Public consultation on proposed future arrangements for hospital and community health services

HAVE YOUR SAY

www.rightcaretimeplace.co.uk
Public consultation about future arrangements for hospital services (including emergency and acute care, urgent care, maternity, paediatrics and planned care) and further improvements to community health services in Calderdale and Greater Huddersfield

...... your views are very important

The public consultation will run from Tuesday 15 March – Tuesday 21 June 2016

Please note there will be lots of opportunities for people to comment on the proposed changes in this document – see page 41

NOTE: Apart from the photographs of our own clinicians, other photographs in the document are from the NHS Photolibrary and are therefore not local.
1 | Who we are

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 significant challenges to improve hospital and community health services and as such we are now consulting the public on some proposed changes which are are explained in this document.

The areas we cover are shown in the map above. 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.

* Hospital services for people living across these two CCG areas, at CRH and HRI, are managed by Calderdale and Huddersfield NHS Foundation Trust
NHS Calderdale and NHS Greater Huddersfield Clinical Commissioning Groups (CCGs) are consulting people about some far reaching proposed changes to hospital services and further proposed changes to community health services. We need to understand the views of all patients, public, stakeholders and staff who live and work in Calderdale, Greater Huddersfield and others who for whom the proposed changes may have a direct impact (which may include patients, public and stakeholders in surrounding areas) about the way in which Emergency and Acute Care, Urgent Care, Maternity Care, Paediatric Care, Planned Care and Community Health Services are provided in the future.

This is so that by the end of September 2016 both CCGs can make an informed decision on progressing the future shape of hospital services ensuring that these are high quality, safe, sustainable and affordable and result in the best possible outcome and experience for patients, as well as on which services should be provided in the community, closer to where people live.

These proposed changes would secure the future of health services for both areas for the next 20 years. They would make sure that our hospital services were in line with national recommendations and guidance. They would also mean that more services were provided in the community, including some outpatient clinics, so that people only needed to go to hospital when they really had to be there.

Our proposed changes would help us to address some big challenges.

Currently our patients don’t always receive the best possible care. Our hospital services are stretched, with some being split between Calderdale Royal Hospital (CRH) and Huddersfield Royal Infirmary (HRI) sites. Some don’t meet national guidance, such as those for children and young people in emergency care. We transfer sick people between hospitals on a daily basis so they can get the care they need. We need to improve our hospital mortality rates which means reducing the number of patients who die in our hospitals. We have difficulty recruiting doctors and therefore rely heavily on temporary (agency) doctors. Like other places around the country, we have an increasing number of older people living longer, often with more than one long term condition who need the right care and support to help them stay well and independent.

We need to move with advances in medicine and technology and make sure that our patients get access to the latest treatments.

Alongside all of this we have big financial challenges, which mean we need to make substantial savings so that we can manage within the money available to us as well as achieving the improvements needed going forward.

Our proposed changes are the result of local discussions that began over three years ago to develop a new model of care to resolve some of these challenges. And we have been clear that leaving services as they are would not allow us to deliver the quality of care that local residents deserve, nor would it provide either of our hospitals with the financial sustainability needed to deliver that care.

During our early discussions with patients, the public and our partner organisations, a very clear message received was that before any changes could be made to our hospitals, there needed to be considerable improvements to community services. People said they wanted as much care as possible provided close to home. They wanted more and better services in the community to help them stay well and independent. They wanted these services to be more joined up which would mean health and social care organisations working much more closely to meet the needs of individual patients and to save patients and their families from having to find their way through what can be a very complicated system.

And this is exactly what we have done. We listened and used local feedback to shape our plans to enhance and strengthen community services. As such, Care Closer to Home programmes are being delivered in both Calderdale and Greater Huddersfield which are already transforming the way that care is provided to the people who need it most, particularly elderly and frail people, those living with long term conditions such as heart disease, chronic chest conditions and diabetes and children with complex needs.

These are making great progress and are supporting people of all ages to stay well and independent and we want to do more to make sure that people receive the care they need at home or in the community and are admitted to hospital only if they really need to be there.
When they do have to come into hospital we want to make sure that patients can be discharged as soon as they are well enough with the right support at home.

While we have been laying the foundations for strong community services we have been developing a model for hospital services. In shaping this model there have been many more discussions with patients, the public and local organisations and with hospital doctors and nurses, GPs and other healthcare professionals working in the community. We have also had two independent reviews from expert clinicians.

We are proposing investments at both of our hospital sites, so that they become state of the art hospitals. CRH would become an Emergency Centre and the Acre Mills site at Huddersfield a dedicated hospital for planned care. We are also proposing to develop Urgent Care Centres at both hospitals. These developments would cost more than £291m but would generate efficiencies to close the financial gap the system is facing.

The Emergency Centre would bring together on the CRH site all of the emergency and acute services that people need when they become seriously ill or have injuries which can be life threatening. It would also have the services people might need when they become unwell and are admitted to hospital for tests and treatment. We would have a Paediatric Emergency Centre which brings together in one place all of the medical and surgical services for children. We would also continue to have consultant-led maternity services at CRH, again so that they could be in the same place as all of the necessary supporting services should these be needed.

The Urgent Care Centres would be open 24/7, staffed by doctors and emergency care nurses and would have x-ray facilities. These would be the front door to care for people who make their own way to hospital with injuries and illnesses. However, while patients could decide themselves to go to the Urgent Care Centres we would be encouraging them to ring NHS 111 first so that they go to the right place first time and get the care they need as quickly as possible.

The new hospital development on the Acre Mills site at Huddersfield would be for routine procedures and operations that don’t need to be done as emergencies but still should be done as soon as possible. This would be a big development with around 120 beds and ten new operating theatres.

We know that people will have questions about our proposed changes and we look forward to meeting with local people and explaining why we feel that this is the right model for hospital services going forward.

The CCGs’ GP leaders and the senior clinical staff at Calderdale and Huddersfield NHS Foundation Trust have worked together to develop this new model and support the proposed changes.

You may wonder why we are now proposing CRH as the site for the Emergency Centre and not HRI as initially suggested by the Calderdale and Huddersfield NHS Foundation Trust, the organisation which manages both of these hospitals. The model of care we are proposing sets out what we believe to be the best way to provide care for our local population. We have carried out a very comprehensive assessment of the alternatives and came to the view that the most affordable was to develop CRH as the Emergency Centre. Also, HRI is more than 50 years old and if it were to be retained there would be a need for significant rebuilding.

You may also be wondering why we are not consulting on more than one alternative. This is because we want to be honest with local people and be clear that our assessment shows doing nothing would not achieve the improvements in quality and safety needed. Other alternatives would be much more expensive and would be unlikely to attract the funding we would need to develop both hospital sites. We believe our proposed changes would result in the greatest overall benefits for people living across Calderdale and Greater Huddersfield.

Section 16 explains how you can make your views known. And we want to stress that your feedback continues to be very important to us because we don’t have all of the answers. There may be things that we have missed or not included, so please let us know. We hope you will take the time to read this document and tell us what you think.

Dr Alan Brook, chair of governing body, NHS Calderdale CCG

Dr Steve Ollerton, chair of governing body, NHS Greater Huddersfield CCG
3 | Why we are proposing changes

We face a number of very significant challenges, which mean that doing nothing is not an option. These are described below.

**Meeting the needs of the population**
The population of Kirklees is around 434,000 of whom 243,000 live in Greater Huddersfield and the population of Calderdale is around 209,000. This gives a total population of 452,000 for Calderdale and Greater Huddersfield. This is forecast to increase by 12% in Calderdale and 13% in Kirklees by 2037, which is consistent with the expected population increase for England of 14%.

As in other parts of the country we are seeing an increase in older people with many more living well into their 80s and 90s. In 2012 there were 102,000 people aged 65 and over (16% of the population). By 2037 it is expected that there will be 169,000 over the age of 65 (23% of the population). This means more people living longer often with long term illnesses such as heart disease, diabetes and chronic chest problems and more with dementia. This has a major impact on health and care services as older people are some of the most frequent users of services. They need the right care and support to manage their illnesses, stay as well as possible and be independent in their own homes.

Modern lifestyles are creating new health issues. Smoking is still the UK's largest cause of preventable illness and early death and we have high levels of people abusing drugs and alcohol. Obesity is increasing which leads to greater risk of illness including diabetes and heart disease.

There are also unacceptable inequalities in health across the area with average life expectancy in some parts being five years longer for men and two years longer for women than in others. More needs to be done to close these gaps.

**Meeting quality and safety challenges**
There are several significant quality and safety challenges which need to be addressed.

- **We don't comply with national guidance**
  Currently the two Emergency Departments (A&E) at Halifax and Huddersfield don’t comply with many of the standards for children and young people in emergency care settings. Also, providing an intensive care unit at each site means that the Trust is not able to fully comply with NHS England’s guidance on critical care workforce standards.

- **The number of patients dying in our hospitals is higher than average**
The Trust’s hospital mortality rates are higher than the England average. This means that more people are dying in our hospitals than would be expected. There is an increased national focus on mortality which means that many more acute Trusts are making significant progress. This brings down the overall England average so that Trusts that are currently outliers, such as Calderdale and Huddersfield NHS Foundation Trust have to reduce mortality even further to move closer to the national average.

- **Too many patients are re-admitted within 30 days**
The number of patients who need to come back into our hospitals as emergency readmissions within 30 days of discharge is above the national average.

- **Too many patients are admitted to hospital with a long term condition**
Adults with chronic illnesses in Calderdale and Greater Huddersfield are more likely to be taken into hospital than other patients in England, as are young people with asthma, diabetes and epilepsy.

- **Too many patients stay longer in hospital than is clinically necessary**
Our Delayed Transfer of Care rate is over target which means older and vulnerable people spending longer in hospital than they need to while arrangements are made to provide care and support at home or in residential and nursing care homes.

- **Too many patients don’t have a good experience in our hospitals**
More is needed to improve the experience of patients using our hospitals, which have a higher than national average number of complaints. While feedback through the Trust’s patient survey and the Family and Friends Test shows similar trends to other hospitals, there is room for improvement.
For example, feedback about A&E care shows a higher proportion of people saying they would not recommend A&E services when compared to other services and a higher proportion leaving A&E without waiting to be seen.

