WAKEFIELD and KIRKLEES JOINT HEALTH SCRUTINY COMMITTEE

Response to the "Meeting the Challenge" consultation on proposals to develop a Mid Yorkshire Hospitals NHS Trust Clinical Services Strategy

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Chair's Foreword

This report presents the findings of the Joint Health Scrutiny Committee for Wakefield Metropolitan District Council and Kirklees Council on the proposals to develop a Mid Yorkshire Hospitals Clinical Services Strategy outlined in the Consultation "Meeting the Challenge"

The Joint Health Scrutiny Committee have undertaken a thorough, evidence based review of the key proposals, looking in-depth at both the clinical arguments for change and the potential impact on patients.

Contextual information, evidence and subjective judgement have been explicitly presented, evaluated and considered by the Committee and the perspective of doctors and managers have been closely examined by a range of other viewpoints drawn from patient, public and professional groups.

My thanks to the many individuals who have given valuable time and input in to the evidence gathering process. I would like to thank the Committee members: Councillor Yvonne Crewe, Councillor Elizabeth Smaje, Councillor June Drysdale, Cllr Derek Hardcastle, Councillor Tony Wallis, Councillor Eric Firth and Councillor John Lawson.

Finally thank you to the scrutiny support team, Andy Wood, Luara Ellis and Penny Bunker.

Councillor Betty Rhodes
Chair
Waklefield and Kirklees Joint Health Scrutiny Committee

Terms of Reference and Working Arrangements

The Local Authority (Overview and Scrutiny Committees Health Scrutiny Functions) Regulations 2002 provide for local NHS bodies to consult the appropriate Overview and Scrutiny Committee where the NHS body has under consideration any proposal for a substantial development of the health service or for a substantial variation in the provision of such a service in the local authority's area.

During consideration of the "Meeting the Challenge" consultation the 2002 regulations have been replaced by the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013. In these circumstances the regulations provide for transitional arrangements:[1]

Under the legistaltion, health scrutiny committees have powers to summon officers of health trusts to committee meetings, to require information from NHS bodies on the planning and provision of health services, and must be consulted by health trusts about significant changes to service provision. It has been agreed that the proposals in the consultation "Meeting the Challenge" were significant and are therefore subject to statutory consultation with Overview and Scrutiny.

Where proposals to change health services span more than one local authority area there is a requirement to establish a joint health scrutiny committee. In Yorkshire and the Humber, a protocol has been established between the 15 upper tier local authorities for establishing a joint scrutiny committee where proposed changes affect more than one local authority area.

The proposals in "Meeting the Challenge" impact on residents in Kirklees and Wakefield Councils and a joint Committee of councillors from both local authorities was therefore established to respond to the proposals.

The Joint Health Committee has the following roles and functions in relation to the Mid Yorkshire Hospitals service configuration consultation:

- To scrutinise the proposed service configuration and its effect on patients and the public.

- To require the Commissioners (Wakefield Clinical Commissioning Board and the North Kirklees Clinical Commissioning Board) to provide information about the proposed service configuration and where appropriate to require the attendance of representatives from relevant organisations to answer such questions as appear to it to be necessary.

- To prepare a report for the Joint CCG Board and participating local authorities, setting out any comments and recommendations on the service configuration.

[1] [1]34 – (1) Where a relevant committee has reviewed or scrutinised a matter under regulation 2 of the Local Authority (Overview and Scrutiny Committees Health Scrutiny Functions) Regulations 2002 ("the 2002 Regulations") before the relevant date but, has yet to make a report or recommendation under regulation 3 of those regulations , the health scrutiny authority may make a report or recommendation on that matter under regulation 22 of these regulations.

- To receive from the Joint CCG Board its formal response to this report and to determine whether any concerns expressed by the Committee has been addressed.

- To report to the Secretary of State in writing if it is not satisfied that the consultation with the Joint Health Scrutiny Committee on the proposals, have been adequate in relation to the content or the time allowed.

- To report to the Secretary of State in writing if it considers that the proposals are not in the interests of the health service in Wakefield and North Kirklees.

The Joint Health Overview and Scrutiny Committee will consider the likely implications across Wakefield and North Kirklees. This will include consideration of the

- Projected improvements in patient outcomes;
- Likely impact on patients and their families (in the short, medium and longer-term), in particular in terms of access to services and travel times;
- Views of local service users and/or their representatives;
- Potential implications and impact on the both the local health economy and the local economy in general;
- Any other pertinent matters that arise as part of the Committee's inquiry.

