Improving Health *TOGETHER*

People's Commission
Calderdale Council
January 2015

What did the People's Commission do?

In February 2014 Calderdale and Huddersfield NHS Foundation Trust (CHFT), South West Yorkshire NHS Partnership Foundation Trust (SWYPFT) and *Locala* published their Strategic Outline Case. The Strategic Outline Case set out five alternative models for the provision of acute hospital and community health services in Calderdale and Greater Huddersfield. The NHS providers indicated that their preferred option was for Huddersfield Royal Infirmary to become the specialist site for acute and emergency care and Calderdale Royal Hospital the site for planned hospital care, which would mean that there would only be limited accident and emergency services in Calderdale.

This news caused considerable anger and concern throughout Calderdale. Several protest marches took place in Halifax, petitions were signed and there was considerable significant local press coverage.

Following from this concern an extraordinary meeting of Calderdale Council was called on 16 April 2014. Amongst other things, it decided to establish a 'People's Commission', *to take evidence, lead consultation and produce proposals regarding the future provision of integrated health and social care services across the Calderdale and Greater Huddersfield health and social care economy.*

The Council's Cabinet agreed Terms of Reference and membership of the People's Commission when it met on 28 April 2014. In particular, Cabinet agreed to recruit an independent chair for the People's Commission. Professor Andrew Kerslake, of Oxford Brookes University was appointed to chair the People's Commission and six Council Members were appointed to the Commission. The Commission first met on 29 July and held six subsequent meetings.

The work of the People's Commission followed two separate strands.

- Formal meetings, held in public, predominantly questioned NHS bodies, Council officers and voluntary organisations in the health and social care field.
- Nine locality events, held throughout Calderdale, gave Calderdale residents the chance to meet People's Commission members and express their views about a wide range of health and social care matters. Members also went to two Age UK day centres and talked with the people who use their services.

Commission members also visited Calderdale Royal Hospital and Huddersfield Royal Infirmary and Council officers met the Local Medical Committee on behalf of the Commission.

Foreword

Over the past six months the People's Commission has listened to members of the public, heard from all the major health and social care organisations in Calderdale, read their proposals and a number of other documents and deliberated long and hard. Our report describes what we have heard, the conclusions we have drawn and presents our recommendations for the way forward. Not everyone will agree with us, but we hope that everyone will carefully consider what we have to say, particularly as it is significantly based on what Calderdale people have told us.

The prospect of radical changes to hospital services for people in Calderdale led to passionate and – at times – angry debate. That comes as no surprise – health is important to every one of us. Therefore, people want to be confident that any changes made to health care provision are for the better.

We recognise both nationally and locally the pressures that are currently on health and care services, the potential increases in demand and the shortages of funding and staffing. Consequently, we do not agree with those who recommend no change. Rather, we want to see improvements in the health and social care system with better outcomes and reduced health inequalities for those who use services and, in particular, for older people and for those that are vulnerable. In order to deliver better outcomes and an affordable and sustainable solution, a whole systems approach needs to be taken; a solution that just finds a *quick fix* for one part of the system, such as acute care or accident and emergency will not work.

These changes need to be based on strong evidence and there needs to be common agreement about the results of any such analysis and about the way forward. We want to see the Council working alongside Calderdale Clinical Commissioning Group and NHS providers to make this happen.

From our public sessions we recognise people's concerns about; the availability of services, their quality, confusion over who does what and who is responsible for ensuring that timely and appropriate health and care services are available. We also recognise that many people spoke about feeling resigned to changes they did not welcome or powerless, not just in the major decisions about hospital reconfiguration, but also about their own personal care and health needs.

Our report makes fifteen recommendations. This is not a 'pick and mix' selection, we would wish them to be considered as a whole but we believe they are offer a constructive and positive way forward. Our conclusions can be summarised as:

- The proposals in the NHS providers' Outline Business Case do not give convincing evidence that their proposed approach will produce better health outcomes for our population or represent good value for money.
- We would equally suggest that the proposals so far from the Calderdale Clinical Commissioning Group do not evidence that they will take demand away from acute services in general and A&E in particular.
- Calderdale Clinical Commissioning Group should not propose any changes to hospital services, including accident and emergency services – that would be far-reaching and expensive – until and unless there is good evidence that changes to community health services can provide a better approach to health care provision.
- The local health and social care system has not worked well *together* in developing changes. Calderdale Health and Wellbeing Board needs to step up to the mark and take a lead in driving improvement across the health and social care system.
- Calderdale Health and Wellbeing Board should be asked by the Council to take forward our recommendations and ensure their implementation.

The NHS, the Council and other organisations have all responded positively to our requests for information and have attended our meetings when pressure on their time has been at a premium. We thank them all.

Professor Andrew Kerslake, Oxford Brookes University

Councillor Janet Battye

Councillor Geraldine Carter

Councillor Barry Collins

Councillor Marilyn Greenwood

Councillor John Hardy

Councillor Bob Metcalfe

Improving Health TOGETHER – Recommendations

Recommendation 1

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

Recommendation 2

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

Recommendation 3

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

Recommendation 4

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

Recommendation 5

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

Recommendation 6

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

Recommendation 7

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

Recommendation 8

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

Recommendation 9

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

Recommendation 10

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

Recommendation 11

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

Recommendation 12

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

Recommendation 13

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

Recommendation 14

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

Recommendation 15

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

Introduction

The People's Commission was established to examine the health and social care system in Calderdale and how it should be changed so that there are better outcomes for Calderdale people. So we have paid careful attention to what local people have said to us and our recommendations aim to achieve those better outcomes.

The NHS belongs to the people and we pay for it through taxation. Despite its problems, we support it because we believe it is the best way of delivering health care for all of us. In times of difficulty, it is more, not less important, to take the public with you. Therefore, decision making has to be transparent and rational. Consultation has to be genuine not undertaken simply because it is a duty. Public discussion and public involvement in critical discussions has sometimes felt to be too little, too late. That is certainly the view of some members of the public who spoke to us.

Our overall message is clear. Having read, reviewed and considered the documents from the CHFT and the CCG we do not consider that either the case for changing Calderdale Royal Hospital and Huddersfield Royal Infirmary to specialist hospitals, with only one of them having a fully functioning accident and emergency department, or the CCGs suggestions for minor injuries units, are well enough evidenced. Hence they are not convincing. In the case of A&E the national argument for developing sub-regional high level emergency care centres has not been properly considered in the hurried reaction to the serious but short term staffing and financial difficulties that Calderdale and Huddersfield NHS Foundation Trust finds itself in. It feels as if a "clinically led" NHS management has taken decisions that are driven by the suitability of buildings for refurbishment rather than a clear, costed and evidence driven plan that starts with the needs of residents.

