Request for information 27th April, 2016 from:
Jenny Shepherd, Calderdale & Kirklees 999 Call for the NHS: Paul Cooney, Huddersfield Keep our NHS Public; Nora Everitt, Barnsley Save Our NHS; Terry Hallworth, Huddersfield Citizen; Rosemary Hedges, Calderdale 38 Degrees NHS Campaign Group; Christine Hyde, N Kirklees Support the NHS

We have answered the questions contained in the body of your email in the table below. Please note there are no questions or comments in relation to the Survey. As requested we are publishing this on our website.

Your Enquiry

Having carefully studied the "Right Care Right Time Right Place - Have Your Say" Consultation Document, we find that it is inadequate to the task of properly informing the public about the proposed reconfiguration of hospital, community care and primary care services in Calderdale and Kirklees.

The consultation is not fit for purpose in the questions it asks in the Survey, and in the information it provides in the Consultation Document.

In order to rectify this problem, we ask that you make good the following errors and omissions in the Consultation Document, by sending us accurate corrections to misleading information and producing missing information, as outlined below.

We ask too that you make this new information available to the wider public, well before the end of the Consultation period, by posting it on the Right Care Right Time Right Place website.

We have an absolute commitment to assessing if the Right Care Right Time Right Place proposal is right, once we have all the information about it. We can't do that until and unless you give us and the rest of the public the information that we need.

The Consultation Document is misleading and uninformative in the following respects, among others:

As stated above, we have an absolute commitment to assessing if the Right Care Right Time Right Place proposal is right, once we have all the information about it. We can't do that until and unless you give us and the rest of the public full, accurate information that is currently missing from the Consultation Document.

Kind regards

Paul Cooney, Huddersfield Keep our NHS Public
Nora Everitt, Barnsley Save Our NHS
Terry Hallworth, Huddersfield Citizen
Rosemary Hedges, Calderdale 38 Degrees NHS Campaign Group
Christine Hyde, N Kirklees Support the NHS
Jenny Shepherd, Calderdale & Kirklees 999 Call for the NHS

Questions and Answers

No	Question	Suggested answer
1	It [the Consultation Document] makes an entirely inappropriate claim that the CHFT's above-average Summary Hospital Mortality Indicator for the period of the year to July 2015 justifies wholesale change of the hospital's clinical model. This flies in the face of guidance from the Health and Social Care Information Centre about how to interpret above average SMHI figures - which is to first look carefully at the most obvious likely reasons for it, such as coding errors and case mix. In particular the claim that having senior doctors present in A&E 24/7 would reduce mortality is not a valid extrapolation of the SHMI data, for reasons that are clear from the HSCIC guidance on interpreting SHMI data.	The Consultation Document makes 3 references to Mortality. P5, Foreword – 'We need to improve our hospital mortality rates which means reducing the number of patients who die in our hospitals.' P7, Why we are proposing changes – **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. P9, Why are we proposing changes **Direction of national policy** 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. None of these references make the claim that the CHFT's above-average Summary Hospital Mortality Indicator for the period to July 2015 justifies wholesale change of the hospital's clinical model. The mortality references are included as part of the broader explanation of why we are proposing changes in order to: meet the needs of the population; meet quality and safety challenges; and take account of national policy.
2	The joint CCGs didn't include a Health Inequalities Assessment in their Equality Impact Assessment and the Consultation Document doesn't refer to the need for one. But the 2015 update of NHSE's '*Planning, Assurance & Delivering Service Change For Patients: A*	The Equality Impact Assessment is Appendix E to the Pre-Consultation Business Case. The Pre-Consultation Business Case has been published on the programme website and shared publicly with the Calderdale and Kirklees Joint Health Scrutiny Committee.

	Good Practice Guide for Commissioners on NHSE assurance process for major service changes and reconfigurations' specifies the Public Sector Equality Duty, to assess the Equality AND Health Inequalities related to the proposals. It also requires a Privacy Impact Assessment, which is nowhere to be seen.	The document referred to – 'the 2015 update of NHSE's '*Planning, Assurance & Delivering Service Change For Patients: A Good Practice Guide for Commissioners on NHSE assurance process for major service changes and reconfigurations', a*lso states that 'Assurance will be applied proportionately to the scale of the change being proposed, with the level of assurance tailored to the service change.' Prior to making a decision to proceed to consultation the CCGs were subject to the NHS England assurance process. The Assurance panel presented their findings to the Regional Management Team on 18th January 2016 and recorded their findings in a letter to the Chair of the Assurance Panel on 19th January which stated 'in summary I am content that you support the CCGs to proceed to consultation'. A copy of the letter is attached for information. The Health Inequalities considerations are taken from both Councils' Joint Strategic Needs Assessment and referenced in the Pre-Consultation Business Case. A full Health Inequalities impact would be taken into account should the proposals proceed to implementation.
3	The joint CCGs have not met many other requirements for significant service changes, eg the Consultation Document doesn't show: • How you have carried out their statutory duty to involve Service users in the development of their proposals • How options would be implemented & safe services maintained in the interim • How the Public Health Directors & Local Authority service leaders have been involved in the plans • - and the Consultation Document doesn't say that both Calderdale and Kirklees Councils have unanimously rejected the proposals, in full Council meetings.	The information to support the requirements in relation to service change is included in the Pre-Consultation Business Case. Section 4 of the Consultation Document, Page 9, sets out how we have involved Service Users in the development of our proposals as referenced above in question 2. The CCGs' successfully completed the NHS England assurance process prior to making the decision to proceed to consultation at the meeting of the CCGs' Governing Body meeting in parallel on 20th January, 2016. The impact on local government services is set out in the Pre-Consultation Business Case in section 4.3 Community based Care proposals. In addition the period of Consultation also provides the opportunity for the Councils to feed in their views on the proposals. The proposals are also discussed in public at the Councils' respective Health and Wellbeing Boards.

		Neither Calderdale Council or Kirklees Council have unanimously rejected the proposals. The decision by Kirklees Council was not unanimous as not all members could vote e.g. it excluded members of the Joint Health Scrutiny Committee. Additionally, the vote was taken on 16th March, 2016, which was after the launch of Consultation and the printing of the documents. We do not agree Calderdale Council has unanimously rejected the proposals. The Council expressed concern, when it met on 16th April, 2014 about earlier proposals submitted by Providers – not the CCGs' proposals as outlined in Right Care, Right Time, Right Place consultation- and agreed to establish the People's Commission. The decisions by the Council from 16th April are reproduced below. A key decision was the agreement to establish the People's Commission to take evidence, lead consultation and produce proposals regarding the future provision of integrated health and social care services across the Calderdale and Greater Huddersfield health and social care economy. The decisions by Calderdale Council on 9th February, 2015 in relation to the People's Commission are also reproduced below. The CCGs are of the view that the proposed changes are in line with the People's Commission recommendations. In particular, the recommendations acknowledge that: • No change is not an option; • the CCGs, CHFT, NHS England and the Council should work together to develop proposals; • that people with urgent, life threatening conditions need access to the best specialist care possible; • people who have what they consider to be urgent, but non-life-threatening illnesses and injuries should have easy and local access to advice and treatment; • alternative proposals to those put forward by the Providers should be developed for public consultation;

		• we should examine options to increase financial stability; • a transport plan should be drawn up; • Care Closer to Home should precede any proposed changes to Hospital services and would need time to bed in. The recommendations in relation to GP Access are being progressed separately to this consultation as part of both CCGs' Primary Care strategies.
3	Calderdale Council, on 16 April 2014 decided: **RESOLVED** that (a) this Council:- • notes that the Strategic Outline Case produced by Calderdale and Huddersfield Foundation Trust, Locala Community Partnerships, and South West Yorkshire Partnership Foundation Trust, and particularly the 'preferred option' identified by CHFT, has generated wide spread public concern and debate about the future of hospital services in Calderdale; • further notes that in November this Council called on all partners "to develop the longer-term strategic means of ensuring continued, safe and appropriate access to 24-hour urgent and emergency care within Calderdale, in full consultation with the public"; and • believes that the preferred option does not guarantee this; (b) this Council therefore calls on the three provider Trusts to withdraw the proposals set out in the Strategic Outline Case, and in particular the 'preferred option', to enable the two local authorities and the two Clinical Commissioning Groups to lead an open consultation about future health and social care provision in Calderdale and Greater Huddersfield; (c) this Council believes this will be best achieved by the establishment of a 'People's Commission', to take evidence, lead consultation and produce proposals regarding the future provision of integrated health and social care services across the Calderdale and Greater Huddersfield health and social care economy. Cabinet is therefore requested to establish such a Commission, the membership of which shall be cross-party, wide-ranging, and include local people and relevant groups to allow the input of local people's perspectives on future service provision; and (d) this Council calls upon the relevant local NHS bodies to provide, as a matter of urgency, this People's Commission with detailed proposals relating to extended opening hours of GP surgeries, the future development of Todmorden Health Centre, and other proposals resulting from the Strategic Review of the health and social care economy. On 9 February2015 the Council responded to the People's Commission report as follows: *****RESOLVED that Council Meeting as a Committee recommends to Council that: (a) Council endorses the report of the People's Commission, Improving Health TOGETHER, and accepts all the recommendations of the People's Commission as follows:	

Recommendation 1
We recognise that no change to the health and social care system is not an option, but any changes proposed must be right for the people of Calderdale. We recommend that the Council, NHS purchasers and providers work together to ensure that any changes proposed will produce real, tangible benefits for Calderdale people and that they have had the opportunity to comment on and contribute to any proposals that are made.

