6 June 2016

John Smith Stadium

Huddersfield

CHAIR: Good evening, Ladies and Gentlemen. On behalf of the NHS Calderdale and the Greater Huddersfield Clinical Commissioning Groups and the Calderdale and Huddersfield Foundation Trust I would like to welcome you to this public meeting to discuss the future of the Services in the area.

I am Richard Horsman and your Chair for this evening. My day job is training journalists at Leeds Trinity University. Those with long memories may recall that I was involved in local radio with the original Pennine Radio and The Pulse in the eighties and nineties and more involved with the teaching side of things.

The theme for tonight really, I think, is going to be about communication and listening.

We have got 8 people on the Panel here. These are the people who are going to be making decisions about the future of something we all care passionately about.

So, I would like you to give them a fair hearing and I would like you, when you are making your observations, I want to get through 26 questions if we can in the course of this evening.

Let me tell you that there have been some 173 questions submitted and I have worked as an independent observer with members of the communications team whittling those down into a number of themes. We have picked exampled questions from each of those themes: I can't think of a fairer way of doing that. We have done the best we can in the circumstances.

What we are going to do is to ask you that when your make your points, please keep everything as brief as possible, and then we can get through as much information in the course of this meeting as possible.

The most important people here tonight are yourselves; the people of Kirklees and Calderdale that will be affected and, on the Panel,

we have the people that are making those decisions on your behalf.

I would like the Panel to introduce themselves starting with Steve Ollerton.

DR STEVE OLLERTON: Hello I am Dr Steve Ollerton, and I am the Chair of Greater Huddersfield CCG and a GP at Skelmanthorpe.

NEW SPEAKER: I am Dr Alan Brook and a GP in Brighouse, and the Chair of Calderdale Clinical Commissioning Group.

NEW SPEAKER: Hello, I am Carol McKenna and I am Chief Officer for Greater Huddersfield Clinical Commissioning Group.

NEW SPEAKER: Hello, I am Matt Walsh, Chief Officer, Calderdale Clinical Commissioning Group.

NEW SPEAKER: I am Owen Williams and the Chief Executive Officer of Calderdale and Huddersfield NHS Foundation Trust.

NEW SPEAKER: Hello, I am Dr David Hughes and I work in Holmfirth where I have been a GP for the last 29 years, and I am on the Greater Huddersfield CCG and their urgent care board.

NEW SPEAKER: I am Dr Mark Davies, a Consultant at Calderdale and Huddersfield NHS Foundation Trust.

NEW SPEAKER: Hello, I am Jo Middleton and I am a nurse, and my job at the moment is I am an Associate Director of Nursing across Calderdale and Huddersfield.

CHAIR: The Panel will remain where they are to answer the questions with all the logistics and camera angles and what is going on there.

I would like to invite the Panel to make a brief presentation.

FROM THE FLOOR: The speakers are not heard at this side of the room (Indicates). I think there is a fault with the PA. (Applause).

FROM THE FLOOR: It's not very good.

NEW SPEAKER: Can you hear me? (Sound test)

DR STEVE OLLERTON: Can you hear us over there?

FROM THE FLOOR: Can hear them outside. (Laughter).

FROM THE FLOOR: (Repeated).

DR STEVE OLLERTON: Okay, right. Thank you for that. Right, let me grab – oh, hang on. Okay. I will start off and hand over to David our urgent care lead, and then hand over to Carol.

I apologise for those that have heard me speak before but we have to assume there are people in the audience that have not heard this, so we will go through our proposed changes once again.

At the top of our changes we want to fundamentally improve the way that the urgent and emergency and planned care services are done in Huddersfield and Calderdale. That's mainly looking to the future, because we feel our hospitals in their current configuration are not heading in the right direction and we need to improve that. That involves some fundamental change rather than keep going along the current path. This will involve significant investment in hospitals at both sites, significantly in Huddersfield where there is a new proposed hospital: two state of the art buildings. We are intending to build on plans for our community, and I have heard about people's concerns close to home and we have taken them on board; we know we must get care at home working; I have heard that loud clear.

We must make sure hospitals meet national standards and we know that staff have been leaving the hospitals in the last year or two, and they have not been happy with the care they have been given.

So, part of our proposals is to make sure that Calderdale and Huddersfield Trust is an attractive place to work. Whenever people say "Why are you doing this?" these are the 4 reasons and I would add quality, safety and patient experience at the top of this list; that is why we started this process. We know that there is growing age and population; people need more health care, and we need to address that.

Finally, there are financial pressures and we can't deny those but that needs to be addressed. So those are the 4 main things.

I will now hand you to David to talk more about the proposed changes.

DR DAVID HUGHES: (Microphone reference).
So, next: you will see that there are 6 separate boxes there which are the different areas that we are consulting on, and you will note that not one of them has the word A and E in it and that is because we are talking about an entirely new model about how we are actually going to provide urgent and emergency care over the patch as well as a new planned care centre.

Next slide: firstly urgent care centres where at least 60% of people that are seen in an A and E department don't need the services of a specialist hospital, so we are proposing a walk-in service, an urgent care centre in both towns and that will be directly accessible by the public and directly bookable for those that decide to ring 111 and those that are directed there.

The second bit is the emergency centre: this is the key. At the moment we are in a situation where we have two A and E departments in neighbouring towns and the acute services such as medicine, surgery, trauma etc are split between the two different sites. An emergency centre will have all the acute services on one site, supporting an emergency department. Now the emergency department will be the new A and E which is where people are taken with life-threatening illnesses by ambulance or sent by their GP; there would be departments that are needed to work effectively so medicine, surgery, paediatrics, trauma etc, and then all the investigatory services like physio will be on the same site and the coordination of that means the sum is greater than the parts.

Specifically there will be a paediatric emergency centre and this is new national guidance that states that actually children should be seen in a separate place and should be able to seen by other paediatric specialists when they are seriously ill as this enables this to happen. At the moment we have the rather daft situation where a GP - well, if I see a child with abdominal pain and think they might have appendicitis or another specific problem, then they may go to a hospital where there is no on-site paediatrician and this means all these services are co-ordinated on one site.

Planned care: at the moment people will have experienced operations that have been cancelled. A lot of the time that is because the bed that was going to be used for their surgery is taken up by somebody that has been admitted as an emergency. This means we will have a planned care hospital, state of the art, 10 brand new operating theatres and 120 beds that will provide much higher quality and that means that the planned surgery will be planned in a safer way.

The maternity services: they will stay as they are at the moment with the midwife-led unit in Huddersfield and a midwife-led unit in Huddersfield and consultant-led unit in Huddersfield.

Community services: we are in a very early stage of the care closer to home debate where we are hoping to move increasing numbers of services away from the hospital to...

FROM THE FLOOR: (Interjection). Privatisation. (Applause).

DR DAVID HUGHES: If you would like to listen. I come from a family who all work - if you don't want to listen, that is fine.

What is urgent care? I was going to say as far as privatisation is concerned, you will not find a better advocate for the NHS than me.

So, urgent and emergency care, which is what most of the debate seems to be around: urgent care is for illnesses where you can't wait for a routine GP appointment. These will continue to be provided in both towns.

Emergency centre, as I said, is for potentially life-threatening conditions where people may need to be admitted to hospital and coordinating these services on one site will improve outcomes and reduce lengths of stay and probably long-stay admissions.

Urgent care centres: these will be open 24/7; that is 365 days a year, and staffed by doctors and emergency nurses, and they will have access to x-ray facilities, consultant advice through telemedicine to the urgent centre and resuscitation equipment as well.

The emergency centre: as I have outlined, is also open 24/7; it's all the acute services around it, so that includes all the acute medical and surgical departments.

Finally, proposals: I use the term advisedly, by location, so Huddersfield and Calderdale will both have an urgent care centre and both have a mid-wife maternity unit and day and out-patients. We are looking for community health-based services on both sides.

In Calderdale we are proposing that is the site for the emergency and acute care and the paediatric emergency centre, and in Huddersfield we are proposing the new planned care centre.

I will hand over. Thank you for listening.

CAROL McKENNA: I will carry to the final part of the presentation.

What we have been asked a lot about in the Consultation is looking at 'how many alternatives did you consider'? So we'll say a little more about this as the evening goes on, but to pick up on a couple of points at this point: what we did was, and I think it's really important to emphasise this, is we started with the clinical model.

We have talked in a number of cases why things can't remain the same, and why the clinical model needed to change if services remain safe and high quality into the future. So, our clinicians and the CCGs, along with clinicians in the Foundation Trust, looked at what the clinical model should be like and how it should be designed. This piece of work was first, before any work was done about what services end up in which town, and the clinical model was designed in such a way that it could work either way around.