Our desired approach is clear. Before we embark on costly and significant changes to hospital and community provision there needs to be clear and unequivocal evidence that shows this is the best cost benefit case available. For example, if there is a move to minor injuries units this should be properly modelled to show how many people this might take out of accident and emergency provision and on what this estimate is based and is it a more cost effective approach. These decisions are too important to make 'evidence free'. Equally that rationale must be shared with the public and consider the range of choices available. Therefore, this needs to take into account wider debates, eg, how health services are going to be delivered across **West Yorkshire** for the next twenty or thirty years. That will require NHS England and the alliance of West Yorkshire CCGs - the 10CC group – to step forward and work with local communities and their elected representatives.

So the proposed changes must be based on hard evidence. And that needs to be evidence that the proposals will be right for the people of Calderdale and – most importantly – that they can see it is right for them. This forms the basis of our first and overarching recommendation.

Recommendation 1

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

We recognise the financial pressures and staffing difficulties that led to Calderdale and Huddersfield NHS Foundation Trust (CHFT) South West Yorkshire NHS Partnership Foundation Trust (SWYPFT) and Locala proposing a specialist hospital model with a preferred option of Calderdale Royal Hospital becoming the "planned site" which would result in a massive reduction in the number of beds in the hospital and would mean that a whole raft of services will not be available locally to Calderdale people. We do not accept this model. We believe the prime drivers should be better health outcomes for the people we represent. Very specialist services should be organised on a sub-regional basis supported by a range of fully functioning community hospitals, as recommended in the NHS Five Year Plan.

Health and Wellbeing Boards were established under the Health and Social Care Act 2012 so the Calderdale Board has now been established for nearly two years. It should be well placed to take a lead on setting the health and social care agenda and driving forward improvements to services. Boards have a clear remit that impacts on the local health and social care system. The Department of Health defines their role as

"Health and wellbeing boards will have strategic influence over commissioning decisions across health, public health and social care…, the board will drive local commissioning of health care, social care and public health and create a more effective and responsive local health and care system. Other services that impact on health and wellbeing such as housing and education provision will also be addressed.

We have made a number of recommendations in this report. We suggest that they are the responsibility of the Health and Wellbeing Board to consider and take forward.

1 The National Context

The national context and policy drive sets an important context for our work. Over the past three years at least the national leadership of the NHS has been clear that there have been too many people in acute hospitals for too long. The Better Care Fund is only one example of a national initiative which recognises that community based alternatives to non-elective hospital admissions can and should be delivered.
The national economic situation has put pressure on NHS budgets, as well as the rest of the public sector and future plans for the NHS and social care services have to be made within these constraints.

We accept these are absolute constraints for local service planning, however unpalatable that may sometimes be. We support initiatives to reduce the number of people admitted to hospital and to minimise the length of time that they stay there. But we want to see alternatives to hospital care that are based on hard evidence and can quantify the number of people who will benefit and any savings on expenditure that will follow.

2 The Local Debate

The Calderdale and Huddersfield Health and Social Care Strategic Review has been considering the local response to providing more care out of hospital and closer to home since 2012. Yet, these have predominantly been internal, officer discussions and have barely appeared on the public or elected Councillor radar.

We would argue that the lack of discussion involving the public was a major factor in bringing about the public consternation that arose when the Strategic Outline Case (SOC)[1] was published by the three providers in February 2014. The publication of the SOC did have the benefit of bringing the public into a debate that hitherto had generally passed them by. But the publication of a clear set of proposals, with a preferred option that the site for unplanned hospital care should be Huddersfield Royal Infirmary inevitably led many people to believe that was the official proposal and the inevitable outcome. We lost count of the number of times the public told us it was a "done deal".

The four largest parts of the health and social care system locally – Clinical Commissioning Groups, health care providers, local authorities and general practice - should be working together to develop proposals for changes to health and social care that bring about better outcomes for our local population. However, we would suggest that we have not seen the four parts of the system working well together since February. CCG and health providers have been either side of the commissioner – provider divide, the process of preparing a Better Care Fund Submission has, on occasion, been tense, and we are not sure that all GPs have engaged meaningfully in the development of proposals to change community health services.

Phase 1 of *Closer to Home*, which intends to reorganise community health services into locality hubs has major implications for general practice, CHFT, who currently provide most of these services, the Council's adult social care services and, of course the Clinical Commissioning Group. It presents a golden opportunity for the four parts of the system to work together and design new ways of working that are evidence based and have a *quantified* financial structure and clear targets for volume of service and for diversion from hospital or institutional care.

We have given this report the title, Improving Health *TOGETHER* and we recommend that the Health and Wellbeing Board should take a lead in making this happen. The Health and Wellbeing Board is an important committee of the Council

[1] The Strategic Outline Case was followed by the Outline Business Case being made public in November, although it was made available to the CCG by providers in May 2014.

where the Council, NHS partners and other meet – in public - to bring about improvements in the health of Calderdale people. We want to emphasise the importance of the Health and Wellbeing Board in leading on this important work, even though the statutory responsibility for commissioning may lie with some of its constituent members. This should also give greater public prominence to partnership work across the health and social care system and so provide a much higher level of public accountability.

Recommendation 2

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

So far health service providers have not been significantly involved in the work of the Health and Wellbeing Board. We think that the Health and Wellbeing Board will be strengthened if they have a seat at the table.

Recommendation 3

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

3 Hospital Reconfiguration

We agree that hospital services for Calderdale people need improving. Here, as across the country, too many people use A&E services. Too many people have to wait more than four hours before being treated. Too many people remain in hospital when they are ready to be discharged. Like hospitals up and down the country there is a critical shortage of A&E doctors and other key clinical specialists. These problems need fixing.

We agree with Sir Bruce Keogh that "*to avoid people choosing to queue in A&E, or being taken to hospital unnecessarily to receive the treatment they need, the service outside hospital must be improved and enhanced"*. This will help fix some of the problems. We also agree with him that there should be *emergency centres* on hospital sites.