Membership of the Committee

The membership of the Joint Health Scrutiny Committee is:

Cllr Betty Rhodes (Chair)	Wakefield Council
Cllr Elizabeth Smaje	Kirklees Council
Cllr Yvonne Crewe	Wakefield Council
Cllr Derek Hardcastle	Kirklees Council
Cllr June Drysdale	Wakefield Council
Cllr Eric Firth	Kirklees Council
Cllr Tony Wallis	Wakefield Council
Cllr John Lawson	Kirklees Council

Committee activity

The Joint Committee held 9 formal meetings between June 2012 and July 2013, to receive information and evidence from a wide range of individuals and organisations.

DATE	COMMITTEE ACTIVITY
1 February 2013	Consideration of the Outline Business Case
8 March 2013	Consider and agree The Joint Committee's project Brief and Terms of Reference
12 April 2013	To consider the proposals in relation to Travel and Transport, and Care Closer to Home

24 April 2013	To consider the proposals in relation to Mental Health, Social Services and Maternity Services
03 May 2013	To consider an interim review of the consultation process
10 May 2013	To consider the proposals in relation to Maternity Services, Obstetrics, Paediatric Services, Emergency Care, and Surgery. To receive public deputations (of which written notice had been given)
24 May 2013	To consider the proposals in relation to Yorkshire Ambulance Service, Evidence from Mike Wood, MP; and public deputation from Paul Wheelhouse from "Save our Hospitals
1 July 2013	To consider the Outcome report of "Meeting the Challenge"; Maternity Services; Community Maternity Services and public health.
22 July 2013	To consider the Joint Committee Findings Report.

The Joint Committee's report was subject to consultation with the NHS prior to final publication

The work of the Committee was supported by an officer team from Wakefield Council and Kirklees Council – Andy Wood, Overview & Scrutiny Officer, Wakefield MDC and Laura Ellis, Principal Governance and Democratic Engagement Officer, Kirklees Council.

The Committee is grateful to the wide range of individuals and organisations who were invited to attend the public meetings of the Committee and to provide evidence including:

ORGANISATION	**INDIVIDUAL**
Mid Yorkshire Hospitals NHS Trust	Stephen Eames Interim Chief Executive Ruth Unwin Director of Communications and Engagement Caroline Griffiths Director of Corporate Planning and Contracts Dr Simon Enright Consultant and Lead for the Clinical Services Strategy Mahesh Nagar Consultant Anaesthetist and Clinical Director for Surgery James Newman Consultant Orthopaedic Surgeon Simon Harrison Consultant Urologist Paul Curley Consultant Vascular Surgeon Chris Macklin Consultant Dr Matt Shepherd Consultant in Emergency Medicine and Clinical Director for Medicine Dr Kath Fishwick Consultant in Obstetrics and Gynaecology and Head of Women's Services Dr Karen Stone, Consultant Paediatrician and Clinical

	Director for Integrated Care Tomasina Stacey Consultant Midwife Dr Ann Carroll Chair of Paediatric Work Stream Group Iain Brodie Head of Facilities Ann Ward Head of Midwifery Richard Jenkins, Medical Director Sarah Robertshaw, Head of Service for Acute and Emergency Medicine Clive Barrett, Safeguarding Lead, MYHT
Wakefield Clinical Commissioning Group	Jo Webster Chief Officer Tracey Sparkes Workstream Lead on Travel and Transport Jeanette Miller Head of Engagement Lee Beresford Head of Commissioning Dominic Lee Project Director Meeting the Challenge Alan Cowie Meeting the Challenge Jayne Beecham Head of Communications Martin Carter – Head of Communication and Engagement Meeting the Challenge Ian Carr Workstream Lead Officer David Hutchinson – Patient Representative
Yorkshire Ambulance Service	Tasnim Ali Senior Service and Quality Improvement Manager Joanne Halliwell Director of Business Development Angela Harris Andrew Simpson
North Kirklees Clinical Commissioning Group	Dr David Kelly – Chair North Kirklees CCG Chris Dowse Chief Officer and Director for Transition Calderdale and Mid Yorkshire Health and Social Care Partnership Helen Severns Assistant Director
Mental Health	Michele Ezro Ms Basford
Transport Advisory Group (TAG)	Valeria Aguirregoicoa Chair Glenys Harrap, Patient Representative

