Public Meeting Question Responses – 6th June 2016

Note: Questions have been 'themed' and collated.

TRAVEL, TRANSPORT & PARKING

Question	***How can you say that traffic conditions, particularly re the Elland Bypass, will not cause issues for ambulances travelling to the proposed Calderdale Emergency Centre? How many lives will be lost due to this increase in travel in busy traffic hours?***
Answer	YAS NHS Trust has been fully involved and engaged with the programme and therefore fully informed of the potential changes within the local health economy. The subsequent travel analysis was designed around YAS NHS Trust specification as well as the programme board's requirements. The full travel analysis which has looked into the impact of travel to CRH for those in the Greater Huddersfield area is available on our website. We do not agree that more people will die if the proposed changes were to go ahead; we are making these changes to save more lives, keep people healthy, make services safer and improve quality of care. It is not possible to accurately quantify the likely reduction in patient mortality prior to the changes taking place. However, we know from other reconfigurations, for example the centralisation of Stroke services, that the centralisation of specialist services leads to improvements in patient mortality. We also have data to show that surgical outcomes improved after acute surgical services were centralised at HRI a few years ago, reducing mortality associated with gastrointestinal perforation and obstruction from approximately 12% to 6%. Additionally, In 2005/06 a partial reconfiguration of some hospital services in Halifax and Huddersfield was implemented to concentrate acute surgery and trauma services at Huddersfield Royal Infirmary. The clinical evidence base for this was recognised and supported by Commissioners at that time. Data published by Dr Foster shows that there has been a significant reduction in surgery and trauma service mortality rates (i.e. General Surgery mortality has reduced from 97 to 64, and Trauma and Orthopaedics mortality has reduced from 90 to 53). A full reconfiguration of all the acute specialities and emergency services on a single hospital site could enable even more people to benefit from similar improved safety and reduction in mortality (more lives saved).

Question	***Are you working with bus companies re creating new bus services directly to CRH from areas of Huddersfield?***
Answer	We have undertaken a detailed travel analysis based on current services which is available on our website (https://www.rightcaretimeplace.co.uk/travel-and-transport/). We have committed to setting up a travel group to give further consideration to travel matters – this is detailed on page 39 of the consultation document.

Question	***What are the plans to upgrade Elland Bypass and does this include an emergency point?***
Answer	The proposed road improvements can be found on Calderdale Council's website. Here is the link to the council's plans http://www.calderdale.gov.uk/v2/residents/transport-and-streets/transport-improvements-and-initiatives/a629-improvements

Question	***What arrangements have been made for people who are elderly, have no transport and no family to take them to Calderdale hospital for appointments or visiting relative.? Also for them being discharged.***
Answer	The travel implications for those who do not have a car are detailed in the travel analysis which is available on the website and also considered as part of the Equality Impact Assessment which is Appendix E of the Pre Consultation Business Case, which is also available on the website. We have also committed to setting up a travel group to give further consideration to travel matters – this is detailed on page 39 of the consultation document. The Equality Impact Assessment is Appendix E to the Pre-Consultation Business Case – reviewed the impact on vulnerable and hard to reach groups including elderly. Planned Care services would be provided at HRI, meaning that elderly patients who would have gone to Calderdale, would go to HRI if their operation was under planned care. Only emergency that would go to CRH – which would involve ambulance travel. Our findings in relation to Access to Care are that:

	• The proposed model of care will improve patient ability to access the right care in the right setting • There are no protected groups who are likely to be impacted disproportionately by the proposed changes • There is no material difference in average travel time impact between the two unplanned care site options • An increase in car parking has been included in the capital estimates Co-location is expected to improve levels of safety and efficiency and allow staff to spend more time on patient care which will minimise delays in care pathways, once in receipt of care.

Question	***Have you done a detailed travel analysis and is this based purely on a theoretical model?***
Answer	We have completed two separate Travel analyses: one considers the implications for Ambulance travel and one considers the implications for patient travel. They have both been published on the programme website. The purpose of the Travel Analyses was to understand if there would be a disproportionate impact on either the public or the ambulance service as a result of choosing one site or another. The Yorkshire Ambulance Service operates across the whole of Yorkshire – not just in the geography covered by the two CCGs and the most important time in any ambulance journey is the time the ambulance takes to reach the patient; treatment starts when the ambulance arrives, not when the hospital is reached. The analysis undertaken accounts for the additional ambulance journey time so that, should these proposals go ahead, we have taken account of the additional demand that this would place on their resources. The second most important part is that you are taken to a place where the specialist resources you need are available. This is often not the nearest Emergency Centre. Patients would be taken to the nearest place with the specialist resource available that they need, as already happens now for patients who need specialist care because they have had a heart attack and need to be taken to Leeds or very serious burns and need to be taken to Wakefield. Under these proposals, both A&E Departments would be replaced by Urgent Care Centres to deal with most ambulant patients, with a single more specialised Emergency Centre supporting both Urgent Care Centres so that although the ambulance journey is a little longer, all of the specialist services needed would be available at the Emergency Centre at CRH, which