Neither Calderdale Clinical Commissioning Group nor Greater Huddersfield Clinical Commissioning Group have yet made any proposals for ensuring that their embryonic plans to deliver changed community health services will reduce demand for hospital based provision. The providers – CHFT, SWYPFT and Locala have made a proposal through the SOC and the Outline Business Case. At the time of the publication of the SOC they expressed a preferred option for two specialist hospitals with Huddersfield Royal Infirmary being the Acute and Emergency Specialist Hospital and Calderdale Royal Hospital being the Planned Specialist Hospital. Although the Outline Business Case does not express a preference, the document gives a clear

steer towards the same end. So, in the absence of other proposals, we have considered the providers' proposals.

The providers' plans for hospital services are essentially a building based strategy, where services are allocated in different ways between the property and land that they have, rather than starting from identifying the services that people need or on the real agenda, which is how can demand for health care be reduced. Without having clarity about how this can be achieved the solutions currently on the table amount to no more than a temporary fix. The proposed approach, of just two options, may not be the right approach but it is certainly not the only approach. It is not consistent with the view expressed to us by Calderdale Clinical Commissioning Group who consider that there are a number of different options. It is not consistent with the work of the West Yorkshire Commissioning Collaborative (the 10cc Group) which is examining *Urgent & Emergency Care – the future designation of major emergency centres* on the West Yorkshire footprint. It is not consistent with NHS England's Five Year Forward View, which identifies the "need to manage systems – networks of care – not just organisations".

People who attended our locality events generally agreed that they wanted specialist services to be available, even if they are not locally based. Their main concerns centred on the perceived risks that may arise because of longer ambulance journeys although the ambulance service was at pains to stress to the Peoples Commission that treatment started when the ambulance arrived not when the patient was delivered to hospital. The Outline Business Case identifies no significant risks arising from the longer ambulance journeys that would occur for some people if Calderdale Royal hospital and Huddersfield Royal Infirmary become specialist hospitals. We accept the clinical judgement that the benefits of having a specialist service outweigh any increased risk that arises from longer ambulance journeys. However, should a hospital configuration be introduced that results in longer journey times, there is substantial work to be done to reassure the public about this.

NHS England has signalled a move to sub-regional Major Emergency Centres and across West Yorkshire the 10 Clinical Commissioning Groups are meeting as the West Yorkshire Commissioning Collaborative to discuss urgent care. Our second recommendation supports taking a sub-regional approach.

Recommendation 4

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

4 Accident and emergency care

We agree that when people are very ill, high quality specialist services must be available at the *emergency* end of the A&E spectrum. Therefore, the quality and availability of provision has to be a higher consideration than its geographical location. This already occurs, where some Calderdale patients already go straight to Huddersfield Royal Infirmary or Leeds hospitals when they become very ill. We also recognise that many people end up using emergency hospital based services either because they feel community services are not available at the time they need them or perhaps they are not aware of the range of services they could use.

We were told by the lead A&E clinician that the current service across the two hospitals is understaffed, struggling to cope and relying too much on locum doctors and nurses. We recognise that, as at the national level, fewer doctors wish to work in A&E services and of those that do, being a locum gives them greater discretion over hours, less responsibility and higher pay. We would want to encourage any national initiative that helps to resolve this, but recognise in the meantime that a safe A&E service is a higher priority than a split A&E service.

At the *accident* end of the A&E spectrum, the Outline Business Case proposes that the Acute and Emergency Specialist Hospital would provide a comprehensive service that is open all hours. The Planned Specialist Hospital would have a nurse-led minor injuries service for both adults and children. Services here would be available from 8.00am until 10.00pm seven days a week. And there would be two “specialist community hubs”, one in Calderdale and one in Greater Huddersfield, that would provide minor injuries services for adults only, opening the same hours as the unit at the Planned Specialist Hospital.

We agree that there should be locally available services where wounds and injuries can be treated. It was one of the clearest messages that people gave us at our locality events. But again this plan of the providers seems to be building based and gives no indication of how much demand the three minor injuries units – Todmorden, Holme Valley and the unit at the Planned Hospital - would divert from the service at the Acute and Emergency Specialist Hospital. We welcome the suggestion of developing a *specialist community hub* at Todmorden but we see no clear argument for this other than the fact that there is a suitable building there and that it is some distance away from the likely location of the Unplanned Specialist Hospital. There are no proposals for other local specialist community hubs in Calderdale other than at Todmorden. We are concerned that, given the limited service that will be available at the specialist community hub and at the Planned Specialist Hospital, rather than diverting services from the Acute and Emergency Specialist Hospital, they may become extra front-doors to A&E or a diversion from GP services.

A comprehensive *urgent care services plan* should be prepared by Calderdale Clinical Commissioning Group, CHFT, general practitioners and pharmacy that starts from the premise of diverting the third of patients from A&E that the hospital says should not be there and then looks at the staffing, premises and resources required to deliver that outcome before coming to any conclusions about location and staffing.

Recommendation 5

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

5 The Hospital Buildings

Calderdale Royal Hospital is owned by CHFT under a Private Finance Initiative (PFI), a way of creating "public–private partnerships" by funding public infrastructure projects with private capital. The PFI agreement runs until 2061. Huddersfield Royal Infirmary is owned by CHFT.
As we said before, there was a sense from both the outline business case and the discussions we had that decisions were being significantly driven by the buildings and land available rather than taking a wider view of what was the best approach to delivery. To an outsider it would seem bizarre that the older hospital with the poorer quality premises would be the site retained whilst the modern purpose built hospital, with a sizeable debt to service, that only a few years ago was heralded as a centre of excellence, would become the lesser site. It is little surprise that the public therefore loses confidence in such decision making or looks for more Machiavellian explanations.

Clearly the Huddersfield site has more land potential for development. However, we were not convinced that a full site appraisal of the Halifax hospital together with the people who hold the debt for the PFI had been undertaken. There was not discussion with the LA over this and some of the explanations put forward seemed trite, ie problems with car parking. Equally, we did not have confidence that if the proposals for Halifax being the planned hospital were approved that any real thought had been given to what should happen to the rest of the building. A throwaway line that 'we could have a care home on the site' would be completely contrary to the councils and the public's wishes to lessen the use of residential care and is ill thought through.

Therefore, we do not accept that the case has been made to reduce the number of hospital beds to 85 at a purpose built, modern hospital like Calderdale Royal Hospital, described by CHFT as "a modern centre of excellence" and then to search around for alternative uses for the site. The *binary* proposal for hospital provision is driven by the requirement to cluster key services on the same site as the accident and emergency department. A West Yorkshire wide hospital strategy could allow for Calderdale Royal Hospital to be used to its full capacity, taking full advantage of the investment that has been made in the estate.