Consultation Institute	Rhion Jones Programme Director
Wakefield Council	Jim Crook Corporate Director Family Services Rob Hurren Director of Integrated Care Kim Curry Service Director Health Commissioning
Kirklees Council	Ms Richards Assistant Director Wellbeing and Integration Mr Smith Assistant Director Personalisation and Commissioning
Public Health	Dr Hooper Director of Public Health
Public Deputations	John Sheen Christine Hyde Mr Hallworth Mr Iqbal Duri-Wala Kevin Swift Mike Wood MP Paul Wheelhouse
Written Submissions	Mary Hardwick Jan Settle Julie Smith Sally Porter Kim Baker Kirklees Council Dewsbury Area Committee Doug Sykes Normanton Town Council Cllr Cathy Scott Dewsbury East Ward Cllr Peter O'Neill Batley West Ward Cllr Amanda Stubley Batley East ward Cllr Darren O'Donavan Dewsbury West Ward Cllr Karen Rowling Dewsbury West Ward Dr Thimmegowda, Practising GP in Dewsbury METRO

Background

Mid Yorkshire Hospitals Trust was formed in April 2002 when the former Pinderfields and Pontefract Hospitals Trust and Dewsbury Care Trust merged together.

The Organisation is a large acute hospital Trust, serving the communities of Wakefield District and North Kirklees. The Trust also treats patients from surrounding areas, including South Leeds, North Yorkshire, Barnsley and Doncaster.

Recommendations /proposals for the future shape of services have been made by NHS Wakefield Clinical Commissioning Group and NHS North Kirklees Clinical Commissioning Group in conjunction with Mid Yorkshire Hospitals NHS Trust. A formal public consultation has been undertaken which concluded on the 31 May 2013.

Over the last 12 months commissioners and the Mid Yorkshire Hospital Trust have been developing plans for a sustainable model of clinical services across Wakefield and North Kirklees.

An external review on strategic viability had been commissioned by Yorkshire and Humber SHA in 2011 which led to the development of a number of reconfiguration options. These options have been developed further into two options which now form the basis of the Trust's Outline Business Case (OBC) for the clinical services strategy (CSS).

Option 1

- Emergency Departments, ICU and HDU facilities at Pinderfields and Dewsbury & District Hospital
- Consolidation of paediatric inpatients and non-elective general and colorectal surgery at Pinderfields
- Dewsbury becomes a midwifery led maternity unit, Clinical Decision Unit for acute medicine, centre for neuro rehabilitation, elective surgery and Day case unit
- Out of hours support services required on Dewsbury site to support some non-elective care.

Option 2

- Pinderfields becomes a 'hot site' and Pontefract and Dewsbury become 'cold sites' mainly for elective activity and sub acute services
- Dewsbury becomes a midwifery led maternity Unit, Clinical Decision Unit for acute medicine, centre for neuro rehabilitation as in Option 1
- Consolidation of all non-elective activity at Pinderfields together with ICU and HDU facilities
- Minimum out of hours support services required on Dewsbury site

The Committee was informed that the prime focus of the CSS is to ensure the future configuration of acute services delivers high quality and safe patient care with optimal levels of efficiency. As part of the wider transformation programme to provide care outside of hospital, the strategy will also play a key role in ensuring the local health system can achieve overall financial viability for the long term.

Capacity modelling for acute service capacity had been completed and sensitivity tests have been undertaken with Clinical Commissioning Groups. In particular further work has been undertaken on the following aspects:

- Length of Hospital Stay – target reductions in length of stay have been agreed across specialties
- Drive Time Analysis of Activity – Further work was being undertaken to understand the impact of 'drive time' analysis for Dewsbury and District Hospital services on alternative providers.
- Growth in Demand – Whilst the acute service capacity model is based on ONS growth of 1.2%, further work was commissioned by CCGs to assess the wider factors impacting on activity trends including the changes in acuity of patients who will be supported by alternative services in the community.

The Trust is working in close partnership with Clinical Commissioning Groups. Discussions have taken place on the following activities:

- Reviewing and undertaking assurance in relation to the length of stay reduction targets
- Developing the integrated community and primary care service opportunities for Pontefract and Dewsbury hospitals
- Developing the approach to a series of clinical meetings to develop service models for key pathways.

The CCGs had commissioned PricewaterhouseCoopers to undertake a review of the current community service provision, and model the financial impact of the changes in pathways in terms of integrated service options and future resources. A dedicated task group was also being established by the CCGs to review patient and public travel requirements. Both CCGs have expressed an initial interest in developing the future opportunities for Dewsbury and Pontefract hospital sites as a 'Health Campus' providing a wide range of community based services.

