CHAIR: Ladies and Gentlemen, good evening I hope you can hear me. I can hear it quite loud in my ear. I am here at the front waving my arms around.

Hello and welcome. We are due to start at 6 but because there are still people coming in, I think we will start at ten past. Okay?

I will run through first things. I am Stephen Williams and the Chair for the evening. And, on your chair, you might be sat on it, or hopefully retrieved it from the chair before you sat on it, the consultation document and other bits of paper that I will walk you through now. The key one is this A5 small piece of paper here which says, "Ask us a question". Okay? Please rest assured every question, every view and every opinion that there is in the room this evening that we want the consultation team and the programme to hear about will definitely be recorded and definitely heard about, but I do have to ask you to write it on here: particularly your question. So when we have the Q and A bit, it's nice and simply for when my colleague comes up to you, it can be read.

When you want to say any of the proposed changes you want to talk about, give it a tick as well. You may want to say your name and what part of the area you are from: you may want to, you may not want to.

On your chairs - and I will walk through this properly - I will introduce the Panel and the Chair. As the Chair, I am unimportant, but there are important people here and they are assembled already.

There are bits and bobs on how we will ask questions and how we will deal with that so you might want to have a little look at that, and then this is the bit that always makes me nervous: the feedback. There is a little bit that includes me at the top, and it's really important, it's really helpful for us if you are able to take this form which is on the hospital community health services, public meeting evaluation form, and just circle the numbers. Rate it out of 10 and perhaps give a few details on any thoughts or opinions you have. There are some little questions at the back as well; answer those. There are some spaces to give general comments, you don't have to, but that is really helpful. Be as detailed as you can.

We have a few minutes before we start, perhaps you can fill that in.

The other form that is dear to my heart, because you can see on my profile that I am a social science researcher, and I love this stuff the form; it's important so we know who we have spoken to during this consultation. It's important for a lot of perspectives not to be flippant. It's REALLY important. Tick the box. It's the usual things: post code, gender, age, religion and, ethnicity. If there is one you don't want to give, that is fine, but please do give it in. I will find out who you have to hand these things to by the time I speak to you in 10 minutes' time as I am not quite sure right now.

I think that is everything on your sheets. Okay? I will come back and speak to you in 10 minutes. Is that okay?

Right, I am not sure if I am on? Yes, I am live. I was saying the pre-amble there about going away for 5 minutes and seeing what people entered. People have sat down and are comfortable, and we are ready to start. Before we go any further, and I am saying this on behalf of Calderdale and Huddersfield, and Greater Huddersfield Clinical Commissioning Group and Calderdale CCG, a big thank you for coming along this evening. It's a great pleasure to see so many of you here on such a really important matter which we know is so dear to many people's hearts. There are a lot of passions in the room and different things people want to talk about and discuss around the proposals for this consultation.
So, first, as I say, a big thank you.

I will go through a few starter points. Welcome from the Chair. As I said I am Stephen Williams and I am part of the independent NHS Organisation. We have been brought in by the CCGs and the Trust to oversee the consultation, and to run these public events, and to take in all the information, all the feedback that you provide and that will all be fed into the report. So as I said at the beginning, everything tonight will be recorded; these microphones are recording and we have ladies typing and recording everything that is said as well so that will all form part of the consultation evidence. Any view that you have, any opinion you have, any question you have is really important and we want to hear that this evening. We are looking forward...

FROM THE FLOOR: Can you clarify which organisation you are from. Independent NHS?

CHAIR: Yes certainly. Yeah, yeah.
We are the commissioning support unit. There are a number of Commissioner support units across the country. We are on an approved list of suppliers to the NHS so there are a number of those, and some of those are within the NHS and some are private organisations external to the NHS: we are within the NHS, NHS organisation.

FROM THE FLOOR: (Inaudible – no microphone).

CHAIR: I am from the Midlands and Lancashire Commissioning Support Unit.

FROM THE FLOOR: Commissioning support units linked to the CCG?

STEVE OLLERTON: They provide some back office functions; a whole range of things.

FROM THE FLOOR: So you are linked to the CCG?

CHAIR: We are linked because we are an NHS organisation but they commission or purchase services.

FROM THE FLOOR: (Inaudible) provide support from the CCGs?

CHAIR: We are linked with the perspective or them purchasing from us; so, it is a transaction support. If you would like to discuss that after that is perfectly fine as I have colleagues that can talk to you in detail so if you put your hand up, someone can come over and discuss in great detail.

FROM THE FLOOR: (Inaudible – no microphone).

CHAIR: I don't know if you have heard of the Consultation Institute? They are private bodies and a totally different organisation, but we work closely with them and to make sure everything we do is within the requirement for all of the law and the rest of it. That is an important question, and if you want to discuss it more, please do.

Right, so, the structure this evening is that I will give this introduction I am giving now and then we will have a presentation that will cover the overall proposals on the consultation.

Now I know from lots of experience previously that there are some people in the room; there is a great spectrum of knowledge; some people have read all the various associated documents on the CCG website that

are available on this consultation. For some people they have seen things in the news papers or the news are whatever.

Presentation: this is a full presentation laying out the reasons for the change, the proposals and what they will look like and what the final proposal is for the reconfiguration, and that will be for about fifteen minutes, not too long. We want to hear from you guys, to hear from you and the floor. The way we will hear from the floor, and it's outlined in this document, we have ten number cards. So, I will say to you and I will talk about this in more detail but I will ask you to raise your hand and if you have a question and we'll give out these ten number cards and then we will go through the ten people. At the end of that group of ten, we'll give out the cards again, so as soon as we have given out number 1 and that is retrieved, put your hand up and I will explain again. Basically it's to get through as many questions as possible. We want as many of you to speak as possible. When we come over with a microphone, it will either be me or my colleague will come over, and we will hold the microphone for you. Don't worry about rattling it and reading the question; just think about what you want to say because we know it can be daunting for people. So, don't worry about that. We will hold the microphone. Say who you are and where you are from and what your question is. We are here to listen to what everybody has to say. We know that people will come along with stories of their own experiences, and we want to hear those, along with your own questions. That is what we will be doing.

Okay. There are lots of other events and I just want to highlight those now. This one we are going to ask a question and get an opinion but if you want a real in-depth conversation and some people want that, we go back and forward with a lot of answers. There are a lot of drop-in sessions that are taking place and you can find out more from Jenny who is at the back waving her hand right now.

The equality monitoring forms and evaluation forms: can you also give those to Jenny when you leave; she will keep them safe when you leave. If you have filled out your question or comment sheet also give that to Jenny at the back when you leave. I will give you a reminder at the end.

We are recording everything. We have BBC Look North here and a live Internet stream. It's a public meeting so therefore you might be on the television or on the live stream. If you don't like that, if you sit at the back then... (to member of the public: it's the way you are positioned; they will get you at the back of your head at the moment).

The next slide: who is doing my slides? Lovely.
So, I think, yes, so as you are aware toilets are at the back. Please use your mobile if you want to tweet or anything like that.

I will go to the next slide. Thank you very much.

As I have already said, these are opportunities for everybody to find out the facts. It's about taking the discussion further. You have seen things in the newspapers, on the television and read some documents and you have some thoughts and opinions and concerns; it's about now listening, so it is about having a direct conversation with CCGs and the Trust about your issues and thoughts and concerns.

On that note, everybody's opinion matters. So, when I come over to everybody and ask them what they want to say, that is fine; we want to hear that. In the heat of the moment it can be very passionate, so think how to express yourselves. There is a range of age groups here; it's not going to be a problem; but just think about that. One voice at a time and one opinion and then over to the Panel.

I will walk you through the Panel.

We have Dr Alan Brook, who is a Clinical Chair at Calderdale Clinical Commissioning Group.

Next we have Dr Matt Walsh - it's in order in here, fantastic - Chief Officer at Calderdale Clinical Commissioning Group.

Then we have Dr David Birkenhead, Consultant Microbiologist, who is the Medical Director at Calderdale and Huddersfield NHS Foundation Trust.

Here we have Dr Steve Ollerton, the Clinical Lead and Chair, Greater Huddersfield Clinical Commissioning Group.

We have Carol McKenna, the Chief Officer at Greater Huddersfield Clinical Commissioning Group.

Then we have Jo Middleton the Associate Director of Nursing at Calderdale and Huddersfield NHS Foundation Trust.

We have Owen Williams the Chief Executive Officer at Calderdale and Huddersfield NHS Foundation Trust.

If you don't know who the person is, refer to this (indicates), and that will help to guide you through.

So, I will hand over to Dr Alan Brook, who will give us a quick presentation).

ALAN BROOK: Okay thank you again everybody for coming tonight. We understand that the changes that have been put in front of you are quite significant and these are of understandable public interest and concern and so I'm first of all going to take you through the proposals in the consultation document which you should have a copy of available to you. And we will be very interested to hear your responses to that and answer any questions you have got. First of all we want to explain why we need to make such significant changes to the Health Service, explain why we think these things will improve the service's available.

We believe that the proposed changes in the document will ensure the future of health services locally in both Calderdale and Huddersfield; that they'll involve significant investment in both towns, far from cost-

cutting moves they'll involve very significant investment and create two state of the art hospital buildings. They'll build on the plans for care in the community or care close to home and ensure that hospitals meet national standards which are something they probably do not now and also make the hospital more attractive place to work and solve some of the manpower problems we face.

