered obstetric care with anaesthesia, surgery and A&E
- Mean less transfer of children between the 2 sites

The principle of having one service and one 'team' for each service is crucial in

order to make this model work and for the model to be acceptable to staff and to the public. There should be maximal usage of both sites by the CHFT clinical teams. The following principles apply equally to children's services as to adult services in this proposed model:

- The service should be developed as one service so that CHFT clinical teams work on both sites according to whether they are providing acute or non- acute care.
- There would be a minor injury/ urgent care centre at both sites. The centres would be primary care led.
- The Ambulance services would ensure that children from 999 calls are taken directly to the acute care site.

The model of having a separate paediatric A&E at CRH would require an additional workforce to run the dedicated paediatric emergency service, and would not address the issue of the paediatric medical , surgical and A&E services at CRH being split from the acute surgical and anaesthetic services at HRI. Furthermore the option of a separate paediatric A&E at CRH was not presented as an option by the A&E and acute surgical leads.

Other solutions which offer separation of neonatal and paediatric services, of which there are very few and which are not duplicated across England, would be unsafe due to the middle grade staffing reduction and other workforce constraints.

Although the purpose of the visit was to look at the options for the future model of care for A&E, any future model for children's services has to take into account the changing needs of the population and with a move to concentrate on health promotion, wellbeing and resilience, and the prevention of illness. This will have an impact on the way primary care services are provided for CYP. By developing patient pathways to minimise any barriers between primary and secondary care provision, and by ensuring children are cared for by teams with the right skills, it may not be necessary for children to attend hospital. There are already established CCNT teams seeing children with medical and surgical problems in both catchment areas for HRI and CRH. The planned care site would continue to be the main site for other planned children's services such as child development, outpatient services and MDT services, and would open up opportunities to develop an integrated care service with primary care on site.

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Other key principles in developing a future model of care for children is to continue developing pathways within the paediatric surgery and trauma networks. There also need to be continuing links with the regional neonatal intensive care services which will be functioning within the NHS England operational delivery network model.

Any further design of the clinical model for CYP should continue to take account the views of CYP and parents and carers.

In developing the model, service provision and policies for CAMH and for safeguarding must be robust, particularly when working across local authority boundaries.

There is an opportunity to further develop services for children who are undergoing transition to adult services. A model for diabetes was highlighted by the adult physicians, and 'transition' is one of the work streams of the primary care stream.

### **NCAT Conclusion**

The unanimity of all the hospital service staff and the two commissioners interviewed in supporting a one acute care site option including obstetrics and

acute paediatrics is remarkable. A unanimity that certainly would help greatly in being a consistent resource to the public in advocating what is an optimal safe high value based sustainable healthcare future.

The clinical governance, in particular of any future hospital Trust emergency and women and children's services, is central to a sustainable reconfiguration.

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#### **NCAT Recommendations**

1. We support a one acute care site option as the best for the future safety, value and sustainability of healthcare. We reached our conclusions drawing on our own knowledge and experience of medical care and equally as we agree with the clinically valid reasons for a one site option presented on our visit on 14 June 2013 and reproduced in this report. If the NCAT recommendation is agreed upon, the actual siting of the separate acute care and planned care option is a local management decision
2. We also strongly support commissioners enhancing primary and community based services for the same high quality reasons. NHS services of the future cannot be of high value to patients unless more care is delivered out of hospital.
3. We recommend implementing the community focused options (see Dr Carol Ewing's comments above) and General Medical Practitioner access to the community paediatric service, the continuing development of community based services for those patients who have a long term condition, in particular for those who have multiple morbidity and especially if frail and elderly. The systematic adoption of case management, risk stratification methodology and multidisciplinary teams working with general practice and the implementation of the proposed 'virtual wards' would enhance care and lessen the need for in-patient hospital care
4. Shared clinical records and clinical pathways across two hospital sites and with community based services will strongly enhance care not least in lessening duplication of care.

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#### **Appendix 1**

Background reading received by the NCAT panel prior to the visit;

- Purpose scope and background of NCAT review
- Slide pack- CHFT Paper version 4
- HSMR analysis
- 3 Year Activity, Workforce and Financial Plan 030613
- NHS Calderdale Clinical Commissioning Group Prospectus 2013-14 v3
- QI Report April 13
- Emergency Medicine response to draft document; CHFT contribution to strategic review March 2013 Version v.0.3
- The five Year Plan on a Page 2013 V6. 2013-18 Greater Huddersfield CCG
- UC Action Plan CCH CCGs v8
- Slide pack- AMENDED SRPB 46 06iv Unplanned Care presentation
- Calderdale Huddersfield A&E services (CM comments)2[1]
- Developing New Models of Primary and Community Unscheduled Care
- Estates Briefing for NCAT

- Lachman report[1]
- NHS 111 NCAT Brief v2
- NURSING QUALITY INDICATORS Final
- QI's April 2013
- Summary of Conclusions Following visit of External Advisors to CHFT for Health and Social Care Strategic Review
- Unplanned care patient engagement

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### **Appendix 2**

CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST

Agenda for the visit of the National Clinical Advisory Team (NCAT) to review A&E Services

Friday 14 June 2013

Large Training Room, Learning centre, Calderdale Royal Hospital

10.00 -11.00 Executive welcome and briefing

David Anderson – Non Executive Director

Helen Thomson – Executive Director of Nursing /

Deputy Chief Executive

Lesley Hill – Executive Director of Planning, Performance, Estates and Facilities

Mark Partington – Director of Operations

Catherine Riley – Assistant Director of Strategic Planning

Dr Barbara Crosse – Executive Medical Director

11.00 -12.00 A&E and surgery

Dr Peter Holdsworth – Divisional Director of Surgical & Anaesthetic Services

Julie Barlow – Assistant Divisional Director

Clare Brearley – Associate Director of Nursing

Dr Mark Davies – Clinical Director A& E

Dr Paul Jarvis – A&E Consultant

Dr Maya Navari – Consultant in Paediatric Emergency

Bev Walker – General Manager, Trauma & Orthopaedic Services & A& E

12.00 -1.00 Medicine

Dr Ashwin Verma – Divisional Director

Judy Moorhouse – Assistant Divisional Director

Lindsay Rudge – Associate Director of Nursing

Dr Rob Moisey – Clinical Director Acute Medical Directorate

Mandy Gibbons-Phelan – General Manager, Intermediate Care & Community Directorate

1.00 -1.30 Lunch and debrief for NCAT

1.30 -2.15 GPs and commissioners, urgent care in primary care

Dr Dil Ashraf GHCCG

Dr David Hughes GHCCG

Dr Majib Azeb CCCG

Pat Andrewartha CCCG

Debbie Graham CCCG

Lesley Slocombe Finance GHCCG

2.15 -3.15 Women and Children

Mr Martin DeBono – Divisional Director

Dr Sal Uka – Clinical Director Paediatric Services

Sajib Azeb – Assistant Divisional Director

Janet Powell – Associate Director of Nursing

Gill Harries – General Manager, Children

3.15 -3.45 Mid Yorkshire configuration

Caroline Griffiths (apologies) – Interim Director of Corporate

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Planning & Projects Mid Yorkshire hospital trust

Simon Enright – Clinical Lead for Clinical Services Strategy Mid Yorkshire hospital trust

3.45 -4.30 DATS (Diagnostics and Therapeutic Services)

Emma Livesley – Assistant Divisional Director

Dr Heshan Panditaratne – Clinical Director Radiology

4.30 -5.00 Yorkshire Ambulance Service

Tasnim Ali – Senior Service & Quality Improvement Manager

Andrew Simpson – Head of Emergency Operations

5.00 -5.30 NCAT team private debrief

5.30 – 6.00 Points for clarification and informal feedback

Helen Thomson – Executive Director of Nursing / Deputy Chief Executive

Lesley Hill – Executive Director of Planning, Performance, Estates and Facilities

Catherine Riley – Assistant Director of Strategic Planning



# **Clinical Senate Review of Community Services Specifications**

**for Calderdale,**

**Greater Huddersfield and**

**North Kirklees CCGs**

Clinical Senate Reviews are designed to ensure that proposals for large scale change and reconfiguration are sound and evidence-based, in the best interest of patients and will improve the quality, safety and sustainability of care.

Clinical Senates are independent non statutory advisory bodies hosted by NHS England. Implementation of the guidance is the responsibility of local commissioners, in their local context, in light of their duties to avoid unlawful discrimination and to have regard to promoting equality of access. Nothing in the review should be interpreted in a way which would be inconsistent with compliance with those duties.

Yorkshire and the Humber Clinical Senate  
[yhsenate@nhs.net](mailto:yhsenate@nhs.net)

Date of Publication: April 2015

## Version Control

Document Version	Date	Comments	Drafted by
Version 0.1	23 <sup>rd</sup> January 2015	Compiled from working group comments	J Poole
Version 0.2	27 <sup>th</sup> January 2015	Amended from working group comments	J Poole
Version 0.3	7 <sup>th</sup> April 2015	Following commissioner comments and discussion at March Council meeting	J Poole
Version 0.4	20 <sup>th</sup> April 2015	Paragraph re-phrased following commissioner comment. Agreed by Chair in absence of Senate Council meeting	J Poole
Version 1.0	24 <sup>th</sup> April 2015	Final version	J Poole

- **1. Chair's Foreword**

The Senate thanks the CCGs for the opportunity to review these proposals on the development of their community services. Following a review of the evidence, the Senate agrees that these proposals have the potential to result in excellent patient care closer to home and we are fully supportive of the values and principles within these documents.

The Senate did find it very challenging to meet our brief. We have raised questions for consideration within this report which we hope will be of assistance to commissioners in both developing the detail with providers and evaluating the providers' tender proposals.

## 2. Summary Recommendations

- 2.1 The Senate commends the CCGs on their vision for the future of their community services and agree that this has the potential to result in excellent patient care closer to home. In general terms, the Senate review group was very supportive of these comprehensive documents and their values and principles for delivering care closer to home.
- 2.2 The Senate was given a specific brief in relation to whether particular risks are addressed within the proposals and to appraise whether there are any missed opportunities within the proposed scope of services. The Senate did find it very challenging to assess the risks associated with the service transformation and we have raised a number of questions in relation to the risks arising from the lack of detail regarding workforce, primary care strategy and engagement with partners, for example. We recognise that there have been extensive discussions with stakeholders during the last 2 years which was not detailed within the evidence provided, and that the detail behind the vision will be worked through in competitive dialogue. The Senate hopes that these questions assist with that procurement process. The Senate recommends that commissioners work in partnership with the providers around the development of the service models. This shared approach to the service model development is particularly important in a system undergoing such a large level of change to help mitigate against the risks to service delivery.
- 2.3 The Senate Review Group has considered the scope of services and agrees that these are comprehensive, with little that could be considered a missed opportunity.

## 3. Background

### Clinical Area

- 3.1 Over the past two years, 7 partner organisations across Calderdale and Greater Huddersfield have been working together to develop a vision and approach to innovate and transform services within the health and social care system.
- 3.2 Greater Huddersfield, North Kirklees and Calderdale CCGs developed a set of proposals for how they would wish to configure and deliver community services in the future. In summary, this proposes a new model for the provision of hospital and community services that comprises integrated teams of health and social care professionals working together in localities to deliver care and support in community settings. The community reforms are in the context of a reconfiguration of hospital based services. There is a provider view on what the reconfigured hospital model could look like, at the time of writing the report the commissioner views on the future model for hospital services were still under development.

3.3 The evidence considered in this Senate report is limited to the community specifications and associated documents and does not consider the reconfiguration of hospital based services. The outline business case for the reconfiguration of hospital based services was not available for the Senate to review at the same time as the community proposals. The Senate therefore advised commissioners of our intention to develop a separate working group for the hospital based services work but with a significant amount of membership overlap with the working group reviewing the community services proposals to ensure the Senate has an understanding of the integrated services across the whole patch. This report therefore, forms the first of 2 reports, this first report focusing on the community specifications, the second report reviewing the proposals for the hospital services, when this is made available. The latter report will take note within it of its fit with the proposed community service.

### **The Senate Role**

3.4 The Senate was approached by commissioners in advance of the formal assurance processes. The commissioners wished to ensure that the Senate had the opportunity to review documentation and to understand the various factors at play, which make this change programme challenging, before the commissioners require evaluation against the 'four tests' by NHS England as part of the major service change assurance process. The advice from the Senate will therefore be used by the commissioners to inform their proposals for service change and their quality impact assessment.

3.5 The Senate received the documentation listed in Appendix 4 in early November 2014 and agreed the terms of reference for this piece of work with the commissioners in mid-December 2014, following further discussion at the Senate Council meeting in November and teleconferences with the commissioning leads. The Senate Working Group was appointed in early December, with an agreed date of the end of January 2015 for the production of the Senate report.

3.6 In the review of the community services specifications, the Yorkshire and the Humber Clinical Senate was asked:

- To consider if the following list of risks are recognised in the proposals and the extent to which the proposals within the specification will mitigate the risks
- To appraise the proposed scope of services and consider if there are any missed opportunities

Risk Id	Principal Risk
HSPB 2	There is a risk that there will be some deterioration in quality of service from the hospital due to the Trust not being able to address the workforce and service configuration issues, resulting in current workforce issues getting worse as the morale and motivation of clinicians continues to deteriorate.
HSPB 13	There is a risk that the whole systems approach is compromised due to insufficient capacity and capability to complete and deliver the Primary Care Strategy resulting in a disconnect between primary care medical services and the vision and outcomes for the programme.
HSPB 15 CC2H r5	There is a risk of lack of clinical workforce and skills to deliver the services due to inadequate resource, resulting in delays and/or issues with implementation of the programme
CC2H 16	There is a risk that lack of information sharing will delay plans resulting in the community changes not being implemented
CC2H 27 CC2H r4	There is a risk that we do not deliver coordinated change across hospital and community services at sufficient pace and scale to address the significant quality, finance and workforce issues in our case for change, resulting in poor services being established/maintained
CC2H r16	There is risk that the agreed outcomes in the overarching specification are not achieved which would result in the original vision for care closer to home and the identified benefits for patients across the local health and social care system not being realised
CC2H r17	There is a risk that a seamless service for patients will not be realised as a result of this work due to the number of organisations / providers involved in delivering services locally which could result in the vision and outcomes for care closer to home not being realised

3.7 The Senate Working Group held a teleconference on 13<sup>th</sup> January 2015 to discuss their emerging thoughts and a teleconference with commissioners on 21<sup>st</sup> January 2015 which provided opportunity for the Senate to discuss the challenges they were facing in completing this work and for commissioners to explain the complexity of this work amongst the 2 year journey on the strategic services review.

## 4. Recommendations

### General Comments

- 4.1 Overall, the Senate commends the CCGs on their vision for the future of their community services and agree that this has the potential to result in excellent patient care closer to home. In general terms, the Senate review group was very supportive of these comprehensive documents and their values and principles for delivering care closer to home.
- 4.2 The Senate was given a specific brief in relation to whether particular risks are addressed within the proposals and to appraise the proposed scope of services and consider if there are any missed opportunities within these. The Senate did find it very challenging to meet our brief due to the visionary nature of the documents. The Senate recognises, however, that the commissioners will be going into a competitive dialogue process during the tender and therefore much of the detail behind the vision will be developed during that process.
- 4.3 The Senate would have found it helpful to have more information on the primary care strategy, the services and activity that is currently delivered, the demographics, and further detail on the discussions with staff and their willingness to work in the ways proposed. Without the demographic and background information about the referral rates and demands in the current system, it was harder to review the proposed functions and capacity of the new system and the risks associated with the service transformation.
- 4.4 The request for additional background information was discussed with commissioners in the teleconference on the 21<sup>st</sup> January 2015 but the procurement timescales demanded a pragmatic approach to these gaps in the Senate understanding. In line with the commissioners preferred approach, the Senate has phrased this report to be of assistance to commissioners in both developing the detail with providers and evaluating the providers' tender proposals.
- 4.5 The Senate recommends that commissioners work in partnership with the providers around the development of the service models and not to provide that responsibility solely to the provider. This shared approach to the service model development is particularly important in a system undergoing such a large level of change, to help mitigate against the risks to service delivery.
- 4.6 The Senate has not considered the funding for these proposals and whether the care closer to home vision is achievable financially.
- 4.7 The 2015/16 planning guidance was published during this review which announced further funding opportunities for working with primary care and health and social care. The Senate is aware that commissioners are under discussion with the Local Authorities to potentially refresh some of their proposals in light of this new opportunity.



- 4.8 The Senate was asked to consider North Kirklees, Greater Huddersfield and Calderdale CCGs specifications and the Senate recognised that there is a shared vision across the 3 CCGs although the mode of delivery may be different to take into account the differing needs of the populations. The commissioners may want to further consider the differences in interpretation of that vision and how this may impact on the delivery of services across boundaries. One such example is the difference in approach to the services being considered for children and young people. The Senate has structured its comments broadly to cover themes across the 3 CCGs. If the Senate was approached for any further consultation it may be preferable to consider the CCGs separately to take into account the differing approaches to achieving the vision and differing procurement processes.

### Specified Risks

- 4.9 One overall comment in relation to these risks is that commissioners may wish to consider breaking down the following list of specified risks into smaller components to help clarify the management of those risks during your dialogue process.

Risk Id	Principal Risk
<p>HSPB 2</p> <p>Comment:</p>	<p>There is a risk that there will be some deterioration in quality of service from the hospital due to the Trust not being able to address the workforce and service configuration issues, resulting in current workforce issues getting worse as the morale and motivation of clinicians continues to deteriorate.</p> <p>The Senate found it difficult to comment on this risk as the workforce detail is to be worked through in procurement discussions. The Senate review group considered it likely that there would be workforce issues during such a large scale transformation and is aware from discussion with commissioners of the extensive engagement with staff during the previous 2 years. Evidence of this engagement was not available within the documentation received which restricted the Senate ability to anticipate the workforce issues that may be encountered.</p> <p>Commissioners may wish to discuss further with providers how the risks to patient care can be mitigated during the transition period because of hospital and community staff unfamiliarity with roles and services and with staff attachment to historical systems and roles. Providers will also need to consider how to ensure alignment between established hospital systems and the new community services.</p>
<p>HSPB 13</p> <p>Comment:</p>	<p>There is a risk that the whole systems approach is compromised due to insufficient capacity and capability to complete and deliver the Primary Care Strategy resulting in a disconnect between primary care medical services and the vision and outcomes for the programme.</p> <p>This has been difficult to comment in any detail without seeing the primary care strategy. From the information we have been given, the link between the</p>

	<p>community services and the primary care system is under-addressed in terms of relationships and interactions. Support from the GP's will be essential to success; the view expressed in the consultation that one size doesn't fit all may be a concern for commissioners as to enable the model to work the hubs have to be similar in order to allow for consistent signposting and referral of patients.</p> <p>Commissioners will be aware that resistance and refusal to change in primary care is a risk that will need addressing and therefore they may wish to give further consideration to the culture change in the relationship between primary care and community services and how they will assist in the development of a new culture. Commissioners will wish to avoid the inter-service conflict which will result in demoralised workforce and add to workforce recruitment and retention problems.</p>
<p>HSPB 15 CC2H r5</p> <p>Comment:</p>	<p>There is a risk of lack of clinical workforce and skills to deliver the services due to inadequate resource, resulting in delays and/or issues with implementation of the programme</p> <p>The Senate understands that CCG's are expecting the contracted provider to deal with the workforce issues and it was not clear within the specifications how many additional staff would need to be recruited or whether the staff currently working in primary and secondary care are adequate for the service reconfiguration. Re-assigning staff from secondary care to community services will require a transition period for retraining and orientation. If the providers need to attract new skills, there is no detail of whether the staff are available regionally or nationally.</p> <p>Within the dialogue with providers, commissioners will wish to consider who would do the triaging of the whole system, which is likely to be beyond the remit of one speciality, and how the staff would be trained to deliver that. Commissioners will also need to discuss how the staff would be moved around to provide 24 hour care for some of the specialities.</p> <p>Workforce within the local health community is likely to be fairly static in the current economic climate. Most of the staff in the new system will be current staff in the older system. The challenge will be in re-orientating the staff and getting the right skills, at the right level, in the right place within the wider system. This may need some joint working between the CCG and organisations involved. Commissioners will wish to develop the models on the services and outcomes required rather than old staffing models and ways of working. The workforce plan needs to be developed around skills rather than professions, to give greater flexibility.</p> <p>Commissioners will also want to build in some assurances about quality of staff and staff turnover to try and ensure a consistent service for patients. If statutory services are expected to provide training to non-statutory organizations, this will need factoring in to the staffing and funding models.</p> <p>The consequences of the lack of clinical workforce and skills mentioned above will not just be delays and/or issues with implementation of the programme but also a poorer service to patients. Commissioners will want to ensure that they have plans to manage the risks of a deterioration in service to patients during the implementation of the new services.</p>

<p>CC2H 16</p> <p>Comment:</p>	<p>There is a risk that lack of information sharing will delay plans, resulting in the community changes not being implemented</p> <p>Liaison with specialist services to ensure a co-ordinated approach is the key to delivering this ambitious service model. Commissioners need to ensure that they maintain that dialogue with their key partners, including local authorities to ensure they are fully behind the proposals. It is not clear from the specifications how commissioners intend to achieve the integration of the data across the services, including social services and mental health systems, and the timescales for achieving this integration. It was also not clear if there is a vision for new technologies to assist with the seamless transfer of data across organisations.</p>
<p>CC2H 27 CC2H r4</p> <p>Comment:</p>	<p>There is a risk that we do not deliver coordinated change across hospital and community services at sufficient pace and scale to address the significant quality, finance and workforce issues in our case for change, resulting in poor services being established/maintained</p> <p>The pace and scale of the intended developments is an important consideration in the assessment of risk. The Senate Review Group had some discussion with commissioners on the timescale and understands that there is to be a phased approach to balance, manage and mitigate the risks in the current system and the risks during the transition. The Senate advises that this risk needs to be further quantified against the key delivery milestones so that commissioners are clear about their achievements and have contingency plans in place if the pace slips.</p>
<p>CC2H r16</p> <p>Comment:</p>	<p>There is risk that the agreed outcomes in the overarching specification are not achieved, which would result in the original vision for care closer to home and the identified benefits for patients across the local health and social care system not being realised</p> <p>This risk is mitigated if HSPB 2, HSPB13, HSPB 15, CC2H 27 risks are addressed. The Senate review group was not clear if this risk was more concerned with setting outcomes that are unachievable within the vision or whether this is more concerned with failure of the provider to deliver</p>
<p>CC2H r17</p> <p>Comment:</p>	<p>There is a risk that a seamless service for patients will not be realised as a result of this work due to the number of organisations / providers involved in delivering services locally which could result in the vision and outcomes for care closer to home not being realised</p> <p>Fractured delivery of care to patients would reflect a commissioning failure. This risk is largely dependent on the number of organisations that commissioners contract with and the commissioners' ability to monitor the delivery of such a complex integrated system. This can be mitigated through the approach to the contracting arrangements and ensuring that commissioners contract for integration rather than with a diversity of providers.</p> <p>Where there are multi-agency teams, there needs to be agreement that they all work to the same policies rather than separate organizational policies. Particular examples of where this causes problems are in risk assessment, moving &amp; handling, information governance standards and care management/coordination.</p>

## Consideration of Other Risks

- 4.10 Commissioners may wish to consider identifying a risk regarding the role and engagement of their partners including Local Authorities. In discussion with commissioners the Senate has been informed of the engagement with all stakeholders including the extensive joint working with Local Authority and secondary care providers. The documents do not detail how these stakeholders have been actively involved in shaping this model and it would have been helpful to understand further how this relationship has been approached. The success of the care closer to home philosophy is dependent on social care involvement and funding at the patient level. Delay of this component of care may undermine the whole care package with knock-on effects through the system. Commissioners may feel that this risk has already been recognised and accounted for through other means.

## Missed Opportunities

- 4.11 The Senate Review Group has considered the scope of services and agrees that these are comprehensive with little that could be considered a missed opportunity. The difference in approach to the services for Children and Young People has been highlighted in this report. The specific comments below do make some reference to wheelchair services for example but generally the Senate felt that these documents were extremely comprehensive in terms of the scope.

## Specific Comments

### *Palliative and End of Life Care*

- 4.12 The specifications cover all aspects of palliative care at a high level. In discussing the detail with providers, commissioners may wish to discuss in more detail the role and responsibility of the end of life care coordinator and the processes for delivering end of life care in the community as this was not clear within the specifications.

### *Older People*

- 4.13 There is much mention of frailty and specialist comprehensive geriatric assessment within the documents but no mention specifically of consultant geriatric provision in the documents. Commissioners may want to discuss this further with providers and given the difficulties in recruiting consultants this will potentially pose a risk to the provision of a joined up service.
- 4.14 **Page 39 Calderdale Care Closer to Home Schedule 2 Service Specification Document Comments;** Commissioners may wish to consider the following points in their service lines included in phase 1
- If vision screening includes diabetic retinal screening
  - Under the therapies section it may be more beneficial to list the specific interventions rather than the profession
  - The review group questioned whether community equipment supplies needed to fit in these service lines as it will be a key enabler in keeping people at home

- 4.15 **Page 47 point 4;** The KPI for reduced health inequalities includes many variables in the way it is written which would preclude tying this to a particular provider performance. Commissioners may wish to consider rephrasing this into a more measurable indicator.
- 4.16 **Page 48 point 6;** There is reference to a matron lead for vulnerable groups but commissioners may wish to consider extending this beyond a nursing role as other Health Care Professionals will have the ability to undertake this lead role.

