# Calderdale and Huddersfield NHS Foundation Trust (CHFT) implementation of the potential outline future model of care for hospital services: Quality Impact Assessment

*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

## Contents

## 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.

## 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

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 |
|---|---|---|---|
| **Medicine - Emergency Department** | It is difficult to recruit sufficient numbers and seniority of staff to provide full senior medical oversight across both emergency departments.<br><br>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 | • 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<br><br>• Access to paediatric emergency care will also be provided at the unplanned site<br><br>• 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<br><br>• 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 | • **Patients:** 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<br><br>• **Patients:** Patients seen at appropriate site based on acuity with access to a wider range of services for patients requiring more complex care<br><br>• **Staff:** 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<br><br>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<br><br>• **Patients:** Access to a wider range of services for patients requiring more complex care |

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| **Medicine - Acute Medical Directorate** | 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<br><br>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 | • Acute medical services (cardiology, respiratory, gastroenterology, acute stroke, elderly complex care and orthogeriatric care) will be provided at the unplanned site<br><br>• 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)<br><br>• 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<br><br>• Enhanced level of ambulatory assessment and treatment with focus on keeping people at home<br><br>• Early rehabilitation will be available on the unplanned site<br><br>• Diabetes and endocrinology can be principally delivered in the community | • **Patients:** Access to a wider range of services for patients requiring more complex care<br><br>• **Patients:** There will be reduction in the need for intra and inter-hospital transfers for people who have more than one clinical need<br>• **Staff / Trust:** 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.<br><br>• **Patients:** Improving quality of care by providing comprehensive geriatric care for this Elderly Care patients |
| **Medicine - Integrated Specialty** | | • Acute oncology and haematology services will be located on the unplanned site<br><br>• Dermatology will be principally delivered in an outpatient and community clinic setting<br><br>• Rheumatology will be principally based on the planned site as most services are delivered in a day case / clinic setting<br><br>• Neurology will be predominantly outpatient based | • **Patients:** Access to less acute medical input will be easier and faster in the dedicated planned site<br><br>• **Patients:** Patients seen at appropriate site based on acuity |

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| | | • Palliative care will be principally delivered in the community | |
| **Surgery & Anaesthetics - Trauma & Orthopaedic Services** | | No change<br>•Acute trauma will continue to be located on the unplanned site<br>•Unplanned orthopaedic surgery will continue to be undertaken at the unplanned site<br>•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<br>• 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<br>• Other elective patients who are likely to require critical care support will be identified at the pre-assessment clinic<br>• 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)<br>• There will be a single fracture clinic on the unplanned site<br>• Majority of daycase work to take place on the planned site | • **Patients:** Continued improvement in safety and mortality rates, already demonstrated by a partial reconfiguration of acute surgery onto HRI in 2005/6<br>• **Staff:** 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<br>• **Patients:** There will be a greater opportunity to review and redesign patient pathways thus improving patient outcomes and the patient experience<br>• **Staff:** 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 |
| **Surgery & Anaesthetics - Operating Services,** | The provision of a critical care unit at each site means that | • 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 | • **Patients:** Improvement in safety and patient outcomes when critical care |

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| **Theatres, Anaesthetics, Critical Care and Pain** | the Trust is not currently in a position to fully comply with D16 guidance on critical care workforce standards. | or downgraded as necessary)<br>• Patients requiring critical care will be transferred from planned site or identified in advance at the pre-assessment stage<br>• Full day case theatre suite needed at planned site including recovery beds / trolleys<br>• Pain services will be centralised at the planned site<br>• Endoscopy services will be available on both sites | workforce standards are met |
| **Surgery & Anaesthetics - General Specialist Surgical Services** | | • No change<br>Acute surgery will continue to be carried out on the unplanned site<br>• Most inpatient planned surgery to be undertaken on the planned site<br>• All vascular and urology surgery (including day case) to be undertaken on the unplanned site<br>• Endoscopy units needed on both sites - GI bleeds will be managed on the unplanned site | • **Staff:** Reconfiguration will improve resilience within the staff rota due to separation of planned and unplanned surgery<br>• **Patients:** Better patient outcomes as more complex procedures will be centralised |
| **Surgery & Anaesthetics- Head & Neck** | | • All ENT surgery (elective and non-elective) to be centralised onto the unplanned site<br>• Ophthalmology to be undertaken on the planned site<br>• Max fax day unit to be moved to the planned site | |
| **Families & Specialist** | Paediatrics is split between the | • Specialist paediatric services will be co-located | • **Patients:** Co-locating neonates with all |