	would give patients a better chance of a good recovery. The purpose of the Patient Travel Analysis was to understand if there would be a disproportionate impact on the public as a result of choosing one site or another. This covers both journeys made by car and journeys by public transport. Patients who need emergency care would be taken in a blue light ambulance to their nearest Emergency centre – please see above. The patients who would be making their own way to hospital would be those with an Urgent Care need who would go to the same place as they do now. We have committed to setting up a travel group to give further consideration to travel matters – this is detailed on page 39 of the consultation document.

Question	***Some from Greater Huddersfield now travel to Barnsley A&E – how much quicker will it be to travel to Barnsley rather than Halifax and is this factored in to the numbers you expect to go to Calderdale?***
Answer	The assumptions we have made in relation to the numbers of patients we expect to go to Calderdale should these proposals go ahead, are set out in the Pre-consultation business case at section 7.1. The Pre-consultation business case has been published on the programme website. We have committed to setting up a travel group to give further consideration to travel matters such as this – this is detailed on page 39 of the consultation document.

Question	***How will the parking problems be addressed/improved at CRH? What plans are already in place for this?***
Answer	We recognise the need to improve car parking & have taken into account the costs of providing two multi storey car parks. At this stage we are in the process of consultation and therefore no planning consents have been sought. The detail would be worked out and any necessary planning consent applied for should the proposed changes go ahead.

RECONFIGURATION OPTIONS/CRITERIA & LOCATION OF SERVICES

Question	***What are the timescales and 'process' if the proposals go ahead?***
Answer	We will not know what our final proposals will look like until after we have considered the information received during consultation and the final decision has been made post close of consultation. Once the consultation has closed, the analysis report will be fully considered by the Hospital Services Programme Board, which comprises of the two CCGs and Calderdale and Huddersfield NHS Foundation Trust(CHFT). This process will include discussions about what changes could or should be made in response to the comments received There will also be discussions with the Joint Scrutiny Committee of the two local councils so they can take a view on the consultation process, the feedback received and next steps. The Committee may also make recommendations on the proposals to the CCGs. The final decision will be made, in public, by the CCGs as the two bodies responsible for planning and buying health services for local people. We anticipate this will happen in October and all reports including feedback and the consideration given by the CCGs will be made public. It is after this point in October that we will then be in a position to start to work through the process for any implementation. Any implementation that does go forward would not be an immediate process and we would expect any changes to make up to 5 years if not longer.

Question	***Why have you chosen the option you have (and not for example one hospital at Ainley Top) and is this just about the money?***
Answer	Our number one priority is to save more live, keep people healthy, make services safer and improve quality of care – not money. The proposed changes in relation to the model of care are based on clinical best practice and reflect what is best for the patient/population. We looked at a number of ideas and 'tested' them against various criteria which you can read in detail in Criteria for assessing the options. We started with the clinical standards we needed to achieve and then identified the outcomes & benefit for patients we needed to deliver. We then involved clinicians from hospitals and CCGs and developed a potential clinical model. You can read more about our pre-engagement work here. We then looked at how we could deliver this model and started with 11 options (that you can read about in this 11 options –

	PCBC extract) from minimum change to reconfiguration. We then looked at the three viable options in greater detail against the criteria we designed to ensure we delivered against both clinical standards and the outcomes and benefits we need to achieve for patients. We want to be honest with local people and are clear that our assessment shows that doing nothing would not achieve the improvements in quality and safety needed. Other alternatives to the proposed changes would be much more expensive and would be unlikely to attract the funding we would need to develop both hospitals. If we do nothing, we will not have sustainable services for the future. Our proposals would be a significant investment significant additional financial investment in facilities, equipment and staffing over the next five years and will see new, modern healthcare facilities being built in both Halifax and Huddersfield.

Question	***The CCG's single proposal is unpopular with GPs, MPs, Local Councillors & the Public. Do the CCG Members agree this proposal cannot proceed without mandate and will they please be honest enough to themselves that they have no mandate to proceed?***
Answer	We are undertaking a public consultation on the proposed changes. All members of the public are welcome to contribute their views including GPs, MPs and local councillors. We are gathering the views of the public, as well as contributing to the consideration/discussion by the Calderdale and Kirklees Joint Health Scrutiny Committee and other stakeholders, in order to inform the decision of the Governing Body of both CCGs. Therefore the views from the consultation will inform this process and the decision on what, if any changes would go forward into implementation.