So the challenges we face: we put staffing at the top of that list, this initially may have appeared to be two years or so ago middle grade doctors on accident and emergency but it's expanded over that time and a shortage of consultants not just in accident and emergency but quite a number of other specialties in the hospital. The Trust and the hospital providers are trying to fill those gaps often at great expense with agency staff, but there are still gaps in the service that result from that and also we have got a problem with retention of experienced consultants. They are choosing to leave Calderdale and Huddersfield and can get more attractive work elsewhere.

We have got a growing, an ageing and changing population. We're not particularly any different to the rest of the country but people are living longer and living longer with more and more long-term conditions. Conditions when I started out as a junior doctor would have been quickly fatal you can now survive many years with and we get people with a number of complicated health conditions that they live with. We have got challenges in quality safety and patient experience so the quality of our hospitals, they don't meet the

standards set for a modern hospital in 2016. We know there are too many deaths occurring in our hospitals. People admitted too often to hospital and too many delays in getting them back out again.

Care closer to home is a great improvement to patient experience. We know people don't like going to hospital, one of the GPs says don't send me to hospital. We know people want services closer to where they live in a more accessible form. What we're consulting on is much, much more than what you may have read about initially about accident and emergency departments. We are talking about emergency and acute services. We're talking about urgent care services, and planned care services, they are operations which you can predict somebody is going to need and carried out but not urgently, and we have got paediatric or children's services, maternity services, and then our community health services the care closer to home. In the middle we have a map to remind you how relatively close together the 2 hospitals of Calderdale and Huddersfield are in proportion to the geography of the people that we serve.

So first thing I want to describe to you is what we mean by urgent and emergency care because urgent care services are really for those people who consider themselves to be the seriously ill but not life threatening conditions so it's something they need dealing with urgently and if you get a appointment with the GP but they understand it's not life threatening and these people make up one of the large groups currently attending hospital and emergency departments.

Emergency care is services for those people with much more life threatening conditions whether trauma, heart attacks, strokes, collapse, these are things which need much more specialised care so as we say on average 142,000 people visit one of our A&E departments every year. This distinction between urgent and emergency care is not something we have invented in Calderdale and Huddersfield. This is coming to the NHS around the country. It's known as the Keogh Review and they are now seen as an out dated old-fashioned model which has been in place for a very long time and needs to be replaced with a network of urgent care centres on at least as many sites as current accident and emergency departments and supported by a number of smaller emergency centres.

So it's proposed in the consultation that there will be urgent care centres on both hospital sites, these will be open 24 hours a day, 7 days a week and staffed by doctors and emergency nurses and will have access to most of the things you expect to be available if you go to A&E now. X-rays we know that 50 per cent of people attending casualty go there because they think they need an x-ray. They have injured a joint or bone and think they need an x-ray. That will be available at both of the urgent centres. Blood tests to identify serious conditions as well. So people will appear there probably who have more serious problems so these urgent care centres will also be properly equipped with resuscitation trolley, oxygen and means to sustain somebody who happens to be very ill and need to be transported elsewhere; the emergency centre will be open 24 hours a day 7 days a week and that will be

staffed by specialists and the specialists and acute emergency care. It's going to be fully equipped with all the essential diagnostic tests and be the place where your life will be saved if it's in serious risk.

So planned care is the other side of things and it's more common for people to have planned care than urgent care and this will be available at both of the hospital sites both Calderdale and Huddersfield. The majority of planned care is carried out as day care procedures but a few people do need to be kept in hospital afterwards and the brand new Acre Mill site is proposed to have 120 beds for people who need to recover after an operation. Now those beds will be protected because they will not be used as is often the case now for people who have got emergency conditions so that a lot of the interruptions that occur for planned care which is important to people if you have been waiting many months for a hip replacement, you don't want it to be delayed so these operations are much more likely to occur if they are occurring on a proper scheduled planned care site but those cases where patients are less well, where you can predict that they may need more facilities after an operation, after having complex operations which might require that support, they would have their planned operations at the acute site, that's where we're proposing Calderdale so that will carry out some of the planned care for those people at greatest risk.

Now paediatrics is something that we're particularly excited about in this proposal because what we have got at the moment falls well short of the national

standards. We're proposing that we have a specialist paediatric emergency centre, it will join again the current split between the children specialists the paediatricians based in Calderdale and the paediatric surgery which is carried out in Huddersfield and children will not be put in with adults in an emergency department, they will be receiving care in a department which is tailored to their needs rather than mixed in with the adult population so that is something we should have and don't have and under these proposals would have.

Maternity is something that we're proposing to change relatively little. Maternity was a subject of the last round and it provides us with evidence of the benefits of putting everything together on one site so the maternity under these proposals would remain at Calderdale, but women at risk would still be able to give birth either at Huddersfield or Calderdale and those who choose it will be able to have home births as well so maternity moving to a more community based service is very much part of these plans. There are also rarely but very importantly opportunities for the other general surgeons to be around when gynaecological and maternity proceedings are taking place because at the moment they are 5 miles away in Huddersfield so we're reuniting those 2 parts of a fragmented service. So the community service is closer to home. That's where we know patients want to be cared for if at all possible. The reason that they have to go to hospital is usually because the services are not provided in the community so it's very important part of this planned development to move services from hospital in to the community. We

have been up to now strengthening the existing services and putting in additional ones, there are important things like the team of nurses to support patients in nursing and residential homes with massive successes. We have got respiratory care nurses and people looking after people at end of life to enable them to end their days in their own home which is their choice so we have got quite a lot more of the community care services and the proposal is to move services currently in hospital out to the community to begin with.

So the proposals by location then as they stand as you see have seen, both Huddersfield and Calderdale will have an urgent care centre, as I said before that really should be seen certainly for the adult population to replicate most of the functions people see when they go by themselves to hospital. Both centres will have a midwife led maternity unit and both hoping to have more maternity care in the community and both have more community health services. Calderdale will be the emergency and acute care site and that's where an ambulance will take you it will not take you to the urgent care centre and Calderdale will have the paediatric emergency centre. A brand new hospital built at Acre Mill will be the planned care centre with 120 beds and 10 dedicated theatres.

There are other aspects we have learned from our engagement with people that we very much need to take in to consideration so thinking about everybody's travel needs, about people with disabilities and how what particular transport problems they may face but

making sure wherever possible transport meets their locations and looking at whether travel times and distances are challenging, seeing how this can work, more flexible appointment times, anything that seems to be a solution so we're setting up a travel group including patients to try and refine these proposals and adapt the travel needs. Ambulance travel is something flagged up by people already. I think we want to reiterate that when you're very seriously ill most important thing is when the ambulance arrives with you. Hospital effectively comes to you with the paramedic and ambulance and care starts there. Ambulances very rarely set off when they collect somebody in the community and they often don't go to the nearest hospital they go to the most appropriate hospital so if you have a heart attack here tonight you will be taken to Leeds, you'll not be taken to Calderdale and Huddersfield and there are a lot of examples like that where you're not taken to the nearest place. We believe thought that this would increase the journey time but that will be more than compensated by having all the right staff available to receive those people and start the necessary treatment when they come out of the ambulance.

So the alternatives we have considered as you see in the documentation set out with many different possible configurations but these are the final 3 we came down to, first one we have had in the emergency centre in Calderdale the planned care site on the Acre Mill site in Huddersfield adjacent to the infirmary and the other is Calderdale hospital as the planned care site and Huddersfield Royal Infirmary as the emergency centre.

Again both hospitals and both configurations will have an urgent care centre to deal with those people able to get themselves to hospital. The third option would have been to have limited or no change and we did an analysis of these various options against the number of criteria and you can certainly see that the no change one faired pretty badly on value for money, sustainability for the future, I think with the other hospitals locally and certainly didn't do quality of care. The choice between Calderdale and Huddersfield as the emergency centre does at the end of the day boil down to money. Huddersfield is an old hospital which requires a lot of work doing to it; Calderdale is an almost new hospital which is perfectly configured to be developed in to a fully fledged community hospital so expense wise the choice that we're promoting to you is to have the emergency centre at Calderdale.

Okay, then. So, that is the product of many senior doctors and nurses working together over quite a long period of time. That's what we have come up with and now it's over to you to see what you think of that and see if you think there is anything we have missed and anything else that we need to take in to account. So thank you very much.

CHAIR: Yes, thank you very much indeed. Right, okay, so I think you are aware of the documents in front of you and you might want to refer to those during the evening, and you know where you can get more information from. Let us have the next slide. Lovely.

Move on to questions now. Okay, so, if you would like to ask a question or make a point of view can you put your hand up and we'll give you a card. Whilst that is being done we'll kick off with a question we received beforehand and then we'll go straight over to you.

So this is a question from a member of the public who lives in Birtley, in Huddersfield: I understand that the size of the existing Huddersfield Royal Infirmary is owned by the Trust and therefore attracts annual rent. Therefore, why has this site not been considered for further development, and save the CCG a minimum sum of £622,000 per annum?

OWEN WILLIAMS: I am the Chief Executive of the Calderdale and Huddersfield NHS Foundation Trust and before I answer the question welcome to everybody; it's great to see so many people here. Hopefully we can have a good conversation this evening.