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| **services - Children's Services** | 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. | with the Emergency Care Centre - this will cover neonates, paediatric surgery and paediatric medicine<br>• Neonates will be co-located with Consultant led Maternity care.<br>• All paediatric surgery (including daycase) and paediatric medical care to be co-located at the unplanned site | acute paediatrics and obstetrics / gynaecology will mitigate against any possible risks from having these separate at present<br>• **Staff:** 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.<br>• **Staff:** 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<br>• **Trust:** 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 |
| **Families & Specialist Support Services - Women's Services** | | • Consultant - led obstetrics and neonatal care(currently at CRH) to be co-located on the unplanned site<br>• Midwife - led maternity will be available on both hospital sites<br>• Acute and inpatient gynaecology services will be | • **Patients:** Patients can access a wider range of maternity care closer to home<br>• **Patients:** 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 |

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| | | provided at the unplanned site | • **Patients:** Patients with complex obstetrics will be cared for in the centre where other specialist services ( ITU/ Surgery/ Interventional radiology) are available<br>• **Patients:** There will be 24 hour consultant cover of the labour ward and 24/7 access to a competent supervising anaesthetist<br>• **Staff / Trust:** 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 |
| **Community Services** | 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. | • Early rehabilitation and reablement will be provided on the unplanned site with some rehabilitation provision at the planned site (TBC) | • **Patients:** 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 |

## 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.<br>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.<br>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.<br>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[1] 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 |

[1] http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_summary/Reconfiguration-of-clinical-services-kings-fund-nov-2014.pdf

## 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

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.

**CHFT**

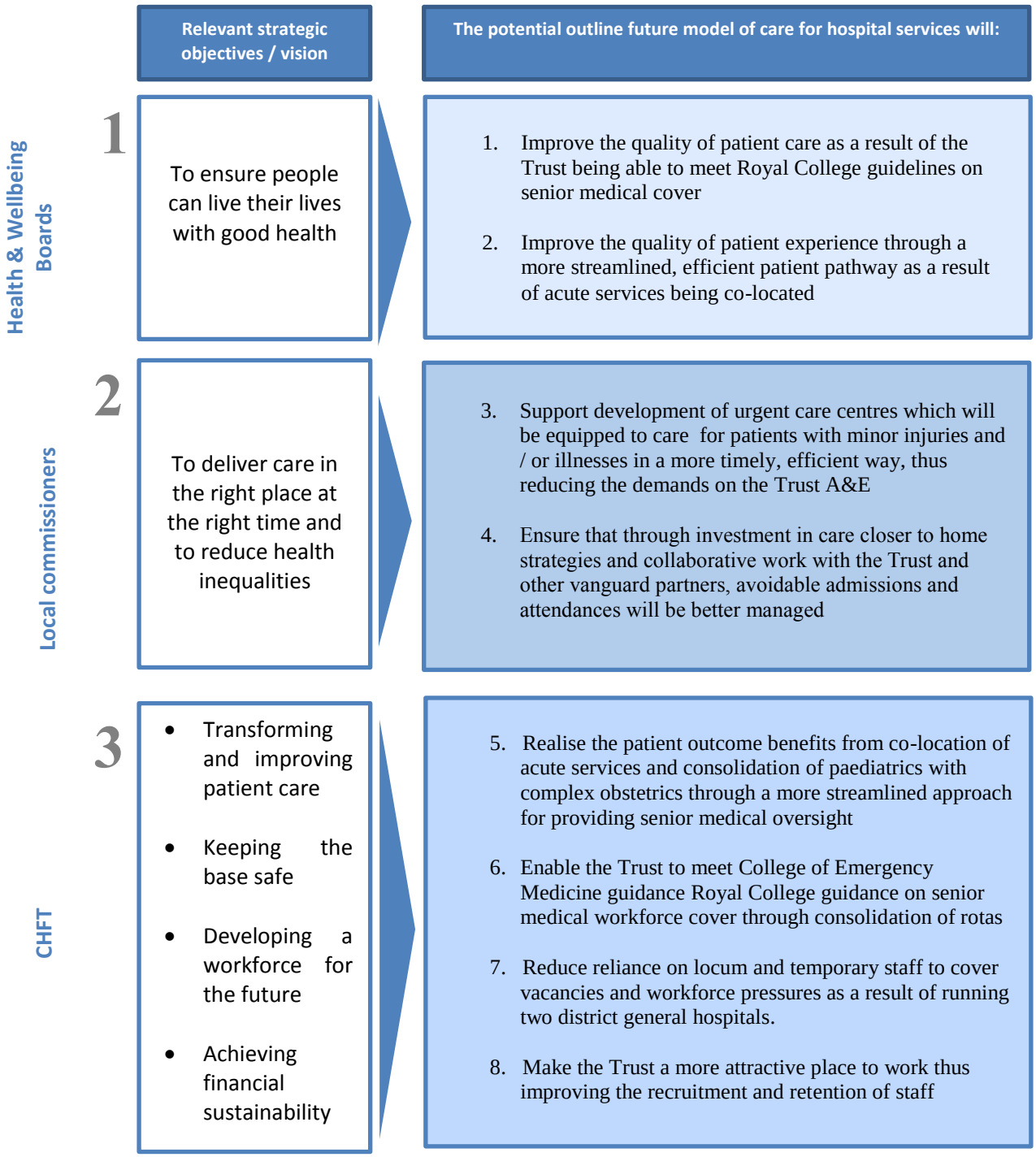
The Trust's vision- *"Together we will deliver outstanding compassionate care to the communities we serve"*- is delivered through 4 key goals focussed on the following:

- 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:


Relevant strategic objectives / vision
The potential outline future model of care for hospital services will:
Health & Wellbeing Boards
1
To ensure people can live their lives with good health
1. Improve the quality of patient care as a result of the Trust being able to meet Royal College guidelines on senior medical cover
2. Improve the quality of patient experience through a more streamlined, efficient patient pathway as a result of acute services being co-located
Local commissioners
2
To deliver care in the right place at the right time and to reduce health inequalities
3. Support development of urgent care centres which will be equipped to care for patients with minor injuries and / or illnesses in a more timely, efficient way, thus reducing the demands on the Trust A&E
4. Ensure that through investment in care closer to home strategies and collaborative work with the Trust and other vanguard partners, avoidable admissions and attendances will be better managed
CHFT
3
• Transforming and improving patient care
• Keeping the base safe
• Developing a workforce for the future
• Achieving financial sustainability
5. Realise the patient outcome benefits from co-location of acute services and consolidation of paediatrics with complex obstetrics through a more streamlined approach for providing senior medical oversight
6. Enable the Trust to meet College of Emergency Medicine guidance Royal College guidance on senior medical workforce cover through consolidation of rotas
7. Reduce reliance on locum and temporary staff to cover vacancies and workforce pressures as a result of running two district general hospitals.
8. Make the Trust a more attractive place to work thus improving the recruitment and retention of staff

## 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 |
|---|---|---|
| **Option 1:** Reconfiguration and implementation of the clinical consensus model | • Consolidation of medical rotas to ensure improved access to senior medical cover<br>• Co-location of all acute services will improve patient pathways and strengthen the quality of patient care<br>• Provision of urgent care centres will reduce demand on already stretched emergency services<br>• Ensure the Trust can maintain and improve performance in national benchmark metrics | • Improved patient outcomes as a result of the surgical division reconfiguration in 2008 |
| **Option 2:** Development of a network / collaborative / co-operative approach | • Drive economies of scale<br>• Ability to overcome workforce challenges e.g. workforce gaps, access specialist skills | • Delivery of a shared acute dermatology service to save locum costs and potential to work with GPs and Locala to provide comprehensive dermatology services<br>• Potential for shared medicine information service and /or medicines storage facility |

## 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 is 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 |
| **Total** | **1589** |

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 |
| **Total** | **12*** |

- *rounded up to take into account part bed requirements*

### 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 |
| **Total** | **1640** |

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 |
| **Total** | **11** |

## 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 |
| **Anaesthetics and Theatres** | | ✓ | 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 |
| **Cardiology** | ✓ | | Service centralised onto the unplanned site |
| **Critical Care** | ✓ | | Expansion of the critical care unit onto the unplanned site only |
| **Dermatology** | | ✓ | |
| **Diabetes** | | ✓ | |
| **Elderly Care** | ✓ | | Service centralised onto the unplanned site |
| **Emergency (excluding urgent care)** | ✓ | | There will be a single ED on the unplanned site |
| **Endoscopy** | | ✓ | Endoscopy will continue to provide a service on both sites |
| **ENT and audiology** | | ✓ | |
| **Gastroenterology** | ✓ | | Service centralised onto the unplanned site |
| **Gynaecology** | | ✓ | |
| **Haematology** | | ✓ | |
| **Maternity Midwifery** | | ✓ | Midwife-led birthing units will continue to be available on both sites |
| **Max fax** | | ✓ | |
| **Oncology** | | ✓ | |
| **Ophthalmology** | | ✓ | |
| **Paediatrics** | ✓ | | Inpatient paediatrics services (medicine and surgery) centralised on the unplanned site |
| **Pain** | | ✓ | |
| **Plastics** | | ✓ | |
| **Respiratory** | ✓ | | Service centralised onto the unplanned site |
| **Rheumatology** | | ✓ | |
| **Stroke** | | ✓ | |
| **Trauma and Orthopaedics** | | ✓ | Unplanned surgery on unplanned site, majority of planned surgery on planned site |
| **Urgent care** | ✓ | | 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 |
| **Urology** | | ✓ | All surgery on unplanned site |
| **Vascular Surgery** | | ✓ | All surgery on unplanned site |