On the 10 January 2013, the Calderdale, Kirklees and Wakefield Cluster Board considered a report on the Outline Business Case which highlighted the commissioning case for change and the configuration options. It is suggested Option 2 provides both a clinically and financially sustainable solution and is the preferred option. The Board agreed to support the Outline Business Case and agreed to proceed through the Service Change Assurance Process to public consultation. A formal public consultation commenced on the 4 March 2013 and concluded on the 31May 2013

Background and case for change

Mid Yorkshire Hospitals NHS Trust (MYHT) is the main provider for hospital services for the population of North Kirklees and Wakefield and community services for the Wakefield District. Community services in North Kirklees are provided by a social enterprise called Locala. The Trust provides services for a population of about 500,000 people and it has areas of significant deprivation where life expectancy is 9.9 years lower for men and 7.2 years lower for women than the most affluent areas. It is expected that the number of older people as a proportion of the population will grow by over 50% by 2031.

Presently the Trust has three hospital sites:

- Wakefield – Pinderfields Hospital which has the full panoply of acute hospital services in addition to specialist services (spinal injuries unit and burns unit).

- Dewsbury Hospital – this is a district general (DGH) style hospital which provides a full panoply of DGH style services including A&E department, acute admissions and some components of specialist surgery, for instance colorectal surgery.

- Pontefract Hospital – this has a limited emergency admissions unit which will see appropriate patients triaged by the ambulance service who do not need acute admissions, in addition there is elective surgery and other cold site services.

Six reasons have been suggested for changing the way in which healthcare is delivered in Mid Yorkshire:

1. The need to adopt new models of care and best practice that can deliver better outcomes for patients and deliver safe and quality services
2. The need to improve the health of people in Wakefield and North Kirklees and ensure healthcare services are meeting public expectations
3. The population is rising and aging, leading to greater and different demands on health services
4. The hospital is not always the answer; more care can be delivered in community settings, and patients may benefit from care closer to home
5. There are workforce challenges which currently prevent delivery of the best quality care and optimal patient outcomes
6. The need to make the best use of taxpayer's money

Three options were considered by the provider and commissioners. The "do nothing" option was dismissed. Option 1 with reconfiguration of general and colorectal surgery, children's and maternity services but leaving a Type 1 ED at Dewsbury and the medical acute services virtually untouched. Option 2- the favoured option- is a more substantial plan of reconfiguration and is the one subject of public consultation.

This will consolidate the changes at Pontefract, preserving the emergency care unit, elective orthopaedic and ophthalmology services, day case surgery, short stay surgery, clinical decision unit, rehabilitation including stroke, midwife led maternity unit (including births), outpatients and diagnostics.

Pinderfields will become the main complex and acute hospital with an emergency care centre receiving trauma and unselected acute medicine, acute surgery, acute and elective gynaecology, elective surgery requiring critical care support, day case surgery, haematology and medical oncology, the specialist centres as before, children's inpatient, consultant led and midwife led maternity units (alongside MLBU would be a new development), neonatal unit, outpatients and diagnostics.

Dewsbury would see a change from being an emergency care centre to being an emergency care unit providing 24/7 urgent care, elective surgery, elective ophthalmology centre, day case surgery, clinical decision unit, medical investigation unit, rehabilitation including stroke, neuro-rehabilitation unit, midwife led maternity unit (losing the consultant led obstetric unit), outpatients and diagnostics. Both the Dewsbury and Pontefract changes would allow for the development of a primary care health campus. This will be a full health campus, not just for primary care.

NHS Response
Dewsbury does not currently have a specialist emergency care centre as it does not offer a full range of sub-specialty acute medicine. The model of services was set out in detail in the presentation and supporting documentation prepared for the evidence session of 10 May 2013. The emergency care model is described in section 2 of the document entitled 'Emergency Care' presented at this meeting which sets out that both Dewsbury and Pontefract A&Es would deal with selected ambulance attendances by pre-agreed protocols together with all walk-in patients. This will amount to around 70% to 80% of existing patients in Dewsbury. There will be no change to the case mix at Pontefract.

Committee Comments
It does in the Outline Business Case. Page 20 "Meeting the Challenge" OBC 24 December 2012. For the purposes of clarity the difference between an Emergency Care Centre and an Emergency Care Unit was explained in the OBC – This response highlights the continuing confusion of what is currently provided and what will be provided if the proposals are implemented**.**

Option 2 would allow savings of up to £10million recurring if the Trust is able to achieve an overall reduction in capacity by 200 beds. The changes would mean that the Trust would need to focus most of its elective work on the Dewsbury campus to free up capacity within Pinderfields to absorb the transfer of the acute work. There would be a new build at Pinderfields (50 beds) to accommodate this increase in acute work.