Question	***How much has been spent in total on the consultation process?***
Answer	The final cost of the consultation will not be known until the public consultation is complete. The estimated cost is £119,000. The detail behind this is set out in our Consultation Plan which is available on the programme website

Question	***On what evidence do we have that funding wouldn't be provided?***
Answer	Value for Money is one of the criteria used to appraise the alternatives and is set out on pages 12 and 13 of the Consultation Document. Monitor has applied to the Treasury for funding on behalf of CHFT. Should the application be successful, CHFT would have responsibility for repaying the loan (or PFI debt if PFI2 were to be used for the capital funding). Both CHFT and the CCGs believe the submission to be the best case for financial support, in that it would provide the least expensive way to deliver the requirements of our clinical model. We have been clear that progression of the proposed changes is dependent on additional funding being secured.

Question	***The CCG admit that the impact will be greater on vulnerable and disadvantaged groups, therefore penalising those who most need help. How is this going to be addressed?***
Answer	The Equality Impact Assessment, Appendix E to the Pre-Consultation Business Case, reviewed the impact on vulnerable and hard to reach groups Our findings in relation to Access to Care include: • The proposed model of care will improve patient ability to access the right care in the right setting • There are no protected groups who are likely to be impacted disproportionately by the proposed changes We are and have been engaging with representative groups through our community assets as well as encouraging individual survey responses to ensure that we gain views from those vulnerable and disadvantaged groups - this will inform any work taken forward should the proposals go ahead. A full Health Inequalities impact would be taken into account should the proposals proceed to implementation.

Question	***With a current bed shortage in the Huddersfield area how many new bed spaces will be created by these plans. The bed capacity of the proposed new 126 unit elective care hospital at HRI is dependent upon achieving a 6%pa reduction in admissions AND dealing with the discharge of patients into the community. How is this to be achieved when the clear evidence on both input and output numbers is the opposite - ie increasing admissions and up to 150 beds blocked waiting***

	discharge. Surely the new unit at HRI will be too small?
Answer	To determine future bed provision we undertook detailed activity and capacity modelling. This work to support the proposed number of beds has been published in the Pre-Consultation Business Case which is available on our website.

Question	***What investigations are being undertaken to understand the wider implications of this change to out of area hospitals and what have you done to engage/consult with these Trusts?***
Answer	As part of the pre-consultation business case, we have undertaken modelling (see section 7.0) regarding any possible potential impact on neighbouring hospitals of for example Barnsley and Pinderfields. Should the proposed changes be progressed, we would work with all partners and neighbouring Trusts to identify the best way to continue to provide safe high quality care for patients.

Question	***A knock on effect of your plan will increase patients using the 111 service. On numerous occasions this service has reached crisis point unable to cope with demand. What measures have you provided to ensure the correct funding and professional skill mix is provided to sustain this increase of demand to sustain a safe efficient delivery of service?***
Answer	NHS 111 is commissioned regionally and in Calderdale and Greater Huddersfield, NHS Greater Huddersfield CCG is the lead commissioner. Should proposed changes go ahead, as part of developing the full Business Case, we would liaise with commissioners regarding any impacts on the service. You can find out more about NHS 111 at http://www.nhs.uk/NHSEngland/AboutNHSservices/Emergencyandurgentcareservices/Pages/NHS-111.aspx

Question	***Given the modifications that large businesses will have to make to their emergency plans, and the reduced attractiveness of Huddersfield as a place to live and study, can the Panel outline the expected impact that the decision to relocate the A&E services to Halifax will have on the economy of Huddersfield? This has not been addressed by the consultation document.***
Answer	We do not believe the proposed changes will have any adverse impact on local businesses as we are not closing services, but changing the way we deliver them. Under the proposals we would have an Urgent Care Centre and Planned Care centre in a new state of the art hospital built at the Acre Mill site in Huddersfield. Emergency planning by businesses will be undertaken as they are now in liaison with the relevant emergency services.

COMMUNITY

Question	***Can CCGs be CERTAIN that care closer to home will be adequate BEFORE any changes and what assessments will be put in place to ensure community services are fit for purpose?***
Answer	The CCGs have considered the impacts of the Care Closer to Home Programmes in their Governing Body meetings in public. They have determined that they have confidence that the Care Closer to Home Programmes are improving the quality of Community Care and reducing demand on hospitals. There are a number of examples given in the Consultation Document which provide evidence that we are strengthening Community Services, and in the example of Quest for Quality in Care Homes, that we are reducing the number of people admitted to hospital and their length of stay should they be admitted. We will continue to monitor Care Closer to Home via our contracting arrangements.