Planned operations can be cancelled at short notice because the surgeons need to give priority to emergency patients. As explained elsewhere, patients can be transferred between sites for the care they need.

The way services are currently provided across the two hospital sites can result in a disjointed service for patients.

**Advances in healthcare**

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 hospital, in GP practices and community settings, while hospitals increasingly focus on the most seriously ill people.

We need to make sure that our health system has adapted to meet these and future advances if we want our patients to get the latest treatments and have the best chances of good outcomes when they become very ill.

**Workforce shortages**

Workforce is one of the key factors driving the need for change, with a number of hospital services experiencing serious challenges in recruiting and retaining staff as well as being non-compliant or struggling to meet the Royal College of Emergency Medicine’s recommendations.

Both hospital sites operate an Emergency Department (A&E) and an intensive 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 settings or not fully compliant with the guidance on critical care (intensive care) workforce standards.

The two sites do not satisfy the Royal College’s recommendation of a minimum of ten consultants per Emergency Department and for 14 hours a day consultant on site cover.

Providing services at two different hospital sites and the significant number of staff vacancies mean that doctors at the Trust work more overnight and weekend shifts than doctors in other Trusts. This places a considerable strain on staff.

While there are national shortages of doctors training in some specialties, this is compounded by the difficulties of recruiting and retaining staff to cover services across two sites and the additional overnight and weekend shifts which are onerous and do not provide opportunities for doctors to sub-specialise.

Overall, the Trust relies heavily on agency and locum staff to provide temporary cover for the gaps in the workforce. This results in a lack of continuity in care for patients and detracts from the ability to build strong clinical teams. It is also more expensive than employing permanent staff.

**Financial situation**

The local health economy is facing a very difficult financial situation. Without change the system would become financially unstable and would not be able to afford the improvements needed to deliver consistently safe, high quality, sustainable care.

The pressures facing NHS organisations nationally were recognised by NHS England in ‘A Call to Action’ in 2015:

“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 viability and sustainability of the NHS.”

The funding available to the CCGs over the longer period would not be enough to cover the rising demand for health services, the cost of inflation and any future investments aimed at improving patient outcomes.

In the Five Year Forward View published in October 2014, NHS England said that against this background if no action is taken the funding gap is forecast to be £30bn by 2020.

The local savings challenge across the NHS in Calderdale and Greater Huddersfield is forecast to be £270m by 2020. This is broken down as follows:
CCGs’ financial gap £60m
- Calderdale and Huddersfield NHS FT £193m
- Other providers £17m

Such significant savings can only be made by designing and implementing major changes to services and patient pathways. Without change our local NHS would not be financially sustainable in the future and the Trust would have an underlying deficit of £27.5m (despite having made the required efficiency savings of £75m, most of which relate to services commissioned from the Trust by our two CCGs).

To bring about the level of change needed would require some considerable investment. We would be seeking funding support from HM Treasury of £291m to redevelop CRH and build a new hospital on the Acre Mills site at Huddersfield. In addition we are seeking £179m from HM Treasury to support the hospital deficit position. Our proposed changes cannot go ahead if we don’t get the money from HM Treasury.

**Direction of national policy**

The clinical model that we have developed and which underpins this consultation is in line with national guidance for urgent and emergency care services and for seven day working for the NHS.

The national guidance for urgent and emergency care services has emerged following a comprehensive review launched in January 2013 by the NHS Medical Director, Professor Sir Bruce Keogh. For more information go to www.nhs.uk/nhsengland/keogh-review

This has involved NHS England working with expert clinicians, patients and partners from across urgent and emergency care systems to develop an evidence base for a set of principles to underpin change which were then published in November 2013 as follows:

- To provide better support for self care
- To help people with urgent care needs get the right advice in the right place at the right time
- To provide highly responsive urgent care services outside of hospital, so people no longer choose to queue at A&E
- To ensure that those people with serious or life threatening emergency care needs receive treatment in centres with the right facilities and expertise in order to maximise their chances of survival and a good recovery
- To connect all urgent and emergency care services together so the overall system becomes more than just the sum of its parts.

In November 2015 a suite of guidance entitled ‘Transforming Urgent and Emergency Care Services in England’ was published to support local organisations.

There has also been a national drive for the NHS to move towards seven day working. In February 2013, Sir Bruce Keogh set up a Forum on NHS Services, Seven Days a Week to address the significant variation in outcomes for patients admitted to hospital at weekends across the NHS (a problem affecting most health systems across the world). This is seen in mortality rates, patient experience, the length of hospital stays and readmission rates.

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**4 | What local people have told us**

Over the past three years we have gathered views from more than 4,000 people on hospital and community services. This has included engagement and stakeholder events about:

- the Strategic Outline Case, produced by Calderdale and Huddersfield NHS Trust in response to the challenges it faced
- Five year strategies and commissioning intentions by both NHS Calderdale and NHS Greater Huddersfield CCGs
- Care Closer to Home programmes 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 used this engagement activity to shape our proposed changes. All engagement reports are available at www.rightcaretimeplace.co.uk

A clear and early message from the public was that we needed to address community services first before beginning to look at the way that hospital services were delivered.

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What local people have told us / How we involved healthcare professionals

Over the last two years there have been many discussions involving hospital doctors, nurses and other clinicians working in the Trust as well as with GPs and other healthcare professionals working in GP practices and community health services about the need for change and the development of a model of care for hospital services.

In addition, advice has been sought from external clinical experts resulting in two independent reviews. Both the local clinical discussions and the independent reviews have resulted in a considerable amount of support for bringing emergency and acute services together onto one hospital site.

- Local clinical discussions
  From November 2014 to August 2015 there were five clinical workshops and five meetings of clinical design groups which covered planned care, urgent care, maternity and paediatrics. They were supported by individual discussions between clinicians from the CCGs and the Trust and by CCG discussions in their clinical development forums.

There were a number of key themes which show that local people want to see:

- As many services as possible close to home in local settings such as GP surgeries with improved waiting and appointment times
- Services that are coordinated and are focused on an individual person’s needs
- Staff who are caring and competent and treat people with dignity and respect
- Services that are properly planned and appropriately staffed and resourced and maintain quality
- More information about health conditions and more communication about what is available
- Services that everyone can access, including the buildings, appropriate information and staff that represent the community that they serve
- Any barriers to travel and transport addressed with a clear plan that 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
- A reduction in delays in getting the treatment required and improved 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.

People have told us they are concerned about:

- Travelling further in an emergency
- Having the same service at the weekend as they have during the week, including the same staff and care
- Having more access to GP services including longer opening hours and being able to get an appointment time when they need it
- Changes and cancellations to planned care appointments which have a big impact on people including time off work, travel, child care and caring responsibilities
- Travelling further in the latter stages of pregnancy and seeing the same people.

While engagement has been continuing, work has progressed in both Calderdale and Kirklees to develop community services, through the Care Closer to Home programmes, in response to the feedback. As outlined on pages 34-38 significant progress has been made and more is proposed.

A stakeholder event was held in December 2015 to update and seek further views on the developing model for hospital services and to seek views on a set of high level criteria (quality of care, access to care, value for money, deliverability and sustainability and co-dependencies with other strategies) that would be used to undertake an appraisal of the alternative ways forward for hospital services. The outcome of the event is referred to again on page 13. We are committed to continuing to work with local people and look forward to hearing your views during the consultation period. We would like to give a reassurance that if any changes were made to hospital services we would be looking to continue to work with community groups to develop a substantial programme of information to support patients, carers and families when they need to access services.

5 | How we involved doctors, nurses and other healthcare professionals
The clinical workshops and the meetings of the clinical design groups represented many hours of clinical time, supported by many hours of research and further discussions outside those sessions. This culminated in the two CCGs and the Trust signing off clinical consensus on the potential outline future model of care for hospital services in October 2015. This model is not location specific.

- **Reviews by external clinical experts**
  
The first review was by the National Clinical Advisory Team (NCAT) whose role was to provide independent expert clinical advice to organisations where major service change may be needed.

In June 2013 a panel comprising national clinical experts in primary care, paediatrics and emergency medicine visited the Trust to identify their preferred option for the delivery of A&E services.

They supported a one acute care site option as the best for the future safety, value and sustainability of healthcare. They also strongly supported commissioners enhancing primary and community based services.

Their report is available on: www.rightcaretimeplace.co.uk

In August 2015 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.”

Both the Senate report and the Quality and Safety Case for Change are available on www.rightcaretimeplace.co.uk

The Senate commended the CCGs on their vision for hospital services and agreed that to improve quality and safety there is a need to move towards greater centralisation of services across hospital sites. Their report said: “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.”

6 | **The alternatives we considered**

We have looked very closely at the different ways that we could use our two hospitals to address the challenges we face and ensure high quality, safe, sustainable and affordable services going forward.

We started by setting out the clinical standards that we need to achieve, based on national and Royal College guidance. From these standards we identified the outcomes and benefits we could achieve for patients. Clinicians from the hospitals and both CCGs then considered national guidance and delivery models from other areas to develop a potential future clinical model. This potential future clinical model is not location specific. It describes the way that services should be configured in order to deliver the best outcomes and quality of care for patients.

We then looked at ways in which the model could be delivered. We started with a long list of 11 different ideas which included minimum change at one end of the scale to exploring whether we should just have one hospital for all planned and unplanned care and if so whether this should be a new build or the development of one of the existing hospitals.

The challenges we face mean we only have one clinical alternative which is to have one Emergency Centre site and one planned care site in order to maintain quality and ensure services are safe.

We ended up with a short list of five. This included minimum change which we knew would not enable us to achieve the clinical model and therefore the improvements needed but we included it to help us to understand the impact of the other four alternatives. These were:

- two focused on developing the Emergency Centre on the existing site at CRH, with one having the...
Alternatives

main site at HRI developed as the planned care hospital (and disposing of Acre Mills) and the other having the Acre Mills site developed as the planned care hospital (and disposing of the main site)

- the other two focused on developing the Emergency Centre on the HRI site with both developing CRH as the planned care hospital but one also exploring different ways of using some of the CRH building (ie that which would be surplus to requirement).