NHS Response
The proposal to build an additional 50 bed unit at Pinderfields will be amended in the full business case and will now constitute redevelopment of office accommodation to provide the clinical capacity within the hospital building and new build of a stand-alone office block.

Elective surgery and orthopaedic work at Dewsbury would need to be selected and all patients risk- assessed to identify those patients who might require critical care post-operatively.

NHS Response
The presentation and supporting documentation prepared for the evidence gathering session on 10 May 2013 sets out the proposed surgical model. Section 2 of the document entitled 'Surgery' describes the proposal that elective work would focus on Dewsbury **and** Pontefract.

It is envisaged that the arrangements for urgent care at Dewsbury would lead to an overall reduction in activity (A&E attendances) by 20% and that a much lower proportion would require inpatient admission. The evidence is that a significant proportion of patients presently only require short-term admission. It is expected that this proportion of patients could be managed differently but other may require transfer by ambulance to the main acute unit at Pinderfields.

Transfers could also be to other acute hospitals such as Leeds.

Bringing together the acute medical team and emergency medicine team on the one site at Wakefield will mean for the first time the Trust is able to meet the requirements for more consultant presence within the emergency medicine department, but it should be able to preserve a during-the-day presence of an emergency medicine consultant at the Dewsbury site and access to advice out of hours.

NHS Response
The emergency care model is described in the presentation prepared for the evidence session on 10 May 2013 and is described in the document entitled Emergency Care. The model described is consultant presence from 9am to 8pm (subsequently amended to 10pm) and on-call consultant cover 24/7. Other consultants are also currently on site overnight and at weekends and an A&E consultant is on call 24/7. This will not change. In addition, the Pinderfields service will provide access to a full range of specialist and sub-specialist teams 24/7.

Committee Comments
The Committee has questioned the comment that "other consultants are also available on site and at weekends" and asked for some clarification on this.

For maternity care the main change is that there would be only one consultant led obstetric unit, and this would be Wakefield. The rest of the maternity services would remain in situ at Dewsbury and Pontefract with the creation of a standalone midwife led birthing unit (MLBU) at Dewsbury, there being an existing MLBU at Pontefract, and the creation of an alongside MLBU at Pinderfields. This decision in part has been driven by the need to provide more consultant cover on the labour unit in keeping with the recommendations of the Royal College of Obstetrics and Gynaecology. It should enable the Trust to raise consultant hours on the labour unit from 60 hours to 168 hours. It is expected that the new obstetric unit and alongside MLBU would cater for over 6,000 births per year.

The other part of the decision is the requirement for a single paediatric inpatient unit. Presently the Trust has found it difficult to recruit and retain medical staff to two inpatient paediatric units. Consolidation on one site will enable the Trust to bring together the paediatric workforce in one place which will improve sustainability and make available specialist services throughout the Trusts sites

NHS Response to the Draft Report

North Kirklees
Clinical Commissioning Group
Wakefield
Clinical Commissioning Group

16 August 2013

Dear Councillor Rhodes

THE DRAFT FINAL REPORT OF WAKEFIELD AND KIRKLEES JOINT HEALTH SCRUTINY COMMITTEE ON PROPOSALS TO DEVELOP A MID YORKSHIRE HOSPITALS NHS TRUST (MYHT) CLINICAL SERVICES STRATEGY (MEETING THE CHALLENGE)

NHS North Kirklees Clinical Commissioning Group and NHS Wakefield Clinical Commissioning Group (CCGs) would like to thank the Joint Health Scrutiny Committee for Wakefield and Kirklees (the Committee) for the opportunity to comment on the draft **Response to the "Meeting the Challenge" consultation on proposals to develop a Mid Yorkshire Hospitals NHS Trust Clinical Services Strategy.**

We have structured our comments as follows:

- Within the body of this covering letter, we have provided our broad response to the report and addressed some key themes; and
- Within the lengthier annex, we have responded with detail to specific elements of the report.

Both CCGs support the Committee's role in ensuring effective challenge to our local strategies and plans and we welcome the depth and detail covered by the thorough scrutiny process undertaken by the Committee. Indeed, we agree with and support many of the observations made in the report. Where we do not, then we also respect the Committee's right to take a different view.

However, we are concerned that there are a number of areas where we believe the Committee had information which provided a more balanced view and which does not, in all cases, appear to have been taken into consideration. We want to draw these to your attention and work with you to ensure the document is a true reflection of the current position. In responding to this draft report, we have received input from Mid Yorkshire Hospitals NHS Trust (MYHT).