The PFI clearly presents a problem to CHFT, especially if they do not wish to or are unable to cost-effectively use the site. It also is a significant burden for SWYPFT, who provide services from The Dales at Calderdale Royal Hospital. The interest

payments on the deal – an eye-watering £10m a year - could be far better spent on health promotion, illness prevention or social care services. We recommend that strenuous efforts are made to explore what variations may be made to the PFI agreement.

Recommendation 6

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

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

6 Financing our Health Services

We received strong assurances from both the Clinical Commissioning Group and health service providers that their proposals for change are clinically-led and aim to achieve better health outcomes for the local population. They have also told us that they need to operate within the budgets that they have been given and achieve their efficiency targets. We accept this– it is the real world.

However, we do have some serious concerns about the approach that is being taken.

A local Commission such as our own can only have a minimal impact on national policy on structuring the NHS. Nevertheless, we set out in this section our concerns that the way of funding NHS services is not efficient and does not drive improvements in the quality of the services provided.

The commissioner / provider split might produce a more efficient and higher quality service if there was actual competition in the "market" that has been created. However, when it comes to acute services we in effect have mock competition, where there is no real choice and no real sanctions if the provider does not deliver. As Professor Alan Maynard said to the House of Commons Health Committee in May 2013;

Commissioners are weak, compared to GP and hospital providers ie PCTs/CCGs are price and quality takers rather than price and quality makers. This problem is evident in both public-NHS and private health care systems ie private insurers also tend to be price and quality takers.

The relationship between Foundation Trusts – such as CHFT – and Monitor creates an economic driver that has a strong risk of not being consistent with local commissioner objectives. The need to attract income leads to Foundation Trusts seeking to "attract business" from other areas, so that CHFT needed to include statements in the Outline Business Case such as:

> ***Income drift***
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> *The relocation of activity to Calderdale may result in a significant decrease in people choosing to access services at CHFT and more people choosing to go to Sheffield or Barnsley due to the demographics in South and East of Huddersfield. The ability at Calderdale to attract additional patients out with the current cohort is limited by the geography to the West of Calderdale and the location of*
> *other Trusts immediately to the East who currently attract activity away from Calderdale. Conversely development on the HRI site may mean patients to the North and East of Calderdale who currently use CHFT services may instead access provision from other Trusts. However this would be more than outweighed by the ability to draw in additional activity to HRI from Denby Dale, Holmfirth and the Penistone areas all of which under the new Government initiatives have plans for additional new homes in the near future. These factors are important to long-term viability.*

We do not criticise CHFT for taking this approach – the system forces them to do this. But we do not see it as benefiting Calderdale residents.

We sense a move away from simple market models by NHS England in the Five Year View. People who spoke to us at our locality meetings were overwhelmingly in favour of a health service funded from public taxation and free at the point of delivery. But some expressed concerns about the way that the NHS is financially structured, so we hope that – after the election – the Government will undertake a root and branch review of the funding mechanisms for the NHS.

Within the difficulties that the system creates, we are not convinced that the Outline Business Case proposals deliver the savings that are required for CHFT to balance the books. That is a view we believe is shared by others within the healthcare system. We have not undertaken a detailed analysis in this report, but from what we saw and read we were not persuaded that the full extent of the costs of the changes had been accurately estimated neither was there a balanced view of the two options. For example on our visits we were told of equipment that might simply be jettisoned and new bought because it was either too difficult or too expensive to move. Therefore, we would refer back to our earlier recommendation that the Health and Wellbeing Board should take oversight of ensuring that commissioners and providers have an agreed financial plan to achieve their ambitions for improving the health

outcomes for Calderdale residents. Although in most of our report we have focused on the needs of our residents, we recognise in this instance that Greater Huddersfield CCG needs to be involved.

Recommendation 8

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

7 Travel to Hospital

Local people told us that they were very concerned about the impact on travel time to hospital arising from any hospital reconfiguration. We have three points to make.

We accept the clinical advice that the advantages of highly skilled specialist units for people who are very seriously ill or have suffered severe trauma outweigh any risk created by increased journey times for ambulances. We agree that treatment begins when the ambulance arises. When the CCG does present firm proposals for any rearrangements to hospital services, however, we would expect to see them supported by a detailed analysis of the impact on ambulance journey times.

Locally based *minor injuries* services should allay concerns about journey times as – hopefully – they will be reduced from the current position, during the opening hours of those units. The more limited proposals of the Outline Business Case offers no reduction in journey times for parents of children needing the service, and some reductions for some adults during opening hours.

We are concerned about the impact that a specialist hospital model will have on the relatives and friends of people who are hospital inpatients. As hospital in-patients have become older, so their wives, husbands, partners and relatives are older, often without access to a car. Daily visiting for some of them could become substantially more difficult. When the CCG consults on plans for changes to hospital services, we expect there to be a clear plan for visitors that takes account of visiting times. The plan should be prepared with the full involvement of public transport bodies and their commitment to address this issue.

Recommendation 9

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

8 Community health services and services closer to home

From the perspective of the Peoples Commission, given the lack of evidence in the OBC we feel it was a wise decision of the Clinical Commissioning Groups to postpone their commissioning decisions until improvements to community health services have been made and their impact assessed.

It would have been helpful if Calderdale Clinical Commissioning Group had made their specification for Phase 1 of Community Services available for the public to consider and comment on. The CCG published this document in January 2015. We wish this could have happened earlier, so the public could have been better involved. However, we have been able to use the specification to help us prepare this report.

Closer to Home Phase 1 anticipates a reorganisation of a range of community health services from Borough-wide services to an integrated service based on five localities built around clusters of GP practices with a single point of access. These services will not be re-commissioned at this stage, but will be amended through renegotiation of existing contracts with the current providers. Most of these services are provided by CHFT.

The Closer to Home Phase 1 specification does have some consistency with the community health services proposals in the providers' Outline Business Case, which may help commissioner / provider negotiations. We are less clear at this stage about the extent of the engagement between Calderdale Clinical Commissioning Group and general practitioners and Calderdale Council's Adults Health and Social Care Directorate. This is an opportunity to provide real improvements to services for local people and build on, and contribute to, the achievements of the objectives of the Better Care Fund. "Services … integrated around the patient" as called for in NHS England's *Five Year Forward View* will – we believe – improve services for people with long term conditions and other needs. But the localities need to be far more than just a different front door to the same services. That will require a radical approach signed up to by all those responsible for delivering services in the community.