### *Greater Huddersfield Care Closer to Home Services Document Comments*

- 4.17 **Page 11;** The specification states that the calls will be triaged by a Single Point of Access (SPA) then transferred to an **Access and Co-ordination hub** within each locality. This Access and Co-ordination hub will be staffed by co-ordinators who will have intimate knowledge of services and functions within their locality. Commissioners may want to consider in further detail, in the dialogue process, the level of health knowledge available in the triage process.
- 4.18 **Page 12;** The rapid response function description refers to this being delivered primarily by Advanced Nurse Practitioners, therapists or social care professionals where appropriate, who will also be **'trusted assessors'** and able to provide defined packages of social care. Commissioners may want to consider the definition and expectation of 'therapist', whether this includes Speech and Language Therapists, podiatry, dietetics and how the shortages of specific therapy skills will be managed.
- 4.19 **Page 13;** The core staff for Supported Transfer Function will include clinicians, therapists and social care professionals who will liaise directly with the hospital's discharge teams to ensure smooth and safe discharges into the community. Commissioners may wish to consider where the equipment store, Aids & Adaptations and the wheelchair service fits into this function.
- 4.20 **Page 14;** In the longer term care model it states that the community staff will have the added support and advice from the access and co-ordination hub and ready access to senior clinical experience and expertise within each locality. Commissioners may wish to flesh out the access to this expertise in more detail with providers.
- 4.21 **Page 16;** The description of the specialist input states that some specialist teams such as mental health are outside the scope of this redesign but it is intended that they seamlessly work with Care Closer to Home services and make use of the access and co-ordination hubs wherever possible to deliver the best care for patients. Commissioners may wish to consider further how the mental health teams will link with this system, bearing in mind that they cover a significantly larger area than the CCG, and how this discussion will be approached with mental health providers. This discussion also needs to consider how the hubs link with the mental health single point of access. The Senate recognises that this need for integration and seamless working with mental health has been emphasised by commissioners.

- 4.22 This section also states that specialist staff will be available in sufficient numbers to support patient care but it is difficult to quantify this without detail on what numbers are required and how this relates to staff employed in the system currently. Specialist staff are not easy to recruit.
- 4.23 **Page 20;** Details the meetings which the provider will wish to incorporate within their operational structure. This does not fit with the principle on page 4 of commissioners not being prescriptive in terms of the service model/ delivery teams/ staffing etc. This is just an observation from the Senate of a slight inconsistency in the approach.
- 4.24 **Page 29 onwards;** In the development of the KPIs it may be helpful to demonstrate to the provider how the CCG will make use of this information in a timely way that means that variances are spotted early and addressed and that there is a process for recognising external factors affecting the KPIs which are beyond the providers' control.
- ***North Kirklees – Key Functions Document Comments***
- 4.25 **Page 1**
- In the description of the hub it will be important to ensure consistency of decision making for the referrers e.g. in a nurse only team having the senior nurse on duty at any one time being the coordinator, or in an MDT setting ensuring there are standards and protocols in place
  - Care co-ordination, well-being and navigation. Commissioners may wish to consider if this is provided by the single point of contact or via the team or service referred on to
  - Commissioners may want to explore how the care navigators are tied into the over 75s named clinician and any other case managers
- 4.26 **Page 2 Care Homes;** A Senate review member informed the Senate of the Care Home Initiative in practice at Gateshead. The model is for each care home to have a link practice and each practice to have a lead GP who works with a nurse specialist for older people. This model has resulted in sustaining a reduction in avoidable admissions and readmissions and reduced length of stay for those patients that do need to be admitted. Essentially, it is through shifting from a reactive to a proactive model of care via comprehensive assessment and shared care planning.
- 4.27 **Page 4 Nursing;** Gateshead are also piloting a Frailty Practice Nurse which has to date, resulted in reduced A&E attendance, hospital admission and GP home visits through case management of 100 patients, when comparing their use of unscheduled care in the preceding year. More widely in terms of practice nursing, the Willis Report of 2012 identified that 45% practice nurses will be retiring by 2022

and commissioners may want to consider further developing the career framework for practice nurses to help alleviate this issue.

- 4.28 **Page 7 specialist nursing (adult);** It is not clear who these nurses are and what specialties they are from and if the specialist skills to reduce the need for admission is specialist, as in disease specific, or advanced practice rapid response generalists. The statement that this access will be achieved within a time limited response e.g. 2 hours if needed, needs consideration as specialist nursing numbers are generally low.
- 4.29 **Page 8 Rehabilitation;** Feedback from the National Audit of Intermediate Care in 2013 highlighted that given the complexity of needs of those most vulnerable and frail, it is becoming challenging to determine who needs recuperation, who needs rehabilitation and who needs re-ablement. Commissioners may want to consider an approach seeking to determine this after referral.
- 4.30 **Page 9 and 10 Occupational Therapy and Physiotherapy;** The Senate was unclear if this service is for rehabilitation and thereby part of an MDT or cluster team or whether this referring to complex adaptations and housing issues.
- 4.31 **Page 19 Medicines Optimisation;** Commissioners may want to further consider the pathways for the community administration of IV drugs and the importance of pharmacists and microbiologists being included.
- 4.32 **Page 22 Care Co-ordinator;** Commissioners may wish to explore how this role links with the over 75s accountable clinician.
- 4.33 **Page 28 Community based respiratory approach;** Commissioners may wish to explore how this ties into the specialist nursing approach and the case management.
- 4.34 **Page 30 Falls;** The review group queries whether it is possible to get standard assessment tools across all providers and whether there are places in patient pathways that can routinely assess for falls risks e.g. over 75 assessments or chronic disease management clinics in primary care.

- **5. Summary and Conclusions**

- 5.1 The CCGs have developed specifications which are based on sound values and principles for delivering care closer to home. The Senate commends the CCGs on their vision for the future of their community services and acknowledges the complexity of the discussions during the last 2 years. The scope of services is comprehensive with little that could be considered a missed opportunity.
- 5.2 The Senate did find it very challenging to assess the risks due to the visionary style of the documents. We acknowledge that the detail will be worked through in the competitive dialogue process and therefore at this stage the presentation of the specification will leave gaps in the Senate understanding of the proposals. This has compromised our ability to assess if the risks have been addressed. Questions are raised within this report and we hope they will assist the commissioner in developing the service model in partnership with the provider during the procurement process.



# APPENDICES

## Appendix 1

### LIST OF INDEPENDENT CLINICAL REVIEW PANEL MEMBERS

#### Council Members

Catherine Wright, Allied Health Professionals Lead, Bradford District Care Trust

Dr Andrew Phillips, Urgent Care Lead, Vale of York CCG

#### Assembly Members

Peter Allen, Public Representative

Stephen Elsmere, Public Representative

David Broomhead, Therapy Consultant, Rehabilitation, Scunthorpe General Hospital

Dr Deepti Alla, General Practitioner, Princess Medical Centre

Simon Plummer, Physiotherapist, Fieldhead Hospital

Carol Weir, Clinical Lead, Children & Family Services, Leeds Community Healthcare Trust

#### Co-opted Members

Anne-Marie Seymour, Consultant in Palliative Medicine, Mid Yorkshire Hospitals NHS Foundation Trust

Dr Jon Scott, Consultant in Elderly Care, South Tyneside District General Hospital

Dr Nikhil Majmudar, Consultant in Elderly Care, Sunderland City Hospitals

Lesley Bainbridge, Strategic Lead, Older People's Services and Integrated Care, Gateshead Health Foundation Trust

## Appendix 2

### PANEL AND COUNCIL MEMBERS' DECLARATION OF INTERESTS

Name	Title	Organisation	Date of Declaration	Reason for Declaration	Date of Response	Proposed way of Managing Conflict
Steve Ollerton	CCG Chair	Greater Huddersfield CCG	12.8.14 & 20.11.14	Chair of the CCG that will be seeking advice from the Senate	20.11.14	To manage this conflict of interest we will need to ensure that Steve does not take part in any Council or sub group discussions as they relate to this matter

## Appendix 3

# CLINICAL REVIEW

# TERMS OF

# REFERENCE

**Calderdale, North Kirklees and Greater Huddersfield Strategic  
Services Review**

**Sponsoring Organisation:** Calderdale CCG

**Terms of reference agreed by:**

Chris Welsh

on behalf of Yorkshire and the Humber Clinical Senate and

Matt Walsh

on behalf of Calderdale CCG

Carol Mckenna

on behalf of Greater Huddersfield CCG

Chris Dowse

on behalf of North Kirklees CCG

**Date:**

**Clinical review team members**

Andrew Philips and Cathy Wright as leads from the Council. A working group comprised of representatives from:

- Community Services
- Primary Care
- Palliative Care
- Care of the Elderly
- Social Care
- Community Paediatrics
- Patient/ Citizen representatives

## Aims and Objectives of the Clinical Review

For the Yorkshire and the Humber Clinical Senate:

- To consider if the following list of risks are recognised in the proposals and the extent to which the proposals within the specification will mitigate the risks.
- To appraise the proposed scope of services and consider if there are any missed opportunities.

Risk Id	Principal Risk
HSPB 2	There is a risk that there will be some deterioration in quality of service from the hospital due to the Trust not being able to address the workforce and service configuration issues, resulting in current workforce issues getting worse as the morale and motivation of clinicians continues to deteriorate.
HSPB 13	There is a risk that the whole systems approach is compromised due to insufficient capacity and capability to complete and deliver the Primary Care Strategy resulting in a disconnect between primary care medical services and the vision and outcomes for the programme.
HSPB 15 CC2H r5	There is a risk of lack of clinical workforce and skills to deliver the services due to inadequate resource, resulting in delays and/or issues with implementation of the programme
CC2H 16	There is a risk that lack of information sharing will delay plans resulting in the community changes not being implemented
CC2H 27 CC2H r4	There is a risk that we do not deliver coordinated change across hospital and community services at sufficient pace and scale to address the significant quality, finance and workforce issues in our case for change, resulting in poor services being established/maintained
CC2H r16	There is risk that the agreed outcomes in the overarching specification are not achieved which would result in the original vision for care closer to home and the identified benefits for patients across the local health and social care system not being realised
CC2H r17	There is a risk that a seamless service for patients will not be realised as a result of this work due to the number of organisations / providers involved in delivering services locally which could result in the vision and outcomes for care closer to home not being realised

## Scope of the Review

The first stage will consider community Services for Calderdale, Greater Huddersfield and North Kirklees CCGs. The second stage will consider hospital services at Calderdale and Huddersfield NHS Trust.

## Timeline – Stage 1

Stages of early discussion	4 <sup>th</sup> July - November 2014
Establishment of clinical review team	December 2014
Information gathering	Community service specifications received 3 <sup>rd</sup> week in November  Clinical Review Team and commissioning leads to arrange early January teleconference to discuss queries
Meeting with provider clinical representatives	queries to be dealt with by email and teleconference
Site visit (possibly combined with above)	not required
Consideration of evidence	December 2014 – mid January 2015
Report writing	mid - end January 2015
Reporting to council	20 <sup>th</sup> January 2015
Commissioner feedback	end January 2015
Report publication	to be agreed with commissioner as the review progresses

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## Reporting Arrangements

The clinical review team will report to the Clinical Senate Council which will agree the report and be accountable for the advice contained in the final report.

Clinical Senate Council will submit the report to the sponsoring organisation and this clinical advice will be considered by the commissioning sponsor. For work undertaken in the assurance role the clinical advice will also be considered as part of the NHS England assurance process for service change proposals.

## Methodology

The review will be undertaken by appointing a clinical review team comprised of Senate Council members and co-opted members. The review will consider the following key evidence:

- North Kirklees CCG Service Specification, Schedule 2 (D4 NKCCG Outline Spec)
- North Kirklees CCG Functions Document V1(D4a)
- North Kirklees CCG Scope of Services V10 (D4b)
- Calderdale CCG Calderdale Closer to Home, Schedule 2, V3 and appendices
- Greater Huddersfield CCG, V0.3, Care Closer to Home Services
- Greater Huddersfield CCG and North Kirklees CCG Overarching Outline Service Specification and Supplementary information. September 2014 V1 and appendices.

The review team will review the evidence within these documents and supplement their understanding with a clinical discussion.

The clinical review team will submit and agree their comments and the writing of the report will be co-ordinated by the Senate Manager. The clinical review team will agree the draft report.

## Report

The draft clinical senate report will be made available to the sponsoring organisation for fact checking prior to publication. Comments/ correction must be received within 10 working days.

The report will not be amended if further evidence is submitted at a later date. Submission of later evidence will result in a second report being published by the Senate rather than the amendment of the original report.

The draft final report will require formal ratification by the Senate Council prior to publication. Council meetings are scheduled for 20<sup>th</sup> January 2015 and 25<sup>th</sup> March 2015.

## Communication and Media Handling



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The final report will be disseminated to the commissioning sponsor, provider, NHS England (if this is an assurance report) and made available on the senate website.

A communications plan will be agreed with the commissioning sponsor.

## Resources

The Yorkshire and the Humber clinical senate will provide administrative support to the clinical review team, including setting up the meetings and other duties as appropriate.

The clinical review team will request any additional resources, including the commissioning of any further work, from the sponsoring organisation.

## Accountability and Governance

The clinical review team is part of the Yorkshire and the Humber Clinical Senate accountability and governance structure.

The Yorkshire and the Humber clinical senate is a non-statutory advisory body and will submit the report to the sponsoring organisation.

The sponsoring organisation remains accountable for decision making but the review report may wish to draw attention to any risks that the sponsoring organisation may wish to fully consider and address before progressing their proposals.

## Functions, Responsibilities and Roles

The **sponsoring organisation** will:

- i. provide the clinical review panel with agreed evidence. Background information may include, among other things, relevant data and activity, internal and external reviews and audits, impact assessments, relevant workforce information and population projection, evidence of alignment with national, regional and local strategies and guidance. The sponsoring organisation will provide any other additional background information requested by the clinical review team.
- ii. respond within the agreed timescale to the draft report on matter of factual inaccuracy.
- iii. undertake not to attempt to unduly influence any members of the clinical review team during the review.
- iv. submit the final report to NHS England for inclusion in its formal service change assurance process if applicable

**Clinical senate council** and the **sponsoring organisation** will:

- i. agree the terms of reference for the clinical review, including scope, timelines, methodology and reporting arrangements.

**Clinical senate council** will:

- i. appoint a clinical review team, this may be formed by members of the senate, external experts, and / or others with relevant expertise. It will appoint a chair or lead member.
- ii. endorse the terms of reference, timetable and methodology for the review

- 
- iii. consider the review recommendations and report (and may wish to make further recommendations)
  - iv. provide suitable support to the team and
  - v. submit the final report to the sponsoring organisation

**Clinical review team** will:

- i. undertake its review in line the methodology agreed in the terms of reference
- ii. follow the report template and provide the sponsoring organisation with a draft report to check for factual inaccuracies.
- iii. submit the draft report to clinical senate council for comments and will consider any such comments and incorporate relevant amendments to the report. The team will subsequently submit final draft of the report to the Clinical Senate Council.
- iv. keep accurate notes of meetings.

**Clinical review team members** will undertake to:

- i. commit fully to the review and attend all briefings, meetings, interviews, and panels etc. that are part of the review (as defined in methodology).
- ii. contribute fully to the process and review report
- iii. ensure that the report accurately represents the consensus of opinion of the clinical review team
- iv. comply with a confidentiality agreement and not discuss the scope of the review nor the content of the draft or final report with anyone not immediately involved in it. Additionally they will declare, to the chair or lead member of the clinical review team and the clinical senate manager, any conflict of interest prior to the start of the review and /or materialise during the review.

**END**

## Appendix 4

### BACKGROUND INFORMATION

- North Kirklees CCG Service Specification, Schedule 2
- North Kirklees CCG Functions Document V1
- North Kirklees CCG Scope of Services V10
- Calderdale CCG Calderdale Closer to Home, Schedule 2, V3 and appendices
- Greater Huddersfield CCG, V0.3, Care Closer to Home Services
- Greater Huddersfield CCG and North Kirklees CCG Overarching Outline Service Specification and Supplementary information. September 2014 V1 and appendices
- Calderdale CCG A2 Community Specifications (received 23<sup>rd</sup> January)
- Calderdale CCG and Greater Huddersfield CCG Community Services List (received 23<sup>rd</sup> January)



**Clinical Senate  
Yorkshire and the Humber**

*“An independent source of strategic clinical advice for Yorkshire and the Humber”*

# **Clinical Senate Review of the Future Model of Hospital Services for Calderdale and Greater Huddersfield CCGs**

December 2015

Clinical Senate Reviews are designed to ensure that proposals for large scale change and reconfiguration are sound and evidence-based, in the best interest of patients and will improve the quality, safety and sustainability of care.

Clinical Senates are independent non statutory advisory bodies hosted by NHS England. Implementation of the guidance is the responsibility of local commissioners, in their local context, in light of their duties to avoid unlawful discrimination and to have regard to promoting equality of access. Nothing in the review should be interpreted in a way which would be inconsistent with compliance with those duties.

Yorkshire and the Humber Clinical Senate  
[yhsenate@nhs.net](mailto:yhsenate@nhs.net)

Date of Publication: December 2015

## Version Control

Document Version	Date	Comments	Drafted by
Version 0.1	6 <sup>th</sup> October 2015	Compiled based on working group conversation and discussion	Joanne Poole
Version 0.2	14 <sup>th</sup> October 2015	Formatting updated and revised to include working group feedback	Joanne Poole
Version 0.3	1 <sup>st</sup> December 2015	Revised in response to commissioner comment	Joanne Poole
Final Version 1.0	4 <sup>th</sup> December 2015	Agreed as final version following commissioner comments and Council ratification	Joanne Poole

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**v.****vi. 1. Chair's Foreword**

vii. 1.1 The Yorkshire and the Humber Senate welcomes the opportunity to work with commissioners on the development of their hospitals model. In its consideration of the proposals, the Senate focused on providing impartial clinical information on the sustainability of clinical services, not about the sustainability of particular institutions.

viii. 1.2 The Senate recognises the work that has gone into these proposals and fully supports the commissioners' direction of travel and their aspirations for the service. It is recognised that the detail is still to be developed and therefore we can only provide broad assurance at this stage.

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## 2. Summary Recommendations

- 2.1 The Senate commends the commissioners on their vision for the future of hospital services and we support the commissioners' aspirations for the service. The Senate agrees that the Quality and Safety Case for Change and the baseline position support the need to move towards greater centralisation of services across hospital sites. The Senate agrees that a clear argument is made that the current configuration of services does not and cannot meet national guidance, and that staying the same is not an option.
- 2.2 The Senate recognises that the documents supplied are a work in progress and the supporting detail regarding activity and workforce will be developed as part of the pre-consultation Business Case.
- 2.3 As a high level strategic document for whole system change, the Senate agrees with the aspirations outlined in the Model of Care. The Senate recommends however, that as the work develops the commissioners describe the model with greater clarity, particularly focussing on detail about the workforce and activity. The lack of detail at this stage left the Senate with questions regarding the ability of this model to deliver the standards proposed. At this point, the Senate can only endorse the vision and give broad assurance of its potential to deliver a quality service. Following the receipt of further additional information about the Urgent Care Centres, the Senate are broadly content with the proposals but there is always the possibility that a very ill patient will attend the Urgent Care Centre and commissioners need to ensure that staff have the medical and nursing skills, experience and capabilities to safely stabilise that patient. Commissioners are recommended to consider this further as they develop the model.
- 2.4 The Senate supports the standards proposed in the documentation which are taken from a variety of national documents and reflect the best of national policy. The standards are very generic, however, and could largely apply to any Trust. Commissioners are recommended to include more detail about the level of local clinical engagement in agreeing how deliverable these standards are.

## 3. Background

### Clinical Area

- 3.1 In February 2014, in response to a 2013 National Clinical Advisory Team report, Calderdale and Huddersfield Foundation Trust (CHFT), South West Yorkshire Foundation Trust (SWYFT) and Locala developed a Strategic Outline Case (SOC) for the future provision of community and hospital services in Calderdale and Greater Huddersfield and expressed a preferred configuration for future provision. The SOC

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was developed by the providers into an Outline Business Case accessed by commissioners in September 2014.

- 3.2 Commissioners decided that they would progress changes to community services in advance of any changes to hospital services. The Senate reviewed the community proposals in March 2015. Commissioners have now developed their proposals for what the potential future model for hospital services could look like and are working with CHFT to gain broad agreement. These proposals are likely to represent significant service change.

### **Role of the Senate**

- 3.3 The Senate is being approached as part of the Clinical Commissioning Group (CCG) preparation for strategic sense check 2 of the Service Change Assurance Process in order that the findings can be considered as part of the CCGs overall assessment of Readiness for Consultation.

- 3.4 The Senate was asked to:

*Consider the hospital standards and the current baseline position, together with the potential future model of care for hospital services and provide an assessment of the extent to which they support the model's potential to deliver the hospital standards and address the issues outlined in the Quality and Safety Case for Change.*

- 3.5 The advice will be used to inform the CCG proposals for service change, provide assurance for the quality impact assessment and form part of the submission to NHS England for the assurance stage 2 checkpoint.

### **Process of Review**

- 3.6 The Senate received the request for review on the 11<sup>th</sup> August 2015 with the associated evidence. The Working Group was appointed by the end of August and the Terms of Reference were also agreed by this date.
- 3.7 The Senate Working Group held a number of teleconferences to aid their discussions during the final two weeks of September. Initially, a meeting was planned with commissioners for the 20<sup>th</sup> October 2015, however, an initial call was held with commissioners on the 1<sup>st</sup> October and it was agreed that a further discussion was not required. The commissioners provided further information on the Urgent Care Centres. The report was drafted by the Working Group following the receipt of this additional information and the discussions and the final draft was provided to the commissioners for comment on the 16<sup>th</sup> October 2015. The report and commissioner comments will be provided to the Senate Council for final ratification on the 19<sup>th</sup> November 2015.



## ix. 4. Evidence Base

- 4.1 The Senate has referred to the National Institute for Health Research Report<sup>12</sup> to identify the evidence base. This report acknowledges that whole-hospital- and -system change is an area in which there is little robust evidence and there is much more evidence to guide change in specific service areas. The report states that more longitudinal studies are needed to track the economic and quality benefits of whole-hospital- and -system change, even though the evolving nature of service change and the lack of the necessary financial and quality information can make this difficult.<sup>13</sup>
- 4.2 The clinicians involved in this review worked to achieve a consensus based on experience and judgement. As this review considers a number of services including urgent and emergency care and maternity services, the lengthy evidence base for these specific service areas has not been repeated in this report but it is summarised in the National Institute for Health Research report<sup>1</sup>.

## x. 5. Recommendations

### General Comments

- 5.1 The Senate commends the commissioners on their vision for the future of hospital services. The Senate agrees that the Quality and Safety Case for Change and the baseline position support the need to move towards greater centralisation of services across hospital sites. The Senate agrees that a clear argument is made that the current configuration of services does not and cannot meet national guidance and staying the same is not an option.
- 5.2 The Senate fully supports the commissioners' direction of travel and their aspirations for the service. The level of detail as yet provided in the model does not clearly translate those aspirations into actions, the model proposed may result in an excellent service but the lack of detail at this stage, particularly regarding workforce, leaves the Senate with questions regarding the ability of this model to deliver the standards proposed. At this stage, the Senate can only endorse the vision and give broad assurance that this has the potential to deliver a quality service.
- 5.3 The Senate has separated its comments into several key areas which we hope will assist commissioners as their model develops.

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<sup>12</sup> Insights from the Clinical Assurance of Service Reconfiguration in the NHS: the drivers of reconfiguration and the evidence that underpins it – a mixed method study. National Institute for Health Research.

<sup>13</sup> Spurgeon P, Cooke M, Fulop N, Walters R, West P, 6 P, et al. Evaluating Models of Service Delivery: Reconfiguration Principles. Southampton: SDO; 2010.

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## The Quality and Safety Case for Change

- 5.4 The Senate agreed that this is a good document which outlines the proposals for change and their rationale. It clearly sets out that there are inconsistencies in outcomes for patients, a hard message to receive and give, but very necessary in gathering support for the propositions. The report states some key challenges such as mortality, re-admission rates, harm free care measures, Standardised Hospital Mortality rate, Length of Stay, long wait for diagnostics, high complaints and nurse sickness. The Senate agrees that this provides a clear, balanced and powerful message that the current configuration of services does not and cannot meet national guidance and that staying the same is not an option. Page 6 clearly highlights that Calderdale & Huddersfield NHS Foundation Trust does not consistently achieve the harm free measures of the national Patient Safety Thermometer. The Senate also agreed that the document clearly points out the variation in the quality of maternity care across the services and makes the case that they are not configured around the patients' needs. Linking this with the staffing challenge supports the case for change, as does the parents dissatisfaction on page 12 of the document.
- 5.5 The Senate felt that in some cases there was opportunity for greater explanation and linkage of the case for change with the proposed solutions and the prioritisation agreed by commissioners does not appear to address all of these issues outlined in the document.
- 5.6 The following comments may assist with the further development of the document:
- 5.6.1 Page 3: Commissioners may wish to consider adding more data about the over 85s. Those in this age group are the frailest, have the most complex of needs that are hugely challenging to address. In terms of integrated care, the other 2 programmes will be looking at alternatives to hospital for them – but while hospital is sometimes the only place to be, it is easy to debilitate if discharge is not optimally timed and coordinated.
- 5.6.2 We felt it would be helpful to have an example of the Quality and Safety dashboard, how it is going to be used and by whom and the escalation frameworks.
- 5.6.3 For specifics like pressure ulcer venous thromboembolism screening and falls, we could not see a clear explanation of specific measures that will resolve them. Similarly, we could not see an explanation about what is going to be done about hospitalisation rates above national average for patients with Long Term Conditions.
- 5.6.4 It would be helpful to provide more information to understand the driver for the 30 day re-admission rate.