From the report, it seems to be the case that we all broadly agree that there is a national and local need for change to ensure the NHS can provide services for local people which are safe, high quality and sustainable. As you are aware, the governing bodies of our two CCGs agreed, at the meeting in public on 25 July 2013, to proceed to commission local services as outlined in the public consultation on the Meeting the Challenge (MtC) proposals taking account of amendments agreed with MYHT (as set out in the public meeting documents) and recognising the key dependencies of and the progress that needs to be made on the wider Mid Yorkshire Health and Social Care Transformation Programme - in particular the services that will deliver health and social care closer to home.

We are not complacent about the work that still needs to be done to develop integrated health and social care, locally. Our local authorities are committed to working with us and we will strengthen these working arrangements through agreeing Memoranda of Understanding to underpin our commitment. Such a memorandum is already in place in North Kirklees. It is interesting to note that this approach to integration is now the way forward for the rest of the NHS and local authorities throughout England.

We will continue to work with the Committee to demonstrate the robustness of these plans as they develop through the usual arrangements for overview and scrutiny. As you know, we are also working closely with our Health and Wellbeing Boards in this respect.

The Committee's report raises specific concerns about the impact of the MtC proposals for North Kirklees communities. Members of our CCGs have also raised these concerns and we have responded by setting out a number of conditions attached to our decision of 25 July 2013 which will be incorporated into our future commissioning intentions. These are reflected in the recommendations approved by our two CCG governing bodies which will create more services delivered locally as well as strengthen services at Dewsbury & District Hospital and in North Kirklees more widely.

Recommendation 5 sets these conditions out as follows:

Note the issues highlighted by the public during the public consultation and agree the following amendments to the strategy, subject to analysis of the clinical and financial impact:

- As a default position, all outpatient appointments across all 3 sites to be provided locally unless there is a sound clinical reason not to do so. The process of this should commence within agreed deadlines.
- The Paediatric Assessment Unit at Dewsbury Hospital to adjust its opening hours to accommodate demand
- Develop services for children, including those with complex needs, by enhancing specialist medical and community nursing in North Kirklees
- Develop urgent local assessment at Dewsbury Hospital for all patients who do not require admission to Pinderfields Hospital
- For planned surgery at Dewsbury Hospital, post-operative care to be developed to increase the number of people who can be treated locally
- Emergency Day Care Units to be consultant led with consultant presence during the day [*this is a new element of the Clinical Services Strategy which will be implemented in Dewsbury and Pinderfields Hospitals*]. Opening times to be finalised following evaluation of the pilots. The units will include surgical procedures and specialist assessment for frail, elderly patients.

During the pre-consultation period and in the sessions with you between 12 April and 1 July 2013 we provided substantial and independent evidence which demonstrates that:

- The consultation process was robust.
- The clinical case for change was verified and supported by independent national experts.
- The proposed new configuration of clinical services would achieve the aims of ensuring local services are high quality and safe in the future for all communities in North Kirklees and Wakefield District.

We have also undertaken detailed assurance processes including Gateway reviews with NHS North of England (Service Change Assurance Process – SCAP) and the Trust Development Authority.

This assurance has not identified any evidence or issues which should impede the process of commissioning services in line with the MtC proposals provided the conditions previously referred to have been incorporated in the models of care.

SPECIFIC AREAS OF CHALLENGE

There are three broad areas we wish to respond to in some detail:

- The quality of the consultation process.
- The clinical case for change.
- The approach taken on the use of evidence.

The quality of the consultation process

The Committee raises a number of issues about the consultation process which are dealt with individually in more detail within the annotated version of the Committee's draft report, annexed to this letter. We would, however, like to respond more generally on your main concerns which seem to be:

- The decision to consult on a single option.
- The consultation questions and process.
- The detail provided in consultation materials.
- The response rate and reliability of results.

Chronology of option appraisal process and the decision to consult on a single option

The process of developing and refining options for hospital service configuration was initiated in 2010 following the report produced by NCAT in June of that year based on its assessment of the proposed reconfiguration associated with the opening of the new PFI hospitals which was due to come into effect in February 2011.

This report concluded that whilst the proposals were clinically safe in the short term, further changes would be necessary to ensure the continued clinical sustainability of services. The NCAT report, a copy of which has previously been shared with the Committee, made particular reference to the four clinical service areas which were the focus of the MtC consultation.

From an initial scoping of potential configuration options, five emerged as being clinically deliverable taking into account necessary co-adjacencies and these were made public in autumn 2011.