Recommendation 2
Calderdale Health and Wellbeing Board should take a lead in ensuring that Calderdale Clinical Commissioning Group, Calderdale and Huddersfield NHS Foundation Trust and Calderdale Council work together to develop a shared plan for health and social care services that are safe and of high quality for the people of Calderdale. NHS England should also help draw up the plan.

Recommendation 3
Calderdale Health and Wellbeing Board should consider inviting the major NHS provider organisations – CHFT and SWYPFT – to become members of the Health and Wellbeing Board.

Recommendation 4
People with urgent, life threatening conditions need access to the best specialist care possible. This specialist service should be planned for the population of West Yorkshire and so may not be always be located within Calderdale. NHS England and the West Yorkshire Commissioning Collaborative should prepare and publish a proposal for the provision of urgent and emergency care across West Yorkshire and set up a process for public engagement and subsequent formal consultation.

Recommendation 5
People who have what they consider to be urgent, but non-life-threatening illnesses and injuries should have easy and local access to advice and treatment. We consider that there should be a network of advice and support services including pharmacies and GP surgeries so that most people can access advice and treatment for urgent “minor injuries and illnesses” most of the time in their own town. The Health and Wellbeing Board should oversee the development of an urgent care services plan as an important local contribution to the wider West Yorkshire strategy.

Recommendation 6
The People’s Commission believes that CHFT and its partners should reconsider their current proposals for hospital reconfiguration and, in doing so, work with the Calderdale Clinical Commissioning Group and the Council to develop alternative models, for public consideration. These should make the best possible use of the facilities and investment at Calderdale Royal Hospital. We believe that such an approach could retain an effective, if changing, role for both Calderdale Royal Hospital and Huddersfield Royal Infirmary, whilst complementing, at a local level, the emerging move towards greater regional specialisation. The future of Accident and Emergency provision should only be considered as part of the above review process.

Recommendation 7
The PFI arrangements that were put in place to fund the construction of Calderdale Royal Hospital have sometimes seen to have driven decision making. Regardless of any proposals for hospital reconfiguration the burden of debt on CHFT finances is substantial. We recommend that CHFT, in partnership with Calderdale CCG, Greater Huddersfield CCG, SWYPFT and the Council, examine options for restructuring these

financial arrangements in order to reduce the debt burden and to increase flexibility.

Recommendation 8
All public services need to be planned within the finances available. But the system for financing health services should be the servant of service delivery not its master. We recommend that CHFT, Calderdale CCG and Greater Huddersfield CCG develop a shared and public plan to achieve financial stability and sustainability for the provision of acute hospital care.

Recommendation 9
Transport links to health services are of considerable importance to people. This applies to ambulance journey times and to accessing health services as a patient or as a hospital visitor. Any proposals for reconfiguring community health services or hospital services should include a realistic travel analysis drawn up in partnership with Yorkshire Ambulance Service and public transport agencies.

Recommendation 10
Calderdale Clinical Commissioning Group has decided to make improvements to community health services before planning hospital reconfiguration. It will take some time for these changes to be implemented and before their impact can be properly assessed. The re-arranged community services should be given time to 'bed in' and given chance to show they can be a viable alternative.

Recommendation 11
NHS England and Calderdale Clinical Commissioning Group should work together to ensure that all Calderdale residents have access to an equitable and consistently high standard of service from their GP.

Recommendation 12
The Clinical Commissioning Group NHS England and providers should ensure that all GP practices are signed up to new community health arrangements and have full engagement in the development of any plans to reconfigure hospital services.

Recommendation 13
The Council's Adults Health and Social Care Scrutiny Panel should assess on at least an annual basis the extent to which the Better Care Fund is achieving its objectives and whether any integration of health and social care services has been effective. The Scrutiny Panel should report its assessment to the Health and Wellbeing Board.

Recommendation 14
The Council's Adults Health and Social Care Scrutiny Panel should assess on at least an annual basis the extent to which the Council, through all its activity, is fulfilling its statutory role to improve the health of the population and consequently reduce demand for health and care services. The Scrutiny Panel should report its assessment to the Health and Wellbeing Board.

Recommendation 15
We recommend that Calderdale CCG – with partners, including the Council - implement a high profile, co-ordinated campaign to help people choose options other than the Accident and Emergency services more often.

(b) Council requests that the Health and Wellbeing Board:

	(i) takes forward the recommendations of the People's Commission; **(ii)** takes a lead on ensuring that all health and social care partners work together to improve the health of the Calderdale population; and **(iii)** reports to Council in twelve months' time on progress made in implementing the recommendations of the People's Commission; (c) thanks be extended to: • Professor Andrew Kerslake for his work as Independent Chair of the People's Commission; • the members of the People's Commission for all their work; • all those who have attended People's Commission meetings to give evidence or have contributed in other ways; and (d) as the report of the People's Commission is now complete, the People's Commission be disbanded.	
4	For people in search of information who turn from the Consultation Document to The Pre Consultation Business Case, this also fails to meet requirements for significant service changes: egg it fails to: • Be clear about the impact in terms of outcomes. • Be explicit about the number of people affected and the benefits to them. • Explain how the proposed changes impact on local government services and the response of local government - neither the PCBC nor the Consultation Document says that both Calderdale and Kirklees Councils have unanimously rejected the proposals, in full Council meetings. • Summarise information governance issues identified by the privacy impact assessment -which is conspicuous by its absence. This is particularly bad since the proposed Care Closer to Home scheme requires "integrated care" delivered by a wide range of providers from the public and private sectors as well as voluntary organisations, family and friends, which means patient consent will be required for sharing confidential medical data, entailing considerable information governance issues. The Care Closer to Home and Vanguard schemes also rely on risk stratification of	The information to support the requirements in relation to service change is included in the Pre-Consultation Business Case. The impact in terms of outcomes contained in the Quality Impact Assessment - Appendix D of the Pre-Consultation Business Case. The number of people affected is included in the Context section of the Pre-Consultation Business Case and the benefits for patients are set out in section 4.5 Future Model of Care – Outcomes for Patients and Section 5.1.2. which is a summary from the Quality Impact Assessment at Appendix D The impact on local government services is set out in The Pre-Consultation Business Case Section at section 4.3 Community based Care proposals. In addition the period of Consultation also provides the opportunity for the Councils to feed in their views on the proposals. The proposals are also discussed in public at the Councils' respective Health and Wellbeing Boards. In relation to rejection of the proposals by the Council, please see the answer to Q3 above. In summary: We do not agree that either Calderdale Council or Kirklees Council have unanimously rejected the proposals. Additionally, the motion passed by Kirklees Council was taken on 16th March which was after Consultation had

	patients most at risk of unplanned hospital admissions - which requires shared access to patients' confidential medical records. • Demonstrate affordability and value for money. • Demonstrate proposals are affordable in terms of capital investment, deliverability on site, and transitional and recurrent revenue impact. This omission is particularly glaring since the PCB and the Consultation Document, far from showing that the proposals are affordable in terms of capital investment, says that if Treasury won't come up with the money, the proposals can't happen. And there is no clarity that the proposals for expanding CRH are deliverable on the site, given the PFI contract and the shortage of additional space on the CRH site, which is leased to the PFI consortium/special purpose vehicle.	started. A Privacy Impact Assessment is not required to be completed at this stage because we are consulting on proposed changes and no decisions have been made, therefore it is not possible for it to be completed in a meaningful way. A Privacy Impact Assessment would require the detail of the specific information which would be used, the name of the provider(s) who will use it and how they would process the data. Affordability is set out in the financial situation on Page 4 and in the Pre-Consultation Business Case at section 7.2. This is supported by the CHFT five year plan which has been completed in line with Monitor's guidelines and is available on the CHFT website. Value for Money is one of the criteria used to appraise the alternatives and is set out on pages 12 and 13 of the Consultation Document. CHFT have submitted to the Department of Health, what we believe to be the best case for financial support, in that it would provide the least expensive way to deliver the requirements of our clinical model. We have been clear that progression of the proposed changes is dependent on additional funding being secured. We will not know if our submission has been successful until after the consultation has finished. If the conclusion of the public consultation process was that we were to proceed with the proposed changes this could only be a recommendation pending the successful outcome of the request for funding. We do not agree that providing clarity on the space requirements at CRH should be part of the Consultation Document. As referenced above in question 2: the CCGs' successfully completed the NHS