Appraising the alternatives

To appraise the alternatives we used a set of criteria (quality of care, access to care, value for money, deliverability and sustainability and co-dependencies with other strategies). These had been developed taking into account feedback from patients and the public and we tested them at an event with patients, the public and representatives from local partner organisations in December 2015.

People present were asked for their views on the criteria and were then asked to rank them in order of priority. There was general agreement with the criteria but there were some comments on the detail. In terms of ranking them, there was a strong message that quality of care was the most important, followed by access to care and then value for money. Following this event, we agreed that we would give quality of care greater weighting than the other criteria.

When the alternatives were assessed against the criteria, the choice between CRH and HRI as the site for a new Emergency Centre was down to value for money. This was the case for whichever of the two shortlisted alternatives for the HRI site (ie focusing on either the main site or the Acre Mills site). See table on page 13.

On the one hand we have a hospital at HRI that is more than 50 years old with outdated buildings. If we were to retain it there would be a need for significant rebuilding as well as £20m a year of backlog maintenance until 2020/21. On the other hand we have CRH which is a modern hospital that is only 15 years old and already meets modern day building standards.

CRH replaced three very old, outdated hospitals. It was developed through the Private Finance Initiative (PFI), which involves a partnership between the public and private sectors. Under PFI the private sector finances and builds public sector buildings and then provides long term facilities management. The building is then leased to the public sector organisation, in this case to Calderdale and Huddersfield NHS Foundation Trust.

So PFI is a way of providing the necessary funding for major public developments and in fact was the only way of raising the funding to build a much needed new hospital at Halifax.

If we wanted to redevelop the HRI site so that it could become the Emergency Centre we would need to either dispose of CRH or find new uses for part of it. We could not dispose of CRH as we have a non-negotiable exit route which has been legally tested. In terms of finding new uses for part of the hospital, we felt it was unlikely that we would be able to do this to the extent needed. We would also have to continue paying for the PFI arrangement.

If we wanted to further develop CRH to become the Emergency Centre we could raise some funding through the sale of either the HRI main site or the Acre Mills site across the road.

While money raised in this way at HRI would not cover the cost of the investment needed for both hospitals going forward it would mean we were better placed to seek the additional funding that would be needed. This would help us to invest in both hospitals so that CRH could be further developed to become the state of the art Emergency Centre and the Acre Mills site at Huddersfield developed to become a state of the art planned care hospital.

The total funding required, including the funding to develop CRH as the Emergency Centre would be £470m, compared to £501m if we were to develop HRI to be the Emergency Centre. These figures (£470m and £501m) include £179m that is needed to support the hospital deficit position. In the five years following the changes, if CRH were chosen as the Emergency Centre the cumulative deficit at Calderdale and Huddersfield NHS Foundation Trust would increase by £47.5m, if HRI were chosen the cumulative deficit would increase by £108m.

After working through these financial considerations we came to the view that the CRH should be proposed as the site for the Emergency Centre.

(The presentation from the December 2015 engagement event which shows all of the alternatives considered and how they were assessed is available on www.rightcaretimeplace.co.uk). People can also refer to information in our pre-consultation business case about how we appraised the different alternatives. It is available at www.rightcaretimeplace.co.uk.
<table>
<thead>
<tr>
<th>Criterion</th>
<th>Summary evaluation</th>
<th>Base case ie minimal change</th>
<th>CRH*(for emergency and acute care)</th>
<th>HRI*(for emergency and acute care)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality of care</td>
<td>The proposed model of care would: Support the Trust in meeting clinical standards, irrespective of choice of planned care site Support redesigned care pathways to enhance quality Improve the Trust’s ability to provide emergency and other clinical cover Support reductions in avoidable hospital admissions</td>
<td>✗</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>Access to care</td>
<td>Service change would make it easier for patients to access the right treatment in the right setting There are no protected groups who are likely to be highly impacted by the proposed changes There is no material difference in average travel time between options at CRH or HRI Improved car parking has been included in the estimated capital costs</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>Value for money</td>
<td>CRH as the unplanned site provides the most positive movement in forecast income and expenditure (I&amp;E) CRH as the unplanned site provides the most positive I&amp;E and cash position from the investment. This option requires less capital and cash funding support and delivers the lowest deficit position. HRI as the unplanned site requires higher capital and cash funding support and does not deliver as much improvement to the deficit position as the CRH option.</td>
<td>✗</td>
<td>✔</td>
<td>✗</td>
</tr>
<tr>
<td>Deliverability and sustainability</td>
<td>All options would require a plan to maintain high quality service Both reconfiguration alternatives are estimated to have the same one-off reconfiguration cost All alternatives would realise benefits of within a 5 year timescale Delivery of the new model of care would support sustainability over the medium term Both reconfiguration alternatives would support improvements in staffing resilience and flexibility</td>
<td>✗</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>Co-dependencies with other strategies</td>
<td>Both reconfiguration alternatives are directly aligned with local health economy plans Both reconfiguration alternatives would support delivery against priorities identified in the Joint Strategic Needs Assessment (JSNA) and Joint Health and Wellbeing Strategy (JHWS) Both reconfiguration alternatives would improve resilience through a reduction in forecast bed occupancy, and would improve recruitment and retention of workforce</td>
<td>✗</td>
<td>✔</td>
<td>✔</td>
</tr>
</tbody>
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*As explained earlier, there were five shortlisted alternatives – minimum change and two relating to developing the Emergency Centre at CRH and two relating to developing it at HRI. As the above tables show, the assessments were the same for both of the CRH alternatives and both of the HRI alternatives.
WHAT HAPPENS NOW

Currently the following services are provided at both hospitals:
- Outpatient and day case services
- A&E services
- Acute medical services
- Rehabilitation for older people
- Complete range of diagnostics
- Endoscopy
- Therapy services
- Intensive care

The following acute services are provided at Calderdale Royal Hospital:
- Stroke service
- Inpatient paediatrics
- Midwife/consultant-led maternity care
- Special care baby unit and neonatal care
- Interventional cardiology services

PROPOSED FUTURE SERVICE ARRANGEMENTS

Services available at both hospitals
- Outpatient services for adults and children
- Therapies
- Day case surgery
- Midwifery-led maternity unit
- Diagnostics

Calderdale Royal Hospital

- Urgent Care Centre, available 24/7:
  - Walk in or ring NHS 111 for advice and booked appointment
  - Staffed by doctors and emergency nurse practitioners
  - Minor injuries and minor illness service for any age patients (under 5s encouraged to attend Paediatric Emergency Centre unless advised to go to Urgent Care Centre)
  - Range of diagnostic tests available, including x-rays and blood tests
  - Direct link to the Emergency Centre for specialist advice and support
- Emergency Centre
  - Prompt access to specialist clinicians with the right skills for people with serious and life threatening conditions (including trauma service)
  - 24/7 consultants available and quicker access to essential diagnostics such as x-rays and blood tests, as well as 24 hr CT/MRI scanning
  - Paediatric Emergency Department/Centre – dedicated for care of children
  - 24 hour consultant-led maternity (obstetrics)
  - Inpatient paediatrics
  - Acute endoscopy – for patients with serious internal bleeding
  - Interventional cardiology – including coronary care unit
  - Intensive care unit
  - Dedicated theatre and operating team for complex and unplanned surgery – for very sick patients who may need to go into intensive care after surgery
WHAT HAPPENS NOW

Currently the following services are provided at both hospitals:
• Outpatient and day case services
• A&E services
• Acute medical services
• Rehabilitation for older people
• Complete range of diagnostics
• Endoscopy
• Therapy services
• Intensive care

Acute service provision at Huddersfield Royal Infirmary:
• Trauma service
• Unplanned surgery
• Paediatric surgery
• Midwifery-led unit

PROPOSED FUTURE SERVICE ARRANGEMENTS

New hospital on the Acre Mills site

• Urgent Care Centre, available 24/7
  • Walk in or ring NHS 111 for advice and booked appointment
  • Staffed by doctors and emergency nurse practitioners
  • Minor injuries and minor illness service for any age patients (under 5s encouraged to attend Paediatric Emergency Department unless advised to go to Urgent Care Centre)

• Range of diagnostics available, including x rays and blood tests
• Direct link to the Emergency Centre for specialist advice and support – if this is needed, for example for patients whose illness or condition needs some specialist advice to decide whether a transfer is needed to the Emergency Centre
• Medical day cases
• Endoscopy – for planned diagnostic testing
• Planned inpatient surgery – which does not need to be done in an emergency – there would be 120 beds and ten operating theatres there.

Services available at both hospitals
• Outpatient services for adults and children
• Therapies
• Day case surgery
• Midwifery-led maternity unit
• Diagnostics
7 | What we are consulting you about and why – a summary

Our proposed changes
Our new model for hospital and community health services has six themes, five relating to hospital services and one to community health services. The following summarises proposed changes, which are supported by the CCGs’ GP clinical leaders and the senior clinical staff at Calderdale and Huddersfield NHS Foundation Trust.

**Emergency and acute care** – developing a single Emergency Centre at Calderdale Royal Hospital to ensure that the very best expertise and facilities are available in one place for patients with very serious and life threatening illnesses and for those patients who are referred to hospital by their GP with symptoms and illnesses that need further investigation. These patients would usually come to hospital by emergency ambulance or by ambulance following a GP referral.

**Urgent care** – developing Urgent Care Centres at both hospitals. These would be open 24/7, staffed by doctors and emergency care nurses and would be the front door to urgent and emergency care for people who make their own way to hospital. However, while people could decide themselves to go to an Urgent Care Centre, to make sure they get the right care as soon as possible we would be encouraging them to ring NHS 111 first. This means people would continue to go to their own local hospital, as they do now, with injuries (including limb fractures) and conditions which need to be seen urgently but are not life threatening. If people chose to ring NHS 111 first, they could be advised to go to a pharmacy for self care, go to their own GP practice, go to the Urgent Care Centre or the Emergency Centre. If the advice was to attend an Urgent Care Centre this would be the one nearest to where they live and a booked appointment would be made by NHS 111.