First of all in terms of the question, I am not quite sure it's accurate to say that we don't receive any annual rent, because, for example, as people may not know, if we take our renal facility, that is something we provide on behalf of Leeds teaching hospitals, so there will be some arrangements in there, and if some of you have had the opportunity to do a bit in Costa or had the opportunity to go to the Co-op pharmacy area, again those are arrangements that currently sit in that current Huddersfield Royal Infirmary site where there are arrangements, and there will be contributions made by those organisations for the utilisation of the HRI site. But to cut to the chase - and I was just whispering to

Jo, my nursing colleague to my right here - to give you an example, about a couple of weeks ago, the reality of the Huddersfield Royal Infirmary, a sewerage pipe burst and it caused two wards to closed and, on top of that, that is a theatre that is also effected, and what we are talking about is with the HRI site being a '50s building. The backlog we have had externally assessed; we estimate it is about a £100m backlog and that building has asbestos in it. If anybody wants, they can come and see what the fabric of that is like for real. I will do a personal tour. It's a real challenge doing a tour of that building which is 50 years old. If we are to think of rent opportunities, one of the things that people might want to rent from us may want to consider is it a building they want to provide services from? We are most definitely challenged by that building. In this conversation, I can see somebody muttering PFI because I am sure that will be discussed tonight. We have not had the same level and scrutiny of the Royal Huddersfield building; it's not fit for purpose, and, if we spend £100m, my understanding is the shelf-life of that building and spending that money together will only get us another 10 or 15 years shelf-life. So that is how I will respond to that initial question.

CHAIR: Thank you very much. We will go to the audience and the first person. Number one. Yes, madam?

FROM THE FLOOR: ---- It can take up to three or four weeks to get an appointment. If you plan to move more

services into the community, how do you know that the GP network will cope?

PANEL MEMBER: Will take that as Calderdale. One of the Commissioning Group's highest priorities is to improve access to GP services, and that is something which is a challenge. The GP workforce is difficult to recruit; the GP workforce is ageing. I can say that as an ageing GP. And, a lot of the current people working in general practice are coming up to retirement age, so we can't suddenly produce a lot of GPs.

I think, certainly, we need to make Calderdale a more attractive place for GPs to work as well because Calderdale has a net loss of GPs and we train quite a lot of GPs to work elsewhere and they certainly have part of a better functioning health service locally. One of the knock-on benefits will be the general practice is also a better place to work: more attractive for people, and to give more available appointments. But we agree people need to have better access to their GP.

CHAIR: Would you like to come back on that at all? Okay. Number two?

FROM THE FLOOR: My name is Terry. Will the CCG release the information as being omitted from the consultation document?

CHAIR: Which information do you feel is omitted?

FROM THE FLOOR: There is nothing on travel times: nothing on the 10,000 additional ambulance travel times. There is no financial, if any, financial information at all. That is just a sample.

CHAIR: Okay, Panel?

PANEL MEMBER: To give a brief response, it's not a case of information being omitted, actually. I know a lot of you have taken time to look at some of the other documents that have led up to the consultation, on the consultation document. You have looked at the pre-consultation business case that the CCG has published and also the 5-year strategic plan. A lot of the data information is in there in terms of our travel analysis and impact on Ambulance Services. In addition to that, at JOSC we have an opportunity to have more detailed information. We meet in Halifax next Tuesday so we are answering questions on those all the time and on the information sessions I have been asked, we have been asked, on some of the questions and whether we are in a position to answer them and whether we are in a position to do so. Equally, we know we have to do more work as part of the full business process; we are quite honest about that as well. There is no attempt to hide any information.

CHAIR: Would you like to come back on that at all?

FROM THE FLOOR: That seems like the horse before the cart; we can't consult with you unless you tell us the information. How will we deal with ambulance times? How will we deal with, what, already, the Trust that is struggling with ambulances?

PANEL MEMBER: I think what I would say is that there is a dialogue established with the Ambulance Trust and we are working closely with the Ambulance Trust. We understand the impact of the proposals in terms of increased journey numbers and increased journey times, and we'll manage, as we move through consultation, we will come to conclusions about the right services. We'll manage the consultation of the Ambulance Service to ensure that there is the right capacity and skill to support the model of care. We have a commitment from the Ambulance Service who will work closely with us on that, as Carol says. So there is a level of detail we can only describe clearly and, once we have consulted on the proposals, we are consulting upon, and what the model of care needs to be, we will get into negotiations and discussions with Ambulance Services and other providers about delivering that.

OWEN WILLIAMS: It's just a request to say that this consultation process goes on until June. If you have specific questions that you feel that are not being answered, use this opportunity to get those questions written down, because we have to give you a response,

and it's a "We" not just a CCGs response - it's CCGs; it's the Trust. So, what I would say to you is if you feel there are gaps, then please make sure you write those questions down so that we can do all that we can to give you a response. It might be that we have to say on some occasions that we don't know but we will try our hardest to give you a response.

PANEL MEMBER: Terry, as Carol said at the Joint Health and Scrutiny that will be on Tuesday, and we will discuss that. We have the ambulance and people there and they are coming to Halifax on Tuesday and they will explain where the figure of 10,000 hours has come from; we didn't dream it up, but it's come from real work done on travel times. So, we will see you on Tuesday.

CHAIR: Thank you very much. I will walk around to number 3.

FROM THE FLOOR: Just another point - (microphone reference) - can I ask Mr Owen: you say "Ask questions at the consultation". I have asked questions and they have all been referred to freedom of information. "We will get back to you". I have had a 4-week wait to any questions I have asked.

OWEN WILLIAMS: I would urge you to put your questions through. I am surprised if all your responses have been FOI-type responses. I think as Steve just

illustrated, we are about to have a discussion about one of the points you talked about and that seems freedom of information-ish from my perspective. Just keep going, because we are duty bound.

CHAIR: I know that people have perhaps more than one question, and there are a lot of people to get around, but I aim to get around as many as possible. Please remember to hand in your sheet at the end; it's going around again.

FROM THE FLOOR: I am Amanda and a service user - although I would prefer 'patient' actually. Given the news today that A and E are reaching all-time record levels, and shortage of staff is at an all-time high, how will the model being proposed get the required staff in? And can they guarantee a full supply to child and adult A and E and family care?

DAVID BIRKENHEAD: At the moment we have currently about ten A and E consultants split between the two sites: we have ten middle grade doctors, so not doctors in training, but we have some real challenges in terms of staffing both our A and E departments. I think, clearly, by centralising that resource into one site, into one A and E, it will give us the ability to provide those Doctors over more hours over the week. There is a standard that says we should have 14 hours for consultant presence on A and E, 7 days a week, and we

can't meet that at the moment. So, that is a real challenge for us.

In terms of there being a national shortage of emergency care doctors: we don't feel it's the complete answer, but we think it will make our job more attractive because we have colleagues leaving because of the pressures of work they are facing. On call makes sure the services are covered, so if we go to a single A and E we think the numbers will be covered, but I can't give you the answer to the problem we have got which is a national shortage. There will be more resilience in the service, I think, by moving that resource together.

STEVE OLLERTON: An additional thing to add: currently the GP out of hours service runs entirely separate to the urgent hospitals and our intention is to actually move those to be working as part of the urgent care centre. So, that is an extra work force that will join in to deal with urgent care in both patches.

FROM THE FLOOR: Are you suddenly finding money to staff all proposals within the capacity?

DAVID BIRKENHEAD: At the moment we have sufficient money in our budget to employ 14 A and E consultants. We are trying to do so but we can't appoint those 14. At the moment we have got a number of colleagues leaving A and E because of some of the challenges they

are facing at the moment. We know the A and E in particular, the service, is not fit for purpose; not big enough. The resuscitation facilities are not adequate and we don't have adequate paediatric services at the Huddersfield A and E, so there is a lot of reasons why colleagues are leaving.

We have more money in the budget if we could find the doctors. I think what we are putting forward would move things forward and attract new doctors and keep the ones we have got.
Number 4, please?

FROM THE FLOOR: I am David and I come from Stainland. I wanted to know where we can find the risk assessment with regard to the possibility, or not, of increased patient deaths, which is related to closure of one of the A and E's, particularly the Huddersfield one. I can't find this on the website; it's not any where.

MATT WALSH: There is an Equality Impact Assessment as part of the pre-consultation business case that would contain, I think, the information you are seeking and that is available on the Right Care, Right Time, Right Place Website.

CHAIR: Do you want to come back on that?

FROM THE FLOOR: No. I will look for that. Fine; I am satisfied.

CHAIR: Number 5. Excuse me.

FROM THE FLOOR: Tony Wilkinson from Halifax. I have watched the process of this Consultation and the proposals for a change over a number of years and been amazed in the way in which the PR exercise has caused so much worry in Calderdale but, as we approach the end of the process, I really can say that what I am finding is that I have been reassured with the process and the more you hear about it, the more you think about it, and the better becomes the proposal, and a better solution to the problems that have been faced. So I do congratulate you on that in actual fact, but I am not always going to.

But, as far as the specific question goes, it is a: a simple one. You have the planned care being moved to Huddersfield and this will create travel problems, not of any urgency but for patients and for their visitors.

What have you done about liaising with public transport authorities to improve the public access to the travel across?

ALAN BROOK: Certainly we have had discussions that have shown us that the Local Authority/Local Authorities are both planning major road improvements to the A 629 both initially and on the Calderdale side at Ainley Top up to the Hospital but also with similar improvements now planned for the Huddersfield side.

There is an openness to consider by the Local Authority to actually work with the providers of public transport to be a bit more imaginative in the services they provide: it's things that are directly under the control of the health service, but we are working in very good constructive partnership with the Local Authority and I am confident they will do what they can to improve these public transport services as well.