WORKFORCE

Question	• ***I am aware that the Trust has not been able to recruit sufficient doctors and nurses to staff A & E. How will the new proposal help this situation?*** • ***What about the staff who don't have their own transport and may have to catch 2 or more buses to get to work?*** • ***Could you please give specific figures for the recruitment and retention of GPs and other staff in community based health services in Huddersfield and surrounding districts*** • ***What if any, protection will the CCG give employees of CHFT about the security of their jobs following the proposed restructuring?*** • ***Will the closure of HRI put pressure on ambulance staff and hospital staff?***
Answer	The implications in relation to staffing are included in the Pre Consultation Business Case which is available on the website. No redundancies are proposed. Section 5 of the Consultation Document sets out the involvement with doctors, nurses and other healthcare professionals. Staff have been throughout the consultation period encouraged to have their say as part of this consultation. YAS NHS Trust has been fully involved and engaged with the programme and therefore fully informed of the potential changes within the local health economy. The subsequent travel analysis was designed around YAS NHS Trust specification as well as the programme board's requirements. YAS has identified the additional resource that would be required to meet these hours and this was presented in public to the Calderdale and Kirklees Joint Health Scrutiny committee by YAS on 19th April, 2016 In addition, the shortage of staff is a national problem and workforce is one of the key factors driving the need for

	reconfiguration. CHFT's Five Year Strategic Plan and Workforce Plan have been developed in response to a number of specific workforce challenges the Trust is facing in delivering sustainable, resilient and affordable clinical services for its local population. Workforce challenges include the following • Non-compliance with Royal College of Emergency Medicine's recommendations on Children and Young People in Emergency Care settings, Critical Care workforce standards and Emergency Department consultant cover • Intense, fragile clinical rotas where unplanned services are provided at two sites • Recruitment, retention and vacancy challenges • Long term sickness absence challenges primarily relating to anxiety, stress and depression • Heavy reliance of locum staff – with £21.2m forecast expenditure for FY16 The challenges above arise specifically due to the current clinical service, and are addressed through the proposed reconfiguration of clinical services.

FINANCES

Question	***What services are packaged in to the PFI deal, how much are they each costing/year, and how much could they have been/could they be delivered directly by the Trust through NHS employees?*** ***CRH under PFI commitment included maintenance & cleaning services. Will the new build services be done by the same company as the existing service? Or will The Trust employ it's own cleaning staff as it now does at the HRI site which will loose many staff as a result of the HRI closure?*** ***Why can't the PFI contract at CRH be amended?***
Answer	Information about the PFI can be found at http://www.cht.nhs.uk/about-us/publications/estates-reports/ including what is covered under the PFI contract. The annual budget for CHFT as reported in last year's annual report is £342m The PFI cost is £22m per annum and comprises two components: • £11.745m – for Facilities Management Services – these would be ongoing costs for the Trust regardless of the PFI, i.e. even if we employed the staff ourselves. The contract permits regular benchmarking/market testing of these ancillary costs to ensure we can demonstrate value for money. • £10.255m - mortgage and capital financing costs (if the site was not financed by PFI the Trust would still incur estate financing costs as per the rates that apply to NHS owned estate).

	Therefore The PFI is 6.43% of the total Budget and the services element is 3.35% of the total budget. For completeness, the comparative figures for HRI are shown below: CRH (£000) HRI (£000) • Hard FM (Estates) costs £3,477 £5,658 • Soft FM (Hotel Services) costs £6,370 £7,981 • Maintenance service costs £1,898 £1,283 • **Total** **£11,745** **£14,922** **Percentage of total budget** **3.35%** **4.36%** The situation in relation to the PFI has been considered. CHFT have obtained advice regarding their ability to change the PFI arrangements. The full report can be found here http://www.cht.nhs.uk/fileadmin/site_setup/contentUploads/Calderdale_PFI_Options_Appraisal_KPMG_May_2013.pdf

Question	***Please explain the impact of the Calderdale PFI deal on this proposal and can you provide evidence that the decision wasn't based purely on dealing with this financially rather than improving outcomes for patients.***
Answer	The proposed changes in relation to the model of care are based on clinical best practice and reflect what is best for the patient/population. The full list of alternatives we looked at to deliver the model is in the Pre Consultation Business Case which is on our website. The short list of options considered is included in the consultation document 'Section 6: The alternatives we considered. Also detailed in that section are the criteria we used to undertake our evaluation. Value for money was one of five criteria used. The future cost of running both hospitals was considered. This included the PFI in place for Calderdale Royal Hospital and also included the £100m backlog of maintenance required of Huddersfield Royal Infirmary. If we do nothing, we will not have sustainable services for the future. Our proposals would be a significant investment. But we think it is important to provide you with the best care at right place at the right time and we believe these proposals will help us do that.

Question	***What happens if the Treasury does not provide the funding? You say that there is no 'Plan B' if so what assurances do you***

	have that the Treasury will provide the funding?
Answer	As stated on page 9 of the Consultation Document 'Our proposed changes cannot go ahead if we don't get the money from HM Treasury'. However, as part of our assessment of the alternatives we considered the finances of each alternative. We believe that the alternative that we have proposed provides the best case for financial support, in that it would provide the least expensive way to deliver the requirements of our clinical model.