In order to use changes in the delivery of community health services to inform proposals for the future shape of hospital services, there need to be measurable outcomes that their success – or otherwise – in diverting services from acute hospital and taking demand out of the system may be judged against. We have not seen these yet.

We have little to say about Closer to Home Phase 2, which will include transferring some services from a hospital base to the community, as there are precious few details available. Calderdale Clinical Commissioning Group have said that they anticipate some of these proposals may constitute "substantial variations in service", which would mean that there would be a period of formal consultation. As with Closer to Home Phase 1, we hope that there will be sufficient time to influence the impact of the changes before any hospital reconfiguration services are finalised.

It is our view that the Closer to Home proposals will take some time to implement. Phase 2 of Closer to Home, which will include transferring some services from a hospital base to community bases, will almost certainly require formal consultation

with the Calderdale and Kirklees Joint Health Scrutiny Committee, which will take at least twelve weeks. These arrangements will need some time to bed-in and be given a chance to make a difference. We think it extremely unlikely that there will be sufficient evidence available on their effectiveness in taking demand out of the system, supporting more people nearer to home rather than in hospital and in improving health outcomes for those people until they have been allowed to run for at least a year. We agree with Calderdale Clinical Commissioning Group that any proposals for reconfiguring hospital services should be informed by how the Closer to Home Services have worked. In order to take well-informed, evidence driven decision on any proposals for hospital reconfiguration, they need to be given a chance to make the changes necessary to justify that hospital reconfiguration.

Recommendation 10

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

9 General Practice and other Primary Care Services

We had more discussion at our locality events about General Practice than anything else. Some people we spoke to had nothing but praise for their GP. Others had a number of concerns, often about access to service and waiting times for appointments. It was clear to us from the locality events and other evidence we have considered that there is a considerable variation in the quality of general practice across Calderdale.

Access to good quality general practice is the cornerstone of the NHS. We heard evidence both at our locality events and from others that there is considerable variation in the quality of services provided by GPs. Variations include access, waiting times for appointments, and the outcomes achieved. We hope that the new inspection regime for general practice will bring about improvements and greater consistency.

We know that across a whole range of conditions, from dementia to diabetes early diagnosis can make a real difference to patient's quality of life and life chances. Good and effective intervention by GPs also reduces demands on other parts of the system.

We also see co-commissioning of general practice by NHS England and Calderdale Clinical Commissioning Group as a golden opportunity to take a Calderdale-wide approach to the provision of general practice that would also help eliminate inconsistency and help ensure that GPs are fully built into different, more integrated ways of working.

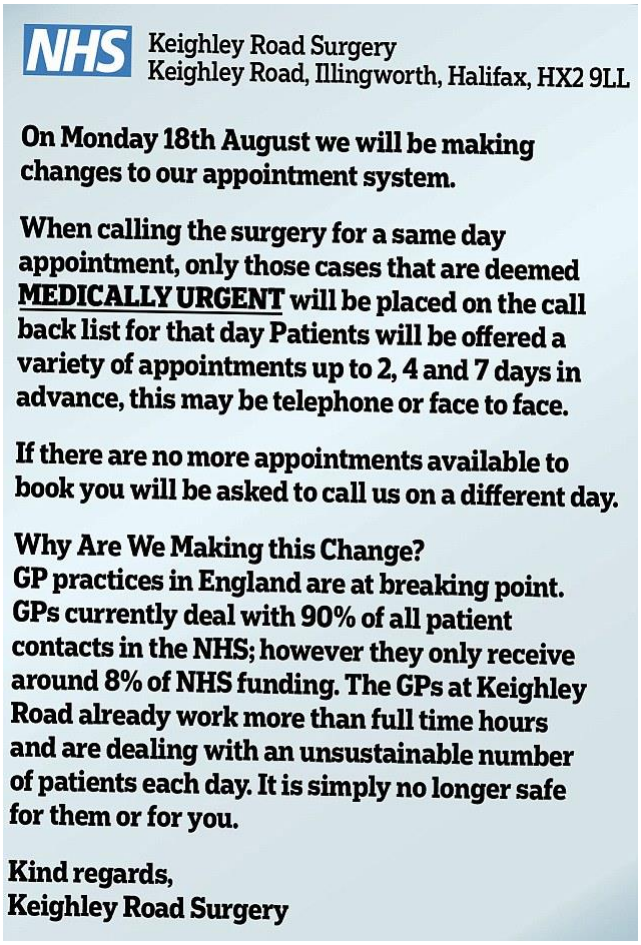
Recommendation 11

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

A number of GPs in Calderdale are now in their fifties and so likely to retire in the next few years. We also heard that new entrants to general practice are less likely than formerly to regard general practice as a career for life. Although West Yorkshire is better placed than other parts of the country in this respect, these workforce pressures are a cause for serious concern.

We are not clear about the extent to which general practitioners (other than those who sit on the Governing Body of Calderdale CCG) have become meaningfully involved in the proposals for realigning community services or in the provider proposals for hospital reconfiguration. It is our view that GPs should play a central role in the provision of integrated health and social care services, managing demand on hospital services, and in planning for change.

We have been told that there is low morale amongst GPs for a number of reasons – we certainly suspect that this was a contributory factor to us not succeeding in engaging with more GPs – and that this is due to increasing demands on their limited resource, and the increasing number of demands on them from a national level. Proposals in the Outline Business Case place some emphasis on the role of GPs in the provision of community health services. We wonder whether the profession is currently well placed to take on new and different roles. In August, shortly after we began our work, one Calderdale practice wrote to their patients about changes to the appointment system. Their letter is reproduced here. Whilst this may not be a representative view across Calderdale, we certainly feel it is indicative of considerable pressures within the system.



NHS Keighley Road Surgery
Keighley Road, Illingworth, Halifax, HX2 9LL

On Monday 18th August we will be making changes to our appointment system.

When calling the surgery for a same day appointment, only those cases that are deemed MEDICALLY URGENT will be placed on the call back list for that day Patients will be offered a variety of appointments up to 2, 4 and 7 days in advance, this may be telephone or face to face.

If there are no more appointments available to book you will be asked to call us on a different day.

Why Are We Making this Change?
GP practices in England are at breaking point. GPs currently deal with 90% of all patient contacts in the NHS; however they only receive around 8% of NHS funding. The GPs at Keighley Road already work more than full time hours and are dealing with an unsustainable number of patients each day. It is simply no longer safe for them or for you.