So, I wanted to get that out there and looked at first, so to look at the outcomes and benefits for patients. It involved clinicians from the hospitals and both CCGs. We needed to look how to deliver that model. What services would you divide across the two sites?

We started with 11 options. They ranged from very little change to more radical reconfiguration than we are talking about tonight. So, if you have had a chance to look at any of the detail on the 11 options, some of the things are looking at centralising all the services in one town for example, and so we also looked at the option around the new build single site hospital which I know a

number of you have asked us about. We narrowed them down. There was a variety of reasons as to why we could not take forward all 11, and we focused on 3 and we put those against each 5 criteria and that is the option that we are consulting you on tonight.

The 3 options up there - it is a bit of a busy slide -but as you look at it, the option one has the emergency centre and associated services in Huddersfield, with the Acre Mill site in Huddersfield being a purpose-built hospital dedicated to planned care, and that is the option we are consulting on.

The second option: that is the opposite way around. That is one that we gave serious consideration to, and in both options both hospitals would have a 24/7 urgent care centre.

The third option we explored more fully was limited: no change.

We narrowed those from the original 11 we started with.
So those are the criteria we looked at. Those that have looked at the Consultation Document will have seen that. You will see down the left-hand side there is the 5 criteria, and you will see that what most people tell us the most important thing in all of this is maintaining quality of care, and safety is paramount.

You will see limited or no option is the one out of the three that we have not delivered so in effect that meant that is not an appropriate way forward.

As you will look at when you see the other two options between the emergency centre in Calderdale and the emergency centre in Huddersfield, you will see that where the difference lay was in value for money in terms of the costliness of the options.

FROM THE FLOOR: It's all about the money.

CAROL McKENNA: To be clear, to be clear, the reasons for change, the reasons for change, is where the need is to be to maintain safe services and the clinical model came first. (Heckle from the Floor).
Thank you. (Applause). All right. Thank you. If I can just keep going, as this is the final slide.

FROM THE FLOOR: (Inaudible) (no microphone).

CAROL McKENNA: I am happy to say more about that. Value for money there means - sorry sir, do you mind? - to answer this lady's point, please.

FROM THE FLOOR: Let us listen.

CAROL McKENNA: Value for money means actually accepting that you get the same outcomes either way depending on whether or not you centralise urgent and planned services on either town. You then have to work out what it would cost in order to make that happen. And when we worked out what it would cost, how much money we would have to ask the Treasury for, what it means is…

FROM THE FLOOR: (Heckle from the Floor).

CAROL McKENNA: That is where the difference lay; so in recognising the straightened financial circumstances that are we in, it's highly unlikely that anybody will give us more money to do the more expensive option. So that is what we meant by value for money.

As we have gone through the Consultation exercise we are picking up from meetings like this and drop-in sessions we have got, and what people's concerns are.

So those are the themes up there, and I will not try and answer those now, but the questions we ask tonight are the main themes coming through. So I want to give you reassurance that we will be addressing all those issues.

I think that is the last thing from me (reference to Powerpoint: just keep that up for a bit), to remind you of the Website and how to get involved.

I will hand you back to Richard.

CHAIR: I think we want to get straight into the meat of it, if you like, to address the questions that you have been asking.

A number of you will have questions that you have got on yellow cards that you will be reading out. One or two people have asked me to ask a question on their behalf and that's the case with the first one that came from Kate Lowe.

Yes, Kate at the back is asking: if the plans do go ahead, what order are you going to do it in? I presume you are going to be extending Halifax, building the car parks, building the new HRI before closing the old one, and knocking it down?

The question with that is what happens if you don't get the money? (Applause).

CAROL McKENNA: Can I just say - did somebody ask the question over there (indicates), so I know roughly who I am looking at?

I will answer the last part first, if I may. The question is ‘what happens if we don't get the money’?

If a decision is taken that the clinical model is the right one, and we want to pursue but the money is not forthcoming, then clearly if we have not got the money then the capital changes that need to happen could not be done, so we could not progress with those changes. However, what we have to look at, and colleagues in the Trust look at it as any alternative sources of funding, is to look to the Treasury. So we would need to look at alternative options for that funding if it's not available through the Treasury route.

Just to answer this lady's question coming to turn to the first part of the question about the order: that piece of work will be done after any decision is taken because we will need to do a full business case, and part of that is setting out the further work that needs to be done before any changes could be made. It is looking at the key milestones on the route to that change. We have not done that piece of work; just now that part is the car parks or what you would knock down, that would be further down the line.

CHAIR: Are you satisfied with that answer? Anything you would like to come back with? She is happy with that one. (General laughter).

CHAIR: There are lots of questions to cover tonight and we'll work through them as best we can. So I would like - nobody can hear you there, unfortunately.

On to our next question: can we have a microphone here please? (Indicates).

FROM THE FLOOR: I think I can shout loud enough.

CHAIR: We'll bring you the microphone.

FROM THE FLOOR: On Radio Leeds this morning you said it was a done deal any way. Yes, you did. My husband heard it as well. Why are we here tonight? God alone knows. It's already sorted out.

FROM THE FLOOR: It's not a done deal. No way. No way. (Applause)

CHAIR: There are a lot of issues we want to cover, and that indeed is one of them.

PANEL MEMBER: I can answer that. I spoke to Liz Green and emphasized that the decision on the Consultation would not take place until October, and that we had been speaking to people, although we had yet to hear anything particularly that undermined our existing...
(Laughter) (Heckle from the Floor). (Applause).

PANEL MEMBER: But the responses to the Consultation would be analysed from the 4-month period from June 21st, and on the basis of that we would make our decision.

FROM THE FLOOR: You have already made your decision.

PANEL MEMBER: We have not yet heard anything that changes the fundamental basis on which we make… (Heckle from the Floor).

CHAIR: Okay. So, now I would like to invite Lee Wilson to ask a question. Would you like to take the microphone?

FROM THE FLOOR: It's very similar to what you have just said. Tell us anything that does not underline your argument: it's flawed in so many places (Applause). It's not just in the way you are putting it across. You are losing people and you have very few friends in this room as a starting point. I am not wishing to say that to be funny or clever.

The first question: is this genuinely a Consultation?

FROM THE FLOOR: No!

Q. Is it a genuine Consultation? (Repeated).

CHAIR: I am most certain it is.

FROM THE FLOOR: Just a yes or no.

PANEL MEMBER: I have said yes.

FROM THE FLOOR: So a Consultation is a two-way thing where the people in authority have the expertise, as yours, who are no doubt clinicians, you listen to people, and effectively we are your patients and you should listen to us. It's not just your decision. Okay? You listen; two-way. So, if it is a Consultation and you have agreed it is, then if it is two-way, which I hope you agree it is, my next and final question is for everybody in this room: please put your hand up if you agree with the proposal being put forward by the CCG. (Applause) (Very few indications in the audience).

CHAIR: Okay.

FROM THE FLOOR: The Chancellor said ‘patients first’.

PANEL MEMBER: Can I come back to that. It's absolutely fair challenge it's absolutely fair question. You need to know that we have heard what you're saying and - no, no, so...

NEW SPEAKER: With an open mind?

PANEL MEMBER: With an open mind to an extent. Listen, there are some limits.

NEW SPEAKER: You are our representatives.

PANEL MEMBER: So the limit to the clinicians involved in this conversation and involved in designing the clinical models that they need to believe that they can deliver something better for you so the basis upon which this model is being put forward is that it's the model can deal with something that is better, is safer than the situation we have got - just as just let me finish, just as we need to listen to you, my personal commitment in this is that you'll see the concerns you have raised are articulated really clearly in any final business case that comes forward what you have put in to the

consultation and we will describe how we're taking account of that and shaping our plans to respond to that. But the bottom line is that clinicians involved in this process need to be able to be confident they can do something safe for you. (Heckle from the Floor).

NEW SPEAKER: Can I ask a question you have not consulted with your front line staff, you might have consulted with clinicians (Applause).

CHAIR: Have you consulted with front line staff?

PANEL MEMBER: I could say that on the back of our colleagues who were here last time I went too specific meeting with them a couple of weeks ago to try and address their concerns and we have been to other meetings in the trust on the back of the questions coming in the last few weeks so it shows how we are listening and trying to engage with more people.

CHAIR: One of the key issues which I think we're all agreed is the idea of movement between one centre and another. We have a number of questions on that. I'd like to ask Jennifer Beaumont: the microphone to Jennifer, please.

NEW SPEAKER: Have you spoken to the homeless? They haven't got internet access and no phone, no transport. It concerns them as well.

CHAIR: Madam, we have got questions to do with access later. Jennifer Beaumont, please.