Question	***What is the total cost of these proposals?***
Answer	As outlined in the Consultation Document, page 12, the total funding required, including the funding to develop CRH as the Emergency Centre would be £470m

Question	***Where will the money go for the sale of the HRI site?***
Answer	The detailed information we have is included in the Pre Consultation Business Case which is available on the website and in CHFT's five year plan – which is available on their website.

Question	***CHFT is potentially winning an award for a new entrance to HRI and, under the proposals, this is to be knocked down. How much did this cost and how can you justify the cost?***
Answer	The changes to the front entrance at Huddersfield Royal Infirmary were made over 12 months ago. There has been no decision made on the future configuration of hospital services. When a decision is made it would still take up to five years to implement any plans. During this time we will continue to undertake necessary building and maintenance work that is required to ensure a fit for purpose, safe environment from which to provide care to our patients.

ENGAGEMENT

Question	***The CCG say there is a high level of dissatisfaction from patients. As a recent attender of A+E and subsequent inpatient I can't see what these complaints are from my experience. Can the CCG please explain?***
Answer	The satisfaction of patients is collected through the Friends and Family test and through the complaints process.

Question	***Have you consulted the Ambulance service, police, councils, staff, clinicians including community pharmacists, doctors, nurses, HCAs and others?***

Answer	1. Re Staff & clinicians We have done significant work to inform and engage staff. The engagement with CHFT staff began three years ago with the development of the outline business case. A note of that work is attached. For CCG staff, The Hospital Standards for the Right Care, Right Time, Right Place Programme were initially developed by a Quality Assurance Group comprising clinical representation from both CCGs. The standards were approved by both CCGs' Quality Committees in August 2014. Following approval of the Hospital Standards, the Quality Assurance Group established the outcomes that we expected these standards to achieve and these, together with the Hospital Standards were subject to engagement at a Stakeholder event in August 2014, and were approved by the CCGs' Quality Committees in December 2014. Subsequent to the development of the Hospital Standards and the outcomes, CHFT worked with their clinicians to establish the Trust's baseline and aspiration for the standards and the CCGs worked to develop a dashboard that would enable us to track our performance. These pieces of work were then used to develop a narrative on the current position in relation to Quality, Safety and Patient Experience. This work, completed by the CCGs and CHFT, was used to produce the Quality and Safety Case for Change that has been included in the Pre Consultation Business Case. The Quality and Safety Case for change was approved by the CCGs' and CHFT's Quality Committees in June, 2015. The membership of the Quality and Safety Assurance Group, The CCGs' Quality Committees and CHFT's Quality Committees is detailed below. In addition to the formal governance, the standards have been part of our developing potential Outline Model of Care for Hospital Services. There have been Five Clinical Workshops and four clinical design groups to develop the overall potential future outline model of care for Hospital Services. These groups have met over a period of ten months between November, 2014 and August 2015. The following paragraphs outline the work undertaken by these groups. Our first workshop, in November 2014 was attended by clinicians from Calderdale CCG and Greater Huddersfield CCG and achieved the following: The development of a common understanding of our journey and where we are on our journey. Agreement of the scope for Hospital services, the standards we want to apply and the outcomes that we expect these standards to achieve. A shared understanding of the different models of Hospital Care described in the Providers' OBC and NHSE 5 year forward

view.

Started to develop a common set of assumptions about the optimum configuration of our future model for Hospital Services

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

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

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

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

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

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

Workshop five was a joint session between senior clinical representatives from CHFT, Calderdale CCG and Greater Huddersfield CCG. This was a strategic session to allow commissioners to share with the Provider, their joint thinking in relation to a potential model for Emergency and Urgent Care, and to understand the Provider's initial views in relation to this. The session then went on to explore the detail of the Providers' Planned Care model as presented in their Outline

Business Case. The overall aim being the further development of a collective view on what our ideal outline model for the future provision of hospital services could look like.