**Maternity** – the current arrangements for consultant-led maternity care at Calderdale Royal Hospital and midwifery-led care at both Calderdale and Huddersfield would continue. This means that consultant-led maternity care would be on the same site as the full range of necessary support services and that women who are eligible would still be able to choose midwifery-led care at both hospital sites. However, we are proposing that more care for women during their pregnancy and following the birth of their baby is provided in the community.

**Paediatrics** – developing a Paediatric Emergency Centre at Calderdale Royal Hospital which for the first time would bring together all medical and surgical services for children onto one site. Parents and carers who have a sick child would be encouraged to ring NHS 111 first for advice and would be directed to the best place for assessment/treatment. This could be a pharmacy for advice on self care, the child’s own GP practice, an Urgent Care Centre or the Paediatric Emergency Centre. If the advice was to attend the Urgent Care Centre this would be the one nearest to where they live and a booked appointment would be made by NHS 111.
What we are consulting you about and why – a summary

Planned care – developing a new hospital for planned care on the Acre Mills site at Huddersfield with ten operating theatres and 120 beds. Planned care includes those routine procedures and operations that don't need to be done as emergencies but from the patient’s point of view need to be done as quickly as possible. There are now more treatments and procedures that can take place in outpatient clinics and we would be hoping to provide more of these in the community. We would also be looking to reduce the number of outpatient follow-up appointments when these aren’t really necessary.

Community health services – we are already developing Care Closer to Home programmes in both Calderdale and Greater Huddersfield particularly for those patients who need it the most, particularly frail, older people, those living with long term conditions such as heart disease, chronic chests and diabetes and children with complex needs. Our aim is to support people to stay well and independent and to reduce avoidable hospital admissions. All of this would continue and we are proposing to provide more services in the community for a range of different conditions that were previously provided in hospital.

Why we need to change

- **Changing population needs** – our population is increasing and more people are living longer with long term conditions. People need more support to live healthier lives and we also have unacceptable inequalities in health across the area

- **Quality and safety challenges** – some of our services don’t comply with national guidance, the number of patients dying in our hospitals is higher than average, too many patients are re-admitted to hospital within 30 days of being discharged and too many stay in hospital longer than they need to. Too many of our patients don’t have a good experience in our hospitals, as shown in feedback from the Family and Friends Test. Also, consultant-led care leads to better outcomes.

- **Advances in healthcare** – there have been great advances in healthcare over the last 15 years and we need to make sure that our health system has adapted to meet these and future advances so that our patients get the latest treatments and have the best chances of good outcomes when they become very ill.

- **Workforce shortages** – a number of our hospital services are having serious problems in recruiting and retaining staff and we are struggling to meet national guidance and recommendations for some services. These problems are compounded by the difficulties in providing split services in two different hospital sites.

- **Financial situation** – we are facing a very difficult financial situation and without change our system would become financially unsustainable. This means we would not be able to afford the improvements needed to deliver consistently safe, high quality, sustainable care.

- **Direction of national policy** – there is new national guidance for urgent and emergency care and for seven day working for the NHS. In developing any new model for hospital and community health services we need to follow this guidance.

There is more information on these challenges in Section 3.
Emergency and Acute Care

EMERGENCY AND ACUTE CARE
What happens now?
Currently there are A&E departments at both CRH and HRI where people who need emergency and urgent care are treated.

Both hospitals also provide services for when people become unwell and need to be admitted to hospital for tests and treatment (this is called acute care). Due to the way that services are currently arranged very sick children and adults often have to be transferred between the two hospitals to get the care they need.

What are we proposing?
We are proposing that CRH becomes the single Emergency Centre for the population of Calderdale and Greater Huddersfield. This would include an Emergency Department, Paediatric Emergency Centre and a range of essential supporting acute medical and surgical services and intensive care.

This centre would provide care for patients who come into hospital as emergencies with very serious, life-threatening injuries or illnesses, such as:
- Loss of consciousness
- Persistent, severe chest pain
- Suspected stroke
- Sudden shortness of breath
- Severe bleeding
- Serious injuries
- Severe stomach pain
- Severe allergic reactions
- Severe burns or scalds

It would also provide services for those patients who are referred to hospital by their GP with symptoms and illnesses that need further investigation.

This brings together all of the necessary emergency and acute facilities and expertise on one site, available 24/7 to give faster access to tests/scans and therefore faster diagnosis. This means treatment can be started faster to give the best chances of survival and a good recovery to children and adults who are very seriously ill. For the first time in our hospitals there would be a dedicated Paediatric Emergency Centre, in line with national guidance and best practice.

If we did this, the following services would be co-located on the same site with the Emergency Centre:
- Acute/general/elderly medicine
- Respiratory
- Obstetrics/gynaecology
- Neonatology (Special Care Baby Unit)/paediatrics (including surgery)
- Upper and lower gastro-intestinal surgery
- Trauma and orthopaedics
- Intensive Care Unit (ICU)/24 hour anaesthetics
- Urology
- Gastroenterology
- Ear, nose and throat (ENT)
- Acute mental health
- Cardiology (including Coronary Care Unit)
- Hyper acute stroke services
- X-ray, ultrasound scanning, MRI, CT and other diagnostics 24x7
- Microbiology/haematology/biochemistry
- Occupational therapy
- Physiotherapy

The proposed change would involve further developing CRH so that all of these services could be accommodated. There would be 612 beds and the potential to increase to 700 if necessary. We recognise the need to improve car parking and have taken into account the costs of providing multi-storey car parks on both sites. Clearly this would need further discussion with the planning authorities.

As happens now, a smaller number of patients would continue to go to an Emergency Centre with Specialist Services, such as to Leeds for very serious head injuries and heart attacks and to Wakefield for very serious burns. This is because those types of serious illnesses and injuries need highly specialist care that is only provided in a small number of hospitals around the country.
Emergency and Acute Care

What would be the impact of our proposed changes?
Both current A&E departments would be replaced by Urgent Care Centres for those people who make their own way to hospital, but there would be no facilities for emergency admission at the new hospital on the Acre Mills site at Huddersfield. In an emergency, people living in Greater Huddersfield would be taken by ambulance straight to CRH. They would also be taken straight to CRH if they became unwell and needed to be admitted to hospital for tests and treatment. This is because the new hospital on the Acre Mills site at Huddersfield would have an Urgent Care Centre but would not have the supporting specialised services needed when people have a life threatening illness or injury – these services would be centralised at CRH.

By doing this, services would no longer be split between two sites which means very sick patients of all ages won’t have to be transferred between two hospital sites for the care they need. For example, currently trauma and acute surgery, oncology and haematology are at Huddersfield, while stroke, paediatrics and complex obstetrics are at Halifax which often results in patients having to be transferred between sites.

Bringing together all acute services onto one site in an Emergency Centre would make sure that patients needing complex care were able to access the best expertise in a timely manner giving them the best possible chance of a successful outcome.

Eliminating or reducing transfers of medical patients would improve safety and make best use of facilities so that patients can be seen more quickly (and within the four hour A&E target).

Impact of travelling further

We understand that some people are worried about the extra travelling time if they need to go to hospital as an emergency. We have had some independent analysis done of ambulance journeys over a 12 month period. This shows that the average journey time now for patients being taken by ambulance to their local A&E departments is 15.94 minutes. For a single Emergency Centre at CRH the average journey time would be 22.13 minutes compared to 21.51 minutes if the Emergency Centre was at HRI. Although the ambulance journey is a little longer, all of the specialist services needed would be available at the Emergency Centre at CRH, which would give patients a better chance of a good recovery. Travelling to the Emergency Centre is the same as happens now for patients who need specialist care because they have had a heart attack and need to be taken to Leeds or very serious burns and need to be taken to Wakefield. (The travel analysis is available at www.rightcaretimeplace.co.uk)

The impact of additional ambulance journeys would be taken into account during contracting discussions with the ambulance service.

We also recognise the concerns that have been raised about the impact of travelling by car and public transport which could impact on families and friends who are visiting patients at the Emergency Centre and have had a study done about this too. It shows that the changes in car journey times for the areas served by both hospitals are all likely to be between 15 and 20 minutes extra.

However, it showed the impact on journey times for people using public transport is likely to be greater than that for car users. Several areas including the south of Huddersfield (Kirkburton, Shelley, Shepley, Denby Dale, Skelmanthorpe and Scissett), the Queensbury/Ovenden area, Stainland, Hebden Bridge and Todmorden are likely to have increases of more than 45 minutes in journey times. We recognise the need to improve car parking and have taken into account the costs of providing multi-storey car parks on both sites. Clearly this would need further discussion with the planning authorities.

As would be expected, the changes in public transport journey times are at their lowest when more public transport is available (on weekdays and weekends during the day). The report also showed that the impact may be greater on some vulnerable and disadvantaged groups. (The full report is available at www.rightcaretimeplace.co.uk)

We acknowledge concerns about increased travelling times, especially for those who have to use public transport but we would balance that against patients receiving the best possible care with better outcomes. In Section 14 we explain what steps we would take to address some of the concerns about additional travelling times and other related issues.
When we talked to people about emergency care they said the most important thing was knowing they can be seen straight away and get the treatment they need.

The clinical view

Dr Mark Davies, clinical director for emergency care at Calderdale and Huddersfield NHS Foundation Trust, said: “Our ability to deliver safe, high quality care for all our patients is at the heart of the proposed changes.” He said the need to provide a system where a patient receives the care they need at the site they walk into is paramount. At the moment there are up to 10 patients transferred each day in one direction or the other and some of these will need emergency transfer. Dr Davies said: “At the moment we are trying to provide the same services on both sites so we can accommodate any patient who comes through the door. If we pool our expertise on one site we can be sure we can manage all patients without the need to transfer. Of course, we currently have ways of making sure people are properly cared for in all circumstances, but it is still far from the best or safest way to deliver care for our patients.”

Dr Julie O’Riordan, divisional director for surgery and anaesthetics at Calderdale and Huddersfield NHS Foundation Trust, said: “We currently have intensive care on both sites with all the issues of staffing up two sites round the clock. If you have one big unit, you will provide better care in terms of medical and nursing staffing and, as a result, improved compliance with best practice standards for critical care. Currently we have patients on two medical assessment units. If patients on the unit at CRH need emergency surgery then they face a 999 blue-light ambulance transfer to come to HRI.” Julie added: “Having acute medicine and acute surgery on one site is a major improvement in the way this Trust delivers care for our patients. It means it is easier for doctors and surgeons from all acute specialities to work more closely together to provide better care for our patients.”