NEW SPEAKER: The road and volume of traffic in the Linley and Salterhebble area do not support care - what is done to address this issue because one death does discount the value-for-money pot. (Applause).

CHAIR: Steve?

DR STEVE OLLERTON: Thank you. I have heard that question many times and it is a concern that we have taken on board. We know that more than 50 per cent of people who currently attend A&E will be able to be looked after in the urgent care centre. People who access the hospital will go for things at both hospitals like day case things like that. And also we know from Calderdale

Council that they have got plans to improve the road infrastructure along there. (Heckle from the Floor). My final point: because we have involved the ambulance service in many conversations in the working of these proposals, the most important thing is the ambulance actually getting to you. Once they have got there they start their treatment when you're in the ambulance and taking you to a high authority hospital is a journey worth making.

CHAIR: A point that followed on from this Dominic Burnett.

NEW SPEAKER: A chance to respond.

CHAIR: What happens to patients who need emergency medical treatment through busy traffic hours? It can be busy getting to the HRI. How many live will be lost during the journey?

PANEL MEMBER: I've seen many patients who come by ambulance and I know when an ambulance needs to get from Huddersfield to Halifax it can get there a damn sight quicker than I can by car.

NEW SPEAKER: Answer the question you might get a response. Thank you.

PANEL MEMBER: The important thing we need to remember is like Steve just said whether we like it or not our emergency care begins the moment an ambulance gets there the vast majority of patients who travel by ambulance to an A&E department at the moment the ambulance has spent anything up to an hour on the scene of the incidents or outside the house to support the patient to get them safe to travel. (Inaudible). We know that at the moment the care we provide in our emergency department isn't as good as it could be that's because of the staffing; we have services over 2 sides.

FROM THE FLOOR: Bad management!

PANEL MEMBER: I'm a doctor and I'm trying...

FROM THE FLOOR: You allowed that to happen. You have allowed that.

PANEL MEMBER: In Huddersfield and Halifax doesn't allow the quality of care we could do under this model.

FROM THE FLOOR: Improve them both.

PANEL MEMBER: It's not possible to improve them both. (Heckle from the Floor) (Inaudible).

CHAIR: The arrangements being made for people who are elderly, people who have no transport and no family to take them from Calderdale hospital or take them to Calderdale hospital to visit relatives. Beverley Peterson, are you here? That's your question so what concerns you, what has prompted this concern Beverley?

NEW SPEAKER: Having been in that situation with family.

CHAIR: You have been in that situation yourself?

NEW SPEAKER: Very, very recently.

CHAIR: So Jo Middleton what are you doing about that?

JO MIDDLETON: Can you hear me?

FROM THE FLOOR: No.

JO MIDDLETON: Is that better? I think this is a really important question I totally agree with you.

FROM THE FLOOR: They are all important questions.

JO MIDDLETON: I know but you want to be able to travel across sites and people are moving between Calderdale and Huddersfield but the really important thing for the point of view of this proposed model is that we'll be able to set something up with you to get a better proposal for you. What went wrong for you; what was so bad?

NEW SPEAKER: My father wasn't allowed on the shuttle bus because he was told it was for staff.

JO MIDDLETON: It’s that kind of thing that isn't okay.

FROM THE FLOOR: What about wheelchairs?

JO MIDDLETON: What I'm hearing is that it's not right now, so...

NEW SPEAKER: You can't get it right now.

JO MIDDLETON: We can do something about it now.

NEW SPEAKER: I've had the experience: my son lives in Halifax he's 15 we were discharged from hospital, we had no way of getting home because he was too young to meet a height requirement and the insurance didn't cover it.

JO MIDDLETON: These are 5 year plans but we need to do something about it now. What I'm trying to tell you is that as part of the model we need to set something up so that we hear your views because clearly that's not happening now. In the plans if you - in the plans there is a proposal to set up a travel group full of people like you...

NEW SPEAKER: Change the plan then you won't need to have a group. (Applause).

JO MIDDLETON: As things stand today you're still travelling to 2 sites. That's not okay.

NEW SPEAKER: You have had the opportunity!

CHAIR: The panel needs to hear about and are going to be able to take on board as they go to the next stage.

JO MIDDLETON: Can I say I think it's really important to get some of the feedback from today because if it isn't right today it isn't going to be right tomorrow.

FROM THE FLOOR: Why do you think we don't like this? It's not right today but you know...

NEW SPEAKER: Two towns: two hearings!

CHAIR: Okay. I would like to stay with that theme and on behalf of Christine Martindale. So Christine has asked a question which relates in part to what we have just said, the consultation document states there will be an emergency centre which will have prompt access to specialist clinicians with the right skills for people with serious and life threatening conditions including trauma service. How will there be access for people in Marsden, Near Edge and Denby Dale?

PANEL MEMBER: We are aware that forming a single emergency centre will increase the travelling time by a small but (Heckle from the Floor) current time is just average journey time from any home.

NEW SPEAKER: It's the worst journey time not an average.

PANEL MEMBER: Under 16 minutes. (Heckle from the Floor). (Inaudible).

PANEL MEMBER: At Huddersfield that would go up to 21 and a half minutes; it will be 22 minutes.

NEW SPEAKER: Averages are irrelevant.

PANEL MEMBER: The most important time is for the ambulance to arrive to you.

NEW SPEAKER: It's the longest journey time.

PANEL MEMBER: Your treatment is initiated there. A decision is made where you will receive the best treatment and then you're transported by ambulance; a small increase in journey time.

NEW SPEAKER: That's an average. What's the longest?

PANEL MEMBER: Those are the services that are available to you when you then come out of that ambulance. And that is a factor that will make all the difference.

NEW SPEAKER: At rush hour?

NEW SPEAKER: Absolute rubbish!

PANEL MEMBER: It is safer to travel longer in an ambulance with the best possible services available when you come out of that ambulance.

NEW SPEAKER: Why bother going at all then?

CHAIR: You have heard the answer to that question Christine. Are you satisfied with the response you have heard?

FROM THE FLOOR: No!

CHAIR: Get a microphone to Christine.

NEW SPEAKER: No I don't want a microphone. We hear the same things over and over again, nobody is listening at all and the difference in the journey time is not that stupid small amount of time. (Applause).

CHAIR: Can I come back to clarify that people who are seriously ill...

NEW SPEAKER: An ambulance that got to a patient quickly… you just don't know where that journey on that bypass is going to lead you.

CHAIR: I think we can help you with this because we have a specialist from the Yorkshire Ambulance Service tonight, can you introduce yourself.

NEW SPEAKER: Good evening. I'm Andy Simpson I work for Yorkshire Ambulance Service. The panel is right, when I started 30 years ago the most complicated piece of kit I had was a blanket. 30 years on in my day we took the patient to the emergency department for treatment. Nowadays we have paramedics, specialist paramedics, and state registered paramedics.

NEW SPEAKER: Are you going to have every one of them in your ambulance then just in case?

NEW SPEAKER: They are used to treat what you need at the scene all patients get first-class treatment in the ambulance. The most important factor is getting the patient to definitive care.

NEW SPEAKER: How can you get along the Elland by-pass at half 8 on a morning?

NEW SPEAKER: I've worked in West Yorkshire now for 30 years. Elland bypass is a bottle neck so is Leeds inner ring road and Bradford ring road. I'd like to assure the public that a blue light ambulance has no difficulty navigating Salterhebble.

CHAIR: Do we have another related question? Could we let the Panel speak so we can get answers to the questions you are asking?

Stephan, are you in the audience tonight? Okay.

‘The travel analysis predicts that travel times are from a purely theoretical model. Would it not be prudent to validate the model's predictions with some testing of actual journey times’? (Applause)

CAROL McKENNA: (Reference to microphone).

To just answer the question that was put to me: it was about whether the modelling work that was done was validated looking at real ambulance journeys. The answer is, yes it was. With any modelling exercise you start with a computerised map/model and that makes certain assumptions, and we tested it with the last twelve month journeys that actually happened so we could validate the work.

CHAIR: Okay, again picking up on that point, Stephanie Pogton?

FROM THE FLOOR: Hello, pleased to meet you.

Sadly I have had cause to go through both A and Es over the last five years of my life. In one incidence it took 45 minutes to get to a quarter of a mile down my road. Once, I shattered a leg and it took (time, inaudible). I know there are discrepancies between travel times but we are given the answer very many times and there does not seem a non-bias with any independent Body to undertake any studies for travelling times to provide us with quantitative and qualitative research.

I gave birth to my further child and it took one hour and forty five minutes to get to Calderdale Royal. If you are in labour or have to go to hospital, sometimes when you are in labour an ambulance is not offered to you because it's quite a run-of-the-mill thing that happens but when it's an hour and forty minutes to travel six and a half miles we need to have some independent investigation to back up the things you are saying. (Applause).