CHAIR: Do you want to put further comments, sir?

FROM THE FLOOR: No. I will leave it at that.

CHAIR: Number 6, please. Coming over. Thank you.

FROM THE FLOOR: I am Carol and I live in Todmorden. My question is about the outlying areas. There was not a lot of detail in your very general introduction; perhaps we should not have expected it, but I am concerned that urgent care centres for minor injuries won't take the pressure off the A and E services which are being cut. And, as I understand, there are a number of staff cuts that you have targeted over the next 5 years. I am thinking about Todmorden health centre. I had thought that it was going to be utilised as a minor injuries unit but I have heard, and perhaps you can correct me here, that it's not going to be a minor injuries unit now in Huddersfield; you have Holmfirth; will they have access, and so where will the minor injuries unit be? And can

you guarantee us that they will take pressure off the A and E services, which I assume that is what they are supposed to do?

MATT WALSH: I will take the question in relation to Todmorden and some of the general overviews. Steve you might want to...?

FROM THE FLOOR: Can you speak up please?

MATT WALSH: Sorry. Can you hear me?

FROM THE FLOOR: A bit louder.

MATT WALSH: It's a little difficult with these things. Okay. I will try and project as well. Is that better?

So, in terms of the Todmorden development, it's not right that we are not planning to develop or enhance the services there. But we made a deliberate decision not to weave this into the consultation. There is a separate process going on in the Upper Calderdale Valley, which is part of the conversation around the vanguard. You may have heard about the vanguard initiative: it is a national initiative we have been successful in securing some engagement in Calderdale, and part of that conversation is how we develop the Todmorden health centre to deliver a wider range of services including testing out whether we can enhance

the GP out of hours and GP emergency service in that building. So, that is still part of our plans.

In terms of taking pressure off the emergency department, the role of emergency, sorry, the urgent care centres: you are right; it's not simply reframing in that way. We are expecting to be able to change how our system is working. It's the connection between that and the work that we are doing in care closer to home to enhance community services, and to move some of those services out of a hospital setting, focusing on how we are managing people with long term conditions. Many of the people who need to go to an accident and emergency centre are there because they have their long term conditions management, which is not really excellent.

As part of this, as part of enhancing our approach to community services, we are expecting, and can demonstrate now, some improvement in terms of the experience of people with long term conditions that will reduce their emergency presentation. So it's the whole combination of initiatives that we are talking about that we think we need to begin to reduce pressure.

STEVE OLLERTON: If I can to add that Matt, certainly in that part of the proposals we're looking at totally redesigning the urgent care system and we want the 111, we want people to use that service more to phone 111 to get their advice and from there they will be booked in to the urgent care centre but if it's during the working week they will be able to book directly in to GP surgeries so I think people will access care in a totally

different way. We're not trying to shift 140,000 people and stick them in Urgent care centres. Granted some of them will still go there but I think people will access urgent care in a totally different way. I live in Denby Dale but I would be expecting 111 would be able to provide a service. If I've got life threatening problems it will be Calderdale but there will be other options available and that may be in GP surgeries themselves.

JO MIDDLETON: I'm Jo, the nurse on the Panel and from the Todmorden perspective in some of our care homes in Todmorden for the patients and residents that live in Ashby Hall who travel to A&E it is not the best thing for them. We have got 2 of our nurses that go in there twice a week and help the staff to put plans in place so actually they don't get to the point where they need to come to the A&E they don't need their GP on many occasions and they work with home staff and the ripple effect is that the care home staff are skilled up as well now so they are starting to recognise signs of illness and it's thinking about how we can do things differently so that everybody has knowledge and skills to go forward to help them do some of that impact as well. Ashby Hall is a good example where it can work well.

DAVID BIRKENHEAD: Can I add to that point. We're predicting 50% of the people currently attending A&E could be seen in urgent care centres. I think that will provide more time for the emergency care consultants and I hope it will get better outcomes as a result of that.

FROM THE FLOOR: Are there specific areas, have you decided where they are going to be?

DAVID BIRKENHEAD: There will be urgent care centres on Both the Calderdale Royal hospital site and the current site of the Huddersfield Royal.

CHAIR: Number 7.

FROM THE FLOOR: Thank you very much. My name is (inaudible). I was a consultant paediatrician and really I find it extremely difficult for me on a personal level to ask the question and make comments because obviously with my wonderful colleagues on the panel either I work with them together or we work for the same normal ends and serving the people in Calderdale and Huddersfield so I apologise if I have totally different view.

I hope you have good heart to listen and hear to my comments. My colleagues I think I have to disagree with you on this occasion because you are totally wrong and you have no (inaudible) at all. The proposal has been put forward is seriously compromising the health and welfare of the people of not only Huddersfield and not only headline is the people of Huddersfield and A&E but in fact the people of Calderdale and will be serious consequences of the life and welfare of people of both areas and they have many, many examples and the time limitation and limited number to ask but if I start with the initial comments made kindly by my wonderful colleague Alan Brook with the proposes why we're proposing the CCG

comments but all the reason which have been met for this proposal are either being self made and make it difficult to A&E in the trust to work or being put because the people have agreed to previous proposal which we impose on the people and I will tell you many, many examples. For example, my colleague commented that the financial pressure. We know that people of this area disagree with the Calderdale hospital because of the cost of 60 million and now £700 million is completely the wrong thing so it's not fair for the people to pay their life and children and love people because they pay the consequences and financial pressure. Other point I would say my comment in paediatrics because I know children's services at the moment anyone on the panel could tell me now how many hours you have to go and wait in the corridor to be seen in the children ward? It's really very, very long so I don't know what is the capacity, where is the capacity to bring the children from Huddersfield area to Calderdale area to be treated and that is really for the quality and safety which my colleague up there will be seriously compromised, you might say you know you have put it very close papers here and the right care at the right time but this is a spend, this is just you know propaganda. I know the reality is not right, I know the reality is different because the people will bring their children in the back of their car and in the back seat to the nearest hospital. You might say that the 111 will be notified or ambulance will be notified to bring them to the emergency in Calderdale but the reality is different. In reality they'll bring them to the nearest place. I've seen it myself. Not only the newspaper and TV I have

seen it myself children do die and suffer serious consequences because they are not treated where they are locally living. I know the people of Huddersfield deserve a proper well founded well staffed like David mentioned to care for 250,000 people living in Huddersfield and the people of Calderdale deserve nothing less than proper need built to serve the people in Calderdale. You are massaging the argument and try to put a picture, I'm sorry this is the worst scenario coming to the people. The people living here almost half a million people deserve something better than this and I hope you will join us together in (inaudible) (applause).

CHAIR: Okay, can we respond to that, thank you.

OWEN WILLIAMS: I'll take that. First of all living proof because there have been a few times when people have said is there a 3 line whip involved in here or suppression of people's views. If ever you wanted a reality about people being given the opportunity to have their say there you have got it. I think it's really, really important that we keep with that reality because these services they don't belong to me or anybody on this panel, they belong to all of us and it's absolutely right that we should all have our say. I think the reality is though and you know it's a reality is that if we leave this building right now and go back to work we aren't providing the care we would want to are we? That's the reality. So these proposals don't come because we think everything is okay and we can stay as we are. We know that we're not providing the level of care we'd want to or at this moment in time if it was my mother or

family in there we know we can do better and that's why we're all here and that's why we need your points of view and we need your passion in terms of where we're going. Paediatrics we have talked about that.

FROM THE FLOOR: For one hour.

OWEN WILLIAMS: You could couldn't you. The reality is that you know the quality of care we provide in paediatrics at this moment doesn't meet national standards.

FROM THE FLOOR: But we have made it this way.

OWEN WILLIAMS: Again we could say we have made it this way, I'm not sure I subscribe to that because part of what you talked about is finances.

FROM THE FLOOR: I have no time or I could go full...

FROM THE FLOOR: Can you use the microphone please?

CHAIR: Can we wait for the panel to respond and we will come back to you.

OWEN WILLIAMS: Again you have talked about paediatrics and you know we're not at the national standards you say we've self imposed ourselves below national standards. I'm not sure I recognise that so perhaps if you get an opportunity you could explain a little bit further how you think we have manoeuvered ourselves in to this position.

On the answer to whether this spin is rhetoric or untrue, this is why we're having the conversation now so that people can put their alternative points of view because there is nobody on the panel here who would say we're dogmatically stuck where we are at this moment in time but I made the point earlier, the proposals we're talking about here, the likes of Jo, David, Mark as well as GP colleagues, those pieces of work, what we're talking about here in terms of the clinical case for change has come from them. It's not come from people like me; it's come from people like yourself who are doctors, nurses and therapists so I'm not quite sure where we go. You talk about we could be here for an hour but please make sure that every single concern you have got and also any ideas about what you think we could do better, I'm begging you please make sure you get them written down so that we have to respond.

CHAIR: Any more comments from the Panel?

ALAN BROOK: I think we would certainly invite people to the information sessions. They are an opportunity to spend quite a long time if necessary with one of the proposers of these changes and for you to make your point and listen to a detailed explanation of why we have arrived at the conclusions we have. It's difficult to do it justice in this quick question and answer session so those sessions can provide you with a different more detailed 1 to 1 opportunity.

STEVE OLLERTON: I've got one brief point as well if that's okay. Because the in patient paediatrics is at Calderdale at the moment over 3 quarters of children

who arrive at our hospitals at the moment go to Calderdale that's currently happening because that's where the sickest children are going at the moment.