		England assurance process prior to making the decision to proceed to consultation at the meeting of the CCGs' Governing Body meeting in parallel on 20th January, 2016.
5	The Consultation Document lacks any assessment of the risk of increased patient deaths that would result from the proposed Huddersfield A&E closure, due to increased ambulance journey distances to the proposed Calderdale Emergency Centre. We need to see this risk assessment	We are not proposing to close services - we are proposing to change the way we treat people. Under these proposals, both A&E departments would be replaced by Urgent Care Centres to deal with most ambulant patients, with a single more specialised Emergency Centre supporting both Urgent Care Centres. Instead of all people going to accident and emergency and waiting to be seen, only people who are seriously ill or have life-threatening emergencies would go to the Emergency Centre in Halifax. People who need urgent medical help would go to an Urgent Care Centre at either Calderdale or Huddersfield. The risk assessment is included as section 3.4 of the Quality Impact Assessment which has been published as part of the Pre-Consultation Business Case. Specifically, the risk assessed is: 'Increase in average ambulance journey time due to the requirement for some patients to be transported further to the single Emergency Care Centre.' Both the prior risk level and the risk level should the proposals go ahead are assessed as low. The mitigating action is as follows: 'Maintenance of an Urgent Care Centre on the planned site which will support the majority of urgent clinical needs. For blue light patients, evaluation undertaken to date indicates an average increase in journey time from 16 to 22 minutes. The 6 minute increase is more than out- weighed by the benefits of being treated in the most clinically appropriate setting.'
6	There is no risk assessment of increased patient deaths at Calderdale Royal Hospital following the proposed HRI A&E closure, despite the identification in a big Californian meta study of increased inpatient mortality in hospitals retaining their A&Es when a neighbouring A&E closes. We need to see this risk assessment.	We are not proposing to close services - we are proposing to change the way we treat people. Under these proposals, both A&E departments would be replaced by Urgent Care Centres to deal with most ambulant patients, with a single more specialised Emergency Centre supporting both Urgent Care Centres. Instead of all people going to accident and emergency and waiting to be seen, only people who are seriously ill or have life-threatening emergencies would go to the Emergency Centre in Halifax. People who need urgent medical help would go to an Urgent Care

		Centre at either Calderdale or Huddersfield. The CCGs and CHFT do not support the assertion that the proposed future arrangements for hospital and community health services would lead to 'increased patient deaths'. The risk assessment is included as section 3.4 of the Quality Impact Assessment which has been published as part of the Pre-Consultation Business Case. It is not clear from your description, which Californian study you are referring to. However, our proposals are not about closing or retaining A&Es. We are changing the way that we treat people- we are not closing services. Therefore, from the description of the study that you have provided, the outcomes of the study are not relevant. Our proposed changes would provide Urgent Care Centres on both Hospital sites and a single Emergency Centre on one site. Only those who are seriously ill or have life threatening emergencies would go to the Emergency Centre.
7	The Consultation Document lacks any quantification of the likely reduction in patient mortality from the centralisation of acute and emergency services in Calderdale Royal Hospital.	It is not possible to accurately quantify the likely reduction in patient mortality prior to the changes taking place. However, we know from other reconfigurations, for example the centralisation of Stroke services in London, that the centralisation of specialist services leads to improvements in patient mortality. We also have data to show that surgical outcomes improved after acute surgical services were centralised at HRI a few years ago, reducing mortality associated with gastrointestinal perforation and obstruction from approximately 12% to 6%. Additionally, In 2005/06 a partial reconfiguration of some hospital services in Halifax and Huddersfield was implemented to concentrate acute surgery and trauma services at Huddersfield Royal Infirmary. The clinical evidence base for this was recognised and supported by Commissioners at that time. Data published by Dr Foster shows that there has been a significant reduction in surgery and trauma service mortality rates (i.e. General Surgery mortality has reduced from 97 to 64, and Trauma and Orthopaedics mortality has reduced from 90 to 53). A full reconfiguration of all the acute specialities and emergency services on a single hospital site could enable even more people to benefit from similar improved safety

		and reduction in mortality (more lives saved).
8	It lacks any indication of the tipping point where the risk of increased patient deaths is outweighed by the reduction in patient mortality.	The CCGs and CHFT do not support the assertion that the proposed future arrangements for hospital and community health services would lead to 'increased patient deaths'. The purpose of these proposals is to save more lives, keep people healthy, make services safer and improve quality of care. The risk assessment is included as section 3.4 of the Quality Impact Assessment which has been published as part of the Pre-Consultation Business Case.
9	The Royal College of Emergency Medicine's Feb 2016 position statement on Emergency Department Closure says, *"Secondary, though important, are the consequences for services at sites that would be required to absorb the diverted patient flows."* We want you to publicly acknowledge the Royal College of Emergency Medicine position statement on Emergency Department Closure and state what you think the consequences would be for CRH - and other hospitals like Barnsley and Pinderfields - of having to absorb patients who could no longer attend HRI and Dewsbury A&Es. And what data your assessment of the consequences is based on.	The proposal for the local reconfiguration is not comparable with the Royal College's statement from February 2016. We are not closing an emergency department. We are reconfiguring our urgent and emergency care so that there is one Emergency Care Centre support by two Urgent Care Centres which between them will take the majority of the patients that are currently seen at the two A&Es. The benefits of this proposal extend far beyond just those anticipated in emergency care. We are reconfiguring the whole of our un-planned in-patient services for which the emergency department is the front door, so that we have a centralised pool of expertise on a single site with all the relevant clinical adjacencies. The implications of activity shift to neighbouring providers is set out in the Pre-Consultation Business Case at Section 7.1.6.
10	The CCGs' assessment of the likely consequences for CRH needs to take account of the following facts: • The Consultation Document claims that 54% of patients who currently use A&E would be treated at Urgent Care Centres following the hospital cuts/changes, meaning that the new Emergency Centre would only treat 46% of patients who would otherwise have gone to A&Es in Halifax and Huddersfield. • But the Royal College of Emergency Medicine's 14.4.2016 press release says that 20% of patients who attend A&E would be as well or better served by clinicians other than A&E doctors - meaning that if this is correct, the new Emergency Centre would have to treat 80% of patients who would otherwise have gone to Halifax and Huddersfield A&Es. • This amounts to 113,600 emergency patients/year instead of the	The analysis supporting the figure of 54% is based on actual attendances over a 12 month period: The assumptions used are set out in section 7.1.1 of the Pre-Consultation Business Case. **Urgent Care Centre Assumptions** • The Clinical Director for Emergency Services agreed a list of treatment codes to identify patients who were suitable for management in an urgent care centre (UCC). These are: – Adults with minor injuries and / or minor illnesses – Children over the age of 5 years with minor injuries • The categories of minor injuries and minor illnesses are highlighted below.

	proposed 65,320 emergency patients/year. (Consultation Doc p28).This would mean that the currently proposed Emergency Centre would be dangerously overcrowded. We need you to publish the College of Emergency Medicine information and say what the CCGs and CHFT are going to do about this.		

Minor Injuries	Minor illnesses
Bites/stings	Allergy (including anaphylaxis)
Burns and scalds	Dermatological conditions
Contusion/abrasion	ENT conditions
Diagnosis not classifiable	Infectious disease
Dislocation/fracture/joint injry/amputation	Local infection
Electric shock	Ophthalmalogical conditions
Facio-maxillary conditions	Psychiatric conditions
Foreign Body	Social problem (includes chronic alcoholism and homelessness)
Head injury	Soft tissue inflammation
Laceration	
Muscle/tendon injury	
Nerve injury	
Sprain/ligament injury	

All A&E diagnosis fields that matched the above criteria were used for modelling purposes.

- Walk in patients who met the UCC criteria are assumed to be treated at the site they present at.
- Walk ins who do not meet the UCC criteria are assumed to firstly attend the current site at which they are treated, but then are moved to the future unplanned care site (if they need to be moved) and hence they would appear as 2 attendances in the modelling work. In other words, these people attend the UCC and then attend the ECC.

The Royal College of Emergency Medicine paper you have linked to is describing primary care provision which does not have access to appropriate diagnostics and reporting and is not open 24 hours (see para 3 under the discussion heading). The urgent care centres will have access to diagnostics and other equipment and facilities which are routinely used now by our emergency care practitioners, who will continue to provide care in our proposal in addition to the medical resource referred

		to the paper. They will therefore be able to care for a higher percentage of patients. We understand the hub referred to in this instance to be a primary care centre not an urgent care centre. The difference being that the RCEM looked at those cases that could be seen by a GP only. Our urgent care centres will have Emergency Nurse Practitioners who will also be able to see minor injuries and who look after, on average, significantly more than 22% of the patients who come to our existing A&Es. We are aware that in other parts of the country where this model has been implemented, such as Northumbria, they are able to treat more than the 54% we are forecasting. Whilst the Royal College of Emergency Medicine's 14.4.2016 press release says that 20% of patients who attend A&E would be as well or better served by clinicians other than A&E doctors – this does not mean that the proposed Emergency Centre would have to treat 80% of patients who would otherwise have gone to Halifax and Huddersfield A&Es. We are not proposing to close services - we are proposing to change the way we treat people. Under these proposals, both A&E departments would be replaced by Urgent Care Centres to deal with most ambulant patients, with a single more specialised Emergency Centre supporting both Urgent Care Centres. Instead of all people going to accident and emergency and waiting to be seen, only people who are seriously ill or have life-threatening emergencies would go to the Emergency Centre in Halifax. People who need urgent medical help would go to an Urgent Care Centre at either Calderdale or Huddersfield. Therefore the staff currently working in both hospitals' A&E departments would be working in the proposed Emergency Centre or both Urgent Care Centres in line with the modelling of the proposed changes as outlined above.
11	We don't think you have adequately thought through the services and resources needed at CRH, if it is to absorb 80% of patients who would have gone to CRH and HRI A&Es, not 46% as you have planned for. We need you to do this.	As above. Our research shows that no more than 46% will go through the Emergency Centre.
12	The Consultation Document says that there will be 732 hospital beds after the cuts - down from around 800 beds at the moment. It	The figure of 732 beds is correct. The population of Greater Huddersfield and Calderdale is estimated to be 452,000 as stated in the Consultation Document. This