CAROL McKENNA: Thank you for that question.

We have heard issues like that as we have gone through that process. The work that has been done on travel times in an ambulance or by public transport is work we have commissioned independently, not work that we have done in-house, so either the CCGs or the Trust have brought in external party/parties to do that analysis for us and they have worked with colleagues and the Yorkshire Ambulance Service as well to make sure they can draw

on the modelling. There is a vast amount of information that they hold in the Ambulance Service as part of doing that work.

What we are also doing - if I can just finish my answer. (Heckle from the Floor) - in order to make sure we are getting that as absolutely right as we can, we have not just stopped with the work we did before we started the Consultation; we have recently commissioned another piece of work to do a final check to make sure we are comfortable with the way that the impact of our proposals on the Ambulance Service when looked alongside the impact on the Ambulance Service or the proposals in the Yorkshire patch, is to make sure they join up. We don't have gaps in Kirklees for example where people can't access services appropriately, and we are doing that piece of work as well and that will inform our decisions when we come through to decision-making.

CHAIR: Andy, would you want to add a comment? Are you confident, Sir, you deliver this service at the end of the day?

NEW SPEAKER: From an Ambulance Service perspective we scrutinise the data and the specification and check with our own internal services and external services; it was a consistent outcome on all the reports: 10,000 hours equating to 10 extra staff and 10 extra ambulances to cover the shortfall in extra journey time.

CHAIR: You heard that. What's your reaction to what you heard?

FROM THE FLOOR: I appreciate your answer and I understand you have taken some consultation thus far, but my concerns are that not everybody rings an ambulance. If my baby daughter at four months old was ill and I could not get an ambulance in five minutes, and I am two/three miles down the road to Huddersfield Royal Infirmary - and I grew up (place-name...) - and when he visited me in hospital it took him two hours and fifteen minutes following the birth of his daughter to get there. The Ambulance Service at times can be with me within three minutes but as other times, when I broke my leg, it took me forty minutes to get a quarter of a mile.

So we need evidence of the alternative journeys you are asking people to make, not just the journeys you can track via one provider which is the West Yorkshire Ambulance Service. (Applause).

OWEN WILLIAMS: Can I give my view to that point. Can you all hear me? Can I check, please?

I think you raised some really good points actually. It's not just a question of the patients travelling but it's also friends and relatives and carers etc. How do they get to these venues?

I think we have had some good points and we have to take that on board and we need to make sure we have some proper responses to that.

Daniel James?
Daniel your question was: 'Will the CCG Commission an independent review of ambulance travel times for the area covered'?

That is Steve.

DR STEVE OLLERTON: Sorry, I am not keeping up. So, yeah, I mean I think we have already discussed this, and Owen has given an honest answer there, and we would support him with that.

There is still an awful lot of work with any of these proposed changes and we're going to have a travel working group that will work on all of this: we know that it's a major concern. But the thing is, as I said before, and I still go back to those 4 reasons we want to change, travel and transport is something that is going to facilitate that. So, we need to make sure that whatever we propose in the future, whatever happens in the future is safe, transport is safe, otherwise the model won't work because transport is fundamental.

So I take on board what everybody has said, and we'll make sure that you have confidence that it's safe before any changes are made.

CHAIR: Anthony? Do we have Anthony here? Microphone to Anthony; staying with the ambulance. Don't worry.
Your question, Sir?

FROM THE FLOOR: 'Can additional ambulance services be purchased, and will you have enough vehicles and paramedics to

cope, because they are not in the targets at the moment with hiring paramedics'.

DR DAVID HUGHES: The answer is, yes, simply.

Can you hear me or do I need to shout?

We are working with the Yorkshire Ambulance Service on this and, as Andy has already suggested, assuming that there are no other changes that happen whatsoever, we are looking at an additional 10,000 hours of ambulance time that is required over 12 months.

Do you want to listen or do you want to shout?

(Heckle from the Floor). If you want to talk that is absolutely fine by me. (Heckle from the Floor).

DR DAVID HUGHES: I am quite happy to discuss this but there is no point in shouting in the middle of talking; neither I can hear, nor can the audience.

So, that is 33 hours a day with my simple maths, so we are talking about an additional amount of ambulances but not a vast additional amount.

We are doing a lot of other work with the Ambulance Service in particular to actually reduce the number of people who are transported unnecessarily to hospital.

At the moment about 30% that are taken to the A and E by ambulance need no treatment. That is a waste of patient and hospital and Yorkshire Ambulance Service time.

What we are suggesting, and what is already happening, which is aside to this Consultation, is a process where we are working with Yorkshire Ambulance over in West Yorkshire so people can be dealt with at home, so they don't have to be taken to hospital, and the services are available to the original call-holder when people ring 999, so it's something more appropriate than a blue light ambulance.

There are other services we can use that are better for the patient.

CHAIR: Anthony, your reaction to that?

FROM THE FLOOR: Can I ask if the clinicians that worked on the design of the proposed model had any input into the design of the Titanic? (Laughter) (Applause).

CHAIR: Let us stay with ambulances.

DR DAVID HUGHES: If you are implying we are doing this for our own good - I am doing this because I believe it's the right thing to do for my patients of whom I have been working with for 29 years.

FROM THE FLOOR: What if you are wrong?

DR DAVID HUGHES: I have been working with many colleagues for the last few years and, whether you like it or not, the present situation is not sustainable. It's not safe. And what we are trying to do is to provide a model of care which will provide better safer care for the population of both towns.

FROM THE FLOOR: What if you are wrong?

CHAIR: Trying to get more factual information.

Andy Walter, please.

Andy's question: ‘What arrangements are going to be made to ensure that emergency ambulances can make the journey to Halifax, to make sure they are not stuck at the bottom of Elland’?

PANEL MEMBER: That question has already been answered.

FROM THE FLOOR: Can all of you up there guarantee that no lives will be lost by moving to Calderdale? Can you guarantee no lives will be lost because of the extra journey?

PANEL MEMBER: I will answer you, but let me finish speaking before you interrupt. I can't tell you that nobody will die on the Elland by-pass. But, I can tell you that the service they get when they get there will be significantly… (Heckle from the Floor).

Let us look at the costs. Can I just finish?
The care that we provide at the moment in the A and E department in Halifax or Huddersfield is not as good as it could be.

FROM THE FLOOR: Why?

DR MARK DAVIES: Because of the problems we described earlier in terms of staffing.

FROM THE FLOOR: Poor management.

FROM THE FLOOR: Put the money into extra staff then.

CHAIR: Looking at the costs of this.

Roger Gill, the gentleman here, please. (Indicates).

FROM THE FLOOR: My first statement may not be too popular with the audience but I believe I do have some sympathy with the benefits of scale. So, your medical solution might have some benefits. But, unfortunately the answer is the wrong one.

If I can look at some information that came to me when the information was submitted: I saw a Government leaflet about Principle 2016 and includes in its second paragraph, …"consult about policies or implement patient plans when the development of the policies of plans are at a formative stage and don't ask issues on which you already have a final view".

Dr Ollerton has been fine saying there is no plan B, but then this is not a Consultation but is elementary. (Applause).

And, even later information, in today's Examiner, there is the estimate of the cost of the plan at £200 million. It only requires a small deviation from the estimate in any range of things to obliterate any possible savings over the original medical case which I think I could go along with the medics and the medical case from having (Inaudible). Many of the reasons given for supporting your plan deserve much more searching examination than you can be allowed to do. My actual question that I started with again we're back to ambulance services. Will the service increased costs do not appear to be included in that £200 million so the overall cost to the taxpayer and that's us, of this scheme, is not complete. Not been considered. We talked about or you have talked about journey times and things like that, the study that you refer to had up there some small print somewhere words like extreme journeys were excluded so they are excluded because they might change the results. Our friend the doctor there talked about average times, wonderful to talk about averages for anything but today it's the extremes that matter to us. (Applause).

I did an exercise on this one Saturday afternoon using the distributed population of greater Huddersfield and Calderdale based on the council wards and it shows that A&E, a single A&E at Huddersfield requires 50 per cent less additional ambulance hours than does the A&E at Calderdale. I estimate that you have talked about 10,000 hours.

CHAIR: You're covering quite a lot of ground here.

NEW SPEAKER: I am…(Interjection).

NEW SPEAKER: Let him speak!

NEW SPEAKER: That was the main part of my question that how you justify these costs when you haven't considered the ambulances. I still have part of my submitted...

NEW SPEAKER: Keep going.