Kind regards,
Keighley Road Surgery

One Calderdale resident told us about talking to a local practice in her role as a town councillor and said, "*The Town Council went to see the GPs. They were clearly stressed. Dr X was angry and very stressed.*"

It seems clear that a good number of people attend A&E because they are not able to get – or believe they will not be able to get – a speedy appointment with their GP. There needs to be a close examination of the whole system for accessing urgent health care. The plans to move community health services closer to home focuses on the needs of people with long term care, reducing inpatient admissions, and helping people get out of hospital more quickly. It does less for people who may visit A&E rather than seek alternatives.

The Outline Business Case sets out those services that could be provided from a "community hub" at Todmorden and the CCG plans for improvements in community health services also *fast-track* the development of services at Todmorden. This presents an opportunity for developing closer working relationships between general practice and community health services that could be replicated in other parts of the Borough.

We were interested to hear from West Yorkshire Community pharmacy about their "Pharmacy First" scheme in Bradford. Whilst there has been publicity about the benefits of consulting a pharmacist rather than going to see your GP or visiting A&E, we believe that more formal ways of enhancing the role of pharmacists should be explored.

Recommendation 12

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

10 The Better Care Fund and Social Care

We heard evidence from the Director of Adults Health and Social Care at our first meeting and some people commented to us about social care services in our locality meetings. But overwhelmingly the evidence we received was about health services and that is reflected in the balance of our report.

The Council's Adults Health and Social Care Scrutiny Panel and Calderdale Clinical Commissioning Group have worked closely together on the Better Care Fund, which identifies schemes for 2015/16 totalling £15.9m, predominantly aiming to reduce hospital admissions and lengths of stay in hospital. The Better Care Fund will be implemented from April 2015. An agreement between the Council and the Clinical Commissioning Group will govern the operation of this pooled budget. All the schemes in the Fund have the overarching objective of reducing the number of unnecessary admissions to hospital.

One of the consistent themes of our work in the People's Commission is that the health and social care system needs to work together, not in competition. Pooling budgets through the Better Care Fund with common objectives is one sensible way of doing this. No one pretends that it has been easy, or will be easy in the future. However, the acid test is not about whether you integrate management or co-locate premises but does the end user, the population of Calderdale, experience a joined up

service. We had some dramatic stories presented to us about how people experience disjointed care where people do not know who will deliver, what help, particularly to older people.

The Better Care Fund has been a start to integrated commissioning and alignment of health and social care aims. The development of a single point of access through the Closer to Home initiative on community health services needs to be consistent with social care objectives and its relationship to those initiatives being supported through the Better Care Fund should be clear.

Sharing objectives and budgets requires partner organisation to cede some influence and understand each other's different service needs. We worry that the funding structures for the NHS and local authorities make this difficult to achieve.

The Better Care Fund and the development of integrated health and social care services are important developments in the ways that Calderdale people are served. We need to ensure that they are working well and making a difference. We consider that the Adults Health and Social Care Scrutiny Panel are the right people to undertake this review. This should take place annually and be reported to the Health and Wellbeing Board.

Recommendation 13

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

11 Prevention rather than cure

For years, pundits and practitioners alike have argued that prevention is better than cure. Clearly patients would prefer to avoid getting ill in the first place (primary prevention) or, if they do get ill, ensure that it is diagnosed at an early stage and that arrangements to manage the condition effectively are put in place as soon as possible to allow them to continue living autonomous and active lives (secondary prevention). Evidence was presented to the Commission highlighting that whilst the NHS came top on most comparisons with other health systems in the developed world, it fared poorly with regard to health outcomes for the population. We also know that whilst people live longer the period of ill-health or morbidity in older age has hardly got less and it is that which is the single highest driver of demand for health and social care services..

Prevention and effective management of conditions in the community is also likely to be more cost effective than waiting for patients to turn up sick at the doors of our GP surgeries or hospitals. Of more than 250 studies on prevention published in 2008, almost half showed a cost of under £6,400 per quality-adjusted life year and almost 80% cost less than the £30,000 threshold used by the National Institute for Health and Clinical Excellence (NICE). And although some interventions take many years to pay-off, others do not - for example, suicide prevention has an immediate impact and

effective management of atrial fibrillation or hypertension can show results within a couple of years. Smoking cessation programmes can have an impact over the short term when targeted on Chronic Obstructive Pulmonary Disease patients at risk of acute admission.

Prevention is also an important way of tackling the persistent inequalities in life expectancy and healthy life expectancy across England. Within Calderdale life expectancy and healthy life expectancy varies across our communities by up to 11 and 15 years respectively. Not only is reducing this unwarranted variation the right thing to do, CCGs also have legal duties to address inequalities in both access to services and in health outcomes. Health and Wellbeing Boards are central to deliver these improvements. The local authority is the lead agency given its statutory function to deliver on wellbeing and the authority should ensure that council decisions are examined for its impact on promoting health and reducing inequalities

The local health and social care system should consider how it can leverage the full range of resources to fund prevention priorities. The Better Care Fund creates a pooled budget that can be deployed with the agreement of Health and Wellbeing Boards to invest in prevention - particularly out-of-hospital services - and early detection. However, it is also likely that existing budgets controlled by other local partners could be deployed more effectively - be they schools, local government, local business or health and care providers. The Health and Wellbeing Board needs to ensure that it supports and drives co-ordinated activity to impact on local prevention priorities.

Public health is a new and important part of the Council's responsibilities. We need to ensure that they are being undertaken effectively and are making a difference. We consider that the Adults Health and Social Care Scrutiny Panel are the right people to review this. This should take place annually and be reported to the Health and Wellbeing Board.

The Council also has a significant role to play in its funding of voluntary sector provision, in the range of services it offers and in the way it exercises its role as a planning authority.

Given the cost and importance of health and social care the Council needs to ensure that in its decision making it is always taking into account whether its actions will reduce the demand for health and care provision. Therefore, in funding voluntary organisations the question needs to be can such bodies evidence that they will reduce the demand for health and care services. When planning roads and highways, libraries and the whole range of services the Council provides or funds, will these help to support and maintain more people in the community. Finally, in its planning decisions are we, as a Council, creating an environment where older people are encouraged to safely remain within the community rather than feeling excluded because local shops and facilities are no longer available, or transport is not accessible or their neighbourhoods are no longer safe. A corner stone of more older people remaining within the community is a community they wish to remain in.