	doesn't say that this means Calderdale and Huddersfield will have 1.61 beds per 1000 population. Only Indonesia, India and Columbia have fewer hospital beds per 1000 population than this. But the Consultation Document claims (p5) that the proposed hospital clinical model will progress the future shape of hospital services ensuring that they are high quality, safe, sustainable and affordable. We would like you to explain how you have traded off the requirement for "high quality and safe" hospital services with the requirement for "sustainable and affordable" hospital services, and what data you have used to determine that you can provide high quality, safe hospital services on the basis of1.61 beds per 1000 population	would provide 1.72 beds per 1000 population. The number of beds per 1,000 population is not a recognised indicator of the quality and safety of care. We have not 'traded off the requirement for high quality and safe hospital services'. The model of care was developed based on clinical evidence. We then looked at a number of alternatives to deliver this model. These are outlined in the Consultation Document. Value for Money is one of the criteria used to appraise the alternatives and is set out on pages 12 and 13 of the Consultation Document. CHFT have submitted to the Department of Health, what we believe to be the best case for financial support, in that it would provide the least expensive way to deliver the requirements of our clinical model. We have been clear that progression of the proposed changes is dependent on additional funding being secured.
13	Ernst & Young's Strategic 5 Year Plan for CHFT, identifies a "new commercial venture such as private patient wing" as a "significant longer term investment". Is a private patient wing part of the 732 beds planned for the reconfigured hospitals? And if so, how many beds would be available for NHS patients under the new hospital clinical model?	A private patient wing is not part of the current proposals. In developing CHFT's 5 year strategic plan, a long list of forty initiatives was devised that the Trust could implement to improve future sustainability. (The long list of initiatives can be found in Appendix 10.4 of the report on pages 218 – 219.) This includes reference to 'new commercial venture such as a private patient wing' and that this would require significant longer term investment. At a workshop held in early October 2015, the CHFT Board discussed the long list of forty initiatives and scored each one against appraisal criteria. The Board agreed 15 priority initiatives to be taken forward for quantification that are included in the strategy. The development of 'a new commercial venture such as a private patient wing' was not included in the 15 shortlisted priority initiatives and therefore this is not part of the bed plan included in the 5 year strategy.
14	The Consultation Document doesn't explain the reason for dropping	The future use of the Todmorden Health Centre is being taken forward as part of the

	the proposal for an Urgent Care Centre in Todmorden Health Centre, or what provision there will be instead, if any. We need to know why this was dropped and what provision there will be instead. Did you drop it because Ernst and Young's 5 Year Strategic Plan for CHFT decided the £1.2m costs to run an UCC in Todmorden was unaffordable, given the drive to cut the Trust's deficit? Or what?	Vanguard proposals related to Care Closer to Home. It is not part of this consultation. More information about Vanguard can be found at www.england.nhs.uk/ourwork/futurenhs/new-care-models/
15	The Consultation Document claims (p10) that "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". The Consultation Document claims that CHFT staff have been properly engaged with and support the proposed hospital clinical model but a current Unison survey of all CHFT staff - not just their own members - has found that 93% oppose the proposals and that there has been little or no engagement with the majority of staff. In addition, at the Hands Off HRI public Question Time last night, CHFT General Surgery and Colorectal cancer services Consultant Dr Adrian Smith stated that he and the Department of General Surgery as group have not been consulted. Tamsin Grey, General Surgery consultant Calderdale hospital also spoke against the proposals. Please supply the data you have about how, when and where you have carried out these discussions, with which hospital doctors, nurses and other Trust clinicians, and what the hospital doctors, nurses and other Trust staff told you.	

We would welcome the submission of the Unison Survey and the responses as evidence into the Consultation process. We will ask them to do this.

We have done significant work to inform and engage staff. The engagement with CHFT staff began three years ago with the development of the outline business case. A note of that work is attached.

For CCG staff, The Hospital Standards for the Right Care, Right Time, Right Place Programme were initially developed by a Quality Assurance Group comprising clinical representation from both CCGs. The standards were approved by both CCGs' Quality Committees in August 2014.

Following approval of the Hospital Standards, the Quality Assurance Group established the outcomes that we expected these standards to achieve and these, together with the Hospital Standards were subject to engagement at a Stakeholder event in August 2014, and were approved by the CCGs' Quality Committees in December 2014.

Subsequent to the development of the Hospital Standards and the outcomes, CHFT worked with their clinicians to establish the Trust's baseline and aspiration for the standards and the CCGs worked to develop a dashboard that would enable us to track our performance.

These pieces of work were then used to develop a narrative on the current position in relation to Quality, Safety and Patient Experience. This work, completed by the CCGs and CHFT, was used to produce the Quality and Safety Case for Change that has been included in the Pre Consultation Business Case. The Quality and Safety Case for change was approved by the CCGs' and CHFT's Quality Committees in June, 2015.

The membership of the Quality and Safety Assurance Group, The CCGs' Quality Committees and CHFT's Quality Committees is detailed below.

In addition to the formal governance, the standards have been part of our developing potential Outline Model of Care for Hospital Services.

There have been Five Clinical Workshops and four clinical design groups to develop the overall potential future outline model of care for Hospital Services. These groups have met over a period of ten months between November, 2014 and August 2015. The following paragraphs outline the work undertaken by these groups.

Our first workshop, in November 2014 was attended by clinicians from Calderdale CCG and Greater Huddersfield CCG and achieved the following:
The development of a common understanding of our journey and where we are on our journey.
Agreement of the scope for Hospital services, the standards we want to apply and the outcomes that we expect these standards to achieve.
A shared understanding of the different models of Hospital Care described in the Providers' OBC and NHSE 5 year forward view.
Started to develop a common set of assumptions about the optimum configuration of our future model for Hospital Services

The second workshop in January, 2015, also attended by clinicians from both CCGs, discussed Planned and Unplanned Care; Accident and Emergency; Specialist Commissioned Services and enabling changes (workforce, estate and Quality and performance management) and agreed that, as Commissioners we should:

- Specify what we mean by an Unplanned Care offer on both sites (for both Accident and Emergency and for other Unplanned Care).
- Specify what we mean by a Planned Care Offer.
- Undertake work to establish which elements of Specialised Provision could be undertaken locally
- Progress the work on Hospital Standards by identifying, baselining and setting ambition for metrics which would allow us to track our progress towards the outcomes we want to achieve.

The third workshop in February, 2015 was a joint session between senior clinical representatives from CHFT, Calderdale CCG and Greater Huddersfield CCG. This was a strategic session to bring together our collective thinking to date as CCGs and as a provider to begin to develop what our ideal model for the future provision of hospital services could look like.

In doing this, we considered the journey to date for Commissioners and CHFT; explored the different perspectives that have informed our thinking, including the collective views of patients and the public; acknowledged the level of risk in the existing system; shared the commissioners' journey in relation to Care Closer to Home; CHFT's position in respect of quality and finance and considered the changing national picture.

We agreed that we needed to create a place where we could continue this collective dialogue in order to reach a position where we could express a consistent view from the local health economy on our future hospital services and further clinicians' workshops were organised for April 2015

The first April workshop (workshop four) was attended by CCGs' clinicians. The workshop established the Commissioners' position on the Urgent Care offer from our Hospital services and considered the possibilities for networking specialist services in local hospitals. The output from this and previous workshops was taken into the second April workshop (workshop five).

Workshop five was a joint session between senior clinical representatives from CHFT, Calderdale CCG and Greater Huddersfield CCG. This was a strategic session

to allow commissioners to share with the Provider, their joint thinking in relation to a potential model for Emergency and Urgent Care, and to understand the Provider's initial views in relation to this. The session then went on to explore the detail of the Providers' Planned Care model as presented in their Outline Business Case. The overall aim being the further development of a collective view on what our ideal outline model for the future provision of hospital services could look like.

Following Workshop five, we agreed that we needed to strengthen the arrangements for how we should continue this collective dialogue and work together in the future. To this end we established a number of clinical design groups working to a joint Hospital Service Programme Board.

The Clinical Design groups covered: Planned Care; Urgent Care; and Maternity and Paediatrics. They met five times in total and were supported by individual discussions between Clinicians from the CCGs and CHFT and by CCG discussions in their Clinical development forums.

The Clinical Workshops and the Clinical Design Groups represent 284 hours of clinical time, supported by research and discussion outside of these meetings. Calderdale CCG, Greater Huddersfield CCG and CHFT signed off clinical consensus on the potential outline future model of care for hospital services in October 2015.

In addition to the above, we have presented and discussed the model and the standards with all our GP practices through the Calderdale CCG Practice Leads meeting and the Greater Huddersfield CCG, Practice Protected Time meeting.