FROM THE FLOOR: Sorry, my friend, but between you and me personally, we know what is happening; I have seen it my eyes. I don't think you have been in A&E in a long time; I have been there and seen it. They need a specialist skills to handle those children coming to A&E they need specialist person to look after them. They need good vision to assess them and transfer

STEVE OLLERTON: And we can't do that in 2 hospitals. We can only do it in one.

NEW SPEAKER: That's why I'm saying the proposals are (inaudible) the local people paying for the bad things being put in, not blaming individual and all those wonderful people, wonderful individuals they are not existing here but we're paying the people, paying the consequences of your decision. Like for example configuration and they put the plan and the reality is imposed and no one can have any say about it. It is for them to deal with the negative things.

CHAIR: Okay I think we're going to move on thank you very much. Number 8.

FROM THE FLOOR: My name is Andy I'm also from Todmorden. Number 6 has of course stolen my question. Number 7 is unfathomable so I do ask another question. Sort of elephant in the room really it's political, I want to know how much of the required

£22 billion required in efficiency savings by the government is being provided by this reorganisation?

MATT WALSH: So this - sorry so, I'm interested in your use of the phrase efficiency savings because that's not what we're talking about here. We're talking about financial gap, national financial gap in terms of our funding arrangements and the costs of running services in the way of they being run at the moment back in effectively how that gap is constructed and you're right that one of the purposes in the conversation we're having with you tonight and the purpose of the consultation is to enable us to reframe our services so that they can operate within the resources we have available to us. That's not savings it's about not spending money we haven't got and won't have. So our share of that gap is about £300 million.

CHAIR: Would you like to come back on that?

FROM THE FLOOR: Efficiency savings is an expression the Chancellor uses a lot and I thought it would have filtered up to the NHS but may be a different language is being spoken in the NHS which we're not talking about.

MATT WALSH: I think that might be fair.

CHAIR: Number 9: they are having issues; I'm hearing this on-line so can I ask the panel to speak as if you're speaking in front of a large audience like this so they can hear you. If you speak like this - we need you to be speaking like this (indicates). So, number 9.

FROM THE FLOOR: Colin from Halifax. On many occasions in Both hospitals are full of patients, planning on reducing of the overall number of beds by 70 in the trust and you're also planning on separating 120 beds on to a remote site so that they can be used to maintain the flow of patients having routine operations, like hip replacements and knee replacements. By doing that you remove the flexibility of the hospital to deal with the peaks and troughs of emergencies that are going to occur, going to get the A&E departments full of patients, ambulances backing up and ambulances being diverted to surrounding hospitals which are all having the same reductions of beds and same reduction of capacity. What you say will convince me this is a good thing to do, well, like the removal of that flexibility and to respond to variation. There are other considerations with separating this group of patients, you will be removing them from the part of the hospital that has the facilities to deal with them if an unexpected complication in their treatment should occur or if they should have a heart attack or go in to kidney failure. The free standing elective care unit will not be in a position to treat them; you're building in inefficiencies that you're going to have to duplicate a lot of expensive equipment and staff rotas to help maintain those 2 separate units. So I understand the idea of maintaining elective patients but I'm sure that this will be to the detriment of those patients that need urgent care and need that as an in-patient?

CHAIR: The Panel?

OWEN WILLIAMS: If I go first Colin and if it's okay if I can refer to the fact that I know you and then David and possibly Jo because it will be good to get all 3 perspectives from the team. It's an interesting one Colin what you talk about there because if I remember back to December 2012 and you had black ice Friday and you were with the Trust that day you remember we had this real sort of spirit because we dealt with somewhere in the region of 800 attendances across both sites which is probably at least 100 per cent more than we'd normally get on a typical day and there was a lot of work done by colleagues. People came in left right and centre to provide local people with the care they needed and I think we did a good job. One of the realities is that we had to cancel quite significant numbers of elected or planned care and there were some people expecting appointments who three months, four months later, their appointment still hadn't been done so there is - I can't say there is a perfect answer to part of what you're saying here but part of the reality is that we are going to have to find - we try to find a way of thinking that can deal with the reality you're talking about, the acute care real need but how can we do it in a way that we can maintain the planned care people would expect and you don't have the consequence we have now which is if you have severity in one it impacts on the other. You know it's not a perfect answer I'm giving you and you know that ideally in a world if we had a single site and everything came on to that single site that would be the utopia perhaps clinically that people would want. But there is the reality and it was on the slides there about value for

money or efficiency. You know, there are other factors that play a part like a PFI like £100 million backlog but that's not the central point of this conversation, to which you're talking about, and I will not hide the fact, but the central part you are talking about is there is a balance we have to come through because you talk about duplication of equipment, but we have diagnostic equipment across both sides, as you know, and it's thin at this time, but I think we get other perspectives because it's important we get a clinical view on this.

DAVID BIRKENHEAD: Colin, you are right, most clinicians and doctors and nurses would prefer having a single site hospital, but in the current financial climate we don't think that is possible and we don't think other sites are big enough to accommodate that. In terms of the 120-bed plan at the Huddersfield site, those patients will be selected; we will not require them to require urgent medical care. Having said that, there will be doctors on site should the need arise to give them that care. If there is an on-going need, we will transfer them to the Calderdale Royal site, and look at new facilities, if that is necessary. So it's a compromised position.

Let us be clear: the model we have at the moment is also a very compromised position. We are transferring 10 patients a day, sometimes in emergency situations, and you could say the expertise is not available, from where they are currently housed. So it's a compromise, but it's a better compromise than the one we have at the moment.

FROM THE FLOOR: Pre-operative assessments, unless they involve a critical are not fully (inaudible word), but for most people managing clinical risk, means trying to manage it out of the system, not to try and make judgements that minimise it... There are continued judgements. I do feel that given with the NHS costs, the cost of running it is 50% of that cost with staff, and running two units and the additional staff that it requires, which is going to be a continued drain on the budget and may well lead to these facilities not being viable in the future.

JO MIDDLETON: Can I say something. You talked about the reduction in beds: I have been lucky; I have been an A and E Matron and I am sat in the surgical division now.

One of the things we used to see a lot, and still seeing a lot in the A and E departments, is people being admitted into our beds by locums, than say for example, by Mark, if he was working, they are quite risk adverse and don't know what is happening in the communities. So, from using capacity we know that sometimes people are admitted into beds that don't probably need to come into hospital. But, that that could be due to the quality of the hospital staff that want to keep them in just in case.

From a right care, right place perspective – and I know it sounds like a strap line - but from a quality perspective, if we get the right patients looked after by the right nurses, the length of stay would be significantly lower. We have medical patients in

surgical beds: it makes a difference in terms of length of stay.

I have sat on the other side recently where we had to use one of our elective wards to look after medical patients. I personally made those phone calls to patients who put their lives on hold for their operation, and it's absolutely heart-breaking to make that phone call to tell them their operation was cancelled.

We are managing, but we have to think about doing things differently. We can't expect to have the same volume. We have to do the stuff in the community. We can't keep on solving the volumes, so we need to think about the other things and how we can manage it differently. You know, I don't want to keep making those phone calls to people; it's not pleasant.

CHAIR: Thank you. Just to remind everybody we have given out the first set of 10, and we have given out the set of 10 again.

It's twenty five past seven so we want to get through the first set of 10, so bear that in mind when you are giving your answers.

FROM THE FLOOR: I am Neil and I am from Halifax.

Mortality rates have risen higher than the national average in this area. Do you think the particular compromise of proposed changes to hospital services in Calderdale and Greater Huddersfield will impact in reducing mortality rates? If so, why?

CHAIR: Thank you very much.

DAVID BIRKENHEAD: I will take that. Okay, I very much hope they will impact positively on reducing mortality rates but it's very difficult to be sure because we don't really know why our mortality rates have been rising in comparison with other organisations. We have done a lot of work trying to understand that. We have been reviewing many of the deaths that occur in our hospital to try and find out whether we could have cared for those patients better and if there is any learning from that. I think some of the learning we are getting from that is that we are going to transfer patients in an emergency situation between the two sites. Occasionally we have patients going to the wrong site for their initial care, and therefore we get delays in their on-going care. An instance might be strokes. If you had a stroke, the stroke unit is based in Calderdale at the moment so if you arrive in Huddersfield you have a delay in your care. By pulling all those services together, we are being able to deliver senior consultant presence across all the specialities on one site which will reduce the duty of care and mortality.

There is a local example I will give you: there could be a very serious condition may be where you perforate your intestine and need an emergency operation. That is currently done on the Huddersfield Royal site. We have centralised those services on that site and brought together two teams of surgeons into one. So we have ten surgeons now working together. They changed the way they work so there is always a

consultant surgeon on call, so if you need an operation at one o'clock on a Sunday morning you will get that and you will have a consultant surgeon doing it. They have halved their mortality rates from about 12% which is about the national average to 6. So, a very significant reduction.

Talking to those surgeons: could they have done that if they were still split across the two sites? They tell me they could not because there were enough surgeons to deliver. So that is one example where pulling services together has made significant reductions in mortality and improved patient outcome.

CHAIR: Okay, Sir, do you want a brief comment back?

FROM THE FLOOR: Very briefly, will there be any independent audit to look at the impact of the changes of the mortality rates, and if they have had any beneficial or any serious effect?