5.6.5 It would be helpful to provide more information within this document of the fundamental staffing issues, the skill mix, numbers and the factors that are causing the workforce pressures. A driver for change is the ability to staff rotas and a description of difficulties in this area would strengthen the case. Commissioners may also want to consider working alongside your providers to fully understand the reasons for higher sickness absence. Higher absences often results in higher use of bank and agency staff which can impact on Trust quality measures. Commissioners will want to seek assurance that there is a plan to fully understand the reasons for this situation and that there is an action plan for recovery.

### **Baseline Document**

5.7 To evidence the improvement in patient safety and care quality, the proposal has provided a baseline for some but not for all of the defined 26 metrics. The Senate questioned whether this means it is anticipated there will be improvement in some but not all metrics. The Senate felt that the baseline would benefit from including differences, if any, in available infrastructure and workforce on the two hospital sites together with more detail on workload volumes.

### **The Standards**

5.8 The standards proposed in the documentation are taken from a variety of national documents and broadly, we cannot disagree with the nature of these standards which reflect the best of national policy and aim for the best service. Largely, these standards have been considered throughout the Future Model of Care document. The Senate agreed that the documentation clearly makes the case that these standards cannot be achieved under this current model of service and that change is required.

5.9 The documentation does not give a sense, however, of what local clinical discussions there have been in agreeing how achievable these standards are locally. The standards are generic and could largely apply to any Trust, which left the Senate with questions about their deliverability. From the information provided, we could not have confidence that the model would guarantee performance in the absence of clarity on the other key factors including staffing levels, which the Senate agreed are crucial to the delivery of these standards. The case for change, the model and our understanding of its ability to deliver the standards would be considerably strengthened by the inclusion of more workforce information. For example, with regards to standards 41 and 43 it would be interesting to note the compliance with senior sisters having supervisory time and senior nurses attending ward rounds. These activities are key in reducing complaints, improving patient experience and enhancing discharge processes.

- 5.10 There were some areas where the Senate could not clearly see how the delivery of some of these standards could be tied solely to the service change, for example, in some of the later standards around patient flow through diagnostics, including 24/7 availability of radiology, and access to lab/x-rays. As a final comment, in standard 68, commissioners may consider a next day service for tuberculosis smears as adequate.

### **The Hospital Model**

- 5.11 The Future Model of Care documentation presents a more centralised model of care which the Senate fully endorses. The Senate agreed that this was a very good articulation of patient centred care. As a high level strategic document for whole system change, the Senate agrees with the aspirations outlined. The Senate felt however, that the proposed model could be described with greater clarity. Our understanding is that the Emergency Care Centre (ECC) along with all specialties required to deliver a fairly comprehensive emergency care service, will be located on one hospital site. This will include acute paediatrics and an obstetric led maternity service. The co-dependencies are described. The rationale for the single emergency centre is clear. We also agreed that the maternity and children's model are clear, with sound rationale. More detail on the non-elective service that will continue to be provided on the other hospital site would be reassuring. In further presentation of the evidence, commissioners are recommended to provide a clearer picture of the current services including geography, population, patient access etc. and articulate more directly how this current model will change. How achievable these aspirations are depends on the operational detail, particularly the workforce model, including recruitment and retention. As already stated, the documentation does not articulate what the workforce challenges are and how they will be addressed.
- 5.12 The aim of "right care, right time right place" rightly places emphasis on community services however, more information could be provided on what role primary care (and social services) have in this plan. The Senate felt that there could be detail within the model about the integration and communication to ensure that the patient pathway is as smooth as possible. The clarity of the part played by each section of the organisation and the ease, with which a patient moves through their journey, could be better reflected here. The Senate also agreed that the links with the work on care closer to home do not come through here clearly enough.
- 5.13 Within the Model of Care document, more could be made of the 3 programmes and the importance of keeping them linked in the coming 2-3 years in order to bring about whole system change. Hospital staff need to understand that reducing length of stay and avoidable admissions and re-admissions depends upon collaborative working and joined up pathways. This may need to be supported by a cultural shift in thinking. On page 3, the honesty about the variability of hospital care is commendable and this could be used powerfully with clinicians in initiating new models.
- 5.14 It was not clear from the information provided, on the level of engagement which there has been with Primary Care. We also felt that the model could be strengthened

with clear information on the link to social services and mental health services. End of life care and palliative care services need a dedicated focus and there is no mention of them in these papers.

- 5.15 On page 7 of the document, the Senate felt that there may be some mileage in separating frailty medicine out from the other specialties, given the opportunities to reduce length of stay and discharge from urgent/emergency settings to appropriate intermediate/care closer to home services for these patients. Interface geriatric models elsewhere have been very successful. This is a different and important work stream that needs a focus.
- 5.16 As a final point, the Senate noted that the documentation does not include the commissioner strategy on the supporting data and intelligence systems.

### **The Urgent Care Centres**

- 5.17 There is a lack of detail within the evidence supplied about the urgent care centre model. Further discussion with commissioners confirmed the following detail on the Urgent Care Centres (UCCs):

*What will be delivered by the UCC and to whom and what facilities will they have?*

- 5.18 The Urgent Care Centre is a primary care facility with minor injuries incorporated. We would expect them to have Point of Care Testing and X-Ray facilities. In the specification it has been agreed that the centres will be medically-led by a clinician with the knowledge and skills to undertake triage and autonomous decision making regarding the next steps in an individual's care. We expect this is likely to be GP's but have to recognise current and future workforce issues. Hand over is expected to include update to the Hospital Electronic Patient Record which is available across all sites. Diagnostics would have been started and patients needing transfer will be discussed (over e.g. Skype) with the Emergency Care Centre (ECC) prior to transfer.
- 5.19 Patients can only get into the Emergency Care Centre via some sort of clinical triage. GPs are a valid form of triage but they are likely to send cases via ambulance. The ambulance staff / paramedics will have protocols which stratify patients so that they can direct them into the ECC depending on the acuity of their illness. Patients in the remote UCC(s) who have serious illness will be triaged, stabilised often with technology assistance (Skype) from the specialists at the ECC, and then transferred.

*If there are 3 sites, will they have the same infrastructure to support care delivery (consistency)?*

- 5.20 Yes, the aim is for a consistent offer on all 3 sites if affordable/can be staffed. The 3<sup>rd</sup> site may not be 24 hour.

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*What are the implications of transfer of patients between sites? Can the UCC stabilise the emergency patient whilst transport is being arranged?*

- 5.21 Yes, Skype type technology would facilitate a discussion with the Emergency Care Centre specialist doctor so that they would be involved in management / stabilisation prior to transfer.

*What is the time line for their development?*

- 5.22 The pre-consultation Business Case is under development. As part of that, commissioners will need to determine feasibility in relation to finance and workforce for the whole model. It is expected that this will be ready for consultation early in 2016.

*What is the current 'in hours GP' service and how will the current out of hours service be incorporated and negotiated?*

- 5.23 There isn't a current GP in-hours service. Commissioners are considering Multispecialty Community Providers (MCP) / Primary and Acute Care Systems (PACS) models to deliver this in future.

*What are the links to social and mental health triage and assessments?*

This will be subject to more detailed future work.

- 5.24 This additional information has answered many of the Senate questions about these centres and we are broadly content with the proposals. In their further development, commissioners are recommended to consider:

5.24.1 The skills of the workforce. The triage skills and staff clinical portfolios need to be sufficient to enable them to make timely and informed decisions. There is always the possibility that a very ill patient will attend the Urgent Care Centre and commissioners need to ensure that staff have the medical and nursing skills, experience and capabilities to safely stabilise that patient. Currently, the Senate has no information on the staffing of these centres and an inexperienced staff member seeking advice from colleagues via Skype does not offer a rounded solution. We are also not clear on the paediatric expertise at each centre.

5.24.2 The signposting to the UCCs. The key to their success is the patient understanding of their role and commissioners need to define the capabilities of these centres. Whilst patients will understand what to expect when they visit their GP and the Emergency Department, they will need educating on what the UCCs can offer them. Patients need to determine how urgent their need is. Although there is the ability for patients to book appointments at urgent care and also to use this as a walk-in centre, this may present a confused picture to patients as to how they are supposed to use the facility.

5.24.3 Secure telemedicine links are required to provide the ability to transfer Digital Imaging and Communications in Medicine files (DICOM) easily together with other imaging and pathology data. Skype is not appropriate for this purpose.

5.24.4 Further information on how the current Out of House Service will be incorporated and negotiated would be helpful.

### **The Wider Context**

5.25 There is work ongoing across West Yorkshire and the wider Yorkshire and the Humber geography to determine a range of service models including urgent and emergency care, stroke and vascular services. The Senate understands the need for commissioners to press ahead and meet the needs of their population and therefore, their inability to await the conclusion of these larger scale pieces of work. The outcome of this work however, will impact upon the Calderdale and Greater Huddersfield Hospital model and in discussion, commissioners gave the Senate assurance that they are fully engaged in all these work streams and that they will have the flexibility to respond to those outcomes as and when they are determined. The Senate also discussed the impact of their proposals on neighbouring services, Mid Yorkshire for example, and commissioners also gave assurance about those ongoing discussions and their understanding of the need to provide a seamless patient pathway across boundaries.

## **xi. 6. Summary and Conclusions**

6.1 The Yorkshire and the Humber Clinical Senate concludes that:

6.1.1 The Quality and Safety Case for Change and the Baseline document demonstrate that the current configuration of services does not and cannot meet national guidance and staying the same is not an option.

6.1.2 The documentation provides a good vision for the future of hospital services and we support the commissioners' aspirations to move towards greater centralisation of services across hospital sites.

6.1.3 At this point, the Senate can only endorse the vision and give broad assurance of its potential to deliver a quality service. The proposed model needs to be described with greater clarity, particularly detail about the workforce, in order to answer questions regarding the ability of this model to deliver the standards proposed.

6.1.4 Further consideration needs to be given to the staffing of the Urgent Care Centres in order to ensure there is the correct medical and nursing skill mix and experience to safely stabilise a very sick patient.

- 6.1.5 The standards are understandably drawn from national documents but they are therefore very generic. The documentation would be improved with further narrative about the level of local clinical engagement there has been in agreeing how achievable these standards are locally.



# APPENDICES

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## Appendix 1

### LIST OF INDEPENDENT CLINICAL REVIEW PANEL MEMBERS

#### Council Members

Professor Chris Welsh, Senate Chair

Catherine Wright, Allied Health Professionals Lead, Bradford District Care Trust

Dr Andrew Phillips, Interim Deputy Chief Clinical Officer, Vale of York CCG

Richard Parker, Director of Nursing & Midwifery & Quality, Doncaster & Bassetlaw Hospitals NHS Foundation Trust

Dr Sewa Singh, Medical Director, Doncaster & Bassetlaw Hospitals NHS Foundation Trust

#### Assembly Members

Peter Allen, Public Representative

Dr Philip McAndrew, Consultant Radiologist, Barnsley Hospital NHS Foundation Trust

Dr David Partridge, Consultant Microbiologist, Sheffield Teaching Hospitals NHS Foundation Trust

Dr Peter Weaving, GP Clinical Director North Cumbria

#### Co-opted Members

Lesley Bainbridge, Strategic Lead, Older People's Services and Integrated Care, Gateshead Health Foundation Trust

Dr Mike Jones, Consultant Acute Physician and Clinical Director Unscheduled Care, Co Durham & Darlington NHS Foundation Trust

## Appendix 2

### PANEL AND COUNCIL MEMBERS' DECLARATION OF INTERESTS

Name	Title	Organisation	Date of Declaration	Reason for Declaration	Date of Response	Proposed way of Managing Conflict	Further Comments
Steve Ollerton	CCG Chair	Greater Huddersfield CCG	12.8.14 & 20.11.14 and re-declared at September 2015 Council meeting	Chair of the CCG that will be seeking advice from the Senate	20.11.14 and restated at September 2015 Council meeting	To manage this conflict of interest we will need to ensure that Steve does not take part in any Council or sub group discussions as they relate to this matter	

## Appendix 3

### TERMS OF REFERENCE

# CLINICAL REVIEW

# TERMS OF REFERENCE

**TITLE: Calderdale and Greater Huddersfield CCGs Future Hospitals Model****Sponsoring Organisation:** Calderdale CCG**Terms of reference agreed by:** Chris Welsh on behalf of Yorkshire and the Humber Clinical Senate and Matt Walsh on behalf of Calderdale CCG**Date:** 28<sup>th</sup> August 2015**1. CLINICAL REVIEW TEAM MEMBERS****Clinical Senate Review Chair:** Professor Chris Welsh, Senate Chair**Citizen Representative:** Peter Allen**Clinical Senate Review Team Members:**

Name	Job Description
Lesley Bainbridge	Strategic Lead, Older People's Services and Integrated Care, Gateshead Health Foundation Trust
Dr Mike Jones	Consultant Acute Physician and Clinical Director Unscheduled Care, Co Durham & Darlington NHS FT
Dr Philip McAndrew	Consultant Radiologist, Barnsley Hospital NHS FT
Dr David Partridge	Consultant Microbiologist, Sheffield Teaching Hospitals NHS FT
Richard Parker	Director of Nursing & Midwifery & Quality, Doncaster & Bassetlaw Hospitals NHS FT
Dr Andrew Phillips	GP & Deputy Chief Clinical Officer, Vale of York CCG
Dr Sewa Singh	Medical Director, Doncaster & Bassetlaw Hospitals NHS FT
Dr Peter Weaving	GP Clinical Director North Cumbria
Catherine Wright	Allied Health Professionals Lead, Bradford District Care Trust

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## 2. AIMS AND OBJECTIVES OF THE REVIEW

### Question:

To consider the hospital standards and the current baseline position together with the potential future model of care for hospital services and provide an assessment of the extent to which they support the model's potential to deliver the Hospital Standards and address the issues outlined in the Quality and Safety Case for Change.

### Objectives of the clinical review (from the information provided by the commissioning sponsor)

To provide strategic independent advice on the extent to which the CCG proposals will address the Quality and Safety Case for change and deliver the Hospital Standards.

The Senate advice will inform the Stage 2 of the assurance process by reviewing the service change proposal against the clinical evidence base key test. The findings will be considered as part of the CCGs' overall assessment of 'Readiness for consultation' and form part of the CCG submission to NHS England for the assurance stage 2 checkpoint.

## 3. TIMELINE AND KEY PROCESSES

**Receive the Topic Request form:** 11<sup>th</sup> August 2015

**Agree the Terms of Reference:** Drafted 28<sup>th</sup> August 2015

**Receive the evidence and distribute to review team:** 11<sup>th</sup> August, review team appointed between 11<sup>th</sup> and 26<sup>th</sup> August and evidence distributed to all members during this time

**Teleconferences:** Working Group internal teleconferences scheduled for w/c 14<sup>th</sup> and 21<sup>st</sup> September.

**Meeting with Commissioners:** Teleconference scheduled 1<sup>st</sup> October

**Draft report submitted to commissioners:** 16<sup>th</sup> October

**Commissioner Comments:** 2nd November

**Senate Council ratification;** 19<sup>th</sup> November

**Publication of the report on the website:** TBC

#### **4. REPORTING ARRANGEMENTS**

The clinical review team will report to the Senate Council who will agree the report and be accountable for the advice contained in the final report. The report will be given to the sponsoring commissioner and a process for the handling of the report and the publication of the findings will be agreed.

#### **5. EVIDENCE TO BE CONSIDERED**

The review will consider the following key evidence:

1. CCG Hospital Standards;
2. CCG current Baseline against these standards
3. CCG Quality and Safety Case for change
4. The Outcomes the CCG expect the Model to deliver (also an Appendix in the model)
5. The potential Clinical Model

The review team will review the evidence within these documents and supplement their understanding with a clinical discussion.

#### **6. REPORT**

The draft clinical senate report will be made available to the sponsoring organisation for fact checking prior to publication. Comments/ correction must be received within 10 working days.

The report will not be amended if further evidence is submitted at a later date. Submission of later evidence will result in a second report being published by the Senate rather than the amendment of the original report.

The draft final report will require formal ratification by the Senate Council prior to publication.

#### **7. COMMUNICATION AND MEDIA HANDLING**

The final report will be disseminated to the commissioning sponsor, provider, NHS England (if this is an assurance report) and made available on the senate website. Publication will be agreed with the commissioning sponsor.

#### **8. RESOURCES**

The Yorkshire and the Humber clinical senate will provide administrative support to the clinical review team, including setting up the meetings and other duties as appropriate.

The clinical review team will request any additional resources, including the commissioning of any further work, from the sponsoring organisation.

## 9. ACCOUNTABILITY AND GOVERNANCE

The clinical review team is part of the Yorkshire and the Humber Clinical Senate accountability and governance structure.

The Yorkshire and the Humber clinical senate is a non-statutory advisory body and will submit the report to the sponsoring organisation.

The sponsoring organisation remains accountable for decision making but the review report may wish to draw attention to any risks that the sponsoring organisation may wish to fully consider and address before progressing their proposals.

## 10. FUNCTIONS, RESPONSIBILITIES AND ROLES

The **sponsoring organisation** will

- xii. provide the clinical review panel with agreed evidence. Background information may include, among other things, relevant data and activity, internal and external reviews and audits, impact assessments, relevant workforce information and population projection, evidence of alignment with national, regional and local strategies and guidance. The sponsoring organisation will provide any other additional background information requested by the clinical review team.
- xiii. respond within the agreed timescale to the draft report on matter of factual inaccuracy.
- xiv. undertake not to attempt to unduly influence any members of the clinical review team during the review.
- xv. submit the final report to NHS England for inclusion in its formal service change assurance process if applicable

**Clinical senate council** and the **sponsoring organisation** will:

- ii. agree the terms of reference for the clinical review, including scope, timelines, methodology and reporting arrangements.

**Clinical senate council** will:

- i. appoint a clinical review team; this may be formed by members of the senate, external experts, and / or others with relevant expertise. It will appoint a chair or lead member.
- ii. endorse the terms of reference, timetable and methodology for the review
- iii. consider the review recommendations and report (and may wish to make further recommendations)
- iv. provide suitable support to the team and
- v. submit the final report to the sponsoring organisation

**Clinical review team** will:



- 
- v. undertake its review in line the methodology agreed in the terms of reference
  - vi. follow the report template and provide the sponsoring organisation with a draft report to check for factual inaccuracies.
  - vii. submit the draft report to clinical senate council for comments and will consider any such comments and incorporate relevant amendments to the report. The team will subsequently submit final draft of the report to the Clinical Senate Council.
  - viii. keep accurate notes of meetings.

**Clinical review team members** will undertake to:

- v. commit fully to the review and attend all briefings, meetings, interviews, and panels etc. that are part of the review (as defined in methodology).
- vi. contribute fully to the process and review report
- vii. ensure that the report accurately represents the consensus of opinion of the clinical review team
- viii. comply with a confidentiality agreement and not discuss the scope of the review or the content of the draft or final report with anyone not immediately involved in it. Additionally they will declare, to the chair or lead member of the clinical review team and the clinical senate manager, any conflict of interest prior to the start of the review and /or materialise during the review.

**END**

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## Appendix 4

### BACKGROUND INFORMATION

The evidence received for this review is listed below:

1. CCG Hospital Standards Version 2.1
2. Calderdale and Greater Huddersfield Trust Overall Quality and Safety Template response
3. CCG Quality and Safety Case for change version 3.4
4. RCRTTRP Hospital Standards Outcomes version 3.1
5. The Hospital Services Future Model of Care Version 0.9

# Calderdale and Huddersfield NHS Foundation Trust (CHFT) implementation of the potential outline future model of care for hospital services: Quality Impact Assessment

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*This quality assessment describes the impact of service changes as a result of implementation of the agreed clinical consensus model (v1.1), for the potential future outline model of care for hospital services, on the Trust's ability to provide high quality patient care. It does not assess the impact of any changes in service delivery location as site specific changes are yet to be decided.*

*A review of travel times in order to provide an assessment on the impact of the potential outline model of care on access to care will be included in the equality impact assessment.*

## **Commercial in confidence**

Date: 7th December 2015

Version: 0.2

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## 1.0 Executive Summary

**The potential outline model of care provides a compelling opportunity to enhance delivery of acute services in accordance with best practice standards for care and patient experience.**

▶ **Clinical sustainability issues currently exist at CHFT in a number of areas.**

- ▶ The Trust is not currently compliant with Royal College of Paediatrics and Child Health and Royal College guidelines.
- ▶ There is a heavy reliance on locums, with a 1:5 on-call for Medical Consultants, significantly impacting recruitment and retention of staff.

The potential future outline model of care would address these issues, strengthening the care and quality received by patients.

- ▶ **There is strong evidence that the proposed model of care will deliver benefits.** In particular, improvements in paediatrics, emergency medicine and critical care staffing.
- ▶ **The potential outline model of care directly supports the local Health and Well Being Board, Commissioner and Trust 5 year strategies.**
- ▶ **Service reconfiguration in accordance with the outline model of care entails a significant degree of organisational change, but provides the opportunity for greater patient benefits than networking or collaboration initiatives alone.**
- ▶ **Modelling indicates a modest potential impact on neighbouring providers as a result of the proposed outline model of care.**
  - ▶ If HRI (Huddersfield Royal Infirmary) is the chosen site for unplanned and emergency care, then there could be an estimated 1,129 additional attendances annually at The Royal Oldham Hospital, with an incremental capacity requirement equivalent to 10 beds.
  - ▶ If CRH (Calderdale Royal Hospital) is chosen as the site for unplanned and emergency care, then there could be an estimated 1,089 additional attendances at Pinderfields General Hospital, with an incremental capacity requirement equivalent to 8 beds.
  - ▶ The modelling assumes that an ambulance divert will be in place at Dewsbury Hospital within the 5 year time horizon, leading to additional activity at CHFT
- ▶ **The potential outline model of care is inextricably linked with the improvements in patient care, and delivery of care closer to home initiatives, that are at the core of local strategic intent.**
- ▶ **No degradation of any existing services is anticipated as a result of the proposed model.** Some services may experience a change in the location at which the service is delivered. However, there is anticipated to be significant associated improvements in quality as a result of the implementation of the model.

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## 2.0 Purpose of this document

Calderdale CCG, Greater Huddersfield CCG and CHFT are working collectively to implement proposals for the future provision of hospital services across Calderdale and Greater Huddersfield.

This Quality Impact Assessment (QIA) of the proposed future model of care has been developed to provide assurance that the proposed reconfiguration of CHFT acute services will not adversely affect the quality of patient care. This is defined by NHS England as care that is clinically effective, safe and that provides as positive an experience for patients as possible.

The QIA describes the service changes as a result of implementation of the potential outline model of care for hospital services but does not assess the impact of any changes in service delivery location as site specific changes are yet to be decided. Travel times and ease of access are areas for review in the equality impact assessment, which is a separate document.

## 3.0 Clinical case for change and risk analysis

### 3.1 The current configuration of services

CHFT provides acute services at Calderdale Royal Hospital (CRH) and Huddersfield Royal Infirmary (HRI), as well as community services for Calderdale. Services currently provided at both sites include:

- A&E services
- Midwife-led maternity services
- Paediatrics (however medicine at CRH, surgery at HRI)
- Outpatient and day-case services
- Medical specialties (majority)
- Level 3 intensive care therapy for adults
- Rehabilitation for older people
- Complete range of diagnostics
- Endoscopy
- Therapy services
- Early supported discharge in respiratory and stroke
- Outpatient chemotherapy

Services provided at only one of the sites include acute surgery, stroke, oncology / haematology and inpatient gynaecology.

### 3.2 Key challenges

The Trust is experiencing a number of pan-Trust challenges in ensuring continued delivery of consistent, safe, high quality care. These can broadly be divided into the following categories:

- Operational and quality
- Workforce related

All of these challenges are set against a difficult financial environment for the Trust, the wider health economy, the NHS, and social care as a whole. The financial pressures being felt across the system are exacerbating many of the operational challenges that the Trust is facing.

### 3.2.1 Operational and quality challenges

- **Split service provision:** In some instances, a service is split across the two sites leading to a disjointed service and experience for patients. One example of this is in paediatrics. At present, paediatric medicine and surgery are not co-located on the same hospital site. This means that currently children that have urgent medical and surgical needs do not receive shared care from a consultant surgeon and a paediatrician. It also means that if an urgent consultant paediatric opinion is required out of hours, a consultant paediatrician on call for CRH may have to attend HRI whilst also being on call for acute paediatrics and neonatology at CRH.
- **Meeting Royal College recommendations / standards:** Currently the two Emergency Departments at CRH and HRI are non-compliant with many of the standards for Children and Young People in Emergency Care settings. Additionally, the provision of a critical care unit at each site means that the Trust is not currently in a position to fully comply with D16 guidance on critical care workforce standards.
- **Patient safety:** The Trust is working hard to improve patient safety performance indicators but there is room for improvement. For example, the Trust reports an above average hospital standardised mortality ratio.
- **Inter-hospital transfers:** The two sites do not provide the same services and there is therefore a need for inter hospital transfer of patients due to a lack of co-location of all the expertise needed on both sites (i.e. trauma and acute surgery, oncology and haematology are at Huddersfield and stroke, paediatrics and complex obstetrics are at Halifax).
- **Patient experience:** Planned operations can be subject to cancellation as the surgeons need to respond to meet the needs of emergency patients.

### 3.2.2 Workforce challenges

- **Medical workforce / senior medical cover:** There are a number of services which are experiencing challenges recruiting and retaining substantive workforce. This is made even more challenging by the need to operate dual site out of hours rotas. Known examples of where this is a particularly difficult issue are acute medicine, radiology and emergency services.

With regards to emergency medicine, at present the Trust is experiencing the effects of a national shortage of emergency doctors. This means that the current consultant pool is stretched through covering vacancies which the Trust is unable to recruit to. As a result, the two emergency departments are heavily reliant on cover from locum middle grade doctors to ensure care remains safe. Double running of emergency medical services leads to very thinly spread middle grade cover particularly out of hours and nights. It is also difficult to flex

other staff including nursing and allied health professional staff across two emergency sites and critical care units.