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

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

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

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

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

Membership of Committees:

Calderdale CCG, Quality Committee Membership

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

Greater Huddersfield CCG, Quality and Safety Committee

GP Governing Body Member, Greater Huddersfield CCG (Chair)
2 x GP Governing Body Member, Greater Huddersfield CCG

	Head of Quality, Calderdale CCG and Greater Huddersfield CCG PPI Lay Member, Calderdale CCG Secondary care advisor Required attendees: Quality Manager Greater Huddersfield CCG Head of Practice Support and Development, Greater Huddersfield CCG **Calderdale & Huddersfield Foundation Trust, Quality Committee membership** Head of Governance and Risk Medical Director Deputy Director of Workforce and Organisational Development Deputy Director of Nursing/Interim ADN, Surgery & Anaesthetic Services Division Executive Director of Nursing & Operations Executive Director of Planning, Performance, Estates and Facilities. Associate Director of Operations and Community Services Divisional Director, Surgery & Anaesthetic Services Division Membership Council Representative Assistant Director to Nursing and Medical Directors Finance Director Company Secretary Divisional Director, Family and Specialist Services Division Associate Director of Nursing, Family and Specialist Services Division Associate Director of Nursing, Medical Division Plus Non-Executive Director representation one of which is the Chair of the committee Subsequently, CHFT have done the following (the CCGs engagement is detailed in the answer to Q16 below): • We encourage all staff to respond to the public consultation. Like any member of the public they can respond to the consultation on www.rightcaretimeplace.co.uk • They can also contact the consultation on rcrtrp.myview@nhs.net 01484 464212, or write to Freepost, RTAA-XTHA-LGGC, Heron House, 120 Grove Road, Fenton, Stoke-on-Trent, Staffs, ST4 4LX

	• There is a dedicated RCTP 'Ask Owen' button on the intranet to ask questions or for support – these have all been responded to promptly • Email chft.nhs.uk if staff would like someone to come along and chat to their department or talk on a one to one (but this is not a substitute for them doing a direct response to the consultation) – as a result of this we have attended: - Community services in Brighouse - Ward sisters' meeting - Quality team - The Health Informatics Service - Outpatients team - Staff side • Two staff drop-ins with Owen Williams at the start of the consultation – one on either site. • Weekly Wednesday walkabout by the senior nursing team has included discussion with ward nursing staff about the proposed changes • Held a 'Big Brief' presentation on both sites about RCTP • 1:1 interviews held with consultants between August 2015 and February 2016 • Held 13 staff events across our estates and facilities teams – catering / portering / engineering / switchboard / general office • We have held two staff drop in sessions on 29 April and 4 May, very similar to the public sessions, where staff can share their view. There is a further one planned for 8 June. • There are posters and leaflets across our sites advertising how to get involved • There are stands next to both restaurants advertising how to get involved • There is an update for staff every Thursday in the e-bulletin • There is a 'rolling banner' on the intranet and screen saver, advertising the consultation • Owen regularly mentions the consultation in his blog. • Held a meeting with surgeons • Listening Events on Wards 3, 10, 15, 19, 20 and 22, Surgical Assessment Unit and the Intensive Care Unit. We have not taken notes at all of these meetings and where there were notes we have fed these straight in to the consultation meetings. We have asked staff to feed directly in to the consultation.

2. GPs

In Calderdale we have presented to the LMC 5 times in relation to proposed future arrangements for Hospital and Community health services. We presented to the Joint Clinical Commissioning and Practice Managers meeting (26 GPs and 26 Practice managers) in October and December, 2015 and in April, 2016. Information has also been included in the Jan, March and April 2016 editions of the newsletter which is distributed to all GP Practices.

In Greater Huddersfield we have presented to the LMC through our interface update every month from September 2015 to May 2016.

We presented a webinar on the 16th September, 2015 which was available to all practices live and then added to the intranet page.

We presented at Practice Protected Time (PPT) on 17th November, 2015 to all Practice Nurses, Practice Managers & GPs – (approx. 150 people).

RCRTRP has been discussed at individual Practice visits – May 2014 (previously called strategic review), September 2014, January 2015, May 2015, September 2015, January 2016.

The September 2014 visit referred practices to the engagement events and the website. Updates have been included in the newsletter which is distributed to all GP practices and there is a dedicated page on GHCCG intranet.

The Programme has been a standard agenda item at Practice Managers Reference Group since September 2015 (meet monthly).

We have supplied evidence as part of the NHSE Assurance process that the four key tests have been met:

- strong public and patient engagement;
- consistency with current and prospective need for patient choice;
- a clear clinical evidence base; and
- support for proposals from clinical commissioners.

A copy of the letter from NHSE is available on the website (under Your Questions).

3. Ambulance and other stakeholders

The Yorkshire Ambulance Service has been heavily involved in the development of the proposed changes and have been engaged both in terms of input into the analysis and development of the proposals and as a staff group. We have worked closely with their communications team to provide information to all staff and invite them to complete the survey, attend information events and read the consultation information.

	We have also engaged with councillors as part of the process of oversight of the consultation by the Joint Scrutiny Committee for both Kirklees and Calderdale Councils. We have a detailed list of other stakeholders which we have provided information to in order to raise their awareness, support their communication teams in providing information to staff, arrange meetings or attend meetings and make available any information to support involvement in the consultation. We have also had an extensive programme of work engaging community groups through our community assets.