Questions

We would like you to think about how these proposed changes would impact on you and your family. We want to know what worries you/what you don’t like. Also what you do like and if there is anything else you would like to tell us or that we have missed. At the end of the survey we ask if you agree or disagree with our proposed changes, if they will have a negative impact on you and any ideas about travel, transport and parking. The survey is attached or you can complete it on line at www.rightcaretimeplace.co.uk. If you need a hard copy please ring 01484 464212.
URGENT CARE

www.rightcaretimeplace.co.uk    @rcrtrp    rightcaretimeplace
WHAT HAPPENS NOW?
At the moment people go to the A&E departments at CRH and HRI with a condition or an injury that needs urgent medical attention but not the full specialised services of an A&E department and could be dealt with somewhere else. They often have to wait longer than they would like because emergencies take priority.

According to the Five Year Plan produced by Calderdale and Huddersfield NHS Foundation Trust such patients make up 54% of attendances at their current A&E departments. While from a medical point of view these are classed as minor, patients rightly wish to be seen and treated as quickly as possible.

WHAT ARE WE PROPOSING?
We are proposing to develop Urgent Care Centres on both hospital sites, open 24/7 to provide access to the right advice in the right place first time at any hour of the day and any day of the week. These would be staffed by doctors and emergency nurses, with x-ray and blood testing available. Equipment available in the centres would include a full resuscitation trolley, oxygen, suction and emergency drugs.

These would be the front door to urgent and emergency care for people who make their own way to hospital, for example, like they do now when they go to A&E. However, while people could decide to go to the Urgent Care Centres themselves, we would be encouraging them to ring NHS 111 first. This is so that they can receive medical help or advice and be signposted to the right service to meet their needs, which could be to go to their own GP practice or a pharmacy. If the advice is to go to an Urgent Care Centre, appointments would be made by NHS 111. These centres would also include the out of hours GP services, which means that the services people use most often, would continue to be available at both hospitals.

THE URGENT CARE CENTRES WOULD BE ABLE TO TREAT:
- Sprains and strains
- Broken limb bones
- Infections that may need treatment
- Minor burns and scalds
- Minor head injuries
- Insect and animal bites
- Minor eye injuries
- A condition that would normally be treated at the GP practice but the practice is closed or the patient can’t get an appointment as early as liked

For this arrangement to work as well as possible we would need to:
- help people understand, through the availability of much more public information, when it is appropriate to call for an ambulance, so that those who need emergency care can be taken straight to the Emergency Centre
- do more to work with NHS 111 and the public so that people could be signposted to the best place to get the right help
- ensure that if people do make their own way to the Urgent Care Centre with problems that need specialist care, the staff in the Urgent Care Centre have the necessary skills to make sure they are stabilised and then transferred.

Both CCGs recognise that improvements are also needed to GP services to make it easier for people to be seen quickly at their own local GP practice as we know from feedback received that this is very important to local people. Both CCGs are planning improvements to in-hours and out of hours GP services to reduce the need for patients to attend hospital when they have an urgent care need.
What would be the impact of these proposed changes?

Instead of going to A&E departments at both hospitals, patients with an urgent condition or illness that does not need the full specialised services of an Emergency Department (see list on previous page) could go to an Urgent Care Centre, open 24/7 on both hospital sites. We would be encouraging patients to ring NHS 111 for advice first so that they go to the right place, first time. NHS 111 might advise them to go to a pharmacy (chemist) for advice on self care, their own GP surgery or be referred to an Urgent Care Centre. Once at the Urgent Care Centre they would be seen quickly.

When we talked to people about urgent care they said their preferred contact for emergency care would be their local GP. They want more appointments and better access to services.

People have said that they want services that are responsive and flexible, particularly when they need urgent care.

The clinical view

Dr Majid Azeb is the urgent care lead for Calderdale, he is on the governing body of NHS Calderdale CCG and is a GP based at the Southowram Practice in Halifax. He said: “As a GP, I know that an Urgent Care Centre would be the right place for many of the people who currently go to A&E. It would be open 24/7 staffed by highly experienced doctors and nurses who have trained and worked in emergency care over many years. There would be the facilities to do tests such as scans and x-rays, interpret the results and begin treatment for patients. Myself and other doctors and nurses have spent a long time considering the best way to provide urgent and emergency care.”

Dr David Hughes, from Holmfirth, a GP for 29yrs, is the urgent care lead for Greater Huddersfield, and is on the Greater Huddersfield CCG governing body. He believes we have a unique opportunity to create a new and better model for the whole of urgent and emergency care across Huddersfield and Halifax. Patients with life threatening conditions would have improved access to consultant led care when they needed it and those with less serious conditions would be treated closer to home in expanded community provision or an Urgent Care Centre. An Urgent Care Centre would have modern telecommunication links to consultants at the Emergency Centre for specialist advice when they needed it; for example in the management of suspected fractures or abnormal blood test results. With this support, a large number of patients with non-life-threatening conditions, who currently attend A&E, could be safely looked after in a modern Urgent Care Centre.

Questions

We would like you to think about how these proposed changes would impact on you and your family. We want to know what worries you/ what you don’t like. Also what you do like and if there is anything else you would like to tell us or that we have missed. At the end of the survey we ask if you agree or disagree with our proposed changes, if they will have a negative impact on you and any ideas about travel, transport and parking. The survey is attached or you can complete it online at www.rightcaretimeplace.co.uk. If you need a hard copy please ring 01484 464212.
PLANNED (ELECTIVE) CARE

www.rightcaretimeplace.co.uk @rcrtrp rightcaretimeplace
10 | What proposed new arrangements for planned care would mean for patients

What is planned care?
Planned care is a procedure or treatment that is not urgent, is often booked in advance and may require a few days’ stay in hospital.

What happens now?
Currently planned care – in the NHS this is known as elective care – takes place on both hospital sites. This means that some patients from Calderdale already travel to HRI for certain services, for example, if they need vascular surgery and some from Huddersfield to CRH, for example if they need planned hip or knee surgery.

Planned care includes those routine procedures and operations that don’t need to be done as emergencies but obviously, from the patient’s point of view need to done as quickly as possible.

What are we proposing?
We are proposing a major new hospital on the Acre Mills site at Huddersfield so that it could become a new hospital dedicated for planned care. This would involve significant investment to provide 120 planned care beds and ten operating theatres (as well as the Urgent Care Centre).

Bringing together planned care in this way would mean that treatment, surgery or therapy could be delivered without risk of disruption from emergency cases.

There are more treatments and procedures that can now take place in outpatient clinics. We would be hoping to provide more outpatient clinics in the community and we would be looking at using technology, for example to have consultations by video or telephone. We would also be looking to reduce the number of outpatient follow-up appointments that take place when these aren’t really necessary. We know that currently many hospital attendances are for outpatient review appointments.

Planned services include outpatient care for adults and children, day case surgery, therapy services such as physiotherapy, occupational therapy, speech therapy and dietetics, endoscopy tests and other specialist services such as specific cancer treatments and diagnostic tests.

A number of services would be available on both sites including day case surgery (where patients come into hospital on the day of their surgery and do not need to stay overnight afterwards), outpatients and therapies.

Patients requiring complex planned surgery, who may need intensive care afterwards, would have their operations at CRH.

The proposed changes for planned care would not affect patients’ legal right as set out in the NHS Constitution to choose to have planned operations, procedures or treatment normally available on the NHS at hospitals outside their local area. (The NHS Choice Framework from the GOV.UK website summarises the choices that should be available for patients).
What would be the impact of these proposed changes?
The proposed changes mean that there would be some additional travelling for some patients who live in Calderdale and their families and carers. However, people from both Calderdale and Huddersfield are already travelling between sites for planned care.

The main impact would be on people who have to use public transport to come to hospital. On page 40 we set out the findings of an independent study which shows that for people travelling by car increases in journey times were likely to be around 15 to 20 minutes extra and would be similar whether people were travelling to Huddersfield instead of Halifax and vice versa. However, for people using public transport to get to the new planned care hospital on the Acre Mills site at Huddersfield, it was shown that the greatest impact would be on those living in the Hebden Bridge and Todmorden areas who would have a 45 minutes longer journey time than they would if they were travelling to CRH.

We are planning to set up a travel group including patient representatives to explore what could be done to support patients and families in these circumstances.

By separating emergency care from more routine, planned care, patients booked for operations and procedures won’t be inconvenienced by last minute cancellations. The main reason for cancellations is because the surgeon needs to respond to meet the needs of emergency patients. There would also be more services provided in the community, closer to home and a reduction in the number of times patients would need to visit hospital for appointments or treatment.

The clinical view

Jo Middleton, assistant director of nursing for surgery & anaesthetics at the Trust said: “Under the proposed changes we would like to include a brand-new, purpose-built hospital, with ten theatres for planned operations and procedures. We know at the moment that patients who are due to have surgery can sometimes have their operation cancelled at the last minute. This may be because there is an emergency, meaning the theatre is needed for urgent surgery; or because we don’t have enough beds available for our surgical patients due to the number of medical admissions. Having a separate centre means that patients’ surgery is much more likely to go ahead as planned, with a shorter length of stay in hospital, in fantastic new facilities which offer a much better patient experience.”

Questions
We would like you to think about how these proposed changes would impact on you and your family. We want to know what worries you/what you don’t like. Also what you do like and if there is anything else you would like to tell us or that we have missed. At the end of the survey we ask if you agree or disagree with our proposed changes, if they will have a negative impact on you and any ideas about travel, transport and parking. The survey is attached or you can complete it on line at www.rightcaretimeplace.co.uk. If you need a hard copy please ring 01484 464212.
Facts and figures
So, you have now looked through the sections where we talk about our proposed changes for emergency and acute care and urgent care.

We thought it might be helpful to summarise:

**Emergency Centre** – this is for the smaller number of patients who come to A&E, usually in an emergency ambulance, with very serious illnesses and injuries which can be life threatening.

It is also for patients who need acute care, which means that they are admitted to hospital with symptoms and illnesses that need to be investigated and again would usually arrive by ambulance following a GP referral.