Pressures are also being felt amongst the wider medical consultant workforce. As a result of vacancies and challenges with recruiting and retaining staff, the Trust is unable to deliver specialty-specific rotas. This means that specialist consultants are left covering general medical on calls. The current on call rotas for medical consultants is 1:5 which hinders recruitment and retention of the medical workforce further exacerbating challenges with operational delivery.

### 3.3 Benefits to be realised from the proposed clinical model

The proposed clinical model will enable the Trust to better respond to the above challenges in the following ways:

- **Split service provision:** Ensuring that paediatric medicine and surgery are located on one site would ensure that consultants can oversight and input into both specialties thus facilitating the provision of shared senior paediatric and surgical care for patients. This would enable the delivery of more streamlined care for patients and ensure a more efficient use of paediatric workforce.

Additionally, co-location of paediatrics with the paediatrics Emergency Department will allow for paediatric emergency medicine (PEM) trained staff to work alongside and support acute paediatrics which has significant workforce issues, especially medical staffing.

- **Meeting Royal College recommendations / clinical standards:** Co-location of paediatrics with paediatrics emergency care will support conformity with the standards for Children and Young people in Emergency Care settings. Furthermore, the co-location of paediatric medicine and surgery would ensure that the Trust is better able to conform with the Royal College of Paediatrics and Child Health (RCPCH) guidance to provide consultant delivered care at peak times within the next 5 years

A single point of access for critical care beds will result in the Trust being better able to respond to the D16 critical care workforce standards thus supporting the delivery of improved patient outcomes for critical care and complex patients.

- **Patient safety:** Consolidation of acute services onto one site will facilitate the design, development and implementation of patient pathways across the patient's full acute journey, thereby strengthening safety mechanisms and minimising the opportunity for harm. Access to acute specialties in one place will ensure that complex patients are able to access the best breadth and depth of care appropriate to their needs and in a timely fashion.
- **Inter-hospital transfers:** The reconfiguration of acute medicine onto one site, to support the activity of the single ED, would have the advantage of reducing inter-hospital transfers which currently take place frequently for acute medical admissions, when one or other site has reached its maximum medical bed capacity. Eliminating transfers of medical patients will improve safety, optimise patient flow in ED, shorten waits to definitive care, reduce ED



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breaches of the four-hour target, and reduce the workload on the ambulance service which is currently responsible for providing these transfers.

- **Patient experience:** Providing planned services, including surgery, in a dedicated site ensures that access to treatment, surgery or therapy input can be structured and planned without risk of disruption from emergency cases.
- **Medical workforce / senior medical cover:** The changes in service and workforce model through consolidation into a single emergency department will ensure that the Trust will be in a position to meet the College of Emergency Medicine recommendation for a minimum of 10 Consultants in Emergency Medicine per emergency department. This will improve the likelihood of survival and a good recovery for patients.

A single emergency department, and separation into unplanned and planned services, will enable the Trust to leverage its workforce more efficiently and leave the Trust in a better position to meet standards around 7 day working in the future.

A summary of the issues pertaining to each clinical division are listed below. Details of the proposed future model and how this will yield actual benefits and address current problems are also described.

Division / Directorate	Current model / problems	Proposed Model	Benefits
<b>Medicine - Emergency Department</b>	<p>It is difficult to recruit sufficient numbers and seniority of staff to provide full senior medical oversight across both emergency departments.</p> <p>The two sites do not provide the same breadth of acute services and there is often a need for inter hospital transfer of patients as there is not a co-location of all the expertise needed on both sites</p>	<ul style="list-style-type: none"> <li>• A single unified Emergency Care centre for providing Emergency/Acute medicine and Accident and Emergency services will be located at the unplanned site. This will include access to MAU, SAU and ITU</li> <li>• Access to paediatric emergency care will also be provided at the unplanned site</li> <li>• There will be urgent care centres (UCC) at each hospital and in one further location for the treatment of adults with minor illnesses and minor injuries</li> <li>• Any child aged 5 years or younger will be referred to the Paediatric Emergency Department. Children between the ages of 5-16 with minor injuries can be seen at one of the UCCs</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Patients:</b> Improved patient safety and quality of care due to the shift to an operationally sustainable model and ability to provide longer periods of on-site consultant cover</li> <li>• <b>Patients:</b> Patients seen at appropriate site based on acuity with access to a wider range of services for patients requiring more complex care</li> <li>• <b>Staff:</b> A single ED will ensure that the workforce will not be stretched across two departments as is the case currently. The changes in service and workforce model will enable the College of Emergency Medicine recommendation of a minimum of 10 consultants in Emergency Medicine per ED to be achieved</li> </ul> <p>Recruitment and retention will improve as at present it is difficult to attract staff due to the 2 site model and frequency of on call shifts</p> <ul style="list-style-type: none"> <li>• <b>Patients:</b> Access to a wider range of services for patients requiring more complex care</li> </ul>

<p><b>Medicine - Acute Medical Directorate</b></p>	<p>Acute medical services are currently provided at both sites. Due to the clinical adjacencies required, if there is a single ED on the unplanned site then all acute medical services will need to be located</p> <p>Due to difficulties recruiting and retaining sufficient numbers of senior medical staff, the Trust is unable to deliver specialty rotas at present meaning patients do not always have immediate access to the level of specialist care they may require</p>	<ul style="list-style-type: none"> <li>• Acute medical services (cardiology, respiratory, gastroenterology, acute stroke, elderly complex care and orthogeriatric care) will be provided at the unplanned site</li> <li>• The following services will integrate with ED: acute medicine, acute elderly + frailty, Comprehensive Geriatric Assessment, respiratory care, stroke and community hub (e.g. crisis intervention, RAID)</li> <li>• Patients will be supported with early care plans so that people that do not need acute hospital care are able to return to their usual place of residence without delay</li> <li>• Enhanced level of ambulatory assessment and treatment with focus on keeping people at home</li> <li>• Early rehabilitation will be available on the unplanned site</li> <li>• Diabetes and endocrinology can be principally delivered in the community</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Patients:</b> Access to a wider range of services for patients requiring more complex care</li> <li>• <b>Patients:</b> There will be reduction in the need for intra and inter-hospital transfers for people who have more than one clinical need</li> <li>• <b>Staff / Trust:</b> The enlarged organisation will be a more attractive proposition to potential recruits, with a greater level of stability, more sustainable rotas, and the opportunity for sub-specialisation. Fewer Consultant vacancies will mean better continuity of care for patients.</li> <li>• <b>Patients:</b> Improving quality of care by providing comprehensive geriatric care for this Elderly Care patients</li> </ul>
<p><b>Medicine - Integrated Specialty</b></p>		<ul style="list-style-type: none"> <li>• Acute oncology and haematology services will be located on the unplanned site</li> <li>• Dermatology will be principally delivered in an outpatient and community clinic setting</li> <li>• Rheumatology will be principally based on the planned site as most services are delivered in a day case / clinic setting</li> <li>• Neurology will be predominantly outpatient based</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Patients:</b> Access to less acute medical input will be easier and faster in the dedicated planned site</li> <li>• <b>Patients:</b> Patients seen at appropriate site based on acuity</li> </ul>

		<ul style="list-style-type: none"> <li>• Palliative care will be principally delivered in the community</li> </ul>	
<b>Surgery &amp; Anaesthetics - Trauma &amp; Orthopaedic Services</b>		<p>No change</p> <ul style="list-style-type: none"> <li>• Acute trauma will continue to be located on the unplanned site</li> <li>• Unplanned orthopaedic surgery will continue to be undertaken at the unplanned site</li> <li>• Planned surgery to take place on the planned site routinely - transfers to critical care to take place if required and patients would only stay on the unplanned site for the duration of their acute/ critical care stay before transferring back to the planned site</li> <li>• Complex elective patients (hip revisions) to take place on the unplanned site as there will likely be a requirement for access to a high dependency unit</li> <li>• Other elective patients who are likely to require critical care support will be identified at the pre-assessment clinic</li> <li>• There is already a split of elective and non-elective activity (majority of acute work takes place at HRI, majority of elective work is at CRH)</li> <li>• There will be a single fracture clinic on the unplanned site</li> <li>• Majority of daycase work to take place on the planned site</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Patients:</b> Continued improvement in safety and mortality rates, already demonstrated by a partial reconfiguration of acute surgery onto HRI in 2005/6</li> <li>• <b>Staff:</b> Consolidating non-electives and electives on single sites will ensure that rotas can be strengthened, staff will not be spread thinly and there will be less of a dependence on locums</li> <li>• <b>Patients:</b> There will be a greater opportunity to review and redesign patient pathways thus improving patient outcomes and the patient experience</li> <li>• <b>Staff:</b> Centralising the 'unplanned' work will ensure that there is greater flex in the team and a better place to work therefore improving recruitment and retention</li> </ul>
<b>Surgery &amp; Anaesthetics - Operating Services,</b>	The provision of a critical care unit at each site means that	<ul style="list-style-type: none"> <li>• Level 2 and Level 3 ITU / Critical Care to be based on the unplanned site (currently Trust does not separate ITU and HDU, beds can be upgraded</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Patients:</b> Improvement in safety and patient outcomes when critical care</li> </ul>

<b>Theatres, Anaesthetics, Critical Care and Pain</b>	the Trust is not currently in a position to fully comply with D16 guidance on critical care workforce standards.	<p>or downgraded as necessary)</p> <ul style="list-style-type: none"> <li>• Patients requiring critical care will be transferred from planned site or identified in advance at the pre-assessment stage</li> <li>• Full day case theatre suite needed at planned site including recovery beds / trolleys</li> <li>• Pain services will be centralised at the planned site</li> <li>• Endoscopy services will be available on both sites</li> </ul>	workforce standards are met
<b>Surgery &amp; Anaesthetics - General Specialist Surgical Services</b>		<ul style="list-style-type: none"> <li>• No change</li> </ul> <p>Acute surgery will continue to be carried out on the unplanned site</p> <ul style="list-style-type: none"> <li>• Most inpatient planned surgery to be undertaken on the planned site</li> <li>• All vascular and urology surgery (including day case) to be undertaken on the unplanned site</li> <li>• Endoscopy units needed on both sites - GI bleeds will be managed on the unplanned site</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Staff:</b> Reconfiguration will improve resilience within the staff rota due to separation of planned and unplanned surgery</li> <li>• <b>Patients:</b> Better patient outcomes as more complex procedures will be centralised</li> </ul>
<b>Surgery &amp; Anaesthetics- Head &amp; Neck</b>		<ul style="list-style-type: none"> <li>• All ENT surgery (elective and non-elective) to be centralised onto the unplanned site</li> <li>• Ophthalmology to be undertaken on the planned site</li> <li>• Max fax day unit to be moved to the planned site</li> </ul>	
<b>Families &amp; Specialist</b>	Paediatrics is split between the	<ul style="list-style-type: none"> <li>• Specialist paediatric services will be co-located</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Patients:</b> Co-locating neonates with all</li> </ul>

<p><b>services - Children's Services</b></p>	<p>two sites – paediatric medicine at CRH and most paediatric surgery at HRI. This means that there is sub-optimal paediatric senior medical doctor oversight at HRI. At present consultants have little time to cover HRI but there is already a single consultant on call rota at present.</p>	<p>with the Emergency Care Centre - this will cover neonates, paediatric surgery and paediatric medicine</p> <ul style="list-style-type: none"> <li>• Neonates will be co-located with Consultant led Maternity care.</li> <li>• All paediatric surgery (including daycase) and paediatric medical care to be co-located at the unplanned site</li> </ul>	<p>acute paediatrics and obstetrics / gynaecology will mitigate against any possible risks from having these separate at present</p> <ul style="list-style-type: none"> <li>• <b>Staff:</b> Co-location of paediatric medicine and surgery will ensure that consultants can have oversight of both. The current model of having them separate is safe but not optimal.</li> <li>• <b>Staff:</b> Co-location of Paediatrics and Paediatrics EM will allow for Paediatric emergency medicine (PEM) trained staff to work alongside and support acute Paediatrics which also has significant workforce issues, especially medical staffing</li> <li>• <b>Trust:</b> Better conformity with the standards for Children and Young people in Emergency Care settings and Royal College of Paediatrics and Child Health (RCPCH) guidance to provide consultant delivered care at peak times within the next 5 years</li> </ul>
<p><b>Families &amp; Specialist Support Services - Women's Services</b></p>		<ul style="list-style-type: none"> <li>• Consultant - led obstetrics and neonatal care (currently at CRH) to be co-located on the unplanned site</li> <li>• Midwife - led maternity will be available on both hospital sites</li> <li>• Acute and inpatient gynaecology services will be</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Patients:</b> Patients can access a wider range of maternity care closer to home</li> <li>• <b>Patients:</b> Improved safety by ensuring only appropriate patients are cared for by the MLU and patients that may require obstetric care are seen at the specialist centre</li> </ul>

		<p>provided at the unplanned site</p>	<ul style="list-style-type: none"> <li>• <b>Patients:</b> Patients with complex obstetrics will be cared for in the centre where other specialist services ( ITU/ Surgery/ Interventional radiology) are available</li> <li>• <b>Patients:</b> There will be 24 hour consultant cover of the labour ward and 24/7 access to a competent supervising anaesthetist</li> <li>• <b>Staff / Trust:</b> The trust will be a more attractive proposition to potential recruits, with a greater level of stability, more sustainable rotas, and the opportunity for sub-specialisation</li> </ul>
<p><b>Community Services</b></p>	<p>The Trust faces a key capacity issue over the next 10 years due to a growth in demand for hospital services from the increasing population.</p>	<ul style="list-style-type: none"> <li>• Early rehabilitation and reablement will be provided on the unplanned site with some rehabilitation provision at the planned site (TBC)</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Patients:</b> The provision of rehabilitation and reablement provision on the unplanned site will ensure that rehabilitation can begin as early as appropriate in the patient’s journey. This will facilitate quicker and more assured discharge back to the patient’s own home or into the community</li> </ul>

### 3.4 Risk evaluation

Implementation of the proposed future model of care entails a number of risks. Evaluation of these risks has been undertaken and is documented below. Mitigating actions have been identified for all risks and no insurmountable risks to the implementation of the model have been identified

Risk Description	Likelihood 1-5	Impact 1-5	Prior risk level	Current risk level	Mitigating action
Failure to achieve the increased staff retention and improved recruitment in key specialties (such as Acute Medicine) from the new model, leading to a failure to realise patient benefits.	4	4	R	L	Successful implementation of the new clinical model coupled with development of detailed cut-over plans, rotas, and new ways of working in line with the overall model to attract and retain key staff. Backfill and temporary support to support a successful transition.
Decrease in quality of patient experience and increase in waiting times due to insufficient acute capacity to support levels of demand.	3	4	M	M	Through the planning process: Tracking of existing planned QIPP schemes and impact on activity. Service planning refinement with the commissioners as part of development of outline and full capital business cases. Following implementation of the new model: Divert to additional providers to handle immediate pressures, coupled with development of a strategic plan to address the demand - either through further activity reduction measures and/or creation of additional capacity.
Excess acute capacity developed to support levels of demand due to smaller than expected increases in demand and/or over-delivery on planned levels of QIPP.	1	2	L	L	Through the planning process: Tracking of existing planned QIPP schemes and impact on activity. Service planning refinement with commissioners as part of development of outline and full capital business cases. Following implementation of the new model: Mothballing of excess capacity with corresponding staffing decreases, coupled with redistribution of activity around the local health economy.
Decrease in quality of patient experience and increase in waiting times due to insufficient acute capacity, as a result of changes in wider system social and community care provision that increase acute demand.	3	3	M	L	Through the planning process: Capacity refinement with local authority input as part of the development of outline and full capital business cases. Following implementation of the new model: Divert to additional providers to handle immediate pressures, coupled with development of a strategic plan to address the demand - either through further activity reduction measures and/or creation of additional capacity.
Clinical and operational service delivery suffers a temporary deterioration due to staff distraction through the reconfiguration.	4	2	M	L	Planned double-running of services for periods of between 1 week and 1 month (service dependent and part of transition planning). Development of detailed cut-over plans, coupled with sufficient backfill and temporary support to enable transition.
Inadequate utilisation of the planned site, with excess demand on the unplanned site, leading to poor patient experience and delays.	3	3	M	L	Clinically led development on the assumptions underpinning the balance of acute vs elective activity across the two sites. Development of detailed ways of working and protocols for the reconfiguration to drive change in accordance with the new model.
Increase in average ambulance journey time due to the requirement for some patients to be transported further to the single Emergency Care Centre.	4	1	L	L	Maintenance of an Urgent Care Centre on the planned site which will support the majority of urgent clinical needs. For blue light patients, evaluation undertaken to date indicates an average increase in journey time from 16 to 22 minutes. The 6 minute increase is more than out- weighed by the benefits of being treated in the most clinically appropriate setting.



## 4.0 Evidence to support the model of care

### Local evidence of better outcomes from service co-location

In 2005/06 a partial reconfiguration of some hospital services was implemented to centralise acute surgery and trauma at HRI. Data published by Dr Foster shows that since 2005/06 to 2012/13 there has been a significant reduction in surgery and trauma service mortality rates (General Surgery mortality has reduced from 97 to 64, and Trauma and Orthopaedics mortality has reduced from 90 to 53). A full reconfiguration of all the acute specialities and emergency services on a single hospital site has the potential to enable even greater benefit from similar improvements in safety and reductions in mortality.

### Evidence of better outcomes from increased senior clinical decision making

A King's Fund report on hospital reconfiguration<sup>14</sup> states that "There is strong evidence about the importance of senior medical and other senior clinical input to care, particularly for high-risk patients." In addition, "There is strong evidence to support a senior doctor presence in A&E seven days a week." The proposed model of care will directly enable increased senior medical and clinical input to care, including in the Emergency Department.

### Evidence of better outcomes from surgery reconfiguration

There is evidence that the co-location of emergency and acute medical and surgical expertise can enable significant improvements in survival and recovery outcomes despite an initial increased travel time to the A&E department. For example the recent national reorganisation of major trauma services which reduced the number of sites showed a 20% increase in survival despite increased travel time. Similar results have been reported for cardiac and stroke patients.

The co-location of acute specialty teams on a single site could prevent potential safety events and delays in care, which are a risk in the current configuration, where medical patients are frequently transferred between the two sites.

Overall, the reconfiguration will directly enable meeting clinical standards.

Service	Standard not being met	Will the reconfiguration directly support meeting the standard?
Children's Services	Royal College of Paediatrics and Child Health (RCPCH) standard that a consultant paediatrician should be present and readily available in the hospital during times of peak activity, seven days a week.	Yes
Emergency Department	The College of Emergency Medicine recommends a minimum of 10 Consultants in Emergency Medicine per emergency department.	Yes
Operating Services, Theatres, Anaesthetics, Critical Care and Pain	D16 guidance on critical care workforce standards.	Yes

<sup>14</sup> [http://www.kingsfund.org.uk/sites/files/kf/field/field\\_publication\\_summary/Reconfiguration-of-clinical-services-kings-fund-nov-2014.pdf](http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_summary/Reconfiguration-of-clinical-services-kings-fund-nov-2014.pdf)

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## 5.0 Alignment with strategic objectives

An assessment of the impact of acute services reconfiguration has been undertaken against the strategic objectives of the local Health & Wellbeing Boards, the Trust and local commissioners.

### Local Health & Wellbeing Boards

Calderdale's joint wellbeing strategy, produced by the Calderdale Health & Wellbeing Board, articulates its vision of care for the local population as:

*"Our vision is for Calderdale to be an attractive place where people are prosperous, healthy and safe, supported by excellent services and a place where we value everyone being different and through our actions demonstrate that everyone matters"*

Ensuring that the people of Calderdale have good health is one of the strategy's key outcomes. Particular health issues identified in the strategy to prioritise include:

- Care of children and young people
- Management of cancer and cardiovascular disease
- Promotion of healthy lifestyle choices
- Tackling health inequalities
- Care of the ageing population

The Kirklees joint wellbeing strategy, which covers the greater Huddersfield area, has described the following vision:

*"No matter where they live, people in Kirklees live their lives confidently, in better health, for longer and experience less inequality"*

Ensuring that the people of Kirklees are as well as possible, for as long as possible, both physically and psychologically is a key objective of the strategy. This includes:

*"Having the best possible start in life through every child and young person being safe, loved, healthy, happy, supported to be free from harm; and have the chance to make the most of their talents, skills and qualities to fulfil their potential and become productive members of society"*

- Encouraging the development of positive health and social behaviours
- Identifying issues as soon as possible that affect health and wellbeing
- Enhancing self-care: people being increasingly independent, self-sufficient and resourceful so able to confidently manage their needs and maximise their potential

### Local commissioners

Calderdale CCG's vision is comprised of the following key objectives:

- Improve health and wellbeing of all our communities
- Support people to be independent
- Deliver care in the right place at the right time

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Significant principles underpinning Greater Huddersfield CCG's vision –

*“No matter where they live, people in Kirklees live their lives confidently, in better health, for longer and experience less inequality”*

– includes objectives that care is:

- based around integrated service delivery across primary, community and social care that is available 24 hours a day and 7 days a week where relevant; and
- led by fully integrated commissioning, workforce and community planning.

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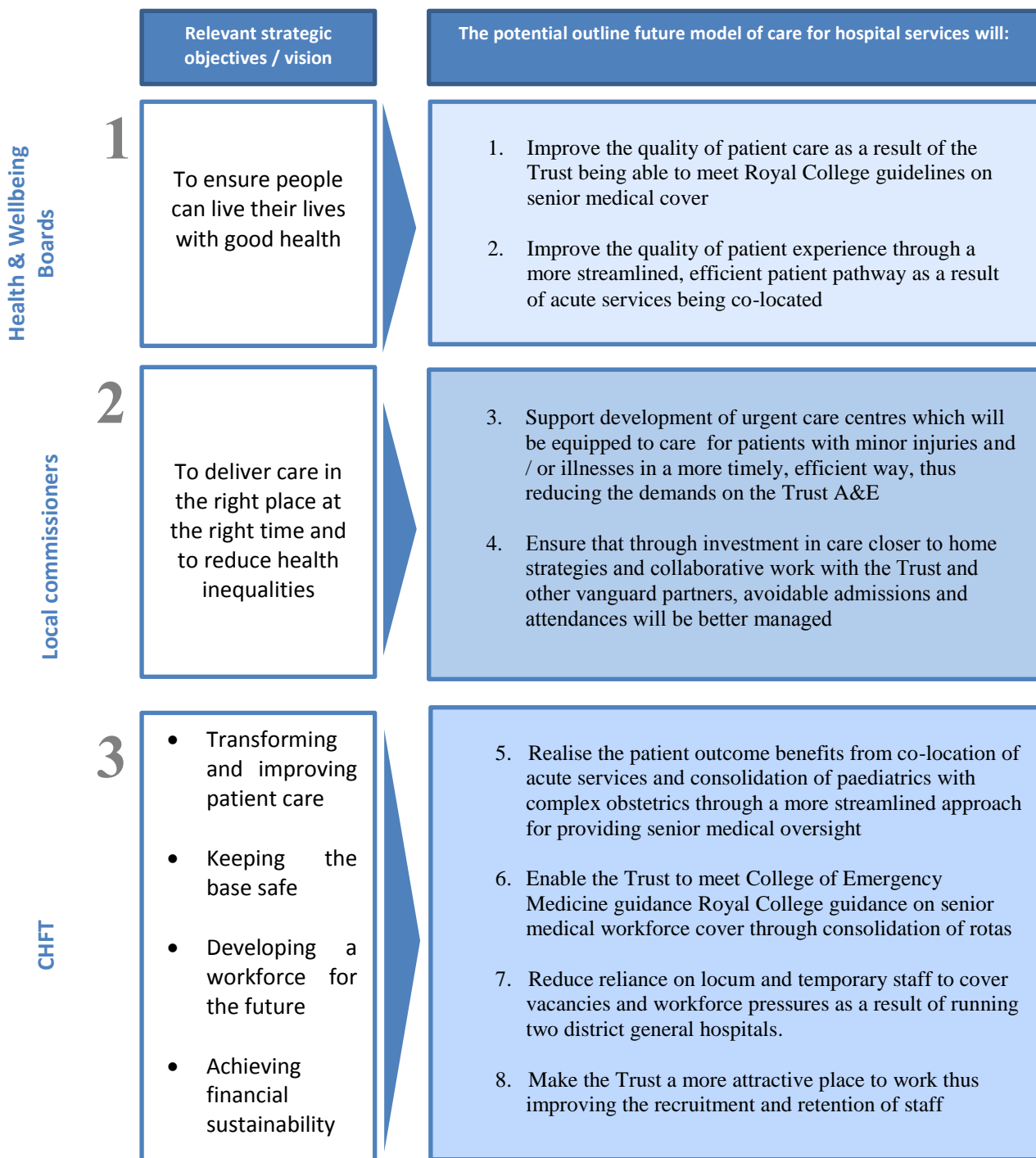
The Trust's vision- *“Together we will deliver outstanding compassionate care to the communities we serve”*- is delivered through 4 key goals focussed on the following:

- Transforming and improving patient care
- Keeping the base safe
- Developing a workforce for the future
- Achieving financial sustainability

Underpinning the Trust's core strategy are the following specific patient care improvement objectives:

- Reduce mortality rates in hospital
- Improve patient experience and safety
- Provide better care for less cost
- Reduce the number of unnecessary emergency admissions
- Improve patient flow and reduce hospital unnecessary waits for care
- Provision of more out of hospital care

The design and implementation of the potential outline future model of care for hospital services, through reconfiguration, therefore aligns with the strategic objectives of both Health & Wellbeing Boards, the Trust and local commissioners in the following ways:



## 6.0 Options appraisal for a network/collaborative/cooperative approach

The Trust has an established track record of working closely with partners to develop and implement bold and transformative long-term strategies for services that otherwise may become financially unsustainable and result in a decline in the safety and quality of patient care. Partners include South West Yorkshire Partnership NHS Foundation Trust, Locala Community Partnerships, Bradford Teaching Hospitals NHS Foundation Trust and Mid Yorkshire Hospitals, NHS Trust, to name a few.