DAVID BIRKENHEAD: We report routinely nationally already and you will have probably have seen, that looks at mortality... so it's higher than it should be. So, that is already looked at nationally and reported nationally. That will continue. We look at services as well. We have had the CQC inspecting and they may do further inspections in the future if they are concerned the mortality rates do not reduce.

FROM THE FLOOR: (No microphone)

CHAIR: We need to move on to the next set so everybody gets to speak.

Number one. Thank you very much; that is coming over.

FROM THE FLOOR: Can everybody hear me? I have a bit of a throat. I am from Barnsley. I am representing Barnsley save our NHS and we work with our local Barnsley CCG, and recently we are working with LMC as well. Both these organisations are concerned that your decision will put Barnsley hospital at risk.

Now national changes have required what they call silly foot prints. Barnsley hospital is in the north of the South Yorkshire and Chesterfield foot print.

We have maternity services which are now over-crowded, and since you moved here, I have that direct from the doctors who work in that service.

Barnsley hospital struggles now. The A and E was built for 80 attendances a day. The last Annual Report reported, I think, said 210 or 215 a day. It's now well over 250 a day. And we are being told that GP practices in the south of Huddersfield tell people to go to Barnsley hospital now, and it looks that is already happening. But because we are an outlying hospital in quite a large area, which has ones that are not so struggling as ours is, it's quite likely ours will be closed because it will not be financially viable now looking at

the cost improvement programme, efficiency savings or budget cuts; they have to spend less than they used to.

PANEL MEMBER: We talked about the impact. One of the things we have emphasised is we want to hear from the organisations as part of the consultation; it's not just about people living in the area that are to respond. If other organisations outside think they want to respond then...

We have met with colleagues and I have met with my opposite number on Barnsley CCG and a colleague from the Barnsley Foundation Trust as well. As proposals were starting to develop, so we were well aware of the work that was going on. Then we had the initial meeting when we had still not concluded where our proposals might land in terms of a preferred site for planned and unplanned care. But when that information became clear, they were briefed fully on that, and in the same way we have done with a number of others.

It's worth noting, as alluded, at the moment some people are choosing to go to Barnsley, looking at any more planned care, and that is because patient choice exists. Some people that live in the south of Huddersfield area and go to practices like Steve in Skelmanthorpe have been choosing for some time to go to Barnsley. There will be no change to patient choice under proposals that would continue to happen. But I think one of the things you were hinting at is that Barnsley, like a number of organisations, has financial

challenges and you may be suggesting if more patients go there they add to the financial challenge.

The system: it works if more patients from other areas go to other hospitals; the money follows them, so it's not that the people are being treated for nothing, for want of a better phrase. So that is built into the system. So, we will continue to talk to Barnsley as neighbours, and we will re-iterate we would be happy to hear from them about the consultation formally.

CHAIR: Is that okay?

PANEL MEMBER: We have a contract with Barnsley, and if the numbers of maternity or the numbers of A and E are going up, we have a conversation and increase the level of contracts. As I say, we have to buy hospital services for all our population. If they go to Barnsley, that is where we pay for it.

CHAIR: Just very briefly, because a lot to get through.

FROM THE FLOOR: It's about safety of services and meeting the targets emergency care need to meet because our hospital is old. It's under staffed. All the problems are the same nationally and you are not alone with problems you face.

CHAIR: Okay thank you very much. Sir? I have got it.

FROM THE FLOOR: Right, I just want to add one thing on what this lady has just said. I have been following all these proposals for quite some time now. Recently, Dr Ollerton was interviewed, as the examiner, and asked if his family have used HRI, which is planned to close down. Curiously he had only used A&E twice and that was at Pinderfields, so I found that remarkable he could even sit on a panel wanting to close down different hospitals when he and his family ever want to use; that is not my question.

STEVE OLLERTON: Can I respond to it? As luck would have it, not as luck would have it: my son had a nasty accident on a trampoline and I had to use HRI and the service was fantastic.

FROM THE FLOOR: In June 2014, there was a preferred option to the changes that Calderdale would lose its A&E, and Calderdale and Huddersfield protested strongly. To date there have been 7000 signatures and door to door petitions and a walk through Halifax was attended by several hundred residents. Calderdale council and local MPs also protested strongly that the hospital should keep its A&E.

It was said by the NHS at that time ... the waiting times for patients were too long and the hospital services were poor and mortality well above the national high, and complaints were high, and needed a changed.

In 2016 a document was released for a business plan for the changes and it mentioned Halifax and Calderdale residents had made it very clear that they didn't want to loose their A&E; and that was noted on page 36 of that document.

Immediately following this release, the Calderdale Royal Hospital planned the hospital in favour of HRI. Media pressure released by Calderdale leader Tim Swift said "It can show what can be achieved by local council and local people working together; we can make a difference".

What is your question, Sir? I am concerned about time. If we move to your question, that would be fantastic.

FROM THE FLOOR: Because of the acknowledgement in the business case, Calderdale people are now becoming concerned that Huddersfield has since got a 60,000 on-line petition with 30,000 to 50,000 paper petition and 7,000 people plus demonstrating in the town centre with a March.

Looking at the influence of the CCGs on the people of Calderdale, a decision was caused by local people's wishes on what now Calderdale people should be concerned; such a vast amount of people in Kirklees demonstrated that it is going to influence the CCG.

ALAN BROOK: I can assure that you that the change in the preferred option was not influenced by any pressure brought to bear on either of the CCGs. We knew from the time that the preferred option was declared to be

Huddersfield about 2 years ago that the finances had not been worked out. That was a gap in the proposal and it was very provisional so throughout last summer senior doctors and nurses got together to develop a clinical model which did not determine which site had the acute hospital. We put a lot of work in to designing a model which would work whether the acute site was Calderdale or Huddersfield, completely unbiased and completely open. It was only when the financial position became more clear when we had external agencies such as the financial regulator monitor, accountants by the trust that we started to understand that the Huddersfield option was going to be much less financially sustainable than having Calderdale as the acute site so it would not be as a result of lobbying on our part, I could claim credit for having won the emergency centre back for Calderdale, that would be completely untrue. Nobody at the CCG campaigned on that and we always had in mind the clinical model was independent of site and the most important factor throughout all of this is to put all the services back together again in to a proper integrated service with all the pressures available on one site. Mr. Hutchinson has also described his support for a single site it's just that he doesn't want the separate elected care site so there is strong doctor and nurse commitment to the provision of a single site; the choice of which one it is always going to be difficult but hasn't been influenced by any other pressure or any of the clinicians either in the hospital or CCGs.

STEVE OLLERTON: I wanted to add it was designed for the whole population.

CHAIR: We're going to move on because of the time we have only got 20 minutes to go. We will finish the questions.

FROM THE FLOOR: I'm a Calderdale resident. I want to say 12 questions before mine I don't believe have been sufficiently answered if I'm honest. My question is when the maternity services were reconfigured we'd be assured no babies would be born on the bypass. We were not aware of any births on the transfer. I know it's not true as we have been approached with people where the birth certificates state that the child is born on the Elland bypass. Can we assume that the promise of no deaths on the bypass is false as well? (Applause)

ALAN BROOK: I think we will struggle with that question without anybody here from maternity but the question which was specifically answered was, was there any births in ambulances because the babies were transferred from the midwife led unit to the Calderdale site? That was the question and he wasn't aware of any. If people are in their own vehicles that's another thing altogether.

CHAIR: Question 4 please.

FROM THE FLOOR: Russell Dawson and I live in Mytholmroyd. I want to ask the savings of £300 million is a lot of money. A few hundred or thousand here and there, £300 million without affecting the service I think is impossible. What is going to happen is that you'll have more stress and strain on the people working in the NHS. As it is nursing is the most stressful job in the

country. You have said that you can't fill posts already. If you're expecting the savings to be put on the extra effort of the staff who are already grossly over worked you'll end up with a bigger crisis of people not being able to stand the strain any longer. They'll leave the NHS in droves. You get those sorts of servants on the back of the work force. It needs more money from the government to pay. (Applause)

CHAIR: Thank you very much. Can we allow the panel to respond to that?

STEVE OLLERTON: I welcome that comment, the thing is that we have said that parts of these proposals are to make working lives for the staff in the hospital better because of all of the reasons you just said. Certainly not doing anything is not going to do that but yes we are continually lobbying up the need for more investment in the NHS and that's why I applaud your comment.

CAROL MCKENNA: Many people said earlier but this is about not spending more money than we have so I think people could go away thinking what we're planning to do is spend less money than we do now which is not the case. The challenge we have the NHS and thinking about the system in Calderdale and Huddersfield the money we get is not sufficient to keep pace with the increasing demand in inflation and all the things coming in to the NHS so to deal with a lot of those issues we need to change the way which services are delivered. So it's important to understand this is about trying to make sure we don't get in to more debt rather than

saying we're planning to spend less than we currently do.

CHAIR: Okay. Question 5 anyone have number 5? Okay, number 6?

FROM THE FLOOR: On paragraph 2 of your form you're actually saying you're trying to ensure that the services will be high quality, safe sustainable and affordable. Yet these proposals are not sustainable. You're going to end up with a 9.5 million ongoing deficit. When will the Trust and CCG and Monitor deal with this? Monitor has said the 419 million you want to lend on loan is eye-watering and they have never had this size of loan before so there is no plan B is there?

CHAIR: Thank you very much.