We contend that the process described above demonstrates significant clinical engagement in the agreement of clinical standards and the development of the potential outline future model of care for hospital services.

Membership of Committees:

Calderdale CCG, Quality Committee Membership

GP Governing Body Member, Calderdale CCG (Chair)
GP Governing Body Member, Calderdale CCG
Head of Quality, Calderdale CCG and Greater Huddersfield CCG
PPI Lay Member, Calderdale CCG
Head of Service Improvement, Calderdale CCG
Head of Primary Care and Improvement, Calderdale CCG
Quality Manager, Calderdale CCG
Consultant in Public Health, Calderdale Metropolitan Borough Council

Greater Huddersfield CCG, Quality and Safety Committee

GP Governing Body Member, Greater Huddersfield CCG (Chair)
2 x GP Governing Body Member, Greater Huddersfield CCG
Head of Quality, Calderdale CCG and Greater Huddersfield CCG
PPI Lay Member, Calderdale CCG
Secondary care advisor

Required attendees:
Quality Manager Greater Huddersfield CCG
Head of Practice Support and Development, Greater Huddersfield CCG

Calderdale & Huddersfield Foundation Trust, Quality Committee membership

Head of Governance and Risk
Medical Director
Deputy Director of Workforce and Organisational Development
Deputy Director of Nursing/Interim ADN, Surgery & Anaesthetic Services Division
Executive Director of Nursing & Operations
Executive Director of Planning, Performance, Estates and Facilities.
Associate Director of Operations and Community Services
Divisional Director, Surgery & Anaesthetic Services Division
Membership Council Representative
Assistant Director to Nursing and Medical Directors
Finance Director
Company Secretary
Divisional Director, Family and Specialist Services Division
Associate Director of Nursing, Family and Specialist Services Division
Associate Director of Nursing, Medical Division
Plus Non-Executive Director representation one of which is the Chair of the committee

Subsequently, CHFT have done the following (the CCGs engagement is detailed in the answer to Q16 below):

- We encourage all staff to respond to the public consultation. Like any member of the public they can respond to the consultation on www.rightcaretimeplace.co.uk
- They can also contact the consultation on rcrtrp.myview@nhs.net 01484 464212, or write to Freepost, RTAA-XTHA-LGGC, Heron House, 120 Grove Road, Fenton, Stoke-on-Trent, Staffs, ST4 4LX
- There is a dedicated RCTP 'Ask Owen' button on the intranet to ask questions or for support – these have all been responded to promptly
- Email chft.nhs.uk if staff would like someone to come along and chat to their department or talk on a one to one (but this is not a substitute for them doing a direct response to the consultation) – as a result of this we have attended:

- Community services in Brighouse
- Ward sisters' meeting
- Quality team
- The Health Informatics Service
- Outpatients team
- Staff side

- Two staff drop-ins with Owen Williams at the start of the consultation – one on either site.
- Weekly Wednesday walkabout by the senior nursing team has included discussion with ward nursing staff about the proposed changes

- Held a 'Big Brief' presentation on both sites about RCTP
- 1:1 interviews held with consultants between August 2015 and February 2016
- Held 13 staff events across our estates and facilities teams – catering / portering / engineering / switchboard / general office
- We have held two staff drop in sessions on 29 April and 4 May, very similar to the public sessions, where staff can share their view. There is a further one planned for 8 June.
- There are posters and leaflets across our sites advertising how to get involved
- There are stands next to both restaurants advertising how to get involved
- There is an update for staff every Thursday in the e-bulletin
- There is a 'rolling banner' on the intranet and screen saver, advertising the consultation
- Owen regularly mentions the consultation in his blog.
- Held a meeting with surgeons
- Listening Events on Wards 3, 10, 15, 19, 20 and 22, Surgical Assessment Unit and the Intensive Care Unit.

We have not taken notes at all of these meetings and where there were notes we have fed these straight in to the consultation meetings. We have asked staff to feed directly in to the consultation.

16	As for the Consultation Document claim that GPs, and staff in GP practices and community health services have been involved in many discussions about the proposals, we would like you to provide evidence of this. From talking with some of these staff, we have found that they didn't have a clue about what you were proposing and we would like you to back up your claim with documentary evidence of which GPs and other primary and community health staff you discussed these proposals with, when and where and what they told you	In Calderdale we have presented to the LMC 5 times in relation to proposed future arrangements for Hospital and Community health services. We presented to the Joint Clinical Commissioning and Practice Managers meeting (26 GPs and 26 Practice managers) in October and December, 2015 and in April, 2016. Information has also been included in the Jan, March and April 2016 editions of the newsletter which is distributed to all GP Practices. In Greater Huddersfield we have presented to the LMC through our interface update every month from September 2015 to May 2016. We presented a webinar on the 16th September, 2015 which was available to all practices live and then added to the intranet page. We presented at Practice Protected Time (PPT) on 17th November, 2015 to all Practice Nurses, Practice Managers & GPs – (approx. 150 people). RCRTRP has been discussed at individual Practice visits – May 2014 (previously called strategic review), September 2014, January 2015, May 2015, September 2015,

		January 2016. The September 2014 visit referred practices to the engagement events and the website. Updates have been included in the newsletter which is distributed to all GP practices and there is a dedicated page on GHCCG intranet. The Programme has been a standard agenda item at Practice Managers Reference Group since September 2015 (meet monthly). We have supplied evidence as part of the NHSE Assurance process that the four key tests have been met: • strong public and patient engagement; • consistency with current and prospective need for patient choice; • a clear clinical evidence base; and • support for proposals from clinical commissioners. A copy of the letter from NHSE is attached as part of the answer to Question 2 above.
17	The Consultation Document says nothing of the fact that the Clinical Senate, in reviewing the Community Services Specifications for Calderdale, Greater Huddersfield and North Kirklees CCGs (PCBC p 137) says that these specifications contain no evidence to support commissioners' claims of "extensive engagement with staff" over the last two years. It considers it "likely that there would be workforce issues during such a large scale transformation" and recommends further work on how " risks to patient care can be mitigated during the transition period" , that would result from current CHFT "workforce issues getting worse as the morale and motivation of clinicians continues to deteriorate". This is identified as a "Principal risk". It also says that there will be "resistance and refusal to change" in primary care. You need to tell the public about this	We published the Clinical Senate Reports as part of the Pre-Consultation Business Case. The report does not say that "these specifications contain no evidence to support commissioners' claims of "extensive engagement with staff" over the last two years – rather it says that the Senate 'is aware from discussions with commissioners of the extensive engagement with staff during the previous two years. Evidence of this engagement was not available within the documentation received'. The Principal Risks were identified by the CCGs and the Senate were asked to comment on them. The summary recommendations from the report, as already published on the website, are: The Senate commends the CCGs on their vision for the future of their

		community services and agree that this has the potential to result in excellent patient care closer to home. In general terms, the Senate review group was very supportive of these comprehensive documents and their values and principles for delivering care closer to home. 2.2 The Senate was given a specific brief in relation to whether particular risks are addressed within the proposals and to appraise whether there are any missed opportunities within the proposed scope of services. The Senate did find it very challenging to assess the risks associated with the service transformation and we have raised a number of questions in relation to the risks arising from the lack of detail regarding workforce, primary care strategy and engagement with partners, for example. We recognise that there have been extensive discussions with stakeholders during the last 2 years which was not detailed within the evidence provided, and that the detail behind the vision will be worked through in competitive dialogue. The Senate hopes that these questions assist with that procurement process. The Senate recommends that commissioners work in partnership with the providers around the development of the service models. This shared approach to the service model development is particularly important in a system undergoing such a large level of change to help mitigate against the risks to service delivery. 2.3 The Senate Review Group has considered the scope of services and agrees that these are comprehensive, with little that could be considered a missed opportunity. In addition the Clinical Senate also reviewed the proposed future model of Hospital Services and the summary recommendations from the report – as already published on the website are: 2.1 The Senate commends the commissioners on their vision for the future of hospital services and we support the commissioners' aspirations for the service. The Senate agrees that the Quality and Safety Case for Change and the baseline position support the need to move towards greater centralisation of services across hospital sites. The Senate agrees that a clear argument is made that the current configuration of services does not and cannot meet national guidance, and that staying the same is not an option. 2.2 The Senate recognises that the documents supplied are a work in progress and the supporting detail regarding activity and workforce will