Question	***Why did the CCG decide not to leaflet every house in Huddersfield and Halifax to ensure ALL residents of the areas impacted by these proposals were fully aware of the consultation and where/how to find out more information?***
Answer	We have leafleted houses in Calderdale and the Greater Huddersfield CCG areas. This was distributed as a non-personalised mail out to all those households (not by individual) that have not opted out of marketing in any way previously. In total just under 130,000 households were sent a copy of the leaflet. We have been pleased to see the large number of calls and emails we have had asking for copies of documents and the survey showing that people are taking notice of the mail drop and getting involved.

Question	***We have not seen consultation information in HRI but have in CRH – why isn't there information at HRI?***
Answer	At HRI there are two main tables – one outside the pharmacy, and one outside the Spice of Life restaurant. At CRH – one table in the main entrance and one in Ingleton Falls restaurant & at Acre Mills – there is a pull up stand in the entrance, and surveys on each floor. There is also a stand and surveys at the bottom of the staircase to catch staff as well as patients that use the stairs. We have also distributed a number to all wards at both hospitals through the post-room, plus I have myself taken surveys to the following high footfall departments: • X-ray • A&E x-ray • A&E • OPD • Eye Clinic (CRH)

	• Blood tests • Endoscopy • Speech therapy corridor (HRI) • Physiotherapy (HRI) • Orthopaedic outpatients (HRI) • Pre-op assessment reception (HRI) • Surgical outpatients (HRI)

Question	• ***Why is this event being ticketed?*** • ***Why such a small venue (again)?***
Answer	We investigated a number of venues with the aim of being able to provide the greatest number of seats as well as have the ability to provide the right technical support etc to enable accessibility needs to be accommodated. John Smith's was the only venue we found to be available on the night with the greatest number of seats, adequate parking and access and able to provide for accessibility. The few venues larger than John Smith's such as the town Hall were not available. Event has been ticketed due to our concerns over health and safety based on the experience of the last public meeting in Huddersfield. There were real concerns over safety of those wanting to attend the event, the impact of large crowds outside the venue and safety of our staff as well. We wanted to be able to better ensure safety of all involved by managing expectations and ticking enabled us to do that.

Question	***Why are you not/did you not take questions from the floor at the meeting?***
Answer	We decided to ask for questions prior to the meeting to help us to manage the number of questions we would be able to answer on the evening by pre-selecting and having people already have their question to hand.

PLANNED CARE

Question	***If someone has a planned operation at Huddersfield, what will happen if they need emergency care?***
Answer	The proposed changes would locate the ICU with the emergency centre. The Planned Care hospital would not have an ICU. Patients for planned surgery will be risk assessed and if they may require HDU/ICU their surgery would be carried out at the unplanned site. For any unexpected complications of planned surgery the patient would be transferred to the unplanned site for ICU/HDU care if required.

	This is the case for most private hospitals and for other stand alone planned care centres.

Question	***How can the proposed new hospital be adequate for the greater number of patients for planned procedures? Will waiting lists increase?***
Answer	To determine future bed provision we undertook detailed activity and capacity modelling. This is included as part of the Pre Consultation Business Case which is available on the website.

EMERGENCY & A&E

Question	***Why should Huddersfield's A&E be transferred to Halifax, the lesser of the two populations? Especially with the population increases and student numbers?***
Answer	The demographics of the population covered by these proposals has been considered in relation to access to care. In order to understand the implications for Access to Care, we have completed a travel analysis and an Equality Impact Assessment. Our findings in relation to Access to Care are that: • The proposed model of care will improve patient ability to access the right care in the right setting • There are no protected groups who are likely to be impacted disproportionately by the proposed changes • There is no material difference in average travel time impact between the two unplanned care site options • An increase in car parking has been included in the capital estimates • Co-location is expected to improve levels of safety and efficiency and allow staff to spend more time on patient care which will minimise delays in care pathways, once in receipt of care. The travel analysis and Equality Impact Assessment are available on our website

Question	***How will CRH cope with the additional admissions?***
Answer	As part of developing the proposals, we undertook detailed analysis of the impact on admissions. Our assumptions and the implications of these assumptions in relation to capacity are set out in section 7 of the Pre-consultation business case available on our website. Under the proposals, we are changing the way we deliver services. There would be an Urgent Care Centre at each hospital (Huddersfield and CRH) which, as our analysis shows, would treat over 50% (54%) of those who are currently admitted to A&E. This is based on actual attendances over a 12 month period and the assumptions used are set out in section 7.1.1 of

the Pre-Consultation Business Case. We have summarised these below:

Urgent Care Centre Assumptions

- The Clinical Director for Emergency Services agreed a list of treatment codes to identify patients who were suitable for management in an urgent care centre (UCC). These are:
  - Adults with minor injuries and / or minor illnesses
  - Children over the age of 5 years with minor injuries

The categories of minor injuries and minor illnesses are highlighted below.