Subsequent to this, the scale of the financial challenge became apparent and it was agreed that more radical proposals were required to deliver a service model which was clinically *and* financially sustainable. A significant pre-consultation engagement exercise was undertaken during this period including a stakeholder deliberative event to agree the scope of the consultation and an options appraisal scoring exercise involving members of the public. It was through this process that the options were refined from five to two. Based on the outcome of the scoring exercise and subsequent financial and risk analysis, the Cluster Board agreed at its meeting on 10 January 2013 to proceed to consultation on one option. The process by which the option was arrived at has been subject to internal and external assurance, including clinical assessment by NCAT and the NHS North of England's Service Change and Assurance Process and the Department of Health's Gateway process. The Committee was fully engaged throughout this period and the issue of whether consultation on a single option was acceptable was further explored during the Committee's evidence gathering sessions during consultation. The draft consultation document was discussed in detail with the Committee on 15 February 2013 where we felt that any concerns about a single option had been addressed. The Consultation Institute has also confirmed that it is

appropriate and lawful to consult on a single option, particularly where alternative options are not viable in reality.

Committee Comments
The statement seems to support the view that finance was indeed the main driver for change and certainly why one option was agreed for consultation. The Joint Committee expressed their concerns at the suggestion to have only one option for public consultation on the 1 February 2013.

Consultation questions and process

There is an assertion in the summary findings which potentially calls into question the integrity of the consultation process. The report refers to 'manipulation' of questions which could be interpreted as an attempt to inappropriately affect the outcome of the consultation. We can assure you that this is not the case. Prior to the consultation, the CCGs and MYHT provided detailed information to the Committee on how the consultation questions were developed through a stakeholder group during the pre-consultation process.

The provenance and format of the questions had also been reviewed by the Campaign Company and subject to an assurance process undertaken by NHS England. We would like to draw the Committee's attention to the Consultation Institute's observation outlined in an email received from the Institute's Managing Director, Rhion Jones, on 31 July 2013:

"Only on one item do I feel it is important to express disagreement with the Draft Report. On page 32, it states that "the Committee has some concerns in relation to the consultation questions, which, in their view were manipulated in such a way as to illicit a preferred answer." The Institute knows of no evidence to support this statement; indeed, were there to be any, we could not have reached the conclusions we have published. We are aware of technical drawbacks to the phraseology used in some of the questions, but on balance did not feel that these had any significant impact on the ability of the consultation as a whole to gather the views of respondents comprehensively. But these weaknesses do NOT support the suggestion that they elicited a biased set of answers. I also suspect that if the JOSC seeks a legal opinion, they may be advised not to use the word 'manipulated' which suggests improper behaviour on the part of public officials – so it might be prudent to avoid this."

We cannot therefore accept that there is any evidence that substantiates the assertion that there was 'manipulation' of consultation questions and we would therefore be grateful if you would consider removing this assertion from your final report.

Committee Comments
The report refers to 'manipulation' of questions and the comment from the Consultation Institute that the word manipulation suggests improper behaviour on the part of public officials. This wording was directly lifted from the Joint Committee minutes of the 3 May 2013 - the NHS did not raise their concerns at that time. The minutes are also reproduced on page 134 of the Campaign Company's Final Report on the public consultation, which is a public document. The NHS now subsequently asks the Joint Committee to remove this assertion from their final report. The Joint Committee would make it clear that in no way was there any intention to suggest the deliberate manipulation of the consultation questions in the way it is suggested in the response. The Consultation Institute indicate that they were aware of 'technical' drawbacks to the phraseology used in some of the questions. The issue is does the Joint Committee feel these 'technical' drawbacks had a significant influence on the outcome of the consultation. There is at least an element of 'nudge' –or choice architecture in the way decisions may and can be influenced by how the choices are presented in order to influence

the outcome. Val Barker, a former Director of Public Health, makes the same point in her evidence to the consultation.

The Committee has agreed to withdraw the reference to the word manipulation and re-word this paragraph "**The Joint Committee believed some of the consultation questions appeared to be structured in such a way as to induce a preferred response"**

At the evidence session held on 10 May 2013 to discuss the consultation materials, format and process, we openly accepted that some of the consultation questions used in the feedback form could have been improved. However, the Consultation Institute stated that, overall, the consultation materials were comprehensive and detailed in content and that there was more than adequate opportunity to identify public concerns through questions and free text aspects of the questionnaire.

Committee comments

The evidence session on this issue was the 3 May and not the 10 May as indicated in the response.

Detail provided

The service proposals set out in public information (in all formats including meetings, media and materials) contained sufficient detail to enable stakeholders and members of the public to be fully informed and form a view about the clinical changes proposed. Considerable detail on each service area setting out the current and proposed future position is contained within the main consultation document (detailing the case for change and benefits) as well as in the summary document.