NEW SPEAKER: How can you justify - and I'll just mention planned care - I have seen it in the small print that neurology is going to be at Calderdale. I have to declare an interest in that I'm a neurology patient when I go to Huddersfield. Is that planned care going to Calderdale as well and if so what other information is missed from the small print? (Applause).

PANEL MEMBER: Thanks for the question there are a lot of legitimate points you made there. I'll try and do as many bits as possible as I can do and if I miss anything you'll let me know. We have had the conversation today about what the ambulance service judges to be what its additional requirements would be. Again you know being quite open with you, some of that we will not know until this actually gets implemented so I'm not going to sit up here in front of you and make guarantees, okay? I want to be straight with you. So we have got some work to do around that so far as I'm concerned to really understand what does this mean for us and when I say we, you know we have got clinical commissioning group colleagues here having that conversation because we are like the ambulance service ourselves and we will have to wait to understand where those negotiations take place. But it is the case - and I think I can speak for the ambulance service and our selves because there are a number of people in here who talked about poor management - I think it's unfair on the doctors and nursing colleague and therapists for them to be taking

that question. Myself, as Chief Exec, it's right I take that question and if people have issues about management what I would say is that there is not now - I think there are only 2 Trusts in the country now that are not now carrying a deficit. Now whether that's good - Roger did take a bit of a thing I want an opportunity to speak tonight - so we're in a situation whereby the money situation that we have right is absolutely unprecedented okay? So it's not like it's been before and I know that part of the feeling is that wouldn't it be great if we could keep the services as they are and we could have more money for doctors and nurses. That's the feeling that people have in the room. The request that we have had is very much about why don't we go back to government and say we need more money?

NEW SPEAKER: Yes.

OWEN WILLIAMS: Is that right? Part of the challenge we have got and unfortunately we have not got - I don't think we have got representatives in terms of political this afternoon - but one of the challenges we have got is that that money for paying for existing models of care is not there. That's nobody in this rooms fault as to why that situation occurs.

NEW SPEAKER: How does 276 million...?

OWEN WILLIAMS: Let's do about the £276 million is towards the capital costs of an overall envelope of just under £500 million. That seems an incredible amount of money when we have said the government have said they haven't got any money. What the government will do is if they can identify different models of care they will be prepared to listen to opportunities or ideas about how different models of care can be given; but, and this is what I have to be honest with you about, they are not going to support more money going to existing models of care. Nobody on this panel likes that situation, you don't like it but I want to be as honest as possible with you about the reality that we have to face to get the services so I'll make this final point. The various services and I think page 19 of the consultation document and also very, very clearly on the web site about the services on the planned care site and unplanned care site so that language you use there, that information is a variable. Can I plead with you, if there are any services beyond neurology where you think we're not being clear

about that can you let me or the consultation team know about that; I want to make sure we get those answers to you.

CHAIR: I would like to continue.

NEW SPEAKER: It's not to do with transformation of services it's purely to cover your debt?

OWEN WILLIAMS: So there is 274 million which would be capital costs so capital build or whatever facilities we get built on one side, and other facilities on the other side. Then there is another 250 million about supporting the Trust through this transition and change and that is also about making sure we can pay people's wages and so on and so forth. That's how the split of the money goes. But to give a scale of where things are at, does anybody know Smethwick in the West Midlands; so building a new hospital at this moment in time, £588 million, 370 million on capital for 674 beds.

NEW SPEAKER: Why did you put that through instead of this one?

OWEN WILLIAMS: For us, for us as a group of people we would love to be in a position where when we looked at the Department of Health, NHS England, NHS improvement and the Treasury in the eye, that they were going to be taking our propositions on side; but we know that if we're in to a situation where they judge it's not value for money, we know that they'll say no.

NEW SPEAKER: So, it's a done deal?

NEW SPEAKER: It's a done deal!

OWEN WILLIAMS: Let's come back to the done deal then. I'm conscious I'm taking a bit of time here. So if we talk about the done deal, all I can say to you is and it goes back to Nathalie's question earlier about front line colleagues who have been involved because I certainly know so far as our trust is concerned I've been face-to-face with front line colleagues talking about this for nearly 3 years okay. It's absolutely the case and I am really, really quite passionate about this, that somehow we have to come to some changes in the way that we do it but you should not believe that your views and input and what you feel is just going to get disregarded.

FROM THE FLOOR: It is!

OWEN WILLIAMS: It is not. What I want to make sure is that I get people feeling angry and I want people to feel emotional about their services because it makes me...

NEW SPEAKER: So you are having us fight for you then?

OWEN WILLIAMS: No, this is the point we're fighting with you (Heckle from the Floor). I might get the BS detectors. Tell the government no. Address the under-funding. I will just say that here okay, there are not people who can directly influence what government - we are in a democratic society here.

FROM THE FLOOR: No we're not!

OWEN WILLIAMS: Let's call it as it is. It's a democratic society here and there is an opportunity for people to exercise their influence over government. I will make that final point. I am sorry I went on too long.

CHAIR: Owen has addressed you there.

NEW SPEAKER: There is a problem. If you're going to - I respect these people's positions and I don't want anybody to believe that I and other people in here have got some negatives about our ambulance service because they do a bloody good job. (Applause). What we're talking about is the inefficiency of these people not clinically but just a little bit of information. I'm addressing this to Calderdale. 2013, the PFI thing which Steve Ollerton said to us last time we met here he said in no uncertain terms that was probably the biggest issue on the finance side. We're all aware of that; the 20-odd million that's going to grow each year. But what about what you're doing now?

Let's think about the PFI thing. There is a percentage of the income from Calderdale and presumably everybody in Huddersfield that goes towards paying that back. In 2013 it was 10 per cent of what Calderdale were dishing out. 10 per cent of its income was going on that. Against a background where in a survey done by the Nuffield Trust the worst were between 1.5 per cent and 5 per cent against the national medium of 0.9 per cent right? So that's a starting point about where you're at. But let's look at something a little bit more recent. That contract for PFI is

no longer in the hands of the people who bid for it is it? It's now in the hands and I better not misquote them it's in the hands of a French company called GDF Suez who have just renamed themselves energy, okay? I hope you're taking notice because you need to discuss this at your next meeting. (Laughter). Last year the Calderdale group decided to award the contract to somebody called Kiwi Power. Do you remember it? You ordered a contract to Kiwi Power you must have seen the books or looked at the accounts.

NEW SPEAKER: Get on with it!

NEW SPEAKER: And that Kiwi Power is part owned by, oh dear … (Inaudible) Energy!

CHAIR: Can I ask you to make the point?

NEW SPEAKER: What we have got is a situation that you're in the sh, sh, sh stuff. You said that last time and you pratted around with issues as you did last time and you have done all the time that you have tried - you were the ones that selected the questions for tonight so some questions have been neatly missed. Questions on the ambulance service our colleague gave a bloody good answer so if you're managing your business in a moment in a particular way and you have got involved with some companies, who is ultimately going to be involved, Philip Green? (Laughter) Are we going to move him to BHS? … And, that is the last thing, especially to hear in this stadium when the team is not doing well as our colleague at that end keeps telling us; they are not doing well, and this football team needs to get rid of the manager! (Applause).

CHAIR: We have touched on a number of fundamentals already.

Micheal Fostbrooke, please?

FROM THE FLOOR: (No microphone).

CHAIR: Can we please move on?

FROM THE FLOOR: No, we can't.

FROM THE FLOOR: What about the answer?

OWEN WILLIAMS: If you recall at the last public session there were 3 routes: a direct capital sum that comes via Treasury/Department of Health, where may whereby permissions are given as a Trust, or a wider board to borrow more commercially on the market, or - just waiting for it to quieten down - may be PFI2.

All right? Just answering your question; just answering the question.

CHAIR: Okay, I think that has been dealt with.

Can I ask Micheal Fostbrooke about another fundamental point on this?

FROM THE FLOOR: 'Should Huddersfield be transferred to Halifax, the lesser of the two populations'?

CHAIR: Owen Williams?

OWEN WILLIAMS: Again, quite rightly, people are talking about A and E as we know, and part of what we are trying to develop here is a different way of providing that care. Okay?

I want to talk about our boundaries: I want to talk about the Trust's boundaries VERY quickly.

Calderdale and Huddersfield NHS Foundation Trust covers a CCG area in Calderdale that is about 10,000ish in population and, and, we cover what is called Greater Huddersfield. In terms of the whole of Kirklees, that is split between ourselves and Mid-Yorks Hospital Trust. Okay.

So, just in terms of the bigger population, what you can say is that Greater Huddersfield's population is bigger on my account by about 40,000. I have heard people talk about 400,000/half a million, and Jo said right at the beginning: "What we do is serve that populous". We serve that populous. That is what I am saying. I am just saying in terms of trying to understand the areas that we cover, we cover an area that is Calderdale and is also Greater Huddersfield.