Recommendation 14

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

12 Communication

Issues around communication were one of the common themes in our locality events. Issues ranged from individual communication between doctors and nurses and patients through to engagement on changes to the health and social care system undertaken by the NHS and the Council. There was also some criticism of the way in which we publicised our own locality events.

Our focus here is on publicity campaigns aimed to encourage people to look after their own health and how best to get help when they are unwell or need support and on communications around service change.

There is a shared objective across the health and social care system of reducing demand on health services by improving people's health and through making sure people are aware of which services are available and appropriate to their needs. Considerable effort and expense has gone into this on a national and local level. Some public health campaigns have had a significant impact – the overall reduction in smoking levels is one outstanding example.

There has also been significant publicity about not attending A&E unless it is absolutely necessary. However, we have been told by the CCG and CHFT that there are still high levels of "inappropriate" attendances. We are not critical of the amount of the efforts that have been put into these campaigns. We think they should continue and that there should be an increased emphasis on the alternatives available to people. All parts of the health and social care system, including GP practices and the Council should be actively involved in these campaigns.

Recommendation 15

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

The publication of the Strategic Outline Case in February 2014 led to high levels of public engagement throughout Calderdale about the future of health services in our Borough. We welcome this. Health is a very important issue for people and they should be fully engaged in debate about every aspect of the services that they pay for. Engagement exercises are important, but are sometimes – either in reality or perception – framed around the questions that health and social care organisations want answering, rather than about finding out what is really important for people. Strong, vigorous, political debate about public services is important and helps build

commitment to those services. Those of us engaged in governance – both in the Council and the NHS - need to embrace that debate, even when it is bruising. We need to make sure that the public have access to all the information they want and that our business is carried out in public and transparently as far as possible.

The NHS is accountable to the public, communities and patients that it serves. *The NHS is a national service funded through national taxation, and it is the Government which sets the framework for the NHS and which is accountable to Parliament for its operation. However, most decisions in the NHS, especially those about the treatment of individuals and the detailed organisation of services, are rightly taken by the local NHS and by patients with their clinicians. The system of responsibility and accountability for taking decisions in the NHS should be transparent and clear to the public, patients and staff.*

NHS Constitution

This report has been written by Calderdale Council's People's Commission. You can contact us at peoplescommission@calderdale.gov.uk

We are currently assembling our back ground papers and research documents, which will be available on our webpage http://www.calderdale.gov.uk/council/consultations/peoples-commission/index.html

What Calderdale people told us

Throughout August and September 2014 nine locality events were held across the borough to speak to members of the public about what they would like from their Health and Social Care Services in Calderdale in the future.

This chapter sets out some key messages from those discussions. We have tried to balance positive comments with those less sympathetic.

The views of the public have been a major influence on our work – and we have reflected public views throughout our report.

At our last formal meeting we were presented with a petition with 1689 signatures saying “No to downgrading of A&E in Halifax or Huddersfield”. The extent of the support for that petition demonstrates the level of concern amongst local people.

Support for the NHS

At our locality meetings there was overwhelming support for the NHS, especially as a service that is *free at the point of delivery*.

Some people expressed strong concerns about whether any changes to hospital services and community health services might lead to privatisation of NHS services.

Others felt that hospital staff undertaking private practice as well as NHS work led to a conflict of priorities and delays for NHS patients.

GPs / General Practice

There were probably more comments made about general practice than anything else. Some people could not speak too highly of their GP.

Many people had comments to make about access to GP services, including difficulties in getting appointments within reasonable timescales, opening hours, and seeing a different doctor every visit.

Positive comments were made about the walk-in centres in Calderdale, although people were uncertain about their current status and the future plans for them.

People were interested in exploring different ways of communicating with their GP, including email, telephone call-backs from the GP, on-line appointments, text reminders for appointments.

I got stung by a wasp and went to A&E. If the clinic down the road had been open I would have gone there.

Some people considered that general practice is a service under considerable pressure and were also aware that the age profile of GPs means that a number of

Calderdale GPs will retire in the next few years. Some said they were aware of low levels of morale amongst GPs. There is considerable disparity in the quality of service offered by individual GPs and different practices.

I am autistic hence I struggle to communicate with people over the phone at my surgery. As I didn't understand what they were telling me the receptionist referred me to A&E

There was an understanding that people use A&E when they can't get an appointment with their GP. There was interest in the opportunities for developing services around GPs, such as walk-in centres and minor surgery services.

The x-ray service is excellent at Todmorden Health Centre. We also have eye consultant services and paediatrics. They can do pre-op assessments at the Todmorden Centre. The blood test centre is fantastic.

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Funding NHS and Social Care Services

People understand that public services are under severe financial pressure and that the NHS and social care services are no different. As you would expect, Calderdale citizens have a wide range of views about national funding for public services.

Financing of the NHS needs to be talked about by all the political parties.

The Private Finance Initiative that was established to build Calderdale Royal Hospital and the cost of servicing the agreement is a source of serious concern to a number of people. Some could not understand a proposal that would "downgrade" the modern hospital at Halifax and then spend considerable sums on improving the hospital at Huddersfield.

Halifax hospital is modern as opposed to Huddersfield hospital. Why are we closing parts of it? It doesn't make sense.

People are aware of the increasing demands on health and social care services. They mentioned the increasing population; house building programmes; technological advances in medicine, and dementia.

The funding of social care was raised by several people, including the fact that whilst health care is free at the point of delivery, service users pay for social care services. Personal budgets were seen both as an opportunity, but also something that some people couldn't cope with.

Our house is the only thing we have, but we may have to use it to fund care.

Members of the public were clear that some people make demands on services that arise from their own actions, so there were several vigorous discussions about whether people who present drunk at A&E should be charged for the services they receive. Others were worried about the resource implications of “health tourism”.

The balance between personal responsibility for looking after our own health and that care provided by services concerned some people, who felt some are too ready to make demands on the NHS. They felt that there were efficiencies that could be made without reducing services, in particular around missed appointments.

I’ve just been to the GP. He told me he had just seen someone who only wanted paracetamol.

Transport to Hospital

The prospect of having further to travel to get to Accident and Emergency alarmed most people, who were worried that insufficient account was being taken of travel times, for ambulances, people travelling to A&E themselves and for hospital visitors.

It takes 2 hours each way to get from Todmorden to Huddersfield hospital – what if you have no money to travel, or no transport. We want services close to home.