All of the specialised services needed by these patients would be on one site, avoiding the need for transfers to get the right care as happens now.

**Urgent Care Centres** – these would be at both hospitals, open 24/7 and staffed by doctors and emergency care nurses. They are the front door to emergency and urgent care for those people who make their own way to hospital with a condition or an injury, including broken limbs, which need urgent attention but are not life threatening. Others attending would be people referred there by NHS 111.

**So what does this mean in terms of numbers?**
Currently 72,000 people a year attend A&E at CRH and 70,000 attend HRI.

- It is estimated that more than half (54%) of these patients (38,880 at CRH and 37,800 at HRI) would continue to go to their local hospital and be treated in the Urgent Care Centres.
- The remainder would be patients with life threatening injuries and illnesses who need the care of the specialised services available at the Emergency Centre.

Some other facts that you might wish to keep in mind as you read through the document

- Our model of care is based on providing much more care closer to home for local people, particularly those who need it most. We want to reduce the number of hospital admissions which would mean that fewer hospital beds would be needed.
- Our modelling has shown that in the future we would need 732 hospital beds – as you can see we would like to create 612 beds at CRH (with the potential to increase to 700 if needed) and 120 at the proposed new hospital on the Acre Mills site at Huddersfield. The current bed base is 811.

Large numbers of people would continue to attend their local hospital for outpatient appointments

- Currently 197,000 people attend outpatient appointments at CRH every year and 193,000 attend HRI. People would continue to go to their local hospital for outpatient appointments and we are looking to provide some of these in the community, closer to where people live.
MATERNITY CARE
11 | Strengthening maternity services in the community

What happens now?
The changes to maternity services in 2005/6 meant that consultant-led maternity services were centralised at CRH and there were midwifery-led units on both hospital sites.

What are we proposing?
These arrangements would remain unchanged but the development of the Emergency Centre would mean that all necessary supporting services were on the same site as the consultant-led maternity unit. The midwifery-led units would remain as they are on both sites. We are proposing to strengthen community based services for women at all stages of their pregnancy (ie antenatal, labour and delivery and postnatal). This would mean providing more care closer to home for women.

What would be the impact of these changes?
Pregnant women and new mothers would receive more care closer to home.

The clinical view
Head of midwifery, Anne-Marie Henshaw said that major changes to our maternity services several years ago brought us up to national standards for staffing and maternity care. The biggest success was bringing together the two consultant-led maternity units on the same site, as we are now able to provide consultant cover for the 98 hours a week in line with national standards whereas before we weren’t. She said: “Reconfiguration meant we had the right specialists in the right places for the right time and this means we can provide the best care for our patients.”

Questions
We would like you to think about how these proposed changes would impact on you and your family. We want to know what worries you/what you don’t like. Also what you do like and if there is anything else you would like to tell us or that we have missed. At the end of the survey we ask if you agree or disagree with our proposed changes, if they will have a negative impact on you and any ideas about travel, transport and parking. The survey is attached or you can complete it on line at www.rightcaretimeplace.co.uk. If you need a hard copy please ring 01484 464212.
PAEDIATRIC CARE
12 | What proposed new arrangements for paediatric care would mean for patients  
(The creation of a dedicated Paediatric Emergency Centre)

What happens now?  
The changes in 2005/6 meant that general paediatric services were centralised at CRH.

Since then children who are unwell and need medical services have been going to CRH but if they need surgery they have to be transferred to HRI. These split site arrangements do not comply with the recommendations of the Royal College of Paediatrics and Child Health and the national guidance for children and young people in emergency settings.

What are we proposing?  
*We are proposing to centralise medical and surgical services in a Paediatric Emergency Centre at CRH. So parents and carers who have a sick child would be encouraged to ring NHS 111 for advice and would be directed to the best place for assessment/treatment. This could be a pharmacy for advice on self care, the child’s own GP practice, an Urgent Care Centre or the Paediatric Emergency Centre.*

NHS 111 would be able to make arrangements for children, of any age, to have an appointment to attend one of the two Urgent Care Centres (ie the one nearest to where they live). Or if NHS 111 thinks the child needs emergency care, arrangements would be made for an ambulance to take the child/patient and their parent/carer to the Paediatric Emergency Centre at CRH.

Protocols in place for NHS 111 and the ambulance service would be refreshed to make sure that any children with injury or illness requiring emergency care were directed to the Paediatric Emergency Centre.

The proposed model for paediatric services also includes enhanced services for children, provided in the community where possible, so that children with certain illnesses and conditions could be seen more quickly. There would be support from and close working with child and adolescent mental health services (CAMHS) and paediatric outpatient clinics on both hospital sites.
What would be the impact of these changes?

Parents, carers and young people would still be able to go to an Urgent Care Centre at their local hospital, although we would be encouraging them to ring NHS 111 first to make sure they go to the right place first time for the care needed.

However, for parents and carers living in Huddersfield if their child needed emergency care for a serious illness or injury and/or to be admitted to hospital for tests and treatment they would need to go to the Paediatric Emergency Centre at CRH.

As explained in the Emergency and Acute Care section on page 19, this would mean additional travelling by ambulance, mainly for Huddersfield residents, if emergency care was needed. Also, if the child had to stay in hospital, some parents and carers would need to travel further for visiting. However, we believe that the benefits of the child being in a hospital where all specialised services were available on the same site (ie in the Paediatric Emergency Centre at CRH) would out-weight the inconvenience of the additional travelling, and would remove the need to transfer sick children between sites as happens now.

Overall, there would be a marked improvement in services for children with the development of the Paediatric Emergency Centre, which would mean children being seen straightaway by a specialist. For the first time these services would comply with the recommendations of the Royal College of Paediatrics and Child Health and the national guidance for children and young people in emergency settings.

With paediatric medicine and surgery co-located on one site, consultants would have oversight and input into both specialties and so there would be shared paediatric and surgical care for young patients. Also, on call consultant paediatricians would not have to split their time between hospital sites. The present arrangements mean that if an urgent consultant paediatric opinion is needed out of hours, a consultant paediatrician on call at CRH may have to attend HRI whilst also being on call for acute paediatrics and neonatology (specialist care for very poorly new born babies) at CRH. This wouldn’t happen in future.

There would also be more services provided in the community for children and young people.

The clinical view

Paediatrician Dr Sal Uka said that many trusts have moved away from split site services and have concentrated the available expertise so that they meet national standards. Dr Uka said: “Under these proposed changes general paediatrics would be co-located with paediatric surgery, neonates and maternity with a new children’s Emergency Centre. Children don’t always come to hospital with an initially obvious diagnosis and so would benefit from being in one specialist unit with a consultant paediatrician who, together with dedicated paediatric staff, would then coordinate their care with other specialist services. At the moment children are being transferred between sites with staff spread across both main hospitals. Being on one site would be better for our patients and our staff.”

Questions

We would like you to think about how these proposed changes would impact on you and your family. We want to know what worries you/what you don’t like. Also what you do like and if there is anything else you would like to tell us or that we have missed.

At the end of the survey we ask if you agree or disagree with our proposed changes, if they will have a negative impact on you and any ideas about travel, transport and parking. The survey is attached or you can complete it on line at www.rightcaretimeplace.co.uk. If you need a hard copy please ring 01484 464212.
Community Health Services

COMMUNITY HEALTH SERVICES

www.rightcaretimeplace.co.uk  @rcrtrp  rightcaretimeplace
What happens now?
The Care Closer to Home programmes were set up in Calderdale and Kirklees in response to the clear messages received during engagement with patients, carers, the public and local partner organisations.

People told us that there should be no changes to hospitals until better services were available in the community, closer to where people live to help them stay well and independent. They said they wanted services that were focused on an individual person’s needs and coordinated with other services.

Much progress has been made in both CCG areas with health and social care providers working in a more proactive, joined up way so that people receiving care spend less time finding their way through what can be a complex system made up of different organisations. This is resulting in benefits for those patients who need it the most, particularly frail older people, those living with long term conditions such as heart disease, chronic chest conditions and diabetes and children with complex needs.

In Calderdale, the momentum around the Care Closer to Home programme led to a successful application for the district to become a pilot site for a new model of care called a Vanguard, one of only 23 across the country. This presents a valuable opportunity to bring together the CCG, the council, local GPs and other providers of health and social care to develop new and innovative ways of providing services.

The Vanguard also brings significant additional funding to Calderdale and means that developments in health and social care services can happen more quickly. The Calderdale Vanguard is being implemented first in the Upper Calder Valley and the learning from this would be rolled out across the rest of the district. As part of our commitment to Vanguard we would also be supporting other areas to learn from us and implement similar changes as we demonstrate that these changes are benefitting service users.

In July 2015 following a competitive procurement, NHS Greater Huddersfield CCG awarded their new community contract to Locala Community Partnerships, as the lead provider for Care Closer to Home services. Locala has taken responsibility for a range of services previously delivered by different providers in hospital or in the community to ensure that going forward these are available in community settings.

Mobilisation of Phase 1 of Huddersfield Care Closer to Home services started in October 2015 and includes a range of general community services as set out below. Improvements have already been made and more are expected.

**Long term conditions** – Respiratory services for adults, with chronic problems. Cardiovascular disease, including services for people with heart failure, angina and atrial fibrillation. Diabetes services, including specialist nursing and supported self-management programmes to support and prevent people with diabetes becoming unwell.

**Musculoskeletal** – planned orthopaedic care, rheumatology, physiotherapy.

**Dermatology** – provision of specialist/acuteservices.

**Older people’s mental health** – services include the dementia diagnosis service and community mental health teams.

**Other services** – introduction of a single point of contact into community services - integrated with the local authorities’ ‘Gateway to Care’, end of life care, specialist nursing and some therapy services.

Phase 2 would include the re-procurement of some additional existing community based services including:

**Pain management** service.

**Ophthalmology** – vision screening, community based optometry, cataract assessment and follow-up, ocular hypertension (OHT) follow-up.
What would be the impact?
Our proposed changes would deliver more care closer to where people live, in GP surgeries and health centres and this would include some services that have previously been provided in hospital, including routine outpatient appointments and diagnostic tests (such as x-rays and blood tests). The services we are looking at are set out below.