What we are proposing in this model is a new and different model of care, in the two areas we have currently, site and locations, it

will have urgent care facilities. Those urgent care facilities will deal with, as it says in the document, at least 53% of what we know currently comes to what we call A and E.

There will be a single emergency care centre, not rehearsing it again, that is where particularly if it's a blue light service; that is where you will go.

Equally, because somebody raised this, I think a point made earlier, what happens if it's not a blue light? What we will have to have in place are the right protocols to make sure that if somebody falls ill, and they might have just come in for a chest pain, but it might be diagnosed that this is quite serious, and so there has to be the right protocols for those people to be transferred.

But, as Jo talked about earlier, those transfers are taking place today. Today those transfers are taking place.

CHAIR: Micheal, a response to what you have heard?

FROM THE FLOOR: Why is it going to Calderdale?

FROM THE FLOOR: Why is A and E going to Calderdale?

OWEN WILLIAMS: Sorry, I don't want to repeat too much. When we looked at the clinical models, and at the clinical care, what we have not been able to do - it could be either site/either location.

FROM THE FLOOR: You are lying.

OWEN WILLIAMS: I am just about to get to the money point. What's the fundamental challenge we have got? The fundamental challenge we have got is a PFI. We can do the fault, do the blame, and you might have those views. You might have those views. You might have views that it's not Huddersfield's fault; you might have a view which is anti-Calderdale, but I am just saying to the question it is about management. We are the people now. Whatever decisions were made in the past, we are the people that have been left to work it through given the realities that we have now.

CHAIR: A more detailed point from Ryan Hutley:
'At what point within the hospital configuration can hospital beds be opened up for emergency cases that present to either A and E

at either hospitals? How will the new Centre cope with the large influxes when they are taken to the hot site and when there are no emergency beds left to accommodate the patients?'

CHAIR: Jo Middleton?

JO MIDDLETON: (Microphone reference). Sorry, was it Ryan?

This is happening every single day and it is the kind of thing we have to cope with in terms of the messages we give to our patients.

Only last week I had to ring people that were due to have a hip operation. I had to speak to a little lady that had her dog in the kennel and I had to cancel her appointment because of a greater emergency need for a bed.

I understand the concerns about capacity, but I don't think the way we are doing things now is sustainable. We have to look - I am trying to answer the question, bear with me one second - we have to look at doing things differently; we can't just accept more and people into our hospitals. We have to have people that stay healthier at home so their chronic conditions can't get worse, and we have to look at community care. We can't accept more and more people through the doors.

So, as it stands today with the way we do things, I would be very worried about this because we would not have a plan B, in where we put people. That is a proposed context of a different way of doing things: it's trying to keep people to stay healthier and trying to put more care into the community.

Who shouted "Will you answer the question?" I have the conversations with patients every week. It's just as important that if you have a planned procedure, you get the care as well. I think the people deserve to have care in our hospital just as much as those people that turn up to A and E with an emergency condition. I know for a fact if there is a locum doctor working in one of our A and E departments that we are more than likely to have a higher number of admissions into our beds because the local doctors don't know what is in the community, they are more risk adverse and less likely to send the people home. We have an influx in terms of emergency admissions, so it's having a doctor in the emergency centre to make decisions and know what is out there in

the community and to admit less people in to our beds. (Applause).

CHAIR: A fundamental question: Rachel Lily?
Can we hear from Rachel? (Microphone reference).

FROM THE FLOOR: Hi. With regard to travel times and 16 minutes, I live in Halifax, just out of town centre. When I was in labour I didn't get there in 16 minutes, so you are wrong there for starters.

Can I have no fluff with my answer; just an answer will do.

Thank you very much. (Applause).

Also, mother said you have two ears and one mouth and to use them in proportion. So, that is my advice.

The question: 'The CCG admitted that the impact will be greater on vulnerable and disadvantaged groups and penalising those that need less help': how will you look at this and address this?

PANEL MEMBER: We have a lot of people working with smaller groups but we are confident that none of these proposals will be other than advantageous to all groups of the population.

What has not been covered tonight so far is just as important, and that is the care closer to home and care outside of hospitals.

We have been talking very much about hospital delivered care; we know that in this country we are far too dependent upon things happening in hospital. But care closer to home will be a particular advantage to people that are disadvantaged as they will be able to access things much easier rather than going to one or two centres.

So, we believe that although the challenges of some groups in society are greater, that we are addressing all of these in this proposal.

CHAIR: Okay, Rachel, you asked for an answer; so, are you happy with that?

RACHEL: Not at all. When I went to the Sowerby Bridge drop-in session I was specifically told a lot about the wait regarding the

proposal, and ‘if’ the wait would fall in care in the communities including some charities.

So, why are already breaking services that are under a lot of strain taking on extra work when you are borrowing nearly half a billion pounds? (Applause).

PANEL MEMBER: We can do a lot more for people if we do not use the hospital (Inaudible), and deliver services closer to home.

FROM THE FLOOR: Until you tell us how the services will be delivered, you can't have a proper consultation because those aspects of the proposal have not been addressed. (Applause).

CHAIR: The next question builds on what you are saying.

FROM THE FLOOR: Answer the question.

CHAIR: Rachel Hodgson, please.

We have already had a question tonight from the floor. I think this is going to kind of pick up on that one a little bit.

Yes, thank you, Rachel.

FROM THE FLOOR: Can you hear me? Thank you.
I am from Unison representing health workers across Halifax and the Huddersfield area.

People are under an immense amount of strain and they are working rock hard.

The clinicians approved the proposal to downgrade Huddersfield A and E but there has not been any formal consultation with staff at both sides, and seeing you few surgeons don't count.

Do the front-line staff opinions not really matter? (Applause).

PANEL MEMBER: I can answer this because I am a member of staff and I know myself that all consultants in Calderdale and Huddersfield Trust were invited to be involved in an engagement process before Consultation. So, that is the consultants.
I know that every member of staff has had information about the Consultation and an invitation to get involved with the Consultation.

FROM THE FLOOR: How do you know?

DR MARK DAVIES: Because every member of staff got it attached to their pay slip and I am pretty sure that every member of staff reads their pay slip.

I have delivered talks to three drop-in sessions where there have been front-line cleaners, porters and health care professionals and I have seen the people involved. I walk past a consultation desk in the main HRI every day, and it's clear that all staff have been invited to put their views on paper.

So, all staff are being engaged in this process, but whether they choose to voice or not…?

CHAIR: Can you identify yourself?

FROM THE FLOOR: I am Natalie Ratcliffe and a regional organiser for Unison, the Trade Union.

There is just a desk in the entrance hall to Calderdale Royal Infirmary. I have not seen anybody stood at a desk in the canteen that has leaflets and surveys on, and the only people that have been encouraged in this are the staff unions and people who have been asked to fill-in surveys. (Applause).

NEW SPEAKER: What I would say to people in this room is that if you are in favour of this proposal I would remain seated but if you're not in favour because we're not going to hear any more decent answers I suggest we leave the room now!

CHAIR: I would suggest Stewart Neil? You can walk out ladies and gentlemen but there are people going to give answers. (Heckle from the Floor).

PANEL MEMBER: Before you all depart; one second; it won't take long. One second. Two seconds. You're morons. You don't listen; you're morons.

NEW SPEAKER: Is that any way to speak to us?

NEW SPEAKER: I really didn't get an answer from my question. The branch secretary or was the whole of Kirklees NHS unions. Now I know past experience when you look back historically -

when we look back historically, all the changes that have taken place in Huddersfield and Halifax have been motivated by money, despite what anybody says, it's a fact. We all have our own health authorities and then they amalgamated and services went downhill. However, having said that panel is right, we do need a change. One of the options examined was a new build which involves a new hospital delivering services on an alternate site. It would provide safer higher faulty services with a 24 hour consultant led undisputed planned care a new purpose-built hospital situated on Lindley Moor halfway between Calderdale and Huddersfield and would remove the opposition from all sides. Having all the staff from both hospitals would resolve staffing shortages and enable the movement of staff from one area to another to cover any sickness etc while the inclusion of an ambulance service would be (Inaudible), having the benefit of services on one site. I do realise it would require heavy capital investment but the long term result would be patient-led service which would be fit for purpose, built not just for the current population but the demographic population for the future.

With all this in mind my question is, on what evidence, through evidence, did you base your decision that funding would be highly unlikely to be provided?

Dr. Alan Brook?

