

**Calderdale and Huddersfield NHS Foundation Trust
Accident and Emergency services.**

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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;
- Locala 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 middle-grade 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 over-reliance 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

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 out-patient 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.

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 take 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.

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

National Clinical Advisory Team - NCAT

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

National Clinical Advisory Team - NCAT

	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