People gave examples of the costs of getting a taxi from their home to Huddersfield Royal Infirmary. Others felt that current public transport routes to the hospitals were inadequate.

Our son had a heart attack, the paramedic was called and our son was taken to Leeds by air ambulance (helicopter). He was stabilised in the helicopter and a stent was fitted within 20 mins.

My grandfather was in the Intensive Care Unit. Grandmother visited every day – she couldn’t have done that if he had been in Huddersfield.

Experiences of ambulance services varied. Some recounted life-saving services. Others long delays. There was a recognition that care starts with the paramedics when the ambulance arrives, but some were unsettled by press reports of reduction in paramedic cover in ambulances.

When an ambulance comes to you it is like the hospital coming to you

Accident and Emergency Services and Hospital Reconfiguration

People who attended our locality events were very clear that they wanted an accident and emergency department retaining at Calderdale Royal Hospital, preferably with the full range of services. This was the most consistent message from the locality events.

Calderdale Hospital should continue to function as a full hospital – with a full A&E service

People were very unclear about what conditions are covered by a minor injuries unit and the distinction between “planned” and “urgent”. A minor injuries unit would need to provide 24 hours a day, seven days a week cover.

Some people accepted the need for specialist hospital care. Pinderfields Burns Unit was quoted as an example. Some welcomed the idea of specialist hospitals.

I couldn’t go anywhere but A&E as it was the only place that was open.

Several people gave examples of very long waits to be seen at accident and emergency and questioned whether one A&E unit covering Greater Huddersfield and Calderdale would be able to cope. Although there was recognition that there is a shortage of A&E doctors, people weren’t sure that a single unit would be able to recruit sufficient medical staff.

A number of people expressed a view that Calderdale Royal Hospital is a more modern and pleasant building than Huddersfield Royal Infirmary. Some felt that the service they received at Huddersfield Royal Infirmary was very good.

Huddersfield hospital is very *tired*

I found the service quite brilliant at Huddersfield

Some people described very positive experiences from hospital services. The eye clinic and dermatology were singled out as being good.

A few people felt that maternity services should be retained at Calderdale Royal Hospital.

The importance of visits to hospital inpatients was emphasised by some, as well as those for whom attending hospital or visiting is more difficult, such as single parents..

What about visitors, it will be half a day trip if people have to travel to Huddersfield hospital.

Reconfiguration / Right Care Right Time Right Place / Integration / General Policy

A number of people expressed strong views about the process for arriving at the proposals included in the Strategic Outline Case, the plans for consultation and the ability of the People's Commission to make a difference.

There was a recurring theme that change is a "done deal" and financially driven, and that consultation will be meaningless.

People feel it is a done deal – it's not about improving quality, it is purely financial – as tax payers we should have a right to be heard. Messages are now so confusing- need to make information around the proposed changes simple

People did want better coordination between general practice, community health services, mental; health services and Council social care services. People offered a range of suggestions for improvements. Improvements in community services were needed to underpin changes in the hospitals.

If you injure yourself you need a walk-in centre which operates out of hours to deal with minor injuries.

And people had views about how to prevent ill health, both through individuals taking more responsibility for their health and through wider societal issues.

We have to get people back into work, get their self-esteem back. This will reduce their health problems

Communication

Communication was also a thread running through the locality events. As well as criticism of the levels of communication about possible changes to NHS structures, people told us that they sometimes didn't know which service to contact or how to contact services. They found it difficult to talk directly to the people they needed to.

I'm at a loss to understand how the system works

The NHS system is seen as increasingly complex.

People told us about how medical records sometimes were not transferred from one Trust to another.

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Some felt that the 111 service was not yet working as well as it could.

The People's Commission was seen as a positive initiative by the Council by some people, but they questioned whether the exercise would reach enough people, particularly black and ethnic minority communities.

Adults, Health and Social Care and Mental Health Services

The role of social care in helping people leave hospital is well understood. But some felt there were battles over "who should pay" between social care services and hospital services, which were to the detriment of the patient.

National concern about 15 minute visits by home care staff were echoed by Calderdale residents, as well as the amount of travel time that staff working for private companies have to undertake, sometime unpaid.

Carers don't get enough time in people's houses, 15 min calls are the norm

Positive views were expressed about the Carers' Service and Gateway to Care, although one person would have welcomed more training.

I have looked after my mother for 15yrs and received no training. Training of any kind would have been appreciated, especially around lifting

Views were expressed that changes to mental health services by SWYPFT and Calderdale Council should be built into the People's Commission work.

The Case of Mr B

Mr B was an elderly man who was a full time carer for his wife who had dementia. He had two daughters one of whom lived with him and his wife and the other who lived nearby. Mr B contracted cancer in June and went downhill rapidly dying in October of the same year. Most of the care was taken on by the two daughters particularly the one that lived ‘at home’ not only of Mr B but also his wife.

It is clear that the family wished to avoid hospital admissions, a death in hospital and that the two daughter were prepared to deliver most of the care, thereby saving health and social care considerable sums of money. However, it was also clear that they did not feel able to do so unaided.

The way in which Mr B was dealt with highlights a number of issues in continuity between health and care services.

- The time of diagnosis is not the best time to answer questions. People are often too shocked and cannot ask the right questions at that time. Equally non-critical data should be captured at a time when the family feel it is right to give it, not when someone outside the family determines they would like to collect it.

- It was not clear about who is responsible for patient management often for services that straddle health and social care and when and from whom those services might be available. Patients facing sudden conditions will not understand systems or who delivers what kinds of services.

- The system is not proactive, even where likely events are known it only reacts once a problem has occurred. In this instance falls and bed sores were predictable but not planned for in advance.

- The existence of one or more carers should be celebrated as both cost saving and as a preferable means of care. Hence they should be fast tracked for additional support on the basis that the longer they can continue caring the better the quality of the care is likely to be and the greater the level of cost saving. This was not the case in this instance.

- Carers did not feel part of discharge procedures and those procedures did not feeling patient sensitive.

- Poor management of incontinence and an expectation that carers can manage this.

What this illustrates is that even within a consistent service for known and common circumstances there are parts of the system that do not work well. Carers are not supported in the way that they wish to be helped and nobody seems to be in charge of the process that they can regularly access. If major changes are planned in health and care it will be vital that new systems are in place before the old are abandoned.

PEOPLE'S COMMISSION - PUBLIC DISCUSSION THEMES