DR ALAN BROOK: We have looked at the option of a brand new hospital to replace all of them. We believe it would be expensive. It would still be required to be financed and used by the NHS and we have been told in no uncertain terms by Monitor the national body that that hospital must be used to its full potential because it's a state of the art hospital and best for many miles. Faced with that why would we build a new hospital? I've looked at it on the map, about 3 miles away. How would 3 miles make such a difference to people's vision here? It is 3 miles from the current site of Calderdale Royal to Lindley Moor. That's on the road; I've worked it out. So, it's interesting that the proponents of this have accepted the clinical model of the need to centralise all services on one site and that's where a lot of the clinicians got to and really the consequences of where that got to is something that we then has to work through over the latter half of last year but I think I have to fire the answer back. Would you want an urgent care centre in the 2 towns?

FROM THE FLOOR: Yes!

DR ALAN BROOK: You'd have an (Inaudible) hospital somewhere in the middle and an urgent care centre, neither of them on the same site as the emergency care centre. It has options but doesn't answer everything and it would all take place at the one site. Now if that is very much more attractive that's something that can be looked at but it has been dismissed as so unlikely to be funded that there is no point misleading you to believe it could be.

CHAIR: Stewart, are you happy with that?

NEW SPEAKER: It wouldn't matter because if you're coming from Huddersfield to Calderdale or Calderdale to HRI the distance is immaterial. I agree with Owen that we do need as a populace to actually protest as we are doing outside but not just to you guys, we need to get in touch with our MPs and with the government and make them do what we want. It's our services, we're on about what they care about, this government and I'm not necessarily pro Conservative or Labour but this government is saying support the NHS. Well let them prove it.

As regards that little bit there, you have got a vast expanse of land, it's not going to interfere with anything at all. You can sell off all your products at hospitals because the travelling time either way is neither here nor there and you can realise the potential in all those developments you have got because you wouldn't have that problem any more. You wouldn't have that hospital. You could sell it off and develop that. You wouldn't have HRI so you could sell that off, if you have got all services on one site. If there is a problem with staffing, and there is always a problem with staffing, you have got more staff on site, unless you don't staff it like you are doing.

CHAIR: Thank you very much indeed. I'd like to pick up on that we have had reference on PFI and Carol Booth, Carol in the audience tonight Carol has asked me to put this question to you on her behalf. Can evidence be provided by the panel that the decision has not been wholly-centred around PFI contract signed by Calderdale rather than round the human impact?

CAROL MCKENNA: I'm going to say a few words on this actually because I think we have covered some of it but I want to put the CCG perspective on it as well. In terms of the other criteria we

looked at we covered them in the earlier presentation and I think Owen has been frank with everyone tonight in setting out the position we're in with regards to PFI and while none of us in the room might like that situation we have a job to do to make the best of the situation which we find ourselves. If you think back to the options that I put back up earlier and saw that either of those clinical models could deliver the criteria around quality and accessibility that we're trying to achieve but the one difference was in cost. If we were - let's imagine that we could go to the Treasury and say we'd like the money for the more expensive model which is Huddersfield emergency centre. That's another £30 million.

Let me finish my train of thought. If you think about the £30 million you think about the totality of the money we're asking for and the fact it will have to be repaid. If we're to find an additional £30 million, that is money that will come from services currently being delivered to the people of Calderdale and Huddersfield. Human impact: that's where the human impact is it's about having to cut another £30 million of services to enable us to pay for a more expensive option that would not make a difference to the outcomes delivered. I know they are really hard decisions but for me you know, and we have all talked at the last public meeting about the services, I don't want to see us lose £30 million of services we don't have to not when we can deliver something we can talk about state of the art and deliver better services for people in the longer term.

NEW SPEAKER: Sorry, can I say something? You talk about how it's going to cost £30 million; it's going to cost £30 million extra to develop Huddersfield but you own Huddersfield. The extra money that you are putting in to Huddersfield will benefit people in not 20 year's time, not 50 year's time but 100 years' time. You sell Huddersfield site and it's gone and after 20 or 30 years whatever you're talking about when this PFI deal is up again in Halifax you have got to go to your landlords and say how much is it going to cost to rent the premises off you again. You already own the premises. (Applause).

OWEN WILLIAMS: What we're sat on at the moment in terms of Huddersfield Royal Infirmary is quite a significant backlog in the state of the that building at this moment in time.

NEW SPEAKER: You should hang your head in shame.

OWEN WILLIAMS: I think that is a good point because that's just not happened overnight. That has been happening for quite a number of years and I have to say to you it's certainly been my experience of the board since I've been there that there has been a real commitment to make sure that the investment that we can afford does get in to that HRI building because I know there has been some complaints about if we knew XYZ about HRI why are we spending money on its infrastructure. We had in some shape or form. Not just health and safety but things we should expect in modern day, the right standards and coming back to the question about single site whatever else. What we still have to deal with is dealing with if you don't use Calderdale then as a minimum, as a minimum, the mortgage payment because I think everyone understands that language, the mortgage payment is £10 million a year. It goes to 2060. So if you're not going to use that site you are committing yourself to the minimum of those payments okay?

NEW SPEAKER: You're not saying you're not going to use the site.

OWEN WILLIAMS: I think your question is that we own some land, and there is a question about whether we own it or whether it's owned by the Department of Health. But let's work it through and say it's the Trust.

NEW SPEAKER: It belongs to the NHS.

OWEN WILLIAMS: Yes the Department of Health ultimately. So our ability in this arrangement there will always be a situation whereby government will have a say over what happens to the assets. Council colleagues will tell you, people working in the NHS right now will tell you right now there is a universal ask from government about assets and land. Anything and I mean anything that is deemed surplus there is a demand from the centre to see it come under the centres management. I'm trying to give you a flavour of the reality and context that we are working in trying to balance these competing priorities but if we build a new site at Ainley Top, there is still a matter of the PFI and the commitment we signed long before anybody was in this room to pay for that by 2060. It still doesn't go away.

CHAIR: While we're on the topic of funding can we get another point on the funding, please.

Margaret Overend?

NEW SPEAKER: We seem to have heard a lot of figures being…

CHAIR: Can we get the mic to Margaret, please? Following on from the PFI funding, Margaret...

NEW SPEAKER: We have had a lot of figures banded around and I'd like to ask how much is this entire project going to cost? So £500 million has been mentioned and yet we're told I think I'm right in saying care strategy which is part of this hasn't been fully devised. We won't know until it gets started how much it will cost the ambulance service. I haven't heard how much each extra ambulance service is going to cost so how robust are the services in light of the uncertainty on the economy in the future. The second part of the question is what is the contingency plan when this project as it inevitably will, busts the budget? Are we going to borrow more money or cut back on the things that you're talking about in this plan?

PANEL MEMBER: In terms of the high levels numbers we have talked about, and we have talked about the numbers this evening, which is somewhere in the region of 270 and somewhere in the region of a 200 million requirement to close the deficit. In fact we don't quite close the deficit with that contribution from the centre.

I think that speaks to the concerns that you have raised today about whether we are in investing enough as a nation in the NHS. I do think anybody on this Panel would not agree that as more should, and could, be forthcoming. When you look at the country to advance its health service with other similar industrialised nations, you will see we are not making the same level of contribution here but it's Political with a big 'P' issue; it sure is. There is no distance between the panel and the audience in relation to that set of questions.

What we have brought forward is high level, and admittedly high level. If we progress then there is a much more detailed piece of work that we need to do that would generate what's called 'a final business case' where we would be obliged, because we are essentially putting a business case together to attract funding from the centre, to address that big financial challenge that I talked about a minute ago. So, that final business case needs to be much more detailed and we need to map-out much more precisely what

the estates and workforce requirements will be and, in that, to pick up issues like the investment that is required to deliver the additional capacity, and the Ambulance Service for instance, that needs to be part of all that.

I want to remind you all that the ask that would be coming forward in those terms is alongside the recurrent allocations that the CCGs manage to purchase services, to purchase activity, and that at the moment is somewhere in the region of £330 million, or thereabouts. That is an annual spend in Huddersfield Foundation Trust. And, fundamental to the model, is how we redesign the way we spend the money: fundamentally that is underneath this.

Care closer to home is using the recurrent allocation and current funding we get that better meets people's needs, and to prevention services, and we need to keep people well and invest in more services in the community-settings to enable to us do that.

The final business case will be the case where we are able to be more precise. At the moment we admit the figures are accurate reflections on the costings we have got, but there is more detail we need to write.

FROM THE FLOOR: You have still not answered the lady's question fully. I will tell you: you are struggling with £10 million a year debt and coolly tell us you will borrow another £500 million back.

That lady asked you what other services you were going to cut but you have not answered that question. So what are you going to cut to balance the books?