Investment in community and integrated care is intrinsic to the direction of travel for the local health economy, irrespective of the reconfiguration of local acute hospital services. Therefore there are two options for consideration to inform the future of the Trust and acute hospital services, namely:

- Option 1: Reconfiguration
- Option 2: Collaboration and networking

In line with the Dalton Review, the greatest benefit for providers is to be derived from transformational change such as reconfiguration and hence this is the preferred option. However, transformation is also associated with the greatest level of change. If reconfiguration cannot be realised, the second, but less preferred option, is to work more closely with others.

Option	Benefits	Examples
<b>Option 1:</b> Reconfiguration and implementation of the clinical consensus model	<ul style="list-style-type: none"> <li>• Consolidation of medical rotas to ensure improved access to senior medical cover</li> <li>• Co-location of all acute services will improve patient pathways and strengthen the quality of patient care</li> <li>• Provision of urgent care centres will reduce demand on already stretched emergency services</li> <li>• Ensure the Trust can maintain and improve performance in national benchmark metrics</li> </ul>	<ul style="list-style-type: none"> <li>• Improved patient outcomes as a result of the surgical division reconfiguration in 2008</li> </ul>
<b>Option 2:</b> Development of a network / collaborative / co-operative approach	<ul style="list-style-type: none"> <li>• Drive economies of scale</li> <li>• Ability to overcome workforce challenges e.g. workforce gaps, access specialist skills</li> </ul>	<ul style="list-style-type: none"> <li>• Delivery of a shared acute dermatology service to save locum costs and potential to work with GPs and Locala to provide comprehensive dermatology services</li> <li>• Potential for shared medicine information service and /or medicines storage facility</li> </ul>

## 7.0 Analysis of the macro-impact

The impact of activity changes as a result of implementation of the potential future model of care has been assessed as the reconfiguration of services in line with the clinical consensus model would result in some changes in patient flow and activity movement away from the Trust depending on which of the 2 sites is chosen as the unplanned site and which the planned site.

The modelling to determine the impact on neighbouring providers was based on an analysis of travel time from the 2 sites. Although this must be used with a degree of caution, the model indicates that reconfiguration may have a modest impact on other providers as shown below. Note: The modelling assumes that an ambulance divert will be in place at Dewsbury Hospital within a 5 year time horizon.

### Option 1: HRI is unplanned, CRH is planned

Table 1: Increase in attendance rates at neighbouring trusts as a result of activity drift

Final Location	Attendances
Fairfield General Hospital	6
Leeds General Infirmary	78
Manchester Royal Infirmary	8
North Manchester	2
Pinderfields General Hospital	81
Pontefract General Infirmary	15
Royal Blackburn Hospital	244
St James's University Hospital	8
The Royal Oldham Hospital	1129
Trafford General Hospital	19
<b>Total</b>	<b>1589</b>

### Option 2: CRH is unplanned, HRI is planned

Table 1: Increase in attendance rates at neighbouring trusts as a result of activity drift

Final Location	Attendances
Fairfield General Hospital	8
Leeds General Infirmary	82
Manchester Royal Infirmary	8
North Manchester	8
Pinderfields General Hospital	1082
Pontefract General Infirmary	27
Royal Blackburn Hospital	19
St James's University Hospital	29
The Royal Oldham Hospital	330
Trafford General Hospital	47
<b>Total</b>	<b>1640</b>

Table 2: Bed requirements at neighbouring trusts as a result of activity drift

Final Location	Beds
The Royal Oldham Hospital	10
Pinderfields General Hospital	0
Royal Blackburn Hospital	1
Leeds General Infirmary	0
Manchester Royal Infirmary	0
Trafford General Hospital	0
Pontefract General Infirmary	0
North Manchester	0
Fairfield General Hospital	0
St James's University Hospital	0
<b>Total</b>	<b>12*</b>

• rounded up to take into account part bed requirements

Table 2: Bed requirements at neighbouring trusts as a result of activity drift

Final Location	Beds
Pinderfields General Hospital	8
The Royal Oldham Hospital	3
Trafford General Hospital	0
Leeds General Infirmary	0
St James's University Hospital	0
Fairfield General Hospital	0
Royal Blackburn Hospital	0
Pontefract General Infirmary	0
<b>Total</b>	<b>11</b>

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## 8.0 Linkages with local strategic plan and QIPP workstreams

The Calderdale and Huddersfield strategic review, commissioner strategic plans and the clinical consensus model all focus on a shift from a reliance on hospital services to greater care in the community. The clinical consensus model describes three interlinked pieces of work:

- Calderdale Care Closer to Home Programme;
- Kirklees Care Closer to Home Programme; and
- The Hospital Services Programme

Strengthening and enhancing community services are the precursors to changes in the acute setting. The successful realisation of the future model of hospital services is therefore dependent on the care closer to home programmes being adequately planned, resourced and delivered.

With this in mind, the design and development of the potential outline future model of care is strongly linked to the initiatives underpinning these programmes.

In particular, the proposed capacity incorporated the agreed reductions in avoidable emergency admissions in the patient cohorts (frail/elderly, ambulatory care sensitive conditions, people with long term conditions).

## 9.0 Analysis of impact on services

There is no degradation of any existing services anticipated as a result of the proposed model. Some services may experience a change in the location at which the service is delivered. However, there is anticipated to be significant associated improvements in quality as a result of the implementation of the model, particularly through the consolidation of all acute services onto the unplanned site.

Services	Impact		
	Yes	No	Comments
<b>Anaesthetics and Theatres</b>		✓	Theatres will be available on both sites. The unplanned site theatres will be used for emergency / non-elective work with little day case and elective activity. The planned site will be exclusively for elective (including daycase) activity
<b>Cardiology</b>	✓		Service centralised onto the unplanned site
<b>Critical Care</b>	✓		Expansion of the critical care unit onto the unplanned site only
<b>Dermatology</b>		✓	
<b>Diabetes</b>		✓	
<b>Elderly Care</b>	✓		Service centralised onto the unplanned site
<b>Emergency (excluding urgent care)</b>	✓		There will be a single ED on the unplanned site
<b>Endoscopy</b>		✓	Endoscopy will continue to provide a service on both sites
<b>ENT and audiology</b>		✓	
<b>Gastroenterology</b>	✓		Service centralised onto the unplanned site
<b>Gynaecology</b>		✓	
<b>Haematology</b>		✓	
<b>Maternity Midwifery</b>		✓	Midwife-led birthing units will continue to be available on both sites
<b>Max fax</b>		✓	
<b>Oncology</b>		✓	
<b>Ophthalmology</b>		✓	
<b>Paediatrics</b>	✓		Inpatient paediatrics services (medicine and surgery) centralised on the unplanned site
<b>Pain</b>		✓	
<b>Plastics</b>		✓	
<b>Respiratory</b>	✓		Service centralised onto the unplanned site
<b>Rheumatology</b>		✓	
<b>Stroke</b>		✓	
<b>Trauma and Orthopaedics</b>		✓	Unplanned surgery on unplanned site, majority of planned surgery on planned site
<b>Urgent care</b>	✓		The single ED located on the unplanned site will be supported by urgent care centres co-located at both the unplanned and planned sites (and may be supplemented by another one in the community), in order to provide treatment for suitable patients with minor injuries and illnesses
<b>Urology</b>		✓	All surgery on unplanned site
<b>Vascular Surgery</b>		✓	All surgery on unplanned site



# RIGHT CARE, RIGHT TIME RIGHT PLACE PROGRAMME- EQUALITY ANALYSIS REPORT FOR CALDERDALE CCG & GREATER HUDDERSFIELD CCG

DATE: 15 JANUARY 2016  
COMMERCIAL IN CONFIDENCE

DRAFT AND CONFIDENTIAL



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## 1. EXECUTIVE SUMMARY

North of England Commissioning Support (NECS) was commissioned to carry out a comprehensive independent Equality Analysis to assure readiness to consult the public on the proposals for the future provision of Hospital services across Calderdale and Greater Huddersfield. The aim was to identify risks and issues and to assure equality through the delivery of the Right Care Right Time Right Place Hospital Services Programme to date.

### • 1.1 SCOPE OF THE EQUALITY ANALYSIS

Calderdale Clinical Commissioning Group, Greater Huddersfield Clinical Commissioning Group and Calderdale and Huddersfield Foundation Trust (CHFT) are working together to set out the proposals for the future provision of Hospital Services across Calderdale and Greater Huddersfield. The Right Care, Right Time, Right Place programme is the Commissioners' response to the Case for Change that was developed as part of the Strategic Services Review. From this Case for Change and the feedback from engagement, it has been identified that significant changes are required in order to ensure health and social care services are fit for the future.

It is clear that transformational change is needed in order to respond to the challenges of:

- An ageing population with increased needs
- National shortages of key elements of the workforce that mean new service models are required
- Continuing to meet ever increasing external standards
- Significant financial pressures facing commissioners and providers

There is a compelling evidence base that the way hospital services are currently organised and provided in Calderdale and Greater Huddersfield is not offering the most safe, effective and efficient support to meet people's needs. Local people and the doctors, nurses and therapists that currently provide services want things to change to achieve better health outcomes, a better experience of care and increased convenience and efficiency of service delivery.

Calderdale CCG, Greater Huddersfield CCG and CHFT have developed and reached clinical consensus on a potential future model of care for Hospital services.

The Equality Analysis has been undertaken in line with the service areas set out in the potential future model of care for Hospital Services; Emergency and Urgent care; Planned Care; Paediatric services and Maternity services. The equality analysis outlines the potential impacts on protected groups of the proposed future model of care for hospital services.

The analysis includes;

- A review of clinical research and data to determine protected groups likely to be impacted on by changes to hospital services
- An analysis of service usage data and comparison with local demographics to identify over / under usage of services by protected characteristic groups
- A consideration of geography and deprivation as an indicator of health inequalities to determine people who are most likely to be impacted and where there is a lack or gaps in service usage data
- A review of engagement activity to date and findings, identifying gaps in data
- Consideration of potential impacts on protected groups and other disadvantaged groups including travel and transport
- Analysis of data to identify impacts (negative and positive) on protected groups and recommendations for mitigating actions from this analysis

## • 1.2 ASSUMPTIONS

In undertaking this work it is assumed that:

- No planned diminution of service has been identified either by withdrawing services, or restricting eligibility for existing services. The drivers for change emphasise the intention to enhance services and improve efficiencies by reducing unnecessary duplication, and offering clinicians and patients alike greater clarity along the treatment pathway.
- The CCGs, in pursuance of meeting their own Public Sector Equality Duty under section 149 Equality Act 2010 will conduct further analysis to cover workforce and service impacts arising from implementation plans.
- The formal consultation period offers opportunities for patients and their families, and other stakeholders to have their say about the proposed model. These opportunities will be receptive to the perspectives of different protected characteristic groups, including targeted outreach work where relevant

## • 1.3 OPPORTUNITIES TO PROMOTE EQUALITY

NHS Calderdale and Greater Huddersfield CCG are committed to making sure equality and diversity is a priority when planning and commissioning local health care, working closely with local communities to best understand their needs.

Patients and carers use and experience health services differently and there are health inequalities within the system. The inequalities need to be reduced in order to improve the health of their local population, including their access, experience and outcomes.

## • 1.4 CONCLUSIONS

We can conclude that there are no protected groups who are likely to be highly impacted by the proposed changes to hospital services. The most likely areas for negative impact is to those groups who are high users of Accident & Emergency services, such as younger, older people and some ethnic groups.

There are certain groups where we found limited evidence; however we feel that all groups have been considered sufficiently for this proposal to be taken to formal Public Consultation, where further work can be undertaken. There is a Maternity and Paediatric Services engagement underway, and the results of this will address some gaps outlined in this report.

## • 1.5 RECOMMENDATIONS

Recommendations are fully outlined in Step 3, 4 and 5 of this report. However, the main themes highlighted by the assessment are as follows:

- Actively consult older people around emergency and urgent care services as they are frequent users.
- Through the public consultation gather further information and views from Asian/Asian British and White Other groups which are over or under-represented in relation to the local population in service use so their views can be considered.
- Reach out to impairment groups that could be significant users of the services where changes are proposed to enable potential negative impacts to be identified and mitigated.
- Once the information from the Maternity and Paediatric Engagement has been collated and analysed review to identify any particular groups that need further consideration.
- Carers should be reached in the consultation to identify if any proposed changes would be experienced more by carers.
- Equality Impact Assessments should be completed for all services as they are redefined/relocated this should be an iterative process every time there is significant change.
- The Trust should work towards improved equality monitoring data; collected, analysed and addressed for protected characteristics not currently routinely collected.
- Actively consult children and young people and children during the public consultation.



## 2. INTRODUCTION AND BACKGROUND

### • 2.1 FUTURE MODELS OF CARE

Calderdale CCG, Greater Huddersfield CCG and CHFT have developed and reached clinical consensus on a potential future model of care for Hospital services. The Equality analysis will be undertaken in line with the service areas set out in the potential future model of care for Hospital Services; Emergency Surgery and Accident and Emergency (A&E); Urgent care; Planned Care; Paediatric services and Maternity services.

#### • 2.1.2 URGENT CARE

'Urgent Care Centres' will provide access to walk in minor illness and minor injury services including GP Out of Hours, and will be part of wider community primary care services. We will encourage patients to ring the NHS non-emergency number (NHS 111) to receive medical help or advice and be signposted to the appropriate service to meet their needs. If this is an Urgent Care Centre, appointments will be made directly into the Urgent Care Centres. They will also incorporate the current out of hours GP services. This means that the services people use most frequently will continue to be available at both hospitals or in a local community setting.

#### • 2.1.3 EMERGENCY CARE

The single unified Emergency Care centre would specialise in providing treatment for people who have serious or life threatening emergency care needs and would provide Emergency/Acute medicine and Accident and Emergency services. The centre will bring together on one site all the necessary acute facilities and expertise 24/7 to maximise people's likelihood of survival and a good recovery. This will reduce or eliminate the need for people to transfer between sites.

#### • 2.1.4 PLANNED CARE

For those patients with planned care needs, care will be delivered as part of an integrated care model that places Hospitals as part of a broader health systems with a responsibility to improve the health of the population they serve.

#### • 2.1.5 MATERNITY SERVICES

Maternity services will be delivered in a way that reflects the critical interdependencies between Paediatric and Maternity services and Emergency Care and Urgent Care (and the key clinical interdependencies outlined in those sections) and Community Care, with an emphasis on provision of care in the community wherever possible.

### • 2.1.6 PAEDIATRIC SERVICES

Paediatric services will be delivered in a way that reflects the critical interdependencies between Paediatric and Maternity services and Emergency Care and Urgent Care (and the key clinical interdependencies outlined in those sections) and Community Care, with an emphasis on provision of care in the community wherever possible.

We will encourage all parents to call 111 for advice on urgent health needs for their child; they will be able to direct them to the best place for assessment/treatment.

We will refresh the protocols in place for 111 and the Ambulance service to ensure that any children with injury or illness requiring emergency care are directed to the specialist Paediatric Emergency Centre that will be co-located with the Emergency Care Centre.

### • 2.2 OUR AIMS

The aim of this report is to provide Commissioners with assurance that they are ready to go to public consultation. This will be undertaken with an analysis of the potential impacts on protected groups of the proposed Hospital Services in relation to Hospital Services in the Future Model of Care and, where the impacts are potentially negative, to identify any mitigation. The report will also provide Commissioners with recommendations on how any gaps within the current engagement can be addressed.

The aims of this report are to provide;

- A review of clinical research and data to determine protected groups likely to be impacted on by changes to hospital services
- An analysis of service usage data and comparison with local demographics to identify over / under usage of services by protected characteristic groups
- A consideration of geography and deprivation as an indicator of health inequalities to determine people who are most likely to be impacted and where there is a lack or gaps in service usage data
- A review of engagement activity to date and findings, identifying gaps in data
- Consideration of potential impacts on protected groups and other disadvantaged groups including travel and transport
- Analysis of data to identify impacts (negative and positive) on protected groups and recommendations for mitigating actions from this analysis

### • 2.3 RELEVANT EQUALITY LEGISLATION

The Equality Act 2010 unifies and extends previous equality legislation. Nine characteristics are protected by the Act, which are age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation. Section 149 of the Equality Act 2010 states that all public authorities must have due regard to the need to a) eliminate discrimination, harassment and victimisation, b) advance 'Equality of Opportunity', and c) foster good relations. Each CCG has developed an Equality and Diversity Strategy which details the approach.

## • 2.4 EQUALITY ANALYSIS

The aim of an Equality Analysis is to improve the efficiency and effectiveness of public services by making sure that service users' needs are met and that there is no discrimination against any groups and that, where possible, they are actively promoting equality.

Paying due regard is the legal duty; an equality analysis is useful evidence in demonstrating due regard.

Equality analysis needs to be undertaken on any proposals for changes to services, policies or functions in order to understand any potential impact on protected groups and ensure equality of opportunity.

## 2.5 PROCESS

In order to carry out this analysis, we have read and analysed existing data, evidence and documentation and used our experience to highlight issues where there may be impacts on those who share protected characteristics.

We have reviewed the following documents:

- Right Care, Right Time, Right Place. Hospital Services Potential Outline Future Model of Care (V 1.1) October 2015
- Right Care, Right Time, Right Place. Transforming Health and Social Care in Calderdale and Greater Huddersfield. Outline Business Case.
- A&E activity by provider including demographic data
- Calderdale and Huddersfield NHS Foundation Trust Journey Time Assessment Study (June 2014)
- Calderdale and Greater Huddersfield Hospital and Care Closer to Home, summary and findings from all engagement and pre-engagement with public, patients, carers and staff (January 2013 – August 2015)
- Greater Huddersfield CCG Public Sector Equality Duty, Annual Equality and Diversity Report (January 2015)
- Calderdale CCG Public Sector Equality Duty Report (January 2014)

- 
- Calderdale and Greater Huddersfield NHS Foundation Trust Public Sector Equality Duty Report
  - Integrated Impact Assessment, The Mid Yorkshire Clinical Services Strategy (July 2013)
  - Calderdale CCG Equality Objectives 2013 – 2017
  - Calderdale & Kirklees JSNA's

We utilised the Equality and Human Rights Commission 8 Step Model to structure this assessment.

- Step 1: Identify the aims of the Hospital Services new model of care.
- Step 2: Consider the evidence using available data.
- Step 3: Assess likely impact on protected groups.
- Step 4: Consider alternatives.
- Step 5: Consultation (this has not yet been done so we have provided recommendations for Public Consultation)
- Step 6: Recommendations regarding decision making
- Step 7: Recommendations regarding monitoring arrangements
- Step 8: Recommendations regarding the publication of assessment results

By using this model, we are able to provide a structured report, reviewing the evidence and assessing impacts and providing recommendations to support decisions on readiness for public consultation.

### 3. STEP 1 – IDENTIFY THE AIMS

In this section of the report, we have identified the main aims of the proposed programme of work, who is intended to benefit, and who is responsible for the decision making and implementation.

#### • 3.1 OVERVIEW

There are around 458,000 people living in Calderdale and Greater Huddersfield, the population is aging and needs are increasing, there is a national shortage of workforce in the health and social care sector, and there are £139m of savings needed over the next 5 years from both commissioners and providers.

Partners are responding with a strategic move to make a system wide change. This will improve access to primary & community care, increase innovation and collaboration including the sharing of information, drive forward early intervention and focus on improving outcomes.

There is a compelling evidence base that the way community, hospital and social care services are currently organised and provided in Calderdale and Greater Huddersfield is not offering the most safe, effective and efficient support to meet people's needs. Local people and the doctors, nurses and therapists that currently provide services want things to change to achieve better health outcomes, a better experience of care and increased convenience and efficiency of service delivery.

Recently, Calderdale CCG and Greater Huddersfield CCG have undertaken comprehensive engagement to better understand the needs of the population they serve, helping to understand where the key issues are and how these can be addressed.

#### • 3.2 AIM OF THE HOSPITAL SERVICES FUTURE MODEL OF CARE

The Right Care, Right Time, Right Place Programme is intended to benefit all patients in Calderdale and Greater Huddersfield. Patients will be treated sooner and more effectively, there will be improved management of patient flow, resources will be located to provide optimal service and meet fluctuations in demand, decisions about treatment will be made earlier and there will be reductions in the average length of inpatient stay.

The high level aims of this model are set out below:

- Deliver care locally for the majority of patients, and where possible bring more services closer to Home.
- Continue to provide an NHS non-emergency number for those patients who need urgent medical help or advice which will, where appropriate, direct patients to the local service that is best placed to help them.

- For those people with Urgent care needs provide a highly responsive service that delivers care as close to home as possible, minimising disruption and inconvenience for patients and their families.
- Care for the smaller number of patients with 'once in a lifetime' life threatening illnesses and injuries in a single emergency centre or a specialist emergency centre with the very best expertise and facilities in order to maximise the chances of survival and a good recovery.
- For those elements of Planned Care where Hospital facilities are required, deliver that care as part of a broader integrated system, working across services, to keep people healthy and improve health at a population level.
- Deliver Maternity care that is integrated with specialist services and provides choice for mothers.
- Deliver Paediatric care that is integrated with specialist services and provides effective transition for children to adult services
- Deliver all in-hospital services in line with our Hospital Quality and Safety standards
- Work with the ambulance service to direct patients to the right place at the right time, including to Community and Primary Care if appropriate as well as to local and specialist services

### • 3.3 WHO SHOULD BENEFIT?

The whole population of Calderdale and Huddersfield should benefit from the proposal; the following protected characteristics have been and will be taken into account to ensure equality;

- Gender
- Race
- Religion/ Ethnicity
- Sexual Orientation
- Gender Reassignment
- Age
- Pregnancy/ Maternity
- Disability

## 4. STEP 2 – CONSIDER THE EVIDENCE

This section of the report analyses evidence of national and local data and demographics. It also considers the available engagement and pre-engagement data.

Engagement has taken place from March 2013 to August 2015, we have analysed this data in relation to local evidence and service usage.

### • 4.1 LOCAL AND NATIONAL DATA AND DEMOGRAPHICS

#### • 4.1.2 AGE

In Kirklees, the proportion of the population aged under 18 will rise by 11% to 1 in 5 (20%) of the population and the working age population will shrink by 2030 from 64% to 57%.<sup>15</sup>

In Calderdale, it is expected that there will be a 25% increase in those aged 65+ and a significant increase in children.<sup>16</sup>

We understand that the population of Calderdale and Greater Huddersfield is aging slightly faster in the rural areas than in urban areas. This means that new service models could place older residents at a slight disadvantage if the services they need to access located further away than the services they are currently using.

#### • 4.1.3 GENDER

Calderdale has a similar population structure to the national picture; there are a lower proportion of young adults (between ages 20-29) in both the male and female populations. There are also slightly lower numbers in both male and female populations in the 40-49 year old groups and 60-64 year old groups. The major difference in numbers comes in the older age groups, and the key determinant is the higher life expectancy of women<sup>17</sup>.

In Kirklees, the life expectancy gap for men is 9.3 years, and for women 5.9 years between the most and least deprived areas<sup>18</sup>. In Calderdale, this is 9.8 years for men and 8 years for women<sup>19</sup>.

#### • 4.1.4 DISABILITY

<sup>15</sup> (Kirklees JSNA Summary for the Greater Huddersfield Area, p.3)

<sup>16</sup> (Calderdale JSNA 2015; The Calderdale Area, P.2)

<sup>17</sup> (Calderdale JSNA 2015: The Calderdale Area, p.6)

<sup>18</sup> <http://www.kirklees.gov.uk/employment/publicHealthDirector/pdf/HealthProfile2014Kirklees.pdf>

<sup>19</sup> <http://www.calderdaleforward.org.uk/workspace/uploads/files/healthprofile2014calderdale00c-53cfcf1bdc594.pdf>

The table below demonstrates that the percentage of people in Calderdale who report having a limiting long term illness (LLTI) has fallen very slightly since 2001, but that the number in the working age group has fallen sharply to below the 1991 figure.

Year	All Ages		Working Age	
	Limiting long-term illness (n)	Limiting long-term illness (%)	Limiting long-term illness (n)	Limiting long-term illness (%)
1991	24,080	12.5	16,925	12.3
2001	35,322	18.4	16,056	13.7
2011	36,600	17.9	17,892	9.7

Source: Office for National Statistics 2011 Census, 2001 Census, 1991 Census

In Kirklees, we know that in 2012:

- Almost 1 in 3 (30%) adults reported living with a long term limiting condition. This had risen from just over 1 in 5 (26%) in 2008 and ranges from 1 in 4 (25%) in Denby Dale and Kirkburton to 1 in 3 (33%) in Huddersfield South.
- 1 in 10 (11%) adults in the area needed help to continue living in their own home. The highest level of need occurred in Huddersfield South and Huddersfield North where 1 in 8 (13%) needed help – more than twice as high as in Denby Dale and Kirkburton (6%).
- Of those with a long term limiting condition more than 3 in 4 (78%) said they were confident in managing their own health. This was highest in the Holme Valley (almost 9 in 10, 86%).
- Almost 1 in 3 (31%) adults with a Long Term Condition (LTC) reported having moderate/ severe/ extreme problems with pain/ discomfort compared with only 2% of adults without a LTC.<sup>20</sup>

#### • 4.1.5 ETHNICITY

The table below shows that in Calderdale since the 2001 Census, the biggest population increases have been in the Pakistani heritage group (4,461) and White Other (2,136) ethnic groups. Looking at country of birth data, it can be seen that most of the increase in the Pakistani heritage population is due to natural growth (i.e. births minus deaths) rather than migration. The growth of the white other population is likely to be as a result of increased migration.