OWEN WILLIAMS: Yes, I mean there is a plan B and it's kind of what's happening now and the reality is now if you take - whether it's our broader health economy, you know the combination of what CCGs spend is what we as a trust spend on behalf of local people, there is a reality if you go up and down this country they are all financially challenged and this links back to the previous question. We're in a world that we haven't been in before and it goes back to the point my colleague Carol talked about the situation where even if the pot of money you can spend on behalf of local people to provide their care stays the same we have the reality where we know people are living longer and so on and so forth. So there are some real challenges I think that sit within that and what we're trying to do

here - and I've been dying to say this really - is that sometimes it's easy to look at us and somehow think we're sat here kind of not feeling some of the same things you're talking about, and I was glad Steve clapped - not making a political point - but making the point that we all feel very passionate about the services that we're involved in providing and. I know it's not the question, but I'm trying to get to the point that sometimes you can come to a dialogue like this and somehow think there is a them and us and I don't think there is a them and us and in terms of the gap that gap is what it is. We get to a 5 year position and actually there is a £9 million gap. If you go on a couple of years the working model takes us in to a surplus but there are so many things, so many things that could happen because it's a 5-year plan, but there are so many things that could happen to shift those numbers either way, it's very difficult. What we do know is the country at the moment if you talk about providers such as Calderdale and Huddersfield NHS Trust, the bill, that overspend we're looking at this moment in time is £2.8 billion nationally. That is serious. There is some seismic shift in the way care is provided and its affordability. I don't gain political points on that except the doctors, nurses, therapist I work with live that reality. This plan is not going to solve all the issues we have, we have around equality or finance but it's better than the situation we're in today.

CHAIR: Think you very much. Question 7, please.

FROM THE FLOOR: Good evening my name is Hilary I was born in Halifax 76 years ago and spent many

decades there but I'm now from Huddersfield where I've lived for the last 35 years. I've spoken to so many people, friends, neighbours; lots of people in Huddersfield about these proposals and their biggest worry and the thing that causes great upset they say it's just a done deal. Why should we go to meetings and protest and try and change things it's probably a done deal. I'm aware of the 5 year sustainability; I know you're involved in the 5 year sustainability and transformation plan; apparently this has to be agreed some time in the next year or so. Well that might be the reason for some of these things but my question is this; assuming all these questions go through and after your consultation you decide this is the way forward, where are the finances coming from for this new hospital in Huddersfield? We're told it's built on the Acre Mill site and I found out from the reading of the Examiner weeks ago we're paying huge amount of rent for the out-patient services on the Acre Mill site. If the new hospital is built on the PFI basis we will be saddled with debt in years to come which is not sensible so where is the funding coming from when the present hospital is demolished and selling the present HRI site to generate income, where are the people in Huddersfield going to get hospital services in the meantime because it might take 5 years plus for a new hospital to be commissioned, contracts finalised and so on, what do people in Huddersfield do when they don't have a hospital?

CHAIR: Thank you very much.

OWEN WILLIAMS: If I can deal with the second part first. So as a part of and let's just assume that we get to a consultation and the clinical commissioning groups feel they're in a position to recommend something to the joint overview and scrutiny committee's of the authorities because that's where this process goes and there is a plan then that runs forward; one of the requirements we will have to satisfy them is an even much more detailed business case and one of the things integral to that is the transition. How do you move from the state you currently provide care now to the model of care you'd aspire to provide in the future and you need a real clear milestone detailed plan about how you can do that with mitigation and keeping patient risk to an absolute minimum so that's part of what we would be expected to do. I'm trying to recall the second part - first part of the question now. Is it a done deal? Well again I don't want to speak on behalf of all colleagues here who have their own views but my feeling of working with this group of people for quite some time is that there is a lot of humbleness and humility across this group and if there are better ideas out there than this proposition this group of people will take those views on board and so far as possible will try and work them in so you can be of no doubt this consultation is real. What I've been saying to people, don't just take the opportunity to say no, take the opportunity to say what else? What else could we do? And it's in that spirit I say to you it's not a done deal but at the same time we need as many views as possible to get to the shape of views to get behind.

CHAIR: Can I ask you to respond to the other question around the cost and where the money is coming from?

OWEN WILLIAMS: There is likely to be 3 potential sources around where the funding will come from. One the Department of Health if it's satisfied that we have gone through all the right process and minded to get behind it will have a conversation with Treasury and one of the options could be that they'll look to fund this from the capital pot that sits between the Department of Health and Treasury. That would be one option. I expect there will be repayments required for that so some sort of loan feature of that but the capital would potentially come from the Department of Health. One of the other options is that they give the Trust or system, the health economy, the borrowing limits okay to be able to get the capital, perhaps on markets or through whichever loan mechanism and what the Department would do is fund what would be the annual payments of that, so that's another way things could be arranged. I'm going to say the final thing that could happen and I say it with a very straight face, that there could be the opportunity of what is called PFI2.

(Booing from the floor)

OWEN WILLIAMS: I say it because there is a new and advanced way of doing PFIs now which are called PFI2s and one of the things we could be required to do is go down that route. It's highly unlikely that any of those 3 options that that decision will be a decision taken by this group of people here. It is quite likely that decision will be determined centrally.

CHAIR: Someone asked what is PFI?

OWEN WILLIAMS: Private finance initiative. Effectively if you look at the private finance initiative that we have got at this moment in time, effectively that is a relationship between a whole set of financial organisations some of which are banking institutions some of which are builders and developers and they come together with a proposition which says for a certain amount of rent or mortgage over a period of time you'll receive back these services. Currently at the moment in time we have a PFI which currently costs us per annum £10 million. Now immediately people might think £10 million what do we get for that? One of the examples is the total cost I think and Keith the finance director will nod or shake his head when I say this, one of the realities for us in terms of repairs et cetera on the Calderdale site is that in the last financial year I think we spent about £300,000. Now that's quite a small sum if you think about the whole physical site. Now last reason why it's at that level is because of what the PFI brings over a longer period of time. I'll say now for avoidance of doubt, I'm not a PFI advocate but I'm one of the groups who have to deal with PFI. It is very, very complex. If you Google it you'll get several different versions of what it is. But PFI2 is the new arrangement that the government is trying to push public sector towards if such arrangement is required.

NEW SPEAKER: PFI is 20 million not 10 million.

CHAIR: If we could stick with this lady over here please.

FROM THE FLOOR: What happens between the decision to knock down the old hospital because you need funding from the sale of the grounds and when a new hospital will be finally built and commissioned? What happens?

OWEN WILLIAMS: That's what I talked about when I talked about the transition plan so part of one of the requirements whoever we're dealing with, the Department of Health, will be to have a clear transition plan which will also be how is it funded and where will the funding come from and our expectations will be any funding requirements will be worked through with our regulator and also the Department of Health. So there is no way that that would occur or the transition of services would occur without us having a robust business plan for that transition. That's what I'm trying to give you some sort of assurance. I can't articulate that out to you because we don't know what we will end up with at the end of the consultation process.

ALAN BROOK: There is another point here Owen which is contrary to what a lot of us would assume the sale of the land that HRI currently sits on is only going to generate a modest amount of income particularly after the old hospital is demolished and asbestos removed. It will involve a very small amount of money and that's not something that would contribute towards the new proposals so that hospital would almost certainly be left standing until it's no longer needed.

CHAIR: So it's 8 o'clock, I think we're going to finish the last couple of questions so it's question 8 now.

FROM THE FLOOR: I am Jamie from Brighouse. With the approval of the people in the audience here, I would like to propose that the A and E at Huddersfield remains attached to a new hospital. Right? It's currently - that is not going to happen. But I propose to this Panel that that would meet the approval of everybody else, and that is certainly something I think should happen.

I am questioning an awful lot of what I have heard tonight for the last 25 years. There has been a dramatic shortage of staff, so how can you talk about reduced staff in the NHS for the last 25 years? We have new proposals and a lot of talk about the value of money but no talk of human lives.

FROM THE FLOOR: Absolutely. (Applause)

FROM THE FLOOR: I was going to say, also, that, it could be that you have to meet again soon because, as I understand it, there is a report due out very shortly from the Care Quality Commission who have inspected Kirklees and Calderdale Foundation Trust, as I understand it. But, I would like to ask: why was it on those inspections? Just about every department was fully-staffed. That is a contradiction to the day-to-day running of the hospitals concerned. What have people to hide from? Why not have the existing staff that are normally there when there is an inspection so, when it's

reported that there is a shortage of staff; why not? Why cover up the inspection by making certain all the places in the hospitals are fully staffed? It impresses people and it gives the wrong information.

OWEN WILLIAMS: Me and Jo will have a fight here to answer that one. All I can say is it's factually incorrect. We had a junior doctors' strike, so even if we want to go down the route, that was not the case.

Jo's response?

JO MIDDLETON: From a nursing staff perspective we are required nationally to report our nursing staff figures. Every single day we have to talk about what we have planned and who is actually on duty. There is no difference between the inspection between the CQC and the (inaudible) inspection, and I can guarantee it, as the Associate Director of Nursing from my division, that I scrutinise every day the staff and we work across the sites and look at the departments to say they are safe; and we move people with the most need. There was no change in practice for the inspection. I can guarantee that, if we tried to, that what we said to the staff is it is business as usual. Certainly from a CQC perspective, that was as much as about them telling us if our services are not right, and if we are not delivering a quality service, we absolutely want to know about it.

FROM THE FLOOR: There is a dramatic shortage of staff in the local hospitals, isn't there?

JO MIDDLETON: We are struggling with recruiting nurses; it's a national problem.