PANEL MEMBER: I am not going to answer that question because we have not made any determination about cutting services, but we are talking about ways to changes in services.

FROM THE FLOOR: How many less nurses?

PANEL MEMBER: If we move forward with these propositions, we have to change the way our workforce operates and people who are currently working in a hospital setting are flexible.

FROM THE FLOOR: You will put up qualified people into privatised …(Inaudible) that are not audited just like it's now, and in mental health, so why is going to be any different?

CHAIR: Your question and your response to that, please?

FROM THE FLOOR: My response is let us talk about around £500 million, but you are saying it might not be that: it may be less than that; might be more than that, so how can we give you any sort of feedback on something that appears to be - I am sure it's not - but appears to be a bit of a finger in the wind?

PANEL MEMBER: It's not a finger in the wind.

FROM THE FLOOR: You have not factored-in these things that may cause a lot more.

PANEL MEMBER: We need to move to a process.

FROM THE FLOOR: I am surprised that you have not got, or you have not started to think about a contingency plan, because these things do invariably go over budget, bust the budget, and then decisions have to be made as to how you address that problem. And, I think the mood of the Meeting probably will be carried on from this Meeting. Then, if you come back and say, "Well, in order to get this through in the funding, we have got, we're going to have to cut X, Y and Z", I think you will get a lot of angry people.

CHAIR: Okay, I think that point is covered. We are running very short on time now.

Maureen Davies. Over here. (Indicates) (Microphone reference). Maureen?

FROM THE FLOOR: Dr Brook has always stated that the pre-Consultation over the past 3 years, that is 4,000 people out of 452,000, show people are provided care local to their home in the local community.

The proposed plan does not give the impression of this being available for the people of Greater Huddersfield. Care in the community at the moment is quite unsatisfactory.

How is this going to be rectified and who will measure and ensure that this is achieved? Are we, in Greater Huddersfield, going to have parity with Calderdale? You have the quality care and the vanguard and there has been money put in for that which Huddersfield, as far as I am aware, has not had.

CHAIR: Okay. Dr David Hughes?

DR DAVID HUGHES: The answer to that is by using this new model of care to enable us to have more finance to spend on care in the community.

You are absolutely right, Huddersfield has gone through a process of care closer to home and there is a contract that was signed and started with the community organisation, Locala, only 7 months into its running. It's an enormous project: it is just phase one on what we are planning on doing. There are a number of other work streams that are going to be looking at how we can actually provide care close to people's homes, in people's homes, where it's appropriate. We know a lot of people at the moment are in hospital and don't need to be there; they are there often because we can't provide adequate services for them in the community. Some of that is money. Some of it is staffing. I mean, in answer to one of the Union questions earlier on, I think we are in a situation of total disgrace where a lot of the community services are provided with staff who have minimum wage, zero-hours contract, low pension, and we are actually then surprised we can't recruit them and we can't get people out of hospital or keep them at home because we don't have the right care packages. That is what we need to make this work.

I am on groups working over in Huddersfield and Calderdale and, to a greater extent, West Yorkshire to see how we can redesign things so that hospitals are for people that need to be in hospital; and, for those that don't need to be in hospital, they are cared for in the community. It’s not just GPs doing all the extra work. If I stood up, I would have rotten tomatoes thrown at me by my colleagues, which I have had on occasion. There is the totality we need to work on and that will go alongside this plan.

FROM THE FLOOR: I just wonder, because it was reported at the beginning of the year that between 1000 and 3000 pharmacists across the UK were going to be closed and in the pyramid of

patient advice, obviously your first point of reference is your pharmacy: that has been taken away.

Then your next point of reference I assume is your GP or NHS 111 rather than rushing to A and E. I agree a lot of people will go to A and E out of sheer frustration because they can't get to doctor appointments, as some people have to wait two or three weeks: that is reliable evidence. It's a concern, and I appreciate what you are saying that people do need care in the community, but I was really surprised that, I think it's on page 36, where it suggests that you might bring x-rays and blood tests out into the community. I thought when I read that, that is a strange thing: how cost effective could it be? People surely, if they are ill, go to hospital for x-rays, and you would not want them in the community, would you?

DR STEVE OLLERTON: I have heard that before. Have I spoken to you on one of the information sessions?

X-rays in the community: I know there are facilities in Todmorden and there are not in Huddersfield. We will not intend to move x-ray machines out of the hospitals yet.

Blood tests: you can do most blood tests on a finger, and we can do blood sugars and a lot more. So, we can do that in the future as the costs come down.

Your point about pharmacists: most surgeries now, certainly mine is one of them, we employ one of our local pharmacists in Skelmanthorpe from the Well pharmacy, which has been from the beginning of this year.

Can I just say what is happening? This has been on the back of other people saying it's a good thing to do, and he is doing a lot of the medication work I/we have done before, so it has been freeing-up time so I can see more patients. I think you will find many doctors' surgeries are doing that, where pharmacists can take over some of the workload that GPs do currently; and we can use that workforce.

I know a pharmacist where they are holding their own surgery and blood pressure reviews, not the complex stuff that GPs do, but I am not worried about that workforce suddenly going off: I think they will be utilised fully in the new system.

DR DAVID HUGHES: Just to add to that, the pharmacist is the one clinical group of the workforce where we do have an excess capacity of numbers. You are also right, it's the first point of contact for many people, and there are more face-to-face contacts with pharmacists. I think it's in the order of 400 million contacts a year, and it's 300 million in general practice. It's a huge resource and I think it's one we can use more effectively.

FROM THE FLOOR: (Inaudible in parts - reference to budgets).

CHAIR: Margaret's question went off on a tangent. But, Margaret, your reaction to what you heard?

FROM THE FLOOR: I don't think he has answered the question. I am sure that the doctors are not surprised by the number of people who turn up at A and E who should not be there, it's because of the panic and because there is no structure in the local community of who to approach for advice. It's anecdotal, but I think that it's brilliant you have a pharmacist in your surgery, Dr Ollerton, but we are just talking about one here and there; you need to know where the 24-hour pharmacists are near to you. That is a small thing.

You could go on to the services of district nurses: difficult to arrange, and so forth, and home care. It's not up and running.

My question: 'How is this going to be rectified and who will ensure and measure it's achieved'?

In your survey it said, "Most people want care closer to home", but they didn't want you to start any alterations until that was established. So, how will you, or we, know when that care in the community has been established?

CHAIR: Final answer on that please, Panel?

DR DAVID HUGHES: It will be measured by the CCG and that will be something that gets fed back to the CCG Board by the individual practices. We have quite a sophisticated system where I, as a GP, have a service from the district nurses where I can report to the CCG and the CCG collates those opinions. It's not the only source of feedback but it's a very useful one.

There are key performance indicators that the community provider, which is Locala, has to fulfil and when it started it was far from

ideal. My experience of my patients is that it's better than it was 6 months ago.

We are moving forward and I think things are getting better.

CHAIR: Thank you very much for that.

FROM THE FLOOR: Is there a problem getting so many funds from the Government? Is that a problem? Because we are no longer one NHS but a load of little Trusts competing for the funds instead of standing up together and standing up for the patients and demanding the money.

CHAIR: I think that is a big question to take forward. But for the Panel tonight, we said tonight…

FROM THE FLOOR: (Interjection - no microphone).

PANEL MEMBER: We continue to follow things through in the vanguard. Our existing funding is being used for that. Certainly Calderdale have experimented with a number of care options close to home that you have heard about, and the nurses have maintained a lot of people in residential homes, but we have people supporting end of life, being able to die at home when that is their choice when they are coming to the end of their lives. But we know that 50% of the foot-fall is the patients, out-patient reviews, and a lot are not very functional. People often have more than one thing wrong with them and they are going to a clinic for different things. We have seen specialist nurses coming out to deliver to patients and this is what happens.

One of the most influential things I have learned though talking to people through our information sessions is the amount of time that people are exacerbated by break-down in communication. There are long gaps between investigations and getting results. There are long periods of time where they are not sure what is being planned for them and wanting to be more involved in the management. Bringing that service out to the occasional out-patients and into the community I think can only serve to improve that.

CHAIR: We said tonight we would get through 26 questions and, by count, we have got through around 20 of them.

Thank you for your questions and thank you to the Panel for their time tonight: Steve Ollerton, Alan Brook, Carol McKenna, Matt Walsh, Owen Williams, David Hughes, Mark Davies and Jo Middleton. Ladies and Gentlemen (Applause).

This is clearly a process that will go on and I know the Panel will want to hear from you, and that has been stressed over tonight.

There is material on the desks when you leave tonight which will enable you to continue this process. I know the Panel have some hard decisions ahead of them, but thank you very much for your attention.

(Close)