		be developed as part of the pre-consultation Business Case. 2.3 As a high level strategic document for whole system change, the Senate agrees with the aspirations outlined in the Model of Care. The Senate recommends however, that as the work develops the commissioners describe the model with greater clarity, particularly focussing on detail about the workforce and activity. The lack of detail at this stage left the Senate with questions regarding the ability of this model to deliver the standards proposed. At this point, the Senate can only endorse the vision and give broad assurance of its potential to deliver a quality service. Following the receipt of further additional information about the Urgent Care Centres, the Senate are broadly content with the proposals but there is always the possibility that a very ill patient will attend the Urgent Care Centre and commissioners need to ensure that staff have the medical and nursing skills, experience and capabilities to safely stabilise that patient. Commissioners are recommended to consider this further as they develop the model. 2.4 The Senate supports the standards proposed in the documentation which are taken from a variety of national documents and reflect the best of national policy. The standards are very generic, however, and could largely apply to any Trust. Commissioners are recommended to include more detail about the level of local clinical engagement in agreeing how deliverable these standards are.
18	The Consultation Document says nothing about any risk assessment of the effects of the proposed hospital cuts on primary care, although the Royal College of Emergency Medicine's Feb 2016 position statement on Emergency Department Closure says, "The additional stress on local primary care systems must also be considered." We need you to acknowledge this publicly and state what risk assessment if any you have carried out of this issue.	The proposal for the local reconfiguration is not comparable with the Royal College's statement from February 2016. We are not closing an emergency department. We are reconfiguring our urgent and emergency care so that there is one Emergency Care Centre support by two Urgent Care Centres which between them will take the majority of the patients that are currently seen at the two A&Es. The benefits of this proposal extend far beyond just those anticipated in emergency care. We are reconfiguring the whole of our un-planned in-patient services for which the emergency department is the front door, so that we have a centralised pool of expertise on a single site with all the relevant clinical adjacencies. Both CCGs are developing their Primary Care Strategies and both acknowledge that

		access to Primary care needs to be improved. These proposals together with Care Closer to Home are complementary.
19	Primary health care is underfunded and struggling. The government is cutting public spending and the Consultation Document fails to show that the proposals will maintain the quality of primary and community health care, let alone improve it. Instead, the consultation document (p35) claims that "strengthening community services" is benefitting the patients who need it the most. It provides no evidence to back up this claim. The only evidence given is that admissions to hospital from care homes that received Quest for Quality in Care homes support were 25% lower, in the year to March 2015, than from other Care Homes. Also that the length of stay was reduced by 26% saving £500,000. This was not a controlled trial and doesn't take account of other differences between the two groups of care homes. By now there should be more data, better evaluated. To present the data in this way is not honest. We need you to publicly produce documentation that shows how you have strengthened community services, how you have determined which patients need these services the most and how they are benefitting these patients.	The CCGs have considered the impacts of the Care Closer to Home Programmes in their Governing Body meetings in public. They have determined that they have confidence that the Care Closer to Home Programmes are improving the quality of Community Care and reducing demand on hospitals. The example given in relation to Quest for Quality in Care Homes does provide evidence that we are strengthening Community Services. The data is correct at the time of publication. The completion of a controlled trial would take a number of years. The need to improve services is immediate.
20	Where is the evidence that Care Closer to Home can justify the anticipated 6%/year reduction in non-elective medical admissions to hospital? We need this to be publicly available and if there is no such evidence, we need you to state this publicly.	The Consultation Document does not state that Care Closer to Home will reduce non-elective medical admissions to hospital. The Pre-Consultation Business Case states that one of the assumptions used in the activity and capacity modelling is that 'Significant Delivery of Commissioner QIPP will be realised (resulting in a 6% reduction in non-elective medical admissions per annum)'. The 6% improvement refers to CHFTs Key Operational initiative to 'Deliver best in class LOS, DNAs, New to FU ratios and ambulatory care – optimise performance to reduce waste and enable bed reduction' as set out on page 36 of CHFT's Five year plan'.
21	The costs of these Care Closer to Home interventions are missing from the Consultation Document, as are the costs of scaling them up to the whole area served by Calderdale Clinical Commissioning	We anticipate that the costs of these services would be lower than the provision of the equivalent services in hospitals. The costs of our proposals are outlined in the Consultation document on page 12.

	Group. This makes it impossible for the public to give an informed opinion on Care Closer to Home. We need you to provide this information.	We are proposing these changes because we think they would save more lives, keep people healthy, make services safer and improve quality of care.
22	The Consultation Document fails to mention that the Clinical Senate stated that there is no evidence in the proposed hospital clinical model, that clinicians at the hospital have been sufficiently engaged with to determine whether the resources exist to realise the claimed benefits of the cuts and changes. The Clinical Senate said that the hospital's clinical model is based on national policies and guidelines, and that there is no evidence of informed local clinicians' assessment about how and whether these are capable of being applied locally, given the available resources, in order to produce the required quality of care. We need you to acknowledge this publicly.	Please see answer to Q17 above.
23	As a result, the Clinical Senate review said that they could not vouch that the proposed hospital clinical model would generate the required quality of care. The consultation document makes no mention of this. On the contrary, it asserts (p13) that the proposed model of care would enhance quality of care. We need you to tell the public about this statement by the Clinical Senate and to provide data that shows how the proposed model of care would be of the required quality. If this is not available, you need to say so.	Please see answer to Q17 above
24	Claims about engagement with the public and key stakeholders are flawed and statements about public and stakeholder support for the proposals are exaggerated. We need the CCGs to publicly acknowledge the limitations of their public and patient engagement and the criticisms of this by Calderdale Adults Health and Social Care Scrutiny Panel Chair, who told the CCGs when they presented their engagement review in August 2015, that they "should seek a wider basis of opinion about their plans" – instead of confining their "engagement" to "people inside the goldfish bowl." When we decided to provide a wider basis of opinion at the CCGs' Stakeholder	We have supplied evidence as part of the NHSE Assurance process that the four key tests have been met. One of these tests is: strong public and patient engagement. A copy of the letter from NHSE is attached as part of the answer to Question 2 above. We do not agree that our claims about our engagement are flawed. We have published reports of all our stakeholder sessions on our website and a composite report of all our engagement has been produced by Healthwatch Kirklees and published on our website.

	Engagement Event, we had to protest vocally in order to gain admission. Once inside, we found that invited "stakeholders" - many of them the CCGs' "community assets" - were saying that they didn't agree with the proposals and didn't understand them. We would like the CCGs to make public all the documentation relating to their public and stakeholder engagement events so we can see exactly what the CCGs base their claims on regarding public and stakeholder support for their proposals.	The Consultation Institute have signed off the scoping stage of their Compliance process – part of which assesses the quality of the pre-consultation engagement. I can find no reference in the August minutes of the Calderdale Adults Health and Social Care Scrutiny Panel Council minutes to support the statement attributed to the Chair of the Scrutiny Panel. The CCGs' Engagement report was not presented to that meeting. The minutes can be found here: http://www.calderdale.gov.uk/council/councillors/councilmeetings/results.jsp?keywords=adult+health+scrutiny&p_SQ_ID=4991603&phrase=N&offset=20&id=188311058 The Engagement report was presented to the August meeting of the Calderdale and Kirklees Joint Health Scrutiny Committee on 13 August. I can find no reference in these minutes to support the statement attributed to the Joint Chair of the Scrutiny Panel. The minutes can be found here: http://democracy.kirklees.gov.uk/ieListDocuments.aspx?CId=144&MId=4846&Ver=4 A full report of findings in relation to the August event has been published on the Programme website.
25	We would like to know why and at what point the mental health Trust (South West Yorkshire Partnership Foundation Trust), stopped being involved as a Right Care Right Time Right Place partner. SWYPFT was one of the 7 original partners in the Strategic Review and the Strategic Outline Case, but it does not seem to have taken part in the "Right Care Right Time Right Place" engagement processes and it is not taking part in the current consultation. We need you to clarify what the relationship is between the CCGs and SWYPFT, why mental health services are not included in the current consultation and in particular what the relationship is between Calderdale CCG and the SWYPFT Arts Psychotherapy Service in Calderdale. Does Calderdale CCG commission this service from SWYPFT? Does it have a view on whether SWYPFT should go ahead	The Strategic Review was established to bring together the seven partners across Calderdale and Greater Huddersfield to develop proposals for transformational change across the health and social care economy of Calderdale and Greater Huddersfield. The programme produced the overall Case for Change which identified that significant change is essential because we want to ensure that everyone gets the right care at the right time and in the right place whilst responding to the challenges of: • An ageing population with increased needs; • National shortages of key elements of the workforce that mean new service models are required • Continuing to meet ever increasing external standards • Significant financial pressures facing commissioners and providers.

	and cut this service entirely, as it was planning to do before legal action caused it to withdraw staff redundancy notices and engage with service users about the future of the service?	In response to the case for change, three of the CCGs' existing Providers (CHFT, SWYPFT and Locala) produced a jointly developed proposal for changing the way community and hospital services in Calderdale and Greater Huddersfield could be provided. They described their proposals in the form of a draft Strategic Outline Case (SOC), which was presented to members of both CCGs' Governing Bodies in January, 2014. It was presented to both the Kirklees and Calderdale Health and Wellbeing Boards (HWB) and Overview and Scrutiny Committees (OSC) in February and March, 2014. The Providers subsequently developed the Strategic Outline Case into an Outline Business Case (OBC). This Outline Business Case was lodged with the NHS Procurement Portal Bravo in June 2014, but was not accessed by Commissioners until September 2014. In May, 2014 the scope of the programme was revised and the partnership of seven was set aside as part of the transition arrangements. In order to signal the transition, the name changed from Strategic review to Right Care, Right Time, Right Place. The revised scope and phases were established as: Phase One- Strengthen Community Services Phase Two - Enhance Community Services Phase Three - Hospital Services The CCGs have a commissioner/provider relationship with SWYPFT. Mental Health Services are not included in the current consultation because we do not intend to change the services as part of this programme. The SWYPFT Arts Psychotherapy Service in Calderdale is not part of this consultation.
26	The Consultation Document mentions the recent public engagement on maternity services. Clinical Commissioning Groups carried out this public "engagement" late, and as an afterthought. The maternity engagement survey was filled in by all kinds of people without the remotest interest in maternity services, but who wished to support a community group in need of money. This was because	The pre-consultation engagement was carried out as planned and as reported to the Calderdale and Kirklees Joint Health Scrutiny Committee in August 2015. Link to minutes above. It is not possible to comment on the reason why or the interest level in maternity services of those who completed the engagement survey.