Calderdale
- **Children and young people** – more paediatric clinics in community settings.
- **Frail older people** – Expanding a scheme called Quest for Quality in Care Homes (see page 37) to the remaining 14 care homes in Calderdale.
- **Long term conditions** – Respiratory – services for children with asthma and adults with chronic chest problems. Heart disease – services for people with heart failure, angina and atrial fibrillation. Diabetes – services for when people with diabetes become unwell.
- **Musculoskeletal** – planned orthopaedic care, rheumatology, physiotherapy and hospital based pain management.
- **Ophthalmology** – vision screening, community based optometry, cataract assessment and follow-up, ocular hypertension (OHT) follow-up.
- **Dermatology** – provision of specialist/acute services.
- **Diagnostics** – radiology and pathology.
- **Other services**
  End of life care, more services for frail older people, children with complex needs and people with long term conditions and delivery of rehabilitation beds in a community rather than acute hospital setting.

Huddersfield
- **Therapies**
  Speech and language therapy, occupational therapy and physiotherapy – delivery of outpatient therapy in a community based setting.
- **Children’s services**
  Community nursing services for children, community paediatric services and specialist nurses – delivery of community children’s services as a primary/community based service rather than an acute-led service.
  Speech and language therapy, occupational therapy and physiotherapy – delivery of outpatient therapy in a community based setting.
- **Other services**
  Rehabilitation beds – delivery of rehabilitation beds in a community rather than acute setting.
- **Diagnostics** – radiology and pathology

Questions
We would like you to think about how these proposed changes would impact on you and your family. We want to know what worries you/what you don’t like. Also what you do like and if there is anything else you would like to tell us or that we have missed. At the end of the survey we ask if you agree or disagree with our proposed changes, if they will have a negative impact on you and any ideas about travel, transport and parking. The survey is attached or you can complete it on line at www.rightcaretimeplace.co.uk. If you need a hard copy please ring 01484 464212.

What has been the impact of the Care Closer to Home programmes?

The following shows how people living across Calderdale and Greater Huddersfield are already being supported to stay well and independent through schemes which are also helping to reduce avoidable attendances at hospital and hospital admissions. The patient stories are based on real experiences.

**Quest for Quality in Care Homes** is a new model of care for older people living in care homes with complex needs which has been running as a pilot for over a year in Calderdale. It includes multi-disciplinary teams comprising dedicated matrons, community geriatricians, pharmacists, clinical psychologists and end of life colleagues working with GPs and care home staff to provide more proactive and integrated care for residents.

They are using telecare in the form of bed sensors and pager alerts to let them know that a resident needs help. This is helping to reduce falls as well as reducing the need for regular checks on residents which can be intrusive. Telecare is being used to monitor residents’ vital signs, so that they can get the right care very quickly when they are becoming unwell.

These arrangements are supporting care home staff to understand more about common problems such as falls and urinary tract infections, with dedicated matrons able to provide bespoke or group training. This is improving the wellbeing of older people. They are also reducing the number of older people being admitted to hospital (down 25% over a year at March 2015) and hospital stays have also been reduced (down 26% at March 2015). The reduction in hospital stays has resulted in almost £500,000 savings. GP visits have also been reduced by 58% compared to those for those homes not yet taking part in Quest.

**Betty’s** son helps her but she relies on home care. Last year she had a fall and was taken to hospital. While she was in hospital her home care was cancelled and it was going to take a week for it to be rearranged so she had to stay in hospital even though she was feeling better. When she got home the equipment she needed wasn’t available so she had to go back into hospital.

When she got home for the second time she had a dizzy spell and was taken back to hospital and again she had to stay an extra few days in hospital while her home care was re-arranged.

Earlier this year she had another fall but because she has a key worker, her experience was different. She and her key worker made a care plan. They talked about Betty going into a care home for a while but she didn’t want this. So the key worker helped her to stay at home with some improvements. She arranged for a six week period of care to help Betty to manage at home, she has arranged for more carers to help with her meals, to keep in touch with her friends at the social club and to join a walking club. She has a falls pendant which she can press if anything happens and her key worker arranged for someone to assess her home for other equipment to help her stop falling. She is feeling more confident and her son is less worried.

**Tarique** has two children and he doesn’t like hospitals which used to be a big problem because he has diabetes and he was going often to hospital. Every appointment meant time off work so his boss wasn’t happy. He didn’t really know how to live with his condition – he just took his insulin and got on with it.

Things are different now because his practice nurse has helped him make a care plan. He now has an app on his phone and a food meter and has been on a course to help manage his diabetes around his lifestyle. He has met people with similar experiences and this has all helped him to manage the risk of
How are people already benefiting from Care Closer to Home?
Continued

any further complications. He feels he is now managing his diabetes better.

Arrangements have been made for him to see his specialist nurse and consultant at his local practice which is better for him.

His practice nurse has also arranged for him to see a social prescribing volunteer and Tarique is now running an after school chess club which makes him feel that he is putting something back into the community.

Megan is a teenager and she has psoriasis. She didn’t used to know much about her psoriasis, just the information she got online. She saw lots of different doctors, sometimes had to wait 12 weeks to go to hospital and had to tell her story over and over again.

She used to skip PE because people would see her patches and make fun of her.

Then she got a key worker who has helped her and her mum to get appointments and found her a support group. She now spends a lot of time there, with other people who understand what she is going through. She is helping people in the group and now feels more confident and happier and has fewer problems with her psoriasis. She said she feels like her whole world has changed for the better.

Keith had been in hospital for several weeks, had muscle wastage and was therefore temporarily bed bound. Following a referral for rapid response from the multi-disciplinary unplanned locality team, his health, social and therapy needs were assessed. This was followed up by occupational therapists and physiotherapists from the team who provided support with exercise and therapy.

Within four weeks, Keith was out of bed and using the stairs. Prior to new Care Closer to Home arrangements, a referral would have resulted in a visit by district nurses, who would then have had to refer to social care and therapy services, rather than to one team, resulting in duplication and delay for the patient. The availability of the unplanned team and the joint working by a range of different professionals meant Keith’s health, social and therapy needs were assessed within 24 hours and support offered and delivered more quickly.

When Janet was first diagnosed with emphysema, a lung disease, she was very frightened and anxious about her condition and felt powerless. Her community matron has worked closely with her to develop a plan and to give her the skills to manage the condition. Janet now knows how to plan her medication, what to do in in an emergency and how to monitor signs and symptoms. She also knows how to do breathing exercises and pace her activities. Janet has since helped others, through being an active member of an exercise group where she supports other patients who live with long term health conditions. More recently she has joined a local choir.

Sarah now has a specialist nurse who has shown her how to manage a skin wound and says this has helped her to stop worrying about it. She says before she was referred to Locala, who provide community health services, she would have panicked and rushed straight to A&E but now she has everything she needs at hand to manage the wound and to know what signs and symptoms to look out for. The community team are still there to help if she needs to contact them but she now has the confidence to do more for herself.
Travel, transport and parking

We know that additional travelling is a concern for some people and that we need to think about what we could do to make it easier for those who would have to travel further. As this document explains, our services cannot stay the way they are and we need to make some changes to provide better care for local people.

While many people from Calderdale already travel to Huddersfield and further afield for some of their hospital services and vice versa, there have been specific concerns already raised about the implications of travelling further particularly in emergency situations. And there have been concerns raised about travelling further generally.

However, no matter which site we propose to be the Emergency Centre or the hospital for planned care, some people would have to travel further.

We also want to stress that the proposed changes for hospital and community health services would result in people having much more care in the community to help people stay well and manage their long term conditions and only being admitted to hospital when they really need to be there. Hospital stays would be shorter for those who are well enough because care would be more streamlined with the right specialists available to see patients more quickly. Discharge arrangements would be better with the right care packages quickly arranged so that more vulnerable people do not need to spend time in hospital waiting for this to happen.

Despite these improvements, we recognise that travel is an important issue and we will be thinking more about what else we could do to reduce the impact for those who would be travelling further. We will also be talking to colleagues at Calderdale Council about the planned changes to the A629 and how these might help make travelling easier. We recognise the need to improve car parking and have taken into account the costs of providing multi-storey car parks on both sites. Clearly this would need further discussion with the planning authorities.

It is also our intention to set up a travel group including patient representatives so that we could explore what more we could do, such as thinking about how the shuttle bus service that currently runs between the two hospitals might be used in future, how voluntary transport schemes could be used, what information patients might need about existing transport arrangements already available through the Patient Transport Service, travelling by public transport and parking arrangements (and ensuring that staff also have this information to share with patients), flexible appointment times and supporting patients who arrive at hospital by ambulance to get home.

In the meantime, to give us a better understanding about what this would actually mean we commissioned two independent reports, one looking at the impact of any changes for patients who are brought to hospital by ambulance and the other at the impact for people who use cars and public transport to get to hospital.

Travel by ambulance
The first report (available at www.rightcaretimeplace.co.uk) considered data from Yorkshire Ambulance Service over 12 months from 1 April 2014 to 31 March 2015. This included emergency calls where a patient is taken to a hospital A&E department and Patient Transport Service (PTS) journeys where patients are taken from home to A&E.

The average journey time currently is 15.94 minutes - (49.4% of the journeys were to CRH and 47.8% to HRI). The remaining 2.8% of patients currently go to hospitals at Barnsley, Bradford, Dewsbury, Leeds, Sheffield and Wakefield.

For a single Emergency Centre at Halifax the average journey time would be 22.13 minutes – 88.5% of the journeys would be to Halifax, 6.6% to Dewsbury and 2% to Barnsley. The remaining 2.9% would be to Bradford, Leeds, Sheffield, Wakefield and Blackburn.

For a single Emergency Centre at Huddersfield the average journey time would be 21.51 minutes – 88.7% of the journeys would be to Huddersfield, 6.5% to Bradford, 1.6% to Barnsley, 1.3% to Blackburn and 2% to Dewsbury. The remaining 1.9% would be to Leeds, Sheffield and Wakefield.

There was a negligible impact on the Patient Transport Service with the total number of journeys over the
Travel, transport and parking / Next steps

12 months involved in the study being 159 (116 for Calderdale Royal Hospital and 43 for Huddersfield Royal Infirmary).