<sup>20</sup>(Kirklees JSNA, Summary for the Greater Huddersfield Area, P.12)



Ethnic Group	2001 (n)	2011 (n)	2001 (%)	2011 (%)
<b>White</b>	178,982	182,787	93	89.7
<b>White British</b>	174,775	176,732	90.9	86.7
<b>White Other</b>	4,207	6,055	2.2	3.0
<b>Asian/Asian British</b>	10,942	16,416	5.7	8.1
<b>Pakistani</b>	9,443	13,904	4.9	6.8
<b>Indian</b>	814	1,130	0.4	0.6
<b>Bangladeshi</b>	297	574	0.2	0.3
<b>Other Asian</b>	388	808	0.2	0.4
<b>Mixed</b>	1,544	2,797	0.8	1.4
<b>Black/Black British</b>	427	899	0.2	0.4
<b>Other Asian</b>	481	927	0.3	0.5

Source: Office for National Statistics 2001 Census and 2011 Census

#### • 4.1.6 RELIGION/BELIEF

In Calderdale, the most common religion is Christianity, though this has decreased by 15% since the last Census. There has been a large increase in the proportion with no religion with almost a third stating that they have no religion. There has also been a 2% increase in those who are Muslim<sup>21</sup>.

The majority of people living in Greater Huddersfield are Christians; although there is a large majority of people who did not disclose their religion in the 2011 census, the second highest ethnicity group recorded were those who are Muslim<sup>22</sup>

#### • 4.1.7 SEXUAL ORIENTATION

The most recent Census of 2011, found that there were 491 people in a registered same-sex civil partnership across Calderdale (0.3% of the population). Ward level data shows a significantly higher proportion registered in same-sex civil partnership in Calder (1.13%), Luddendenfoot (0.67%) and Todmorden (0.45%).

Nationally it has been estimated that 5 to 7% of the population is lesbian, gay or bisexual (LGB) and if this figure was applied to Calderdale this would equate to approximately 10,300 to 14,400 LGB people in Calderdale.

<sup>21</sup>(Calderdale JSNA 2015: Calderdale Area Summary, P8 Source: Office for National Statistics 2001 Census and 2011 Census)

<sup>22</sup>[http://www.greaterhuddersfieldccg.nhs.uk/fileadmin/greaterhuddersfield/documents/Public\\_Sector\\_Equality\\_Duty\\_Information\\_Report\\_GHCCG.pdf](http://www.greaterhuddersfieldccg.nhs.uk/fileadmin/greaterhuddersfield/documents/Public_Sector_Equality_Duty_Information_Report_GHCCG.pdf) ; data source; Census 2011

Despite the significant LGB population in Calderdale, sexual orientation is often not recorded when people access services, so there is little local information on this population.<sup>23</sup>

#### • 4.1.8 GENDER RE-ASSIGNMENT

There is limited information available in the Greater Huddersfield and Calderdale area around Gender Reassignment.

#### • 4.1.9 PREGNANCY AND MATERNITY

This protected characteristic has been fully considered under the Maternity Services section of this report.

#### • 4.2 GROUPS NOT PROTECTED BY THE EQUALITY ACT 2010

There are some key groups which are not covered by the Equality Act but are vulnerable, often marginalised, which has a significant impact on their health and on health services.

The Equality and Human Rights Commission has stated:

“There is evidence that groups about whom very little research has been conducted, notably Gypsies and Travellers, asylum seekers and refugees, have particularly low levels of health and wellbeing. Those without fixed addresses, such as Roma, gypsies and travellers, asylum seekers and refugees, have difficulty in accessing services and their needs are often different and unknown.”<sup>24</sup>

The Faculty of Public Health briefing (2008) states that:

“Asylum seekers are one of the most vulnerable groups within our society, with often complex health and social care needs. Within this group are individuals more vulnerable still, including pregnant women, unaccompanied children and people with significant mental ill-health” (p1)

The Social Care Institute for Excellence (2010) publication ‘Good Practice in social care for asylum seekers and refugees’ though targeted at social care, has a useful set of principles which should be considered in the detailed service planning:

- A humane, person-centred, rights-based and solution-focused response to the [health] care needs of asylum seekers and refugees
- Respect for cultural identity and experiences of migration.
- Non-discrimination and promotion of equality

<sup>23</sup>(Calderdale JSNA 2015, The Calderdale Area, P.9)

<sup>24</sup>(EHRC 2010)

- Decision making that is timely and transparent and involves people, or their advocates, as fully as possible, in the process.

From the table below, it can be seen that in Calderdale there has been an increase of around 4,300 non-UK born residents between the 2001 and 2011 Censuses. The largest increase has been in those born in Poland, which has increased by around five times since 2001. There has also been a large increase in those born in Pakistan, which has increased by 1,200 since 2001<sup>25</sup>.

Country of Birth	2001 (n)	2011 (n)	2001 (%)	2011 (%)
<b>UK</b>	181,488	188,590	94.3	92.5
<b>Other Europe(excl. UK)</b>	4,062	6,008	2.1	2.9
<b>Ireland</b>	1,683	1,386	0.9	0.7
<b>Poland</b>	290	1,575	0.2	0.8
<b>Asia</b>	5,443	7,412	2.8	3.6
<b>Pakistan</b>	3,906	5,125	2.0	2.5
<b>India</b>	625	763	0.3	0.4
<b>Africa</b>	597	1,012	0.3	0.5
<b>Other</b>	816	804	0.4	0.4
<b>All</b>	192,406	203,826	100	100

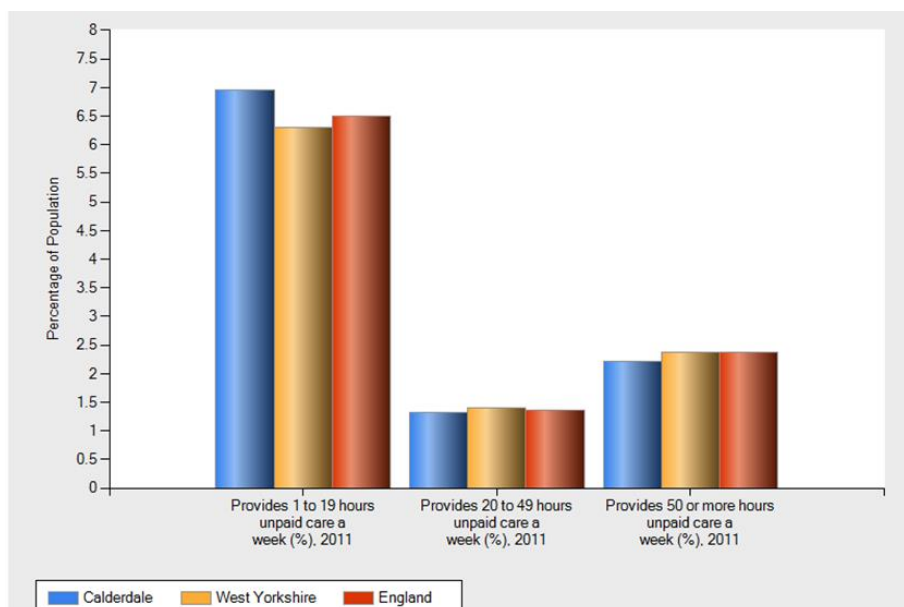
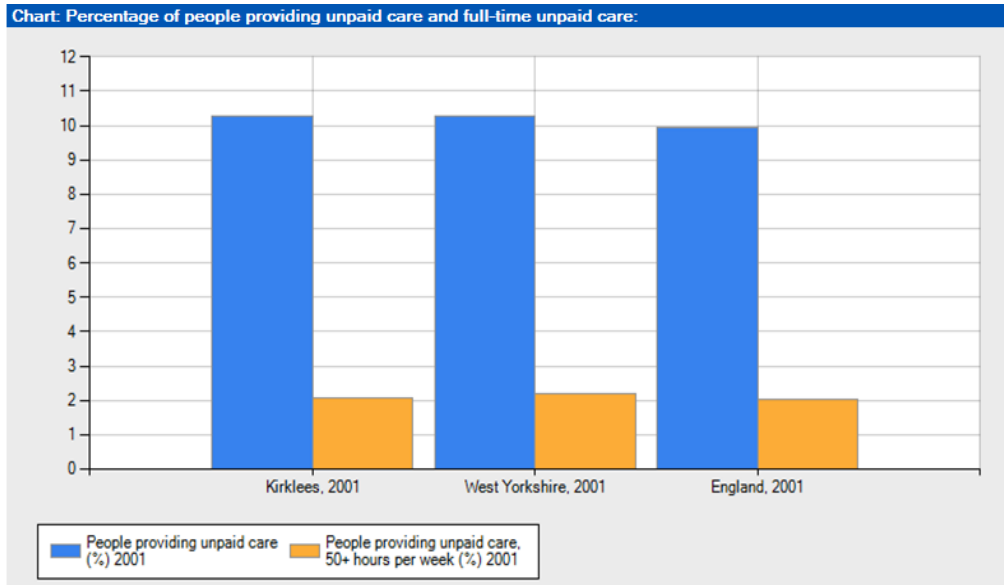
(Source: Office for National Statistics 2011 Census)

Carers are not a protected group but are considered here given their significant potential for poorer health outcomes. The impacts on this group are considered both in relation to their ability to continue to provide care and their own health needs. The support of carers can be critical to the recovery of patients from procedures and illnesses. It should be noted that carers need continued support around their own health to make sure this is not compromised.

The tables below show those providing unpaid care in Kirklees and Calderdale<sup>26</sup>. In Kirklees, just over 10% of the population are providing unpaid care; this is slightly higher than the national England Average. In Calderdale 7% of people are providing up to 19 hours of unpaid care a week, again, this is slightly above the national England average.

<sup>25</sup>(Calderdale JSNA: The Calderdale Area, P.3)

<sup>26</sup> (Census 2011)



Detailed planning of the service changes should ensure that the specific requirements of all these groups are considered.

**4.3 LONG TERM HEALTH CONDITIONS**

Within Calderdale CCG, 5.9% of those over the age of 17 are registered as having diabetes, although this is below the national England average of 6.2%, this relates to 0.7% of admissions (per 1000). In Greater Huddersfield, 5.7% of patients are recorded as having diabetes, relating to 0.8% of A&E admissions. It is worth noting

that these patients could be treated in a setting such as Urgent Care for minor illnesses related to diabetes which may prevent them attending A&E<sup>27</sup>.

In 2011, around 9.4% of people living in Greater Huddersfield are estimated to have Cardio-vascular disease; this is slightly lower than the 9.5% England Average. 3.42% of people are estimated to have COPD, this is higher than the national England average of 2.91%. Around 24% of people are estimated to have Hypertension<sup>28</sup>.

In Calderdale, 9.3% of people are estimated to have Cardio Vascular disease, 2.58% are estimated to have COPD, and 24.9% of people are estimated to have hypertension.<sup>29</sup>

#### • 4.4 DEPRIVATION AND HEALTH INEQUALITIES

Analysis identifies that the areas of highest deprivation are predominately based in and around the centres of the two main towns, namely Huddersfield and Halifax, with the majority being based in and around Huddersfield. Deprivation in both Kirklees and Calderdale is higher than the national England average and life expectancy is lower than the national average in both areas<sup>30</sup>.

There are 864 year 6 children in Kirklees who are classed as obese and 457 children in Calderdale. 21.8% of adults in Kirklees are classed as obese and 26.7% in Calderdale.<sup>31</sup>

There is a 9 year life expectancy gap for men between the most deprived and least deprived areas of Kirklees, and a 6.3 year gap for women. In Calderdale, for men there is a 9.3 year gap and 9.2 year gap for women.<sup>32</sup>

Early Death Rates for both men and women in Kirklees have fallen gradually between 2003 and 2012, however in Calderdale the rates have remained fairly stable and dropped only very slightly.<sup>33</sup>

Early deaths from cancer, heart disease and stroke have dropped in Kirklees between 2003 and 2012. Interestingly, while the rates for heart disease and stroke have dropped in Calderdale (although still above the national average) the rate for

<sup>27</sup> (<http://fingertips.phe.org.uk/profile/general-practice/data#mod,1,pyr,2014,pat,19,par,E38000025,are,-,sid1,2000002,ind1,241-4,sid2,-,ind2,->)

<sup>28</sup> (<http://fingertips.phe.org.uk/profile/general-practice/data#mod,1,pyr,2014,pat,19,par,E38000064,are,-,sid1,2000010,ind1,721-4,sid2,-,ind2,->)

<sup>29</sup> (<http://fingertips.phe.org.uk/profile/general-practice/data#mod,1,pyr,2014,pat,19,par,E38000025,are,-,sid1,2000002,ind1,241-4,sid2,-,ind2,->)

<sup>30</sup> (Public Health England, Health Profile 2015 Calderdale & Public Health England, Health Profile 2015 Kirklees)

<sup>31</sup> (Public Health England, Health Profile 2015 Calderdale & Public Health England, Health Profile 2015 Kirklees)

<sup>32</sup> (Public Health England, Health Profile 2015 Calderdale & Public Health England, Health Profile 2015 Kirklees)

<sup>33</sup> (Public Health England, Health Profile 2015 Calderdale & Public Health England, Health Profile 2015 Kirklees)

early deaths in cancer has remained fairly stable and remains above the national England average.<sup>34</sup>

#### • 4.5 SERVICE USAGE

This section discusses the use of services by each protected group and also takes into account the data from the Engagement and Pre-engagement, helping us to identify who is using these services and where the gaps are in service provision.

Pregnancy and Maternity is not considered as this is covered in its own service line under “Maternity Services”.

The main themes from the engagement reflect that the priority for patients from Calderdale and Greater Huddersfield is to receive seamless, holistic care in all services. They want to see health services delivered by caring and competent staff and that all service changes are properly planned and resourced and do not lead to problems accessing services.

Patients want information to be provided in a way that is clear and easy for the patient to understand and can be accessed in different ways, including speaking to the clinician, looking online, reading a leaflet, and being able to access this information at any time.

Focus groups highlighted that their English language skills were limited and they needed access to an interpreter, at present they were not confident that they would get this in services provided by the hospital.<sup>35</sup>

##### • 4.5.1 Urgent Care

Engagement and Pre-engagement tells us that in an urgent care situation, people preferred to be seen by their GP, Chemist or Walk –in Centre and to be seen by someone with knowledge and experience.<sup>36</sup>

The only local data available in relation to urgent care is sample equality monitoring in a Walk in Centre in Calderdale completed between December 2013 and November 2014. This has been used within this section of the report to analyse service usage under each protected characteristic, however, this is only a small sample and not all service users completed the form.

#### • AGE

The table below shows service use of the Walk in Centre in Calderdale, with the highest users being those under the age of 5. We can see that there are much

<sup>34</sup>(Public Health England, Health Profile 2015 Calderdale & Public Health England, Health Profile 2015 Kirklees)

<sup>35</sup> (Calderdale and Greater Huddersfield Engagement and Pre-Engagement, March 2013 – August 2015)

<sup>36</sup>(Calderdale and Greater Huddersfield Engagement and Pre-engagement, March 2013 – August 2015)

smaller numbers of older people using this service in comparison to those who use A&E, which may reflect the urgency of their need or their ability to travel without support. However, there are also a large proportion of people who did not disclose their age.

Age	Number	%
0-5 years	101	16.5%
6-16 years	83	13.5%
17-20 years	22	3.6%
21-30 years	90	14.7%
31-40 years	93	15.2%
41-50 years	52	8.5%
51-60 years	33	5.4%
61-70 years	22	3.6%
71-80 years	10	1.6%
81+ years	6	1.0%
Blank	101	16.5%
<b>Total</b>	<b>613</b>	

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## • GENDER

Sex	Number	%
Female	322	52.5%
Male	185	30.2%
Male/Female	1	0.2%
Prefer not to say	18	2.9%
Blank	87	14.2%
<b>Total</b>	<b>613</b>	

<sup>37</sup> (Calderdale Walk-in centre Equality monitoring data Report)

Sample data provided in the table above shows that the Walk in Centre in Calderdale appears to be used mostly by females 52.5% compared to 30.2% males. This reflects national trends in the higher use of health services by women than men.

38

## • ETHNICITY

The local sample report shows that the highest users of the Walk in Centre in Calderdale are those of a British and Pakistani Heritage<sup>39</sup>. The Pakistani heritage group are over represented compared to the community, though this may be due to the locations of the walk in centre and the age profile of the service users, but would need to be picked up in any further work about urgent care.

Ethnicity	Number	%
<b>Asian/Asian British</b>		
Indian	6	1.0%
Pakistani	97	15.8%
Bangladeshi	1	0.2%
Chinese	0	0
Other Asian Background	4	0.7%
<b>Black African/Caribbean or Black British</b>		
F African	2	0.3%
Caribbean	0	0
Any other Black/African/Caribbean background	2	0.3%
<b>Mixed/Multiple ethnic groups</b>		
White and Black Caribbean	4	0.7%
White and Black African	2	0.3%
White and Asian	2	0.3%
Any other mixed/multiple ethnic group	2	0.3%
<b>White</b>		
British - English/Scottish/Welsh/Northern Irish	349	56.9%
Irish	2	0.3%
Gypsy/Traveller	1	0.2%
Any other white background	13	2.1%
<b>Other ethnic group</b>		
Arab	1	0.2%
Any other background	21	3.4%
Prefer not to say	4	0.7%
Blank	100	16.3%
Total	613	

(Calderdale Walk-in centre Equality monitoring data Report)

<sup>38</sup>(Calderdale Walk-in centre Equality monitoring data Report)

<sup>39</sup>(Calderdale Walk-in centre Equality monitoring data Report)



Research suggests that, compared with the white British population, people of South Asian origin are three times more likely to require an emergency hospital admission for their asthma, and Black people are twice as likely<sup>40</sup>. Although they would attend A&E at present, it could be more appropriate for those with Asthma to attend an urgent or acute care setting.

#### • RELIGION/ BELIEF

Within the data collected (shown in the table below), the most commonly identified religion was Christianity at 26.8%; this is much lower than the 56% stated in the census. The second highest was Islam at 17.6% and this is a little over twice the 7.3% stated in the census, however, it is in line with sample findings for ethnicity and country of birth. Over a quarter of respondents left this question blank at 30.2%.

Religion and belief	Number	%
Christianity	164	26.8%
Islam	108	17.6%
Sikhism	4	0.7%
Hinduism	3	0.5%
Buddhism	3	0.5%
Judaism	1	0.2%
Atheism	1	0.2%
Other	1	0.2%
Yes	1	0.2%
No	137	22.3%
Prefer not to say	5	0.8%
Blank	185	30.2%
<b>Total</b>	<b>613</b>	

#### • DISABILITY

Sample data in the table below shows a lower than expected identification of service users having a disability at 2.8% compared to the census which states 16.6% (Day-

<sup>40</sup>(NHS Wakefield District (2011) Annual Public Health Report, see: [www.wakefielddistrict.nhs.uk/your-health/phreport2011/on\\_23\\_August\\_2012](http://www.wakefielddistrict.nhs.uk/your-health/phreport2011/on_23_August_2012)).

to-day activity limited a lot and day to day activity limited a little combined). Over a fifth of respondents, 21.9% choose to leave this question blank. This low response may be due to not understanding the definition of disability and / or discomfort or concern about disclosure<sup>41</sup>.

Disability	Number	%
Yes	17	2.8%
No	455	74.2%
Prefer not to say	5	0.8%
Blank	134	21.9%
Not sure	2	0.3%
<b>Total</b>	<b>613</b>	

(Calderdale Walk-in centre Equality monitoring data Report)

The engagement activity tells us when people are seen by a GP in an urgent care situation, a BSL interpreter should be available for GP appointments for those who need them<sup>42</sup>.

## • SEXUAL ORIENTATION

The sample data (shown in the table below) shows that the highest response was left blank, with many people preferring not to say, this is not unexpected as it is considered a sensitive personal question and people can be reluctant to answer<sup>43</sup>.

Sexual orientation	Number	%
Heterosexual	231	37.7%
Lesbian	5	0.8%
Gay	1	0.2%
Bisexual	4	0.7%
Other	5	0.8%
Children	2	0.3%

<sup>41</sup>(Calderdale Walk-in centre Equality monitoring data Report)

<sup>42</sup> (Calderdale and Greater Huddersfield, Engagement and Pre-Engagement, March 2013 – August 2015)

<sup>43</sup>(Calderdale Walk-in centre Equality monitoring data Report)

Prefer not to say	48	7.8%
Blank	317	51.7%
<b>Total</b>	<b>613</b>	

## • GENDER REASSIGNMENT

The sample data (In the table below) shows a small number of respondents, 0.8% identified as transgender. Due to the lack of robust data around this, it is difficult to ascertain if this is reflective of the local population. The high 34.3% blank response is likely to reflect that this is a sensitive question <sup>44</sup>.

Transgender status	Number	%
Yes	5	0.8%
No	390	63.6%
Prefer not to say	9	1.5%
Blank	210	34.3%
Total	613	

## • 4.5.2 EMERGENCY SURGERY AND ACCIDENT AND EMERGENCY

Calderdale CCG registered patients had a total of 69,155 A&E attendances between April 2014 and March 2015. 92% of these occurred at Calderdale and Huddersfield Foundation Trust.

Greater Huddersfield CCG registered patients had a total of 73,440 A&E attendances, 88% of which occurred at Calderdale and Huddersfield Foundation Trust. Calderdale CCG A&E activity (93%) predominantly takes place at Calderdale Royal. Greater Huddersfield CCG A&E activity (94%) predominantly takes place at Huddersfield Royal. This creates the compelling case that A&E should be located at either Calderdale Royal Hospital or Huddersfield Infirmary. <sup>45</sup>

Approximately 14% of A&E activity from both CCG's is grouped as "no investigation and no significant treatment". This is an indicator that at the very least 14% of attendances could be avoided under these new models of care. <sup>46</sup>

<sup>44</sup> (Calderdale Walk-in centre Equality monitoring data Report)

<sup>45</sup> (A&E Reconfiguration data)

<sup>46</sup> (A&E Reconfiguration data)

36% of those admitted to A&E arrive in an Ambulance. The data does not show how many of those people arriving by an ambulance are followed up or discharged without further care.<sup>47</sup>

- AGE

The Age range for A&E attendances in Calderdale and Greater Huddersfield is shown in the table below. Those aged 4 years and under are the highest users of Accident and Emergency, this data also tells us that there is high use of A&E for people aged between 20 and 29.

A & E data	NHS Calderdale CCG		NHS Greater Huddersfield CCG	
AGE BAND	ACTIVITY	% Total	ACTIVITY	% Total
0-4	5,820	9.18%	6,093	9.43%
5-9	3,262	5.14%	3,289	5.09%
10-14	3,743	5.90%	3,552	5.50%
15-19	4,191	6.61%	4,333	6.71%
20-24	4,887	7.71%	5,406	8.37%
25-29	4,782	7.54%	4,657	7.21%
30-34	3,936	6.21%	3,949	6.11%
35-39	3,470	5.47%	3,379	5.23%
40-44	3,644	5.75%	3,761	5.82%
45-49	3,701	5.84%	3,695	5.72%
50-54	3,404	5.37%	3,378	5.23%
55-59	2,840	4.48%	2,905	4.50%
60-64	2,478	3.91%	2,495	3.86%
65-69	2,371	3.74%	2,438	3.77%
70-74	2,224	3.51%	2,196	3.40%
75-79	2,418	3.81%	2,587	4.01%
80-84	2,423	3.82%	2,623	4.06%
85-89	2,170	3.42%	2,264	3.51%
90-94	1,299	2.05%	1,272	1.97%

<sup>47</sup>(A&E Reconfiguration data)

<b>A &amp; E data</b>	<b>NHS Calderdale CCG</b>		<b>NHS Greater Huddersfield CCG</b>	
<b>AGE BAND</b>	<b>ACTIVITY</b>	<b>% Total</b>	<b>ACTIVITY</b>	<b>% Total</b>
95-99	288	0.45%	278	0.43%
100-104	52	0.08%	39	0.06%
105-109	1	0.00%	4	0.01%
<b>Grand Total</b>	<b>63,404</b>	<b>100.00%</b>	<b>64,593</b>	<b>100.00%</b>

(SUS Data, September 2013 – August 2014)

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- OLDER PEOPLE

Nationally, we know that older people are frequent users of A&E departments; UK research suggests A&E attendances are high among those aged between 65 and 80 and highest amongst those over 80 years of age.<sup>48</sup>

The local data shows us that those aged 65 and above (including those over 85) have the highest attendance combined.