	the CCGs paid £5 per completed survey to cash-strapped community groups who promoted the survey. This was widely advertised on social media by well-meaning members of the public who wanted to support these community groups. This must surely invalidate the outcome of the engagement. We need you to explain why it is right that you fund cash-strapped voluntary organisations in this way, in exchange for them promoting your engagement activities, and how you assess as valid responses to the engagement that are made in order to benefit the cash-strapped voluntary organisations.	The actual value of payments is not promoted outside the programme. Engagement Champions are representatives of local communities. They are trained to talk with people about local health services. They give local people the chance to influence the way services are delivered. The CCGs are responsible for buying local health services in hospital and in the community. They need to talk to all communities when they are considering changes to local health services. We purchase this resource to reach an audience we would require extra capacity to reach – this would include staff time, additional resources such as interpreters, venue hire and administration including marketing and promotion. The reimbursement acknowledges the time facilitation and administration costs of delivering in house activity. Engagement Champions ask questions so that when changes to services are being considered the views of local people can be taken into account.
27	Some if not all of these groups are also serving the Clinical Commissioning Groups as “community assets” aka “community engagement champions”. Their role now is to act as a mouthpiece for the Clinical Commissioning Groups and to encourage people to respond positively to the consultation. This seems entirely unethical. At least one member of the public has complained to the Consultation Institute about inappropriate social media messages that include downright disinformation about the hospital cuts proposals provided by one of these “community assets” and rude dismissals of members of the public who have questioned the false information that the community asset has put on their fb page. We need you to explain: how and whether you monitor the accuracy of the information put out by your communuity assets and the ways in which they communicate with the public; and how you justify the ethics of paying cash strapped voluntary organisations to be your	Please see the answer above in relation to the use of Community Asserts. We do not agree that they act as a mouthpiece for the CCGs. We are aware of the complaint that has been submitted to the Consultation Institute and we have agreed with the individual that this will be dealt with through the CCG’s complaints process.

	mouthpiece.	
28	It is unclear from the Consultation Document that the CCGs have properly considered alternatives to the Right Care Right Time Right Place proposals. We need full access to all relevant papers concerning the consideration of all alternatives. The lack of disclosure of all the documents relating to all the alternatives the CCGs considered makes it impossible to see if there's anything in the other options you've rejected that shows you've made the wrong decision, or if there's an alternative that deserves to be considered that is worth raising.	The consideration of alternatives is set out in the Pre-Consultation Business Case. We do not agree that there has been a lack of disclosure.
29	As far as we can see, the Consultation Document doesn't say anything about the extra 10,071.86 hours/year of ambulance journeys that would result from the closure of Huddersfield and Dewsbury A&Es. We need to know what assessment has been made of whether YAS can cope with this. And if no assessment has been made, we need you to make one well before the consultation period ends. Otherwise, how can the public comment on whether or not they agree with your proposals, or comment on how these proposals will affect us? We also need to know how this figure was calculated, on the basis of what assumptions	We are not proposing to close services - we are proposing to change the way we treat people. Under these proposals, both A&E departments would be replaced by Urgent Care Centres to deal with most ambulant patients, with a single more specialised Emergency Centre supporting both Urgent Care Centres. Instead of all people going to accident and emergency and waiting to be seen, only people who are seriously ill or have life-threatening emergencies would go to the Emergency Centre in Halifax. People who need urgent medical help would go to an Urgent Care Centre at either Calderdale or Huddersfield. The assessment of additional ambulance hours is summarised in the Pre-Consultation Business Case and the full report detailing how these figures were determined is also available on the website. YAS NHS Trust has been fully involved and engaged with the programme and therefore fully informed of the potential changes within the local health economy. The subsequent travel analysis was designed around YAS NHS Trust specification as well as the programme board's requirements. YAS has identified the additional resource that would be required to meet these hours and this was presented in public to the Calderdale and Kirklees Joint Health Scrutiny committee by YAS on 19th April, 2016
30	There is no proper equality impact assessment in the Consultation	You referenced the availability of the published Equality Impact Assessment in

	Document. You need to address this	Question 2 above. The Equality Impact Assessment is published as Appendix E of the Pre-Consultation Business Case.
31	Neither is there any adequate information about how people who rely on public transport would cope with having to travel further for planned care and to visit family and friends in either the planned care or acute/emergency care hospital. At the 19th April JHSC meeting, Neil Wallace, Bus Services Manager for West Yorkshire Combined Authority said that he had had no involvement in plans for transport between the 2 hospitals and there had been no consultation from the CCGs on the issue. The 2014 transport document by Jacobs identified a disproportionate effect on public transport users, but Mr Wallace said that he doesn't know what to do to improve this because that would depend on the issues and but the CCGs haven't consulted him, so he doesn't know what the issues are. He wants to talk about the options, but the CCGs need to talk about where the money would come from. We think the CCGs need to explain these facts to the public and say if they have money to commission bus services to improve travel for people who will have to travel further to hospital using public transport and if so, how much.	The Travel analysis has been published on the programme website. We have committed to setting up a travel group to give further consideration to travel matters – this is detailed on page 39 of the consultation document. The minutes of the Calderdale and Kirklees Joint Health Scrutiny committee on 19th April, 2016 have not yet been published. The purpose of Consultation is to provide the opportunity for people and organisations to contribute their views. This includes the West Yorkshire Combined Authority. Additionally, The West Yorkshire Combined Authority is launching a 12 week public consultation on 23rd May in relation to their Bus Strategy. We will feed into that work.
32	The Consultation Document (p 20) talks about people's worries about travelling further to A&E and says that the average ambulance journey time to the "Emergency Centre" at Calderdale Royal Hospital would be 6.48 minutes longer than the current average ambulance journey time to A&Es at both hospitals. This is misleading. For people in Calderdale, the average ambulance journey time would stay the same - not increase by 6.48 minutes. So since roughly equal numbers of patients travelling by ambulance to A&E in both areas, this would means that for Kirklees people, the average increase in ambulance journey times would be 13 minutes. The Consultation Document misinformation needs to be corrected.	We do not agree that the consultation document is misleading. The document states that: 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).

33	Further, by only reporting average journey time, the Consultation Document avoids telling people in the most remote parts of Kirklees what their actual ambulance travel time would be. The Consultation Document should report actual distances and ambulance journey times to the proposed Emergency Centre from the main towns and villages in Kirklees.	It is not possible to tell people what their actual journey time would be. The ambulance takes the most direct route to the most appropriate place depending on the care needed and the state of the roads at the time the journey is made. For example, as per current arrangements, people with serious multiple injuries, heart attacks or burns would go to a specialist emergency centre, such as Leeds or Wakefield In addition, the most important time is the time taken for the ambulance to reach the patient. The ambulance staff will then spend time stabilising the patient and then taking them to the place where the required specialism is in place to provide the required care.
34	The Consultation Document (p6) makes the inaccurate claim that the proposed hospital clinical model would close the financial gap that the system is facing. We know from what Monitor told the Joint Health Scrutiny Committee, that although the proposed changes would reduce the "financial gap", CHFT would still be £9.3m in deficit by 2020/21, when the proposed changes would have been implemented. And the Consultation Document says on p 12 that in the five years following the changes, if CRH were chosen as the Emergency Centre, the cumulative deficit at CHFT would increase by £47.5m. This gives the lie to the p6 claim that the proposed changes would close the financial gap - £47.5m is rather a large financial gap. Please explain to the public that while these proposals may narrow the financial gap the system is facing, it will not close it for at least a decade from now.	The claim on Page 6 of the Consultation Document is accurate. It states that: 'That these developments would cost more than £291m but would generate efficiencies to close the financial gap the system is facing'. The breakdown of these costs is provided on page 8 and 9 which clearly state: '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. And on page 12 we state:

		'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.'
35	At the Hebden Bridge consultation drop in, Dr Alan Brook told a member of the public that CHFT expected to go into surplus at some point after the whole Care Closer to Home scheme had kicked in. Please provide the modelling for this expectation and show when the surplus is expected to occur.	Dr Brook cannot remember the exact details of the conversation but it was a conversation which explained that the financial projections are based on current activity but when we succeed moving Care Closer to Home then the numbers should look even better.
36	The Consultation Document says that "These proposed changes would secure the future of health services for both areas for the next 20 years." But according to Monitor, it isn't true that the proposed changes would secure the future of health services for both areas for the next 20 years. Monitor told the Joint Health Scrutiny Committee on 9 March that "Running a £9.5m deficit/year that can't be funded by the Trust or the Clinical Commissioning Group, that's not a sustainable position." And that at the end of the 5 year period of the proposed hospital cuts and changes, the hospitals Trust will: "obviously be unsustainable in the longer term unless the government changes its funding policy." The Monitor rep continued, "We're heading into an unprecedented phase of the NHS, with many Trusts going into deficit this year. We're looking at wider footprints now than individual Trusts." We need the CCGs to	The £9.5m deficit/year – is outlined in the Consultation document on Page 12 – where it is stated as a cumulative deficit (i.e. 5 x 9.5): 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. The full meeting of the Calderdale and Kirklees Joint Health Scrutiny Committee, outlining the full extent of Monitor's comments is available as a webcast here: http://www.kirklees.public-i.tv/core/portal/webcast_interactive/215866/start_time/3000

	spell out Monitor's warning that these proposed changes won't secure the future of health services for both areas for the next 20 years, and your reaction to it.	
37	Monitor's comment about "looking at wider footprints than individual Trusts" seems to be a reference to Sustainability and Transformation Plans. The CCGs need to explain these Plans to the public as part of this Consultation, since they are going to determine the future of our local services. The implications for the likely future of our hospitals need clarifying - particularly the implications of the fact that each STP "footprint" will have to make sure that the sum of plans for individual areas stick within the allocated budget - meaning it will not be possible for a "footprint" go into deficit. Given that the hospital cuts proposals will not return the Hospitals Trust into the black even by 2025/6 (when a cumulative deficit of £47.5m is predicted), this surely has to put a question mark over whether the proposed hospital clinical model will be acceptable under the terms of the STP; and if it is, what other service will have to be cut to carry that £47.5m deficit - let alone the current deficit. The CCGs need to explain this to the public.	We cannot answer on behalf of Monitor or speculate on what they were thinking at the time they made their comments. In relation to Strategic Transformation plans (STPs), we can confirm that the CCGs are closely involved in the conversation and planning in relation to STPs. This is a parallel process to these proposals and the CCGs are briefing in public at their Governing Bodies and Health and Wellbeing Boards as those plans become clearer.
38	Without accurate financial information, the public cannot possibly judge whether this proposal represents good value for money. But the Consultation Document doesn't provide this. It says (p 12) that the total funding required to develop CRH as the Emergency Centre and HRI as a new planned care hospital would be £470m, and that that figure includes £179m to "support the hospital deficit position." So £179m of the "financial gap" reduction would come from outside funding - not from any "efficiencies" generated by the proposed hospital clinical model. £291m would be needed to cover the capital costs of the hospital changes (Consultation Document p 6). The Consultation Document is vague about the sources of finance for the £470m. It says (p12) that the sale of either the HRI main site or the Acre Mill site wouldn't pay for the capital costs of the hospital	The financial information is as accurate as it can be at this stage. As detailed above, the purpose of these proposals is to save more lives, keep people healthy, make services safer and improve quality of care. The Consultation Document is clear that the bid for additional funding includes £179m to support the hospital deficit position. The remainder of the £470m would be used to implement to arrangements proposed as part of this consultation. As referenced earlier, we believe that the proposed clinical model, that we are proposing would configure services in a way that would enable us to generate efficiencies to close the financial gap. CHFT have submitted to the Department of Health, what we believe to be the best

	changes, but it would make it easier to get the extra funding needed for this. The Consultation Document (p9) says that HM Treasury is the intended source of the £470m additional funding and that if this isn't forthcoming the proposed changes can't go ahead. It doesn't explain that Monitor has, with "some caveat" put in an application to the Department of Health for what it considers to be "extraordinary funding of £470m for a single Trust reconfiguration" – extraordinary in that it compares with £300m that it cost for a Northern Trust to build a whole new hospital, according to Monitor. Monitor told the Joint Health Scrutiny Committee on 9 March that the Department of Health is liaising with the Treasury and that there is no indication of the time frame "or what they'll stomach". What is this "extraordinary funding" from the Department of Health? There is nothing in the Consultation Document about this. And how confident are the CCGs that this funding will be forthcoming, and why? The Pre Consultation Business Case (p97) identifies these sources of the £470m external funding: • loan funding to support the capital requirement • non-recurrent reconfiguration revenue costs funding • non-recurrent deficit support funding The public needs to know on what terms and conditions the Department of Health would provide "extraordinary funding". Is it from a loan and/or Public Dividend Capital? https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/365134/SofS_Finance_Guidance_under_Section_42A.pdf	case for financial support, in that it would provide the least expensive way to deliver the requirements of our clinical model. We have been clear that progression of the proposed changes is dependent on additional funding being secured. We will not know if our submission has been successful until after the consultation has finished. If the conclusion of the consultation process was that we were to proceed with the proposed changes this could only be a recommendation pending the successful outcome of the request for funding. The further detail in relation to the terms and conditions provided by the Department of Health is not known at this stage.

	What is the rate of interest and how long would it take to repay the loan and interest charges? At the Halifax public consultation drop in, Owen Williams said there are 3 potential funding sources: • A capital pot between the DoH and the Treasury, which would require repayments • The DoH/Treasury could give CHFT a borrowing limit to get the loan on the commercial market and the DoH would pay the interest • PFI 2 - could be required to go down that route. The CCGs need to provide clear, accurate financial information that makes sense.	

Engagement with CHFT staff on the development of the clinical model – initially as part of Strategic Outline Care and the Outline Business Case.

<table>
<tr><td>April 2014</td><td>Membership Council (including staff representatives) update on Strategic Outline Case</td><td></td></tr>
<tr><td>April 2014</td><td>Stakeholder meetings on OBC held including Trust staff</td><td>Summary report of the events available. These outcomes were cross referenced into the outline business case.</td></tr>
<tr><td>April 2014</td><td>1:1 interviews regarding the strategic outline case with ward leaders, consultants, staff working independently in the community, middle grade doctors and midwives. All interviewees were clinical staff involved in delivery of clinical services. This exercise was explicitly aimed at getting the views of staff that deliver the clinical services. This feedback influenced the service model in the OBC

Key points summary:
The Trust employs 6000 staff.
2 rounds of 1:1 interviews
Interviewers used a standard interview template base on the ‘Working Together to Get Results’ change methodology adopted by the Trust.
Round 1 67 interviews offered, 52 undertaken
Round 2 93 interviews offered, 51 undertaken</td><td>Staff reported that the proposed service model would provide care closer to home for patients and would allow patients to be more in control of their own care. Staff felt the service model was safer and would improve patient care. Staff felt the model would provide the opportunity to improve services, particularly through the provision of 1 unit rather than 2 locations. For the Trust staff felt the model improved efficiency, quality and safety.
Staff were very supportive of the split of the planned and unplanned sites. They supported the focus on the community models and also integration with other teams and providers.
Staff felt we needed to improve the communication about the service model, to improve the understanding of what we are trying to do for both staff and the public. Many felt there was nothing we needed to do to improve the proposal.
Staff felt they could improve some things now, such as appointing more staff or improving sharing information, but were unable to do it because they didn’t have the technology or capacity to do it or it wasn’t in their gift.
Specifically staff were very supportive of proposals to improve consistency of care 7 days a week.
When asked how comfortable staff are with the service proposals, on a scale of 1-10, where 1 is not at all comfortable at all and 10 is extremely comfortable staff reported the following scores:
<table>
<tr><td></td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td><td>10</td></tr>
<tr><td>Nov 13</td><td>1</td><td>3</td><td>1</td><td>1</td><td>7</td><td>10</td><td>8</td><td>12</td><td>11</td><td>5</td></tr>
<tr><td>April 14</td><td>0</td><td>0</td><td>1</td><td>1</td><td>3</td><td>8</td><td>10</td><td>11</td><td>7</td><td>3</td></tr>
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Engagement with CHFT staff on the development of the clinical model – initially as part of Strategic Outline Care and the Outline Business Case.

		In November 2013 77% of staff scored 6 or higher in how comfortable they are. In April 2014 88% of staff scored 6 or higher in how comfortable they are. To increase this score staff required more information about the detail of the proposals, and to be more involved in developing the plans. • In conclusion staff were very supportive of proposals to deliver more integrated services, more services in the community, services 7 days a week and to do this through greater specialisation of each hospital site. They felt communication needed to be improved to help the public understand how much better care would be if we could make these changes.
March 2014	Staff briefing sessions on SOC and service model	
Feb, May, June 2014	Staff briefings on SOC (signed off by the Board January 2014)	

Summary of Communication and Engagement Activities for the Outline Business case - April/May 2014

The following is a summary of some of the key engagement and communication activities for the Outline Business Case.

- Staff engagement has continued at local and individual level across all areas of the Trust.
- A Frequently Asked Questions document of common themes arising at Staff Information sessions published on the staff intranet.
- An email address (communications@cht.nhs.uk established for staff to ask questions or raise concerns.
- Articles about the Strategic Outline Case continue to feature in the Trust's publications (Trust News and GP Update).
- Briefings and engagement has taken place with the Trust's Membership Council.

Other strategies were used to obtain staff views, these included:

- Open staff drop in sessions
- Nurse focused staff drop in sessions
- Meetings with staff side
- Cascade briefing through the divisions
- Briefings to any groups of staff who requested them
- Staff directly involved in the development of the service model through the divisions.