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

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

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

Question	***With the current hospital configuration, opening up elective care beds is possible in order to accommodate for excessive emergency cases who present to A&E at either hospital. With the RCRTRP plans, how will the new emergency centre cope without this resource when large influxes of emergency cases are taken to the 'hot site' (which there will be) and there are no emergency beds left to accommodate the patients?***
Answer	As above, we have done detailed analysis of the impact of the proposed changes to admissions to an Emergency Centre. We have also undertaken detailed activity and capacity modeling. This has shown that we would need 732 hospital beds- this would mean 612 beds at Calderdale Royal Hospital (CRH) (with the potential to increase to 700 if needed) and 120 at the proposed new hospital on the Acre Mills at Huddersfield. The current bed base is 811. Both modelling on admissions and activity and capacity are in the Pre-Consultation Business Case available on the website.

AMBULANCE & AIR AMBULANCE

Question	***Will the CCG commission an independent review of the Ambulance travel times for the area covered?***
Answer	As part of the Pre-Consultation Business Case independent analysis of travel times was undertaken. This is available on our website. We have committed to setting up a travel group to give further consideration to travel matters – this is detailed on page 39 of the consultation document.

Question	***Will additional ambulance services be purchased, and will YAS have enough vehicles and paramedics to cope?***
Answer	The assessment of additional ambulance hours is summarised in the Pre-Consultation Business Case and the full report detailing how these figures were determined is also available on the website. YAS NHS Trust has been fully involved and engaged with the programme and therefore fully informed of the potential changes within the local health economy. The subsequent travel analysis was designed around YAS NHS Trust specification as well as the programme board's requirements. YAS has identified the additional resource that would be required to meet these hours and this was presented in public to the Calderdale and Kirklees Joint Health Scrutiny committee by YAS on 19th April, 2016

Question	***Facilities for air ambulance to land near CRH if Huddersfield A & E is closed.***
Answer	The Air Ambulance is mainly deployed in two main sets of circumstances: Major Trauma or Access difficulties (and sometimes both). Approximately 70-80% of the deployments are for Major Trauma and in these instances the patient would usually be taken to one of the Major Trauma Centres. This is usually either Leeds, Sheffield, Hull or Middlesborough but can on occasion be other major Trauma centres in Wythenshawe or Preston. No patients with Major Trauma are currently taken to Huddersfield or Halifax. There are a small number of instances where a patient in HRI requires the services of a Major Trauma centre and in those instances the Air Ambulance is deployed to take them to a Major Trauma Centre. In those instances where the deployment is solely in relation to poor access (e.g. away from the main road network). The Air ambulance does currently take the patient to Huddersfield. This is in line with current service location. Should this change to Calderdale, the Air ambulance would land at Saville Park, as it used to do when services were previously located at Halifax.

URGENT CARE

Question	***How will UCC in Huddersfield compensate for lack of high quality diagnostic & clinical support?***
Answer	The proposed changes would locate the ICU with the emergency centre. The Planned Care hospital would not have an ICU. Patients for planned surgery will be risk assessed and if they may require HDU/ICU their surgery would be carried out at the unplanned site. For any unexpected complications of planned surgery the patient would be transferred to the unplanned site for ICU/HDU care if required. This is the case for most private hospitals and for other stand alone planned care centres.

MORTALITY

Question	***What risk assessment have you done in regard patient mortality due to the travel to Calderdale from areas in Huddersfield to the proposed Emergency Centre rather than the current A&E at HRI?***
Answer	Our number one priority is to save more lives, keep people healthy and make services safer and improve quality of care. Our proposed changes are based on the clinical standards developed by Royal Colleges and NHS England. These standards are designed to improve mortality rates for people attending the hospitals. In addition, the most important matter in relation to ambulance journey times is how soon the ambulance gets to the individual. Treatment starts as soon as the ambulance arrives and ambulance staff may spend an hour stabilising the patient before taking them to the most appropriate place for treatment. Often this is not the nearest Emergency Centre and would be the nearest hospital that had the specialist resource and equipment to provide the care they need.

	The specific risk assessment in relation to increased journey times is included as section 3.4 of the Quality Impact Assessment which has been published as part of the Pre-Consultation Business Case. Specifically, the risk assessed is: 'Increase in average ambulance journey time due to the requirement for some patients to be transported further to the single Emergency Care Centre.' Both the prior risk level and the risk level should the proposals go ahead are assed as low. The mitigating action is as follows: 'Maintenance of an Urgent Care Centre on the planned site which will support the majority of urgent clinical needs. For blue light patients, evaluation undertaken to date indicates an average increase in journey time from 16 to 22 minutes. The 6 minute increase is more than out- weighed by the benefits of being treated in the most clinically appropriate setting.'