A supplementary report is also available (www.rightcaretimeplace.co.uk) which examines journey times in the event of changes being made to emergency services at Dewsbury District Hospital.

Clearly, there are implications for the ambulance service as we would need to ensure the right contracts were in place with Yorkshire Ambulance Service to meet the requirements of the proposed changes.

Travel by car or public transport
The second report (available at www.rightcaretimeplace.co.uk) looked at the implications for travelling by car and public transport on different times of the day and different days of the week which took into account travelling for outpatient appointments, patients coming to hospital for planned procedures, staff on shift working and those travelling for visiting times.

The analysis showed that the changes in car journey times for the areas served by both hospitals are all likely to be between 15 and 20 minutes extra. The changes are similar whether patients have to travel to HRI instead of CRH or vice versa.

It showed the impact on journey times for people using public transport is likely to be more significant than that for car users. Several areas including the south of Huddersfield such as Kirkburton, Shelley, Shepley, Denby Dale, Skelmanthorpe and Scissett, the south of Halifax, the Queensbury/Ovenden area, Stainland, Hebden Bridge and Todmorden are likely to have increases of more than 45 minutes in journey times.

As would be expected, the changes in public transport journey times are at their lowest when more public transport is available (daytimes on weekdays and weekends).

The report also showed that the impact may be greater on some vulnerable and disadvantaged groups and this is something that would be an important consideration for our transport group.

(As indicated elsewhere in this document, we recognise the need to improve car parking and have taken into account the costs of providing multi-storey car parks on both sites. Clearly this would need further discussion with the planning authorities.)

15 | Next steps and decision making after the consultation

After the consultation all of the feedback will be collated and given very careful consideration by the Hospital Services Programme Board, which comprises representatives from the CCGs and Trust. This will involve discussions about what changes could or should be made in response to the comments received.

Calderdale and Kirklees Councils have set up a Joint Scrutiny Committee to consider these proposed changes. The Joint Committee will take a view on the consultation process. Legislation also allows the Joint Committee to make recommendations on the proposed changes to the CCGs, which it may choose to do after it has examined these in detail.

The CCGs will also need to satisfy a very detailed assurance process carried out by NHS England. This process is used for all service reconfiguration and organisations proposing changes need to show that such proposed changes are based on strong patient and public engagement, patient choice and clinical evidence and have support from local doctors and other clinicians, sound workforce plans, are financially viable, that consideration has been given to accessibility and have been subject to an equality impact assessment. Proposed changes also need to be underpinned by a communications and engagement plan.

The final decision will be made, in public, by the CCGs as the bodies responsible for planning and buying health services for local people. Reports including feedback and the consideration given by the CCGs will be made public.

As indicated elsewhere in this document we would need to seek funding from HM Treasury to enable the proposed changes to the hospitals to take place. There would also need to be discussions with the ambulance service to take into account the impact of increased journeys. If we gained all of the necessary approvals, implementation could begin quickly but would take up to five years to complete.
16 | How you can make your views known

All comments are welcome and we are really keen to hear how you think these proposed changes would impact on you and your family, what worries you, what you like about them and if there is anything else you would like to tell us or that we have missed. We would also like you to think about whether you agree or disagree with the proposed changes. A copy of the consultation survey is attached to this document or can be completed on line (see opposite).

We will be doing as much as we can to make sure local people know about our proposed changes, why change is needed, how comments can be made and when and where consultation meetings and events are to be held.

- Copies of this document and a summary leaflet will be shared with a wide range of local groups and organisations and we will offer to meet with them to discuss the proposed changes.
- Copies will also be made available in public places such as GP surgeries, the two hospitals, libraries and council offices.
- All of our consultation materials and information about events will be available on www.rightcaretimeplace.co.uk.
- We will work with the local media and make the most of social media to raise awareness.

We are also planning a range of events where you can find out more and make your views known, including:

- Two public meetings, one in Calderdale and the other in Greater Huddersfield
- Fifteen sessions in 15 local venues where we will be available to meet with individuals, provide some information, take comments and answer questions.

If you would like us to talk to your group or organisation, please contact us at rcrtrp.myview@nhs.net or by ringing 01484 464212 and we will try our best to come and see your group or organisation.

Local community and voluntary organisations will be seeking views from their own local communities. This will include people from a range of local areas and different backgrounds including young people, people with a disability, people who do not have English as their first language and carers. We have already considered the impact that the proposed changes could have on some groups and communities, and will be doing some targeted work to get a better understanding of how they feel they are likely to be affected.

We will also be attending meetings of the local councils’ Joint Health Scrutiny Committee, Health and Wellbeing Boards, as invited and we will work with Healthwatch to raise awareness and provide further opportunities to take comments.

A postal survey with a sample group of households living in Calderdale and Huddersfield will also take place over the 14-week period.

It is easy to complete the survey online at www.rightcaretimeplace.co.uk or you can complete the survey attached to this document or write to us with your views at: Freepost Plus RTAA-XTHA-LGGC Heron House 120 Grove Road Fenton Stoke on Trent Staffordshire ST4 4LX

(We have an independent organisation receiving and analysing the feedback)

CLOSING DATE
The consultation will end on 20 June 2016. All surveys must be received by midnight that day to ensure they are considered.

If you have other queries please contact us by:
- emailing us at rcrtrp.myview@nhs.net
- calling us on 01484 464212, or
- texting us on 07771 334724

In periods where we have a high volume of enquiries we will respond to your call, text or email as soon as possible. Remember to leave your contact details.

For more information please visit www.rightcaretimeplace.co.uk

DATA PROTECTION
No personal information will be released when reporting statistical data and data will be protected and stored securely in line with data protection rules. This information will be kept confidential.
Glossary

**Acute care** – care people need when they are very unwell and are admitted to hospital for tests and treatment.

**CCGs** – refers to NHS Calderdale Clinical Commissioning Group (CCG) and NHS Greater Huddersfield CCG. These organisations are led by GPs, supported by other healthcare professionals and lay people. Their role is to plan and commission (buy) the majority of hospital and community health services for their populations.

**Care Closer to Home** – programmes that are running in both Calderdale and Greater Huddersfield to provide more care closer to where people live, to support them to stay well and independent and reduce avoidable hospital admissions.

**Centralised** – this means bringing together services on one site (ie rather than them being provided on the two hospital sites).

**Consultant-led maternity unit** – this is where there are consultants available should problems arise during labour and delivery.

**Elective care** – care that is planned and includes those routine procedures and operations that don’t need to be done as emergencies but from the patient’s point of view need to be done as quickly as possible.

**Emergency care** – specialised care people need when they are very ill or have a serious injury which can be life threatening.

**Health and Wellbeing Board** – bodies set up by the Government to ensure there are agreed objectives between NHS and local authorities across health and social care.

**Healthwatch** – bodies set up by the Government to be the consumer champion for health and social care. They ensure that the views of consumers are strengthened.

**Joint Overview and Scrutiny Committee** – set up by Calderdale and Kirklees local councils, in line with their statutory powers, to scrutinise proposals for the development of hospital and community services.

**Joint Strategic Needs Assessment** – this is an assessment of the current and future health and wellbeing needs of a population to help improve the health and wellbeing. These are produced by local authorities and clinical commissioning groups through the Health and Wellbeing Board.

**Long term conditions** – conditions that cannot be cured but are managed through medication, therapy and supported self-management (ie diabetes, heart disease, chronic chest disease).

**Midwifery-led unit** – where care during labour and delivery is led by midwives.
Glossary

**NHS 111** – telephone service available around the clock to provide advice to people when they have an urgent health need and signpost them to where they can get the right care as soon as possible.

**Neonatal** – care relating to new born babies.

**NHS England** – is the national body that leads the NHS in England. It sets priorities and direction for the NHS.

**Paediatric care** – healthcare services for babies, children and young people.

**PFI** – Private Finance Initiative, schemes to help finance major public projects, including hospitals using private sector funding.

**Pre-consultation business case** – this sets out why change is needed, feedback received during public engagement and how this has shaped the proposed changes, the proposals for change to hospital and community services, the impact of the changes and the appraisal process that has taken place.

**Strategic Outline Case (SOC)** – refers to a report written by Calderdale and Huddersfield NHS Foundation Trust, Locala Community Partnerships and South West Yorkshire Partnership Foundation Trust. It outlined some ideas about how health services in Calderdale and Greater Huddersfield could change to meet challenges.

**Urgent care** – care people need when they have a condition or injury that needs to be attended to urgently but is not life threatening.

**Trust** – refers to Calderdale and Huddersfield NHS Foundation Trust, the organisation that manages Calderdale Royal Hospital (CRH) and Huddersfield Royal Infirmary (HRI).

**Vanguard** – a new model of care being developed in Calderdale and some other places around the country. It brings additional national funding to the area and presents an opportunity for much closer working by local health and care organisations.
If you need this document in another language or another format such as large print or audio please call 01484 464212 or email rcrtrp.myview@nhs.net

Czech
Potřebujete-li tento dokument v jiném jazyce nebo v jiném formátu, jako je například velký tisk nebo audio, zavolejte nám na čísle 01484 464212 nebo rcrtrp.myview@nhs.net

Hungarian
Tisztelt Olvasó!
Ha szüksége van erre a documentumra más nyelven, vagy más formátumban mint például nagybetűs írás, vagy Audio-vizuális, kérjük forduljon hozzánk telefonon: 01484 464212, vagy jelentkezzen email-en: rcrtrp.myview@nhs.net
Köszönjük

Polish
Jeśli wymagasz tego dokumentu w innym języku innym lub formacie, np: z dużym drukiem lub audio prosimy o kontakt 01484 464212 lub rcrtrp.myview@nhs.net

Urdu
یہ دستاواں اگر آپ کو کسی دیگر زبان یا دیگر فورمیٹ جیسے پریز– حروف کی چھپانی یا آلیو پر
درکار ہو تو براتے مہربانی نمبر 01484 464212 یا ای میل rcrtrp.myview@nhs.net ہو رہے۔ کریں۔

Produced by Calderdale Clinical Commissioning Group and Greater Huddersfield Clinical Commissioning Group
For more information please visit www.rightcaretimeplace.co.uk