FROM THE FLOOR: But if you struggle now with another hospital and everything else, how will you make it work?

JO MIDDLETON: Equally, if we recruit nurses - there is an awful lot of time and effort going into our recruiting practices. We are not managing to recruit nurses at the moment because of the pressures of the A and E Department, and I think that is the highest I have known it since working at the Trust. Some of that is because the nursing staff are just not coping with the pressures. Some of those pressures include when they are working with doctors and it's night time and they are not feeling supported, and people are leaving for a number of reasons.

One of the things from my perspective, the nursing perspective, is if we create a high quality service, then people want to come and come to where high quality is delivered. We want to recruit the staff and recruit more staff definitely.

FROM THE FLOOR: What about the A and E proposed at

Huddersfield? With more people living longer from 74, there is going to be more elderly people going to need A and E.

PANEL MEMBER: Alan explained in his presentation at the beginning: a modern emergency centre has to have the backing behind it, and has to have the emergency surgery and intensive care unit. It's not just about having an A and E Department. For all the reasons we have said, we are failing to provide a high quality of service duplicated on two sites, and we want an emergency centre on one site to concentrate all the acute services in one hospital.

So, you know, it's not just about the A and E department. It has to have so much stuff behind it. That is why we are struggling to do that on two sites.

FROM THE FLOOR: Why is there no (inaudible) presence tonight?

PANEL MEMBER: We have.

FROM THE FLOOR: The Secretary of State should have been here because he is your boss.

FROM THE FLOOR: I agree with that!

STEVE OLLERTON: And we all like him.

CHAIR: Let us move on. Thank you very much, Sir. Number 9.

FROM THE FLOOR: I live in Halifax and the first thing to say is it's good to be here at this Meeting.

My question: why can't pregnant women stay in hospital a few days longer after giving birth?

OWEN WILLIAMS: I will defer that one to David.

DAVID BIRKENHEAD: I don't know (Laughter). I don't know I can give you an answer to that. I think most pregnant women, once they have delivered they are quite happy to go home and, when they are happy to do so, we have to release space for other ladies to give birth. We do not have sufficient space when they are well enough to go home.

PANEL MEMBER: I wonder if there is a conversation we could have after we have finished actually, to get underneath the question? Because there may be some personal experience that you have got that might help us understand a bit more why you are asking the question. I would be very happy to talk to you after the meeting. Okay, Sir?

STEVE OLLERTON: From a personal point of view having had three children in the last 10 years, I was itching to get them out of hospital as soon as possibly could. I didn't have the baby (Laughter), but you know

my wife and children, we were all there 12 hours and it was 'Let's get out of here'. But that is a personal thing. We had no complications and no need to be there. If you have had a Caesarean section and complications, you need to stay on the ward and some people do.

PANEL MEMBER: ...I think the point is that hospital is not a safe place to be, so you don't want to unnecessarily be in hospital. There is a risk of significant infections in hospital. Also, when you have given birth, women may have blood clots, so obstetrics aim for the women to get back home and back to activities as quickly as possible.

CHAIR: Question 10.

FROM THE FLOOR: Chris Day from Luddendenfoot area.

Nationally there has been talk of (figure/inaudible); the sort of cuts we are talking about. It's an enormous amount of money; it's a very large amount of money. The new hospital was at about 150m. Is it still the case that it's still 150m? It's a lot of money, 50% of your estimate for repairs that we obviously need to look at carefully. But will the Government fund this? What guarantees are there? The Government is interested in privatisation, selling the hospital off... the brand new hospital as a loss... The Government, the NHS, the A&E has a massive PFI there of £10m a year, I think it is. I can't remember now. Any way, that is PFI debt. Then

they use that as an excuse to move the hospital to Leeds. Local jobs go with that and it fits the positives very well. Then, move to an American health-based care system. Very few hospitals or NHS care only for half the population.

Now those are the sort of things we are talking about over 5 years. Can you give us you assurance on that? I know we are all in this together in a way and I know a lot of people on the Panel are sincerely trying to maintain the health service. But, have you thought through some of the ideas and are you sure your advisors are giving you the best political advice?

PANEL MEMBER: I don't recognise from those manifestos that have been shared but, all I can say, as I have mentioned to you, the Key-hole proposals and the national plans for reconfiguration of emergency and medical care, and our proposals fit that so consistently that we stand as much chance as anywhere of getting the resources invested because we are almost perfectly sure of the plans that are being given to us.

So, we don't have any guarantees but, so far as we can tell, what we are proposing is completely consistent within the direction of travel that we are being asked to seek.

OWEN WILLIAMS: Just a couple of things: just to follow on with what Alan had to say, one thing that everybody up here are concerned with, including doctors, nurses therapists etc, is making sure that given the context that you just set out there, is what the future might look

like, and the finances, that this part of West Yorkshire does have services provided to the highest standard that local people can expect because what you have just outlined there is if we remain passive as a community into the future, and just let things happen in and around us, we could find ourselves in a situation where actually some of the opportunity we have got now to at least shape some of our future destiny gets taken out of our hands for all sorts of reasons: may be financial, national and so forth.

So, if there is one point I would build on the back of and to re-iterate on what I said earlier, there is very much a shared space, I think, between this Panel and everybody sat out there today that we are REALLY passionate about making sure that there are good quality services left particularly in this part of West Yorkshire. If there is one thing I could add, and ask you to think about, we are VERY passionate about the populations that we serve, and we want to do our best to do something about it.

I wonder if your question 5 might have been down here (Indicates). I want to check it not been missed.

CHAIR: We are doing two more final questions. Okay?

FROM THE FLOOR: I have to get on the stage. My name is Bernard and I am the Chairperson of Calderdale Deaf Association. I am here in my capacity as Chairperson. Lots of Deaf people have been contacting me about all the issues at the hospital, about the lack

of interpreting contract that is going through at the moment. We have not heard anything. Last August, lots of Deaf people went over to Calderdale hospital and we talked and fought for our rights about interpreting services so that we can access all these new places and services you are talking about here tonight.

I would like to know what is happening about the interpreting contract for Deaf people in Calderdale and Huddersfield. It is important so that we can actually - sorry I can't read my writing; it's a bit far away - so we can come to the hospital and communicate with staff and have access to the services that you're proposing to provide.

So that's my question for this evening. (Applause).

OWEN WILLIAMS: I think from my point of view - I will just wait until you are set up there - are you okay?

INTERPRETER: I am okay.

OWEN WILLIAMS: Quite happy to take the question to see what we can do and just get some feedback.

CHAIR: Okay we have one final question at the back.

FROM THE FLOOR: Sorry, can we just say that nobody ever contacts us! And it took us to come to this public meeting to get an answer; it's difficult.

OWEN WILLIAMS: We'll look at that.

FROM THE FLOOR: Okay, thank you.

CHAIR: Yes, thank you very much.

We'll move on to the final question.

FROM THE FLOOR: I understand the A and E staff are hard to recruit due to the constraints involved. How do you propose to attract sufficient good quality staff to support an A&E hospital if services are separated as proposed?

JO MIDDLETON: Certainly, in Huddersfield, we train our practice nurse practitioners. I will see if Mark wants to chip-in here. We have nurses with advance skills that can assess X-rays and look for broken bones and minor treatments, and those kinds of things. We have good training posts and retention, and as I understand it, Mark, we do not have a problem with recruitment and retention of the work nurse practitioners. But the problem we have at the moment is the junior staff nurses, and some of that is because we are diluting our senior nurses across two departments. If you are running a department, if I am looking to staff an emergency department, I want to know that not only are the numbers right, but we have the skill mix right, so that we have the right number of senior nurses to support the right number of junior nurses. We are trying

to have senior nurses on two sites, and that is causing problems with the training and development opportunities they need. So, we think that is more attractive because we will have emergencies where we can have the right doctors and the right nurses with the right skills and expertise that can supervise some of our junior staff so we can help them in emergency services and so they don't feel they want to leave and go somewhere else.

Would you add anything else, Mark? Sorry, Mark Davies is our consultant.

NEW SPEAKER: I am Mark Davies and I am the Clinical Director for community care. I find that staff that work on a daily basis struggle doing the job that they didn't want to do, and what they really want to do is the ER-type emergency medicine; it's the really sick people. That is why people go into emergency medicine. But because of the way our service is set up at the moment, we see all sorts of urgent care as well as emergency care, and by centralising emergency services on to one site, then we'll make our jobs more attractive to those staff to
and by working on one site in one big department again it makes it a much more attractive post so that's why we think it will make recruitment better.

CHAIR: Any further comments? Ladies and gentlemen I'd like to thank you very much for coming this evening. Thank you very much for impressing the panel - I know a lot of you have. I would like to thank the panel very

much for the answers, what I would say this is not the end of the discussion on the debate, you have got this leaflet on your seat, if you look at that there is a drop-in information centre this Saturday so if you wish to go along and I'm not sure whether the panel will be there but I know sometimes they are, you can explore these issues in more detail. Before you all leave I would like to say can you please drop in your question paper to Jenny at the back and also your equalities monitoring form, question cards put them in here, comment cards put them in here, comment and question cards I think that was it, equalities monitoring and also within the brochure you have, within this here is the consultation questionnaire so take that away, read through this in far more detail and fill that in and drop it back. I think there is a free postal address and you can do it on-line as well. It will be read and make their way into final consultation report. I think that covers everything so I'll say thank you very much for coming good night and safe journey home.

(End)