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- CHILDREN

- Nationally, children are considered to have disproportionate need for A&E services, this is evidenced below:

- The emergency admission rate for children under the age of 15 in England has increased by 28% in the past decade, from 63 per 1000 population in 1999 to 81 per 1000 in 2010<sup>49</sup>
- Figures show that young children under the age of five have high levels of attendance and high levels of emergency admissions<sup>50</sup>, those under the age of five are admitted more frequently than those aged 5-44 years. In 2010, two thirds (68%) of emergency admissions were among children under the age of five; A&E admission rates for this age group have steadily risen by around 3% a year<sup>51</sup>
- In 2011/2012, 27% of all emergency attendances in England were aged 0-19<sup>52</sup>
- Statistical analysis by the Kings Fund found that 14 per cent of all admissions were patients under 5 years old, with 10.4% of emergency admissions being attributable to acute conditions such as ear, nose and throat infections<sup>53</sup>

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- GENDER

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<sup>48</sup>(Downing A and Wilson R (2005): 'Older people's use of Accident and Emergency services'. In Age and Ageing Vol 34. (1) Nuffield Trust (2010): 'Understanding trends in emergency care')

<sup>49</sup>([http://academia.edu/2557082/Increase\\_in\\_emergency\\_admissions\\_to\\_hospital\\_for\\_children\\_aged\\_under\\_15\\_in\\_England\\_1999-2010\\_national\\_database\\_analysis](http://academia.edu/2557082/Increase_in_emergency_admissions_to_hospital_for_children_aged_under_15_in_England_1999-2010_national_database_analysis))

<sup>50</sup>(NHS (2009 b): The Hospital Element of Unscheduled Care)

<sup>51</sup>(<http://group.bmj.com/group/media/latest-news/Yearly%20rise%20in%20emergency%20admissions%20for%20kids%20in%20England%20since%202003.pdf>)

<sup>52</sup>(HES (2013): Accident and Emergency Attendances in England (Experimental statistics),2011-12 )

<sup>53</sup>(Kings Fund (2012): 'Emergency hospital admissions for ambulatory care-sensitive conditions: identifying the potential for reductions')

The tables below show the gender split of those attending A&E in Calderdale and Greater Huddersfield. In Calderdale, 52% of A&E attendances were female and 48% were male between April and September 2013. 49% female and 50% of males in Greater Huddersfield attended A&E between September 2013 and August 2014. However, there are more males living in Greater Huddersfield than there are in Calderdale.<sup>54</sup>

Gender	Population	A and E
Male	50.6%	50.7%
Female	49.4%	49.3%
Grand Total	100.0%	100.0%

(SUS Data September 2013 – August 2014, Greater Huddersfield)

Gender	Population	A and E
Male	51.1%	52.0%
Female	48.9%	48.0%
Grand Total	100.0%	100.0%

(SUS data Sept 13 – August 14 –Calderdale)

National research indicates that men could have a disproportionate need for A&E and acute services. The supporting evidence is presented below.

- There is much evidence to suggest that young males have a higher propensity to require emergency services. For example, males are more likely to be involved in road traffic accidents than females, particularly males under the age of 30 who represent the most common group in speed-related collisions (The characteristics of speed-related collisions: Road safety research report No. 117 (2010) Department for Transport)
- Young men are at greater risk of being involved in accidents than females. In particular, men are twice as likely to be involved in (and die from) accidents at work and four times more likely to suffer major accident while practising sports.<sup>55</sup> In addition, young men are most likely to experience and become victim to violent crime<sup>56</sup>

<sup>54</sup>(Calderdale CCG PSED, SUS data, Greater Huddersfield PSED, SUS data)

<sup>55</sup>( See: East Midlands Public Health Observatory, (2007); ‘Profile of avoidable injury in the East Midlands: All ages, all causes’; ONS (1999): ‘1999 Health Survey for England’)

<sup>56</sup>(ONS (2013): ‘Crime statistics: Violent crime and sexual offences 2011/12’) (It is recognised that a proportion of these cases may be too complex for a local A&E and would instead be treated as a major trauma case)

There is a fairly even spread of males and females using accident and emergency services nationally and locally, however slightly more males nationally. This needs to be taken into account as there is a potential for males to be impacted slightly more than females.

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- ETHNICITY

In Greater Huddersfield, 79% of those who attended A&E were of a White ethnicity, the second highest attending ethnicity group is Asian/ Asian British. This data is similar to that of the proportion of people within each ethnicity group.<sup>57</sup>

In Calderdale, of the A&E attendances, 87% were White British people; this is slightly more than Greater Huddersfield however there are more White British people living in Calderdale than Huddersfield. The second highest attending ethnicity is the Asian/ Asian British group, this being 11% of attendees.<sup>58</sup>

The Public Health Profiles for Calderdale and Kirklees show more proportional data, which highlights that Asian people are using A&E services more than white British people. There is particular evidence to suggest that people from South Asian backgrounds have higher need for the above services, as evidenced below.

Parslow et. al. (2009) identified that the incidence rate for emergency hospital admission from children requiring intensive care was found to be significantly higher for South Asian children.<sup>59</sup>

One of the most common reasons for emergency admission amongst ethnic minority groups is for strokes and other cardiac problems such as coronary heart disease and diabetes; this highlights the need for consideration of this group in the provision of acute services. (There is a lot of evidence to suggest that rates of stroke and cardiac conditions are higher in certain ethnic minority communities, particularly south Asian communities)

Although there is a high attendance of the White British group locally, this is proportionate in line with representation of this group within the local population. The Asian/ Asian British group has a high attendance in relation to their representation within the population, and in correlation with the national data, we know that one of the groups most likely to be impacted is the South Asian Group.

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- SEXUAL ORIENTATION

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<sup>57</sup>(SUS data, Greater Huddersfield, Sept 13 – August 14)

<sup>58</sup>(SUS data, Calderdale, Sept 13 – August 14)

<sup>59</sup> (Parslow RC. Tasker RC. Draper ES. Parry GJ. Jones S. Chater T. Thiru K. McKinney PA. (2009) "Epidemiology of critically ill children in England and Wales: incidence, mortality, deprivation and ethnicity." Archives of Disease in Childhood. 94(3):210-5, 2009 March.)



Data around sexual orientation is not collected locally around those accessing A&E, however we do have some national evidence which suggests that there may be disproportionate need for those accessing A&E within this group:

- Three in five lesbian, gay and bisexual people over 55 are not confident that healthcare and support services would be able to understand and meet their needs<sup>60</sup>
- Half of lesbian women and bisexual women reported negative experiences in the healthcare sector between 2009/10 and a third of gay men who accessed healthcare between 2009/10 reported to have had a negative experience in relation to their sexual orientation. In a 2011 survey, 9% of lesbian and gay people, and 10% of bisexuals rated their doctor 'poor' or 'very poor' compared to 5% of heterosexuals.<sup>61</sup> These experiences could mean more limited attendance for regular health check-ups which presents a higher risk of the need for emergency services to treat conditions which have worsened due to lack of earlier intervention;
- Nationally, lesbian and bi-sexual women are more likely to suffer from mental health problems and are more vulnerable to suicide than heterosexual women<sup>62</sup>
- Lesbian and bi-sexual women are also more vulnerable to episodes of self-harm; between 2011/12 one in five lesbian and bi-sexual women within the UK have deliberately self-harmed<sup>63</sup>

For a more local picture, out of 6,178 lesbian and bi-sexual women surveyed in 2007 in Kirklees, 8.6% had deliberately self-harmed, and 29.4% had been told they have an eating disorder<sup>64</sup>

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- **OTHER GROUPS**

There is currently limited data available in relation to Religion/Belief, Gender Reassignment and Disability.

- **4.5.3 EMERGENCY MEDICINE (UNPLANNED ACUTE CARE)**

A survey done around Emergency Care showed that the most important aspect is to be seen straight away followed by getting the treatment needed. Patients wish to feel

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<sup>60</sup>(Stonewall Booklet -Sexual Orientation "The Equality Act Made Simple" )

<sup>61</sup>(Prescription for Change, Gay and Bisexual Men's Health Survey and GP patient survey.2011)

<sup>62</sup>(National Institute for Mental Health in England (2007): 'Mental disorders, suicide and deliberate self-harm in lesbian, gay and bi-sexual people: A systematic review')

<sup>63</sup>(Stonewall (2012): 'Mental health: Stonewall health briefing')

<sup>64</sup>(Stonewall (2007): 'Stonewall Lesbian and Bi-sexual Women's Health Survey')

safe and see professionals with specialist knowledge, skills and equipment needed to care for them.<sup>65</sup>

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- AGE

In Greater Huddersfield we know that there are more Emergency Admissions for those under the age of 14, that A&E attendances and Elective Planned Admissions is the same for those aged 85 and above.<sup>66</sup>

In Calderdale, those over 85 are more likely to attend as an emergency admission than present to A&E.

Age Band	Population	A and E	Emergency
0-14	17.9%	19.7%	24.7%
15-24	13.5%	16.2%	6.4%
25-64	52.7%	44.6%	32.7%
65-84	13.9%	14.3%	25.5%
85+	2.0%	5.3%	10.7%
Grand Total	100.0%	100.0%	100.0%

(SUS data Sept 13 – August 14 Greater Huddersfield)

Age Band	Population	A and E	Emergency
0-14	18.3%	20.1%	24.2%
15-24	11.9%	15.1%	5.9%
25-64	53.8%	45.4%	32.4%
65-84	13.9%	14.2%	26.1%
85+	2.1%	5.3%	11.4%
Grand Total	100.0%	100.0%	100.0%

(SUS data Sept 13 – August 14 Calderdale)

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- GENDER

<sup>65</sup>(Calderdale and Greater Huddersfield, Engagement and Pre-Engagement, March 2013 – August 2015)

<sup>66</sup>(SUS Data Greater Huddersfield and Calderdale, September 2013 – August 2014)

In Greater Huddersfield, there are more females using Emergency Medicine Services than Males, however the split is fairly even. This is the same in Calderdale and the data is reflected in the tables below.<sup>67</sup>

Gender	Population	Emergency
Male	50.6%	48.5%
Female	49.4%	51.5%
Grand Total	100.0%	100.0%

(Greater Huddersfield, SUS data)

Gender	Population	Emergency
Male	51.1%	49.0%
Female	48.9%	51.0%
Grand Total	100.0%	100.0%

(Calderdale, SUS data)

## • ETHNICITY

Again, in Greater Huddersfield and Calderdale the highest proportion of people using Emergency Medicine is those from the White ethnicity group, the next highest is those from the Asian or Asian British group. This is expected, due to the representation of these groups within the local population.<sup>68</sup>

We know that nationally, one of the most common reasons for emergency admission amongst ethnic minority groups is for strokes and other cardiac problems such as coronary heart disease and diabetes; this highlights the need for consideration of this group in the provision of acute services (There is a lot of evidence to suggest that rates of stroke and cardiac conditions are higher in certain ethnic minority communities, particularly south Asian communities.)

## • DISABILITY

A local survey tells us that people feel that transport should be able to accommodate passenger needs, particularly for those with a disability.

<sup>67</sup>(Greater Huddersfield CG PSED, Calderdale CCG PSED)

<sup>68</sup>(Greater Huddersfield CG PSED, Calderdale CCG PSED)

Focus groups were also held during engagement and this also confirms the survey response, however it was also mentioned that those with a learning disability need to feel safe and this is a high priority.

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- OTHER GROUPS

With regards to Emergency Medicine, we have not found any available data in relation to religion or belief, sexual orientation or gender reassignment.

- 4.5.4 PLANNED CARE

The local survey done as part of the Engagement shows that the most important aspect of patients care was to be treated by someone who knows their condition and knowing they will get the treatment that they need. Access should be provided to information needed to enable staff to give the best care they can. <sup>69</sup>

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- AGE

Again, we are unable to interpret the data in relation to age due to the differences in ranges that the data has been collected. However, In Greater Huddersfield, we are aware that there is only a small proportion of those under the age of 14 admitted for elective planned care.

Age Band	Population	Elective
0-14	17.9%	3.5%
15-24	13.5%	4.4%
25-64	52.7%	51.3%
65-84	13.9%	36.5%
85+	2.0%	4.3%
Grand Total	100.0%	100.0%

(SUS data Sept 13 – August 14 Greater Huddersfield)

Age Band	Population	Elective
0-14	18.3%	3.6%

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<sup>69</sup>(Calderdale and Greater Huddersfield Engagement and Pre-engagement, March 2013 – August 2015)

Age Band	Population	Elective
15-24	11.9%	4.1%
25-64	53.8%	51.6%
65-84	13.9%	36.1%
85+	2.1%	4.6%
Grand Total	100.0%	100.0%

(SUS data Sept 13 – August 14 Calderdale)

We know that nationally, there is a disproportionate need for elective services for older people, this is demonstrated by the following evidence;

- Older people are reported to experience poor health due to the ageing process; this can often result in the need for non-emergency hospital care as a preventative measure or to ensure the stabilisation of long-term and non-threatening conditions<sup>70</sup>
- In 2008 the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) reported that the most common operative procedures were hemiarthroplasty and slide hip screw (24% and 23%) respectively, laparotomy (13%) and amputation. All are usually planned procedures which are common to older people;
- Cancer Research UK reported bowel cancer as one of the most common forms of cancer which is strongly linked to age. In the UK between 2007 and 2009, on average 72% of bowel cancer cases were diagnosed in people over the age of 65<sup>71</sup>
- Between 2006 and 2008, diagnoses rates for stomach cancer within the UK increased steeply from the age of 60, reaching 140 per 100,000 population in men aged 85 and over, and 67 per 100,000 in women aged 85 and over<sup>72</sup>

## • GENDER

In Greater Huddersfield, we know that 45% of males and 55% of females accessed elective/planned care between September 2013 and August 2014, however in Calderdale, there are more males than females accessing this service.

<sup>70</sup>(Mott McDonald, Better Services, Better, Value 2013)

<sup>71</sup>(Cancer Research UK (2012): 'Bowel cancer incidence statistics')

<sup>72</sup>(Cancer Research UK (2012): 'Stomach cancer incidence statistics')

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- ETHNICITY

In Greater Huddersfield 88% of planned admissions were from the White ethnic group, with 6.6% of planned admissions being from the Asian/Asian British group. Around 10% of the population are Asian which shows a slightly lower usage than expected. 82.6% of the population are White, which shows there is a higher usage than expected.

In Calderdale 94.5% of attendances were from the White ethnic group which is slightly higher than the population of 89.5%, and again, the second highest attendees were those of an Asian/ Asian British ethnicity, this being 4.5% of attendees which is almost half of their representation within the population, which is just over 8%.

Locally, some people in the engagement expressed that they felt staff providing care need to be more culturally aware and information provided needs to be clear so that patients know what to expect. They also felt that treatment plans should be written in a language appropriate to the reader <sup>73</sup>.

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- RELIGION/ BELIEF

Information in the table below taken from Calderdale Hospital Foundation Trust patient information is difficult to interpret due to the high proportion of people listed as “not known”. However, we do know that Christians and Muslims are high attenders. Only 7.5% of the local population are recorded as “not known”, whereas 53.32% are recorded as this within the hospital system. This suggests that there is room for improvement in data collection in this area.

<b>Patient religious group profiles Dec 2013 to Nov 2014 (source CHFT Patient Administration System) compared with local population religious group profiles (source West Yorkshire Observatory website: <a href="http://www.westyorkshireobservatory.org/dataviews/">http://www.westyorkshireobservatory.org/dataviews/</a> ) Religious group</b>	<b>Percentage of patient population</b>	<b>Percentage of local population</b>
Not known	53.32%	7.50%
Christian	35.25%	67.99%
None	4.89%	14.81%
Muslim	4.84%	8.53%
Sikh	0.23%	0.51%
Hindu	0.07%	0.28%

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<sup>73</sup>(Calderdale and Greater Huddersfield, Engagement and Pre-engagement, March 2013 – August 2015)

Other	1.36%	0.21%
Buddhist	0.02%	0.13%
Jewish	0.02%	0.05%

#### • DISABILITY

Local data following engagement tells us that staff delivering planned care needed more training on their knowledge of disabilities, including autism and dementia. (Calderdale and Greater Huddersfield, Engagement and Pre-Engagement, March 2013 – August 2015)

Nationally there is evidence to show that change to planned care is likely to have an effect upon this group as the research shows:

- It is commonly acknowledged that disabled people have poorer health, not just in relation to their primary impairment or long term health condition but because of reduced access to health services and generally higher levels of social deprivation. This puts this group at a higher risk of illness and likely to have a greater need of planned care and procedures (NCEPOD (2008): Elective and emergency surgery in the elderly: study protocol, p2.)
- The potential for abuse and the vulnerability experienced by people with learning disabilities are present throughout their lives. People with learning disabilities have markedly worse health than the general population as a whole and are therefore more likely to use health services (Equality and Human Rights Commission (2013): 'How fair is Britain?')

#### • OTHER GROUPS

National or local data around Gender Reassignment and Sexual Orientation is limited.

#### • 4.5.5 MATERNITY SERVICES

Further engagement around Maternity Services is currently underway locally, and this information will be reviewed and analysed once this engagement is complete.

#### • AGE

Currently, those between the ages of 24 and 33 are mostly likely to use Maternity Services in both CCG's (CHFT Maternity Reconfiguration Analysis, April 2014- March 2015). The data below shows the age range of those using Maternity Services in Calderdale and Greater Huddersfield. The data shows that younger people in

Calderdale (under the age of 23) are much more likely to use inpatient services than those in Greater Huddersfield.

	NHS Calderdale CCG				NHS Greater Huddersfield CCG			
	IN PATIENT		OUT PATIENT		IP		OP	
AGE	ACTIVITY	% Total	ACTIVITY	% Total	ACTIVITY	% Total	ACTIVITY	% Total
0	42	0.52%	0	0.00%	36	0.46%	0	0.00%
13	0	0.00%	0	0.00%	3	0.04%	7	0.06%
14	2	0.02%	5	0.04%	0	0.00%	0	0.00%
15	18	0.22%	15	0.11%	4	0.05%	5	0.04%
16	31	0.38%	19	0.15%	17	0.22%	10	0.08%
17	81	1.00%	62	0.47%	62	0.79%	67	0.54%
18	118	1.46%	111	0.85%	106	1.36%	137	1.10%
19	219	2.71%	180	1.38%	195	2.50%	248	2.00%
20	286	3.54%	280	2.14%	245	3.14%	287	2.31%
21	344	4.25%	354	2.71%	292	3.74%	366	2.95%
22	362	4.48%	389	2.98%	303	3.88%	397	3.20%
23	396	4.90%	475	3.63%	328	4.20%	459	3.70%
24	421	5.21%	602	4.61%	435	5.57%	556	4.48%
25	491	6.07%	679	5.20%	397	5.09%	606	4.89%
26	483	5.97%	714	5.46%	526	6.74%	754	6.08%
27	490	6.06%	790	6.04%	448	5.74%	659	5.31%
28	448	5.54%	805	6.16%	439	5.63%	685	5.52%
29	488	6.04%	903	6.91%	460	5.89%	783	6.31%
30	497	6.15%	849	6.50%	489	6.27%	869	7.01%
31	400	4.95%	820	6.27%	557	7.14%	858	6.92%



	NHS Calderdale CCG				NHS Greater Huddersfield CCG			
	IN PATIENT		OUT PATIENT		IP		OP	
AGE	ACTIVITY	% Total	ACTIVITY	% Total	ACTIVITY	% Total	ACTIVITY	% Total
32	418	5.17%	841	6.44%	400	5.13%	710	5.73%
33	435	5.38%	772	5.91%	418	5.36%	709	5.72%
34	310	3.83%	649	4.97%	327	4.19%	682	5.50%
35	345	4.27%	667	5.10%	365	4.68%	614	4.95%
36	271	3.35%	506	3.87%	231	2.96%	459	3.70%
37	150	1.86%	403	3.08%	179	2.29%	333	2.69%
38	173	2.14%	340	2.60%	160	2.05%	331	2.67%
39	87	1.08%	212	1.62%	120	1.54%	247	1.99%
40	72	0.89%	223	1.71%	83	1.06%	212	1.71%
41	87	1.08%	164	1.25%	80	1.03%	141	1.14%
42	64	0.79%	107	0.82%	41	0.53%	80	0.65%
43	32	0.40%	61	0.47%	21	0.27%	69	0.56%
44	5	0.06%	19	0.15%	23	0.29%	39	0.31%
45	15	0.19%	32	0.24%	5	0.06%	7	0.06%
46	3	0.04%	6	0.05%	2	0.03%	4	0.03%
47	0	0.00%	6	0.05%	0	0.00%	0	0.00%
48	1	0.01%	8	0.06%	7	0.09%	11	0.09%
83	0	0.00%	1	0.01%	0	0.00%	0	0.00%
<b>Grand Total</b>	<b>8,085</b>	<b>100.00 %</b>	<b>13,069</b>	<b>100.00 %</b>	<b>7,804</b>	<b>100.00 %</b>	<b>12,401</b>	<b>100.00 %</b>

(CHFT Maternity Reconfiguration Analysis, April 2014- March 2015)

Nationally, women aged 15 to 45 years are the primary users of maternity services; at the age of 46, women are assumed to have completed their child bearing (<http://www.ons.gov.uk/ons/rel/vsob1/characteristics-of-Mother-1--england-and-wales/2010/stb-live-births-in-england-and-wales-by-characteristics-of-mother-2010.html>)

We also know that:

- Teenage mothers and their babies are more likely to experience poor nutrition, being at a higher risk of low birth weight and lower rates of breast feeding. Young mothers are also more likely to smoke during pregnancy, as well as being at greater risk of infant mortality and poor mental health, therefore having more particular needs for maternity services (Department of Health (2010) “Teenage Pregnancy Strategy: Using lessons learnt to go beyond)
- In comparison, the teenage conception rate in Kirklees in 2010 was 43.8 per 100,000 females, which is higher than the national average (Kirklees Partnership (2012): ‘Picture of Kirklees 2012/13’) the fact this area has above average rates of teenage pregnancy highlights the need for consideration of this group’s provision of maternity services.

#### • GENDER

There are self-evident links between women and maternity services and, as such, they will be disproportionately affected by changes in this service area.

#### • ETHNICITY

The Ethnicity breakdown of those using maternity services is shown in the table below. The majority of patients accessing Maternity Services across both CCG’s are White British (CHFT Maternity Reconfiguration Analysis, April 2014- March 2015) the second highest attendees are those of Pakistani Heritage.

ETHNIC GROUP	NHS Calderdale CCG				NHS Greater Huddersfield CCG			
	In Patient		Out Patient		IP		OP	
	ACTIVITY	% Total	ACTIVITY	% Total	ACTIVITY	% Total	ACTIVITY	% Total
African	16	0.20%	19	0.15%	117	1.50%	240	1.94%
Any other Asian background	34	0.42%	79	0.60%	114	1.46%	130	1.05%
Any other Black background	18	0.22%	39	0.30%	51	0.65%	99	0.80%
Any other ethnic group	56	0.69%	102	0.78%	256	3.28%	490	3.95%

ETHNIC GROUP	NHS Calderdale CCG				NHS Greater Huddersfield CCG			
	In Patient		Out Patient		IP		OP	
	ACTIVITY	% Total	ACTIVITY	% Total	ACTIVITY	% Total	ACTIVITY	% Total
Any other mixed background	20	0.25%	27	0.21%	65	0.83%	121	0.98%
Any other White background	346	4.28%	468	3.58%	366	4.69%	601	4.85%
Bangladeshi	43	0.53%	94	0.72%	19	0.24%	30	0.24%
British	6,208	76.78%	9,654	73.87%	4,916	62.99%	7,525	60.68%
Caribbean	12	0.15%	21	0.16%	141	1.81%	256	2.06%
Chinese	31	0.38%	54	0.41%	40	0.51%	70	0.56%
Indian	51	0.63%	122	0.93%	127	1.63%	235	1.90%
Irish	18	0.22%	57	0.44%	33	0.42%	66	0.53%
Not stated	1	0.01%	1	0.01%	0	0.00%	5	0.04%
Pakistani	1,121	13.87%	2,220	16.99%	1,261	16.16%	2,081	16.78%
White and Asian	48	0.59%	48	0.37%	49	0.63%	76	0.61%
White and Black African	15	0.19%	15	0.11%	17	0.22%	24	0.19%
White and Black Caribbean	47	0.58%	49	0.37%	232	2.97%	352	2.84%
<b>Grand Total</b>	<b>8,085</b>	<b>100.00%</b>	<b>13,069</b>	<b>100.00%</b>	<b>7,804</b>	<b>100.00%</b>	<b>12,401</b>	<b>100.00%</b>

(CHFT Maternity Reconfiguration Analysis, April 2014- March 2015)

Those who are recorded as “Any Other White” are over re-represented in comparison to the local population in Calderdale and Greater Huddersfield.

During the Pre-Engagement Focus Groups, it was highlighted that staff providing care need to be more culturally aware and information provided needs to be clear so that patients know what to expect. Treatment plans should be written in a language appropriate to the reader.

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- DISABILITY

There is no local data available in relation to disability and Maternity Services, however, a UK study on physically disabled parents' experiences of maternity services reveals that physically disabled people embarking on parenthood face a number of challenges. In addition to working to provide the best start for their babies before and during pregnancy, through birth and into parenthood, they often also face a challenge in getting appropriate information and support to enable them to plan and prepare for birth (<http://www.dppi.org.uk/projects/episurvey.php>)

Little research has been undertaken nationally into disabled women's maternity needs, but they have been identified as a group which maternity services are failing. Much of the evidence for this is anecdotal in nature; for example, women relating their own maternity experiences as reported at the Maternity Alliance conference in 1994, after which the Royal College of Midwives (RCM) published, and later revised, a paper (RCM, 2000) providing guidelines for midwifery practice<sup>74</sup>.

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- RELIGION/BELIEF

The table below is taken from a survey of women's experiences of maternity services 2013 in Calderdale and Huddersfield NHS Foundation Trust . Although this is only a small sample of people using this service, we can see that the highest respondents were those of a Muslim or Christian belief, with a high percentage of people having “no religion”.

The sample	This Trust (%)	All Trusts (%)
Number of respondents	202	23077
Response rate	46	46
Demographic Characteristics		
<b>Religion</b>	This Trust (%)	All Trusts (%)
No religion	35	33
Buddhist	0	1
Christian	49	55
Hindu	1	2
Jewish	0	1
Muslim	13	6
Sikh	1	1
Other religion	1	1
Prefer not to say	1	1

(Care Quality Commission (CQC) Patient survey report 2013

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<sup>74</sup>(RCN *Pregnancy and Disability – RCN guidance for midwives and nurses- March 2007*)

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[http://www.nhssurveys.org/Filestore/MAT13/Benchmark\\_LB/Labour%20and%20Birth%20Reports/MAT13\\_LB\\_RWY.pdf](http://www.nhssurveys.org/Filestore/MAT13/Benchmark_LB/Labour%20and%20Birth%20Reports/MAT13_LB_RWY.pdf)

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- SEXUAL ORIENTATION

Again, there is limited local data other than the previously referred to survey of women's experiences of maternity services 2013 in Calderdale and Huddersfield NHS Foundation Trust. We can see from the data below that the majority of respondents to this survey who have used maternity services are Heterosexual/Straight and a minority are gay/lesbian/bisexual. Few respondents preferred not to disclose.

The sample	This Trust (%)	All Trusts (%)
Number of respondents	202	23077
Response rate	46	46
Demographic Characteristics		
<b>Sexual Orientation</b>	This Trust (%)	All Trusts (%)
Heterosexual/straight	96	96
Gay/lesbian	1	0
Bisexual	1	1
Other	0	0
Prefer not to say	2	3

(Care Quality Commission (CQC) Patient survey report 2013

[http://www.nhssurveys.org/Filestore/MAT13/Benchmark\\_LB/Labour%20and%20Birth%20Reports/MA T13\\_LB\\_RWY.pdf](http://www.nhssurveys.org/Filestore/MAT13/Benchmark_LB/Labour%20and%20Birth%20Reports/MA T13_LB_RWY.pdf)

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- OTHER GROUPS

There is very limited available data nationally and locally in relation to Maternity Services with regards to Gender Reassignment.

- 4.5.6 PAEDIATRIC SERVICES

There is currently a Paediatric engagement underway, once this is completed and analysed the data will be used to inform the consultation.

In relation to paediatric services, between 2008 and 2010, the following national averages are noted:

- 40.9% of admissions (52,337 in total) to PICU are planned - 34.2% (17,891) following surgery, and 6.7% (3,513) for non-surgical reasons.
- 59.1% (30,933) of admissions are for unplanned emergency care.
- The top three indications for admission to a paediatric intensive care unit are:
  - cardiovascular (28.6%);

- respiratory (26.0%);
  - neurological (11.0%).
- 65.7% require invasive mechanical ventilation (i.e. via an endotracheal tube) during their stay; 14.9% will require non-invasive ventilation.
  - These averages conceal substantial inter-unit variation, with the percentage of children on PICU requiring invasive ventilation varying from 6 to 85%.  
[http://www.picanet.org.uk/..Documents/General/Annual%20report%20publishe d%202011/Annual\\_report\\_02\\_12\\_11v2.pdf](http://www.picanet.org.uk/..Documents/General/Annual%20report%20publishe d%202011/Annual_report_02_12_11v2.pdf)

During the engagement, there was little evidence in relation to Paediatric Services as a whole, however, people caring for children did express that they wished for services to go ahead when planned as it can often be difficult to change availability arrangements when plans have already been made<sup>75</sup>.

#### • AGE

The proposed changes to Paediatric Emergency Department for Calderdale and Greater Huddersfield are most likely to impact on children under 14 and their families.

#### • DISABILITY

There is no data locally in relation to Paediatric services. However, we do know that 1% of those with a disability under the age of 15 have their daily activities limited a lot in Greater Huddersfield<sup>76</sup>.

#### • OTHER GROUPS

There is limited data available in relation to Sexual Orientation, Gender Reassignment, Gender, Ethnicity and Religion or belief in relation to Paediatric services, however further engagement is currently underway.

### • 4.6 OTHER INFORMATION

This section of the report picks up the protected characteristic data held that does not specifically fall under the above service lines.

#### • TRANSGENDER / GENDER REASSIGNMENT

NHS Greater Huddersfield CCG and Calderdale CCG are members of the West Yorkshire Trans Equality Multi-Agency Partnership Group which began meeting in

<sup>75</sup>(Calderdale and Greater Huddersfield Engagement and Pre-Engagement, March 2013 – August 2015)

<sup>76</sup> Greater Huddersfield PSED report, January 2015

July 2012 with the aim of improving Trans people's experiences and reducing health inequalities.

When participants were asked how they would rate their experiences as Trans people, or people with a Trans history, of using the NHS in West Yorkshire in general, many were very positive, however further engagement is needed with this group throughout the consultation.

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## • CARERS

From the JSNA almost 1 in 5 (19%) of the adult population in Kirklees are carers. By 2037, the number of carers is set to rise by 40%, to over 80,000 locally.

- 1 in 7 (14%) 14-year olds are carers. Young carers are less likely to be happy at school and more likely to be bullied than young people with no caring responsibilities.
- In Kirklees, in 2012, carers were more likely to have poorer health, especially pain and depression, than non-carers. They were as likely to have a job but many were restricted to part-time work, which restricts income and pension rights, and benefit take up is low.
- Almost 1 in 5 (18%) carers in Kirklees stated that their present home is not suitable. A significant proportion stated that this is because of physical or mental health conditions or illnesses, or mobility needs.

Compared to non-carers, in 2012:

- Carers had poorer emotional and physical wellbeing, with 6 in 10 (62%) carers rating their overall health as excellent or good compared to almost 7 in 10 (66%) non-carers.
- Carers were a little more likely to report suffering from a health condition in the last 12 months, experiencing depression or other mental health problems and experiencing pain.
- Carers were more likely to be obese, more likely to drink excessively, and less likely to smoke.

In Greater Huddersfield:

- The 2011 Census that shows the peak age for caring is between 50 and 59, 45% of those aged 45-64 were carers, compared with 19% of those aged over 65 years and 34% of those aged 18-44.



- Women carers are more likely to be younger i.e. 50% of female carers were aged 18-44. Male carers were more likely to be older with 48% of male carers being aged 65 or over.
- Carers reflected the ethnic diversity of Kirklees.
- 1 in 4 14-year old carers were of south Asian origin compared to 1 in 7 of the overall population.
- 2 in 3 people being cared for were aged over 65 years, 6% aged under 16 years (and tended to be learning disabled). The mean age of carers was 67.
- The group aged 50-64 provide care most 20% at 13% the over 65's, are providing care, and significantly provide the most hours of care at 5% providing 50 or more hours a week.
- The health of carers is often impacted by their provision of care. Those who provide 50 or more hours a week reporting bad or very bad health 5% compared to 2% who have very good or good health.

In Calderdale, The Census asked residents whether they look after or give help or support to family members, friends, neighbours or others because of long-term physical or mental ill health or disability, or problems related to old age. In 2011, 6.68% of residents in Halifax North and East provided 1 to 19 hours or unpaid care, while 1.42% provided 20 to 49 hours, and 2.48% provided 50 or more hours of unpaid care. This compares to figures of 6.51%, 1.36% and 2.37% respectively in England <sup>77</sup>

#### • RELIGION/BELIEF

The table below shows religious group profiles held on the Patient Administration System at Calderdale Hospitals Foundation Trust. However, the data does tell us that 53% of people are recorded as “not known”. This is an area where data collection could be improved.

<b>Patient religious group profiles Dec 2013 to Nov 2014 (source CHFT Patient Administration System) compared with local population religious group profiles (source West Yorkshire Observatory website: <a href="http://www.westyorkshireobservatory.org/dataviews/">http://www.westyorkshireobservatory.org/dataviews/</a> ) Religious group</b>	<b>Percentage of patient population</b>	<b>Percentage of local population</b>
Not known	53.32%	7.50%

<sup>77</sup>(Office for National Statistics, Census).

Christian	35.25%	67.99%
None	4.89%	14.81%
Muslim	4.84%	8.53%
Sikh	0.23%	0.51%
Hindu	0.07%	0.28%
Other	1.36%	0.21%
Buddhist	0.02%	0.13%
Jewish	0.02%	0.05%

#### • OTHER GROUPS

There is limited information from the engagement around Pregnancy and Maternity and Gender Reassignment, we have therefore used the Public Sector Equality Duty Report for Greater Huddersfield to assess the groups under-represented in the consultation.

We are aware that engagement around Maternity and Paediatrics specifically is currently under way and this information should be fully taken into account when these services are developed.

#### • 4.7 OTHER DATA IN RELATION TO HOSPITAL SERVICES

Data tells us that the highest users of inpatient services are those between the ages of 30 and 44 years old and the highest users of outpatient services are younger people under the age of 24.

#### • INPATIENT

Age profiles Dec 2013 to Nov 2014 (source CHFT Patient Administration System) compared with local population age profiles (source West Yorkshire Observatory website: <a href="http://www.westyorkshireobservatory.org/dataviews/">http://www.westyorkshireobservatory.org/dataviews/</a> ) Age Band	Percentage of admissions	Percentage of local population
0 – 15	13.19%	20.12%
16 – 29	14.07%	17.77%
30 – 44	15.23%	20.20%
45+	57.51%	41.91%
45+ age	band broken down:	

45 – 54	10.02%
55 – 64	12.41%
65 – 74	14.80%
75 – 84	13.28%
85 +	6.99%

#### • OUTPATIENT

Age profiles Dec 2013 to Nov 2014 – source CHFT Patient Administration System Age Band	Attendances	DNA rate
00 – 04	16,816	13%
05 – 14	25,087	12%
15 – 24	27,312	14%
25 – 34	50,640	11%
35 – 44	44,236	10%
45 – 54	51,133	8%
55 – 64	56,863	6%
65 – 74	66,042	4%
75 – 84	54,192	5%
85 +	19,680	7%

The data shows that the highest rate of DNA's is from younger people under the age of 24. This population of this age group is 31% in Greater Huddersfield population and around 30% in Calderdale.

#### • 4.8 ENGAGEMENT EQUALITY MONITORING

This section of the report provides a summary of those protected groups who have been represented or under-represented in the Engagement and Pre-engagement activity.

#### • AGE

The engagement activity undertaken to date has reached a fairly representative sample of the local population in relation to age, with the exception of children and young people. Currently young people are being engaged around paediatric

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services but in a future consultation their views and that of their parents and carers must be adequately heard.

Older people as more significant users of emergency and urgent services must be reached in view of potential changes in location or development of new services.

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- GENDER

The engagement so far has reached a higher percentage of women, this may be due to their willingness to participate, as there has been limited identification of significant concerns for gender within the potential changes to service there should be no need to target either gender particularly, other than for maternity services.

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- ETHNICITY

The engagement so far has reached a mostly representative sample of different ethnic groups, however in consulting around potential change for the future it would be necessary to target consultation to aim to understand where services have an over-or under-representation compared to the local population. Where this is clearly due to an increased need for service, ie maternity the relevant groups must be properly consulted to understand the impact of any proposed changes. This will enable suitable mitigation to be developed to support and reduce any negative impacts.

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- RELIGION/BELIEF

The engagement so far has done well to reach a mostly representative sample of different religious groups, however in consulting around potential change for the future it would be necessary to target consultation to aim to better understand service usage. Where this is clearly due to an increased need for service, the relevant groups must be properly consulted to understand the impact of any proposed changes. This will enable suitable mitigation to be developed to support and reduce any negative impacts.

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- DISABILITY

While the engagement has reached disabled communities it would be necessary for the consultation to note if there would be any particular impairment groups that could be significant users of the services where there are proposed changes. These should be identified and the impairment groups targeted for consultation to enable any potential negative impacts to be identified and mitigated.

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- SEXUAL ORIENTATION

The various engagements have reached the LGB communities; however there has never been a large enough sample to understand any potential trends. Further research should be considered to understand if there is likely to be an impact on LGB people in any of the affected services, if so targeted consultation should be undertaken to gather intelligence on the likely impact and any appropriate mitigation.

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- **GENDER REASSIGNMENT**

Further research should be considered to understand if there is likely to be an impact on transgender people in any of the affected services, if so targeted consultation should be undertaken to gather intelligence on the likely impact and any appropriate mitigation.

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- **PREGNANCY/ MATERNITY**

There is currently further engagement being undertaken in relation to maternity services, once this has been analysed it would be necessary to see if the consultation should target particular groups, as they have been under-represented in the engagement. The over representation of particular ethnic groups would suggest that their views should be particularly sought.

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- **CARERS**

Carers have been reached through engagement activities and this should be replicated in the consultation to identify if any particular impacts would be experienced by carers in the services subject to changes.

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- **4.9 TRAVEL ANALYSIS**

From the Engagement, we know people want to have services based locally, to be cared for closer to home. It was felt that location of services is very important; as the local area has many hilly areas and this could prove difficult for those with mobility impairments. Accessibility needs to be considered in wider context than the building itself.

During the Engagement, travel and parking was raised as an issue, Carers said that parking concessions are important and they can often be restricted from travelling further away. They also highlighted that they may need same day appointments due to the unpredictability of when they had time to themselves (Calderdale and Greater Huddersfield Engagement and Pre-engagement, March 2013- August 2015).

A full travel impact analysis has been carried out in 2014 by Yorkshire Ambulance Service and Jacobs Engineering, the conclusion of this analysis was that there are no disproportionate impacts of the change in travel time related to whether Huddersfield Royal Infirmary or Calderdale Royal Hospital is the planned or

unplanned hospital care site. Currently, 60% of the population are within a 15 minute drive of either hospital and 96% of the population being within a 30 minute drive of either Calderdale Royal Hospital or Huddersfield Royal Infirmary (Jacobs, Calderdale and Huddersfield NHS Trust, Journey Time Assessment Study, June 2014).

People without access to private transport are likely to experience barriers in accessing key services including hospitals, employment centres, supermarkets and other amenities (particularly in rural areas where distances to services are large and public transport provision is poor).

The table below shows the number and proportion of households by the number of car or vans owned Across Calderdale and Greater Huddersfield Wards.<sup>78</sup> Although a large proportion of the population is within a 30 minute drive, consideration needs to be made to those who do not own a car. The table below shows the percentage of people owning a car by ward in Calderdale and Greater Huddersfield.

Area/Ward	% of people owning a vehicle (average)
<b>Calderdale</b>	
Halifax Central	66%
Halifax North and East	70%
Lower Valley	78%
Upper Valley	77%
<b>Greater Huddersfield</b>	
Almondbury	66%
Crosland Moor	56%
Dalton	60%
Denby Dale	87%
Golcar	72%
Kirkburton	80%
Lindley	87%
Newsome wards	56%

(<http://observatory.kirklees.gov.uk/profiles/profile?profileId=98&geoTypeId>)

(<http://observatory.calderdale.gov.uk/profiles/profile?profileId=98&geoTypeId>)

As already identified in this report, older people are mostly located in the suburbs of the main towns of Halifax and Huddersfield which does result in slightly longer travel times to either hospital site, however, under the new model, more of their care will be delivered in their home or at a site close to their home.

Current public transport journey times show that there are some patients in rural areas who are currently experiencing public transport journeys of more than 80

<sup>78</sup>(<http://observatory.kirklees.gov.uk/profiles/profile?profileId=98&geoTypeId>)

minutes if they wish to access services at either hospital site (Jacobs, Calderdale and Huddersfield NHS Trust, Journey Time Assessment Study, June 2014)..

The key areas of deprivation are located around the main towns of Halifax and Huddersfield, those living in closer to where the A&E site will be placed will be an immediate advantage, however those living nearby a service that will no longer be available may see a negative impact in relation to travel. This is also likely to affect people with a disability and older people, as there is a large proportion of this group living in rural areas.

The areas in Calderdale reporting poor health are in Central Halifax, it should be noted that 66% of people living in this area have access to a car, this is the lowest percentage of car owners in the Calderdale area. Those living in the lower and upper valley report better health, however there are more people living in these areas who have access to a car or van <sup>79</sup>.

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- PUBLIC TRANSPORT

Within the Journey, Time Assessment Study already undertaken, it was identified that those areas with highest reliance on public transport are people with a disability, older people, people from BME background and those living in social deprivation<sup>80</sup>.

Any changes in journey times is likely to have a greater impact on those using public transport, resulting in longer and possible more complex journeys, than that for car users. Several areas including the south of Huddersfield, the south of Halifax, the Queensbury / Ovenden area, Stainland, Hebden Bridge and Todmorden are likely to incur a significant increase in journey time in excess of 45 minutes if proposed changes result in a change of base for services.

Any increase in journey times is likely to disproportionately affect older people; people with disabilities; those living in rural areas, people living in areas of deprivation and those using public transport<sup>81</sup>.

## 5. STEP 3 - IMPACT

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- 5.1 EQUALITY IMPACT ASSESSMENT

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<sup>79</sup> (<http://observatory.calderdale.gov.uk/profiles/profile?profileId=191&geoTypeId=27#iasProfileSection4>).

<sup>80</sup> (Calderdale and Huddersfield Foundation Trust, Journey Time Assessment Study, June 2014)

<sup>81</sup> (Calderdale and Huddersfield Foundation Trust, Journey Time Assessment Study, June 2014)

This section of the report provides a comprehensive impact assessment showing how protected groups could be both positively and negatively impacted by the changes of the new model of care

We understand that the population of Calderdale and Greater Huddersfield is aging slightly faster in the rural areas than in urban areas. This means that new service models could place older residents at a disadvantage, however the new model of care in the community is likely to make access to services easier for the elderly population, care that is typically delivered in hospital can be delivered closer to or around their home.

## • 5.2 OVERVIEW

This section goes into further detail around the ways in which we would recommend promoting equality and mitigating risks for those negative impacts highlighted throughout this report.

The opportunities in relation to the proposal set out in the context of this report are as follows;

- More people will be supported to self-manage and self-care
- 7 day integrated services can be provided closer to home
- Safety and Quality of Hospital Care will be improved
- People will be in control of their own Health and Wellbeing Needs
- Investment will be made in Staff Capabilities and Skills to enable quality improvements
- Information technology will support new ways of working

## • 5.3 IMPACT BY SERVICE AREA

The table below shows those protected groups who are likely to be impacted.



Potential impact (positive or negative)
High impact
Medium impact
Low impact
No impact
Insufficient information

Equality Characteristic	Accident and emergency	Maternity services	Paediatric services	Planned care	Urgent care	Acute services
Age 0 to 15	Medium impact	Low impact	Medium impact	Insufficient information	Medium impact	Medium impact
Age 16-25	Medium impact	Low impact	Low impact	Insufficient information	Medium impact	Medium impact
Age 26-64	Low impact	Medium impact	No impact	Medium impact	Low impact	Low impact
Age 65 and above	Medium impact	No impact	No impact	Insufficient information	Medium impact	Medium impact
Deprivation	Medium impact	Insufficient information	Insufficient information	Insufficient information	Medium impact	Medium impact
Disability	Low impact	Medium impact	Medium impact	Insufficient information	Medium impact	Medium impact
Mental ill health	Medium impact	Low impact	Low impact	Insufficient information	Medium impact	Low impact
Ethnicity - White British	Low impact	Low impact	Low impact	Medium impact	Low impact	Low impact
Ethnicity – Black and minority ethnic groups	Medium impact	Medium impact	Medium impact	Low impact	Low impact	Low impact
Ethnicity – other	Medium impact	Medium impact	Medium impact	Low impact	Low impact	Low impact
Gender - Female	Low impact	Medium impact	Low impact	Low impact	Low impact	Low impact
Gender - Male	Low impact	No impact	Low impact	Low impact	Low impact	Low impact

Equality Characteristic	Accident and emergency	Maternity services	Paediatric services	Planned care	Urgent care	Acute services
Lesbian, Gay & Bisexual						
Gender Reassignment						
Religion and belief						
Carers						

## • 5.4 RECOMMENDATIONS

The data above has been considered and the following chart has been developed to represent the areas where impact is most likely to be experienced and which should be subject to targeted consultation to ensure the issues have been identified, analysed and understood so where necessary appropriate mitigation can be developed.

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## 6. STEP 4 – RISK AND MITIGATING ACTION

There may be potential negative impacts on certain equality groups as a result of the changes.

The analysis undertaken has concluded there are no protected groups that are likely to be impacted highly by the changes in relation to hospital services. There is likely to be no, medium or low impacts on certain groups in relation to services.

The Trust are collecting some equality data but not all, which limits the accurate information we have available for analysis, so while we have robust hospital service use data for age, sex and ethnicity for other characteristics we are dependent on other data sources, such as national or local research. Where this has been used this has been detailed through the report.

Changes to A&E are likely to have a medium impact upon older people, younger people, those with mental ill health and also people from BME backgrounds. These groups are the highest users or report poor experiences so may be negatively affected by changes to A&E.

In relation to Maternity Services, women aged between 26 and 34, disabled people and again those from BME backgrounds are likely to be impacted by changes to this service. The model describes emphasis on provision of care in the community, greater choice and Midwifery led maternity on both hospital sites, this is likely to improve the care of this group, they are therefore more likely to see a positive impact through the changes.

There will be a medium impact upon those under the age of 15, disabled people and those from BME backgrounds in relation to changes to Paediatric Services. Again, there will be provision of care in the community, enhanced services and outpatient facilities on both sites, the impact upon these groups is most likely to be positive.

Those aged 26 – 64 of a White British ethnic origin are the highest users of planned care and therefore changes to this service will have a medium impact upon this group. The co-location and split of activity between sites could cause a negative impact upon this group, this should be planned appropriately to prevent confusion and anxiety amongst the care that this age group receive in respect of planned services.

Urgent care is widely used by younger people, disabled people and also those with mental ill health, therefore these are likely to receive a medium impact in relation to this service if the services they need to access are located further away than the services they are currently using.

Those groups impacted by Emergency Medicine/Acute services are likely to be younger people, older people and disabled people. These services will be co-located with A&E, therefore this group will see the same or a similar impact of those groups affected by changes to this service. There is potential for a negative impact for those groups using Emergency Medicine or Acute services, if there will only be one centre, the majority of older people are living in rural areas (causing transport issues) and people with a disability may find access more difficult.

There are gaps in data in relation to Gender Reassignment, Sexual Orientation and Religion/Belief which limits the ability to assess how these groups will be impacted.

There are also gaps within the Engagement and Pre-Engagement younger people and children, older people and carers. There should be some targeted work in the formal consultation in order to further engage these groups to prevent any inequalities in their care.

## 7. STEP 5 – CONSULTATION (NOT YET DONE)

Recommendations for consultation such as groups to target who may have greater need or who have not had their views considered already (protected groups not greatly reflected).

The full Public Consultation has not yet been started; however, we do see this as an opportunity to improve on the Engagement and Pre-engagement. From all of the evidence gathered, we can see that that within the engagement exercises, some protected groups are underrepresented. We would recommend during the next stage, when the proposed new models go out to public consultation, that these groups are targeted more effectively, these groups include younger people, impairment groups in relation to disability, LGB (as in previous engagement there has never been a large enough sample) and Gender Reassignment, should evidence suggest that they would be impacted by the service changes.

As there is a high proportion of Carers in the local area, we would advise continued engagement in relation to all service lines. In particular, families and carers and young children in relation to Paediatric Services. Data collection in engagement is currently low in this service area which suggests that there is room for improvement.

The consultation should be publicised well to ensure those protected groups who have been under-represented in the past are fully considered. Consultation documentation should be available in a variety of formats, including different languages, braille and audio. Up to date information about the consultation should be available on the Right Care, Right time, Right Place website.

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## 8. STEP 6 – RECOMMENDATIONS FOR DECISION MAKING

We have concluded that there are no high impacts on any particular groups in relation to the Hospital Services provisionally outlined in the new model. We feel that Calderdale CCG and Greater Huddersfield CCG are ready for formal Public Consultation and that those with protected characteristics have been adequately considered. The groups who are likely to see a medium impact have been considered throughout the engagement and where gaps are identified, these will be mitigated with further consultation and through the Maternity and Paediatric engagement that is currently underway.

We would recommend that NHS Greater Huddersfield CCG and Calderdale CCG take the steps outlined in step 7 to continue to mitigate the risk to equality that we have identified throughout this assessment and to enable opportunities for protected groups to be maximised.

## 9. STEP 7 – RECOMMENDATIONS FOR MONITORING

This equality analysis is an iterative process and should be used to inform the public consultation and development of proposed services in the following ways:

- findings to be considered by services and any mitigating actions required incorporated into proposed models before going out to consult.
- ensuring that protected groups identified as being impacted are targeted;
- equality analysis remains an integral part of the public consultation and this analysis should be added to as further data and findings become available;
- the ongoing equality analysis and individual Equality Impact Assessments for all services undergoing changes should be used to inform the development of any new contracts, service specifications and KPIs;
- all new service specifications will include the need to undertake equality monitoring and patient engagement and to analyse this information to identify further service improvements; and
- service specific Equality Impact Assessments should include looking at the impact on staff of any changes and include recommendations for mitigating actions

It is suggested that the PMO works with equality leads to oversee the above recommendations and to enable the Hospital Programme Board to be assured that it is meeting its equality duties and able to demonstrate 'due regard'.

## 10. STEP 8 – RECOMMENDATIONS FOR PUBLICATION

The final public consultation report and an executive summary should be published on the Right Care, Right time, Right Place website and should be available on request in other formats including easy ready, large print, Braille and audio.

**This information is available in other formats and in other languages by telephoning NECS on 01642 745049 or emailing [NECSU.Equality@nhs.net](mailto:NECSU.Equality@nhs.net)**

**Ky informacion disponohet në formate të tjera dhe në gjuhë të tjera duke telefonuar ose duke i dërguar email ekipit për barazinë të NECS-së në numrin 01642 745049 ose në adresën [NECSU.Equality@nhs.net](mailto:NECSU.Equality@nhs.net)**

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**ਇਹ ਜਾਣਕਾਰੀ ਐਨ.ਈ.ਸੀ.ਐਸ. ਬਰਾਬਰੀ ਟੀਮ (NECS Equality team) ਨੂੰ 01642 745049 [NECSU.Equality@nhs.net](mailto:NECSU.Equality@nhs.net) ਤੇ ਫੋਨ ਜਾਂ ਈਮੇਲ ਕਰਕੇ ਹੋਰ ਰੂਪਾਂ ਅਤੇ ਹੋਰ ਭਾਸ਼ਾਵਾਂ ਵਿੱਚ ਉਪਲਬੱਧ ਹੈ।**

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