In addition, a substantial amount of information – including detailed data sheets and relevant publications on each key service area - were available through a number of face-to-face and multimedia channels and on the MtC website. Opportunities to explore issues in more detail were provided at a wide range of public and other smaller meetings, through media coverage and in responses to letters and emails.

A key criterion used by the independent expert body – the Consultation Insitute – in its compliance assessment process, was to assess whether or not a range of approaches had been used to give as many people as possible the opportunity to engage in the consultation. The Institute also assessed the quality of the various approaches and consultation materials used. The Institute closely monitored the consultation throughout and has since awarded the MtC consultation its Certificate of Compliance with best practice (as per the Consultation Charter).

Our draft consultation plan and consultation documents were shared and discussed with the Committee on 15 February 2013 and changes were made in response to comments received from Committee members. In particular, the summary document was significantly extended (doubled in size) to allow more opportunity for respondents to submit their views about individual aspects of the proposals.

Committee comments
Some changes were made but not all suggestions of the Committee – for example further public meetings in North Kirklees.

We also increased the number of roadshows held, arranged focus groups at a local school, increased consultation activity in North Kirklees and ensured that many public and

stakeholder meetings were held during the evenings and, on occasions, at weekends reaching a wider range of groups within our communities, including groups the NHS traditionally finds hard to reach,through such vehicles as community radio and webcasts. We note that the minutes of that Committee's session do not make any specific references to concerns about the questions included in the public feedback form contained in the summary document distributed to more than 240,000 homes.

Committee comments The Committee's concerns in relation to consultation questions were raised on the 3 May 2013 as a result of public feedback insofar that some members of the public had declined to complete the questionnaire.

Response rate and reliability of results

The responses received in whatever format (eg emails, comments at meetings, questionnaires returned etc - approx. 1% of the whole population) was broadly in line with other similar public sector consultations. The table below shows the response rates for seven other NHS public consultations since 2006:

Programme and year of consultation	**Area/s covered**	**Population**	**Responses received**	**Percentage**
Safer, closer, better (2006)	Barnet, Enfield Haringey	804,630	10,000	1.24%
A picture of health (2007)	Five SE London boroughs	1,222,030	11,000	0.98%
The shape of things to come (2009)	London wide	7,172,091	9,000	0.13%
Health and NEL (2009)	Seven NE London boroughs	1,508,390	3,000	0.20%
Healthy futures (2011)	Five local authorities NE of Manchester	800,000	1,700	0.21%
Shaping a Healthier Future (2012)	Eight NW London boroughs	1,900,000	17,022	0.89%
Improving Lives, Saving Lives	East of England	5,847,000	4,600 (est.)	0.08%

Whilst we would always wish to maximise the numbers responding to the consultation, we consider that the effectiveness of the consultation process lies not in the numbers of participants or respondents, but in the quality of the engagement that takes place. A wide variety of techniques were used during the consultation process to encourage people to take part and to engage with patients and the public. They included a telephone survey of 1,013 residents using a stratified and therefore representative sample. The analysis undertaken by the Campaign Company was credible, good quality and complies with Market Research Society guidelines.

We do not consider that the results were inconclusive but represented a fair and full reflection of what people said and what their views are and this should not be confused with a petition or voting process driven by high volume response. The Consultation Institute also advised the Committee to consider the consultation activity as a whole and base its observations on whether or not people had been given the opportunity to contribute rather than the level of response, which can be very variable. The Institute concluded that within

the process implemented, communities had been given appropriate and reasonable opportunity to take part in the consultation and that a low response rate cannot be interpreted as a poor quality of response or poor quality process.

The clinical case for change

We are concerned that throughout the draft report, it could be interpreted that the Committee feels that the clinical case for change has not been appropriately made, or has not proved convincing enough to justify proceeding with the MtC proposals. We noted that the Committee's report does not refer to the entire scope of information/evidence we have provided throughout the process. For example, the emphasis given to the D'Souza/Guptha report on the impact of care outside hospital on acute admissions does not reflect the wider debate in a range of publications on this aspect of care.

Committee comments
The Clinical Case for Change – concern that the clinical case for change has not been made and the selective use of evidence, particularly to the D'Souza/Guptha report. There are two reports not referred to by the NHS: Nuffield Trust "Evaluating integrated and community-based care" and the Royal College of Physicians "care closer to home" which support the concerns raised by the Joint Committee, which have not been cited by the NHS.

There are also some references to the NCAT reports of 2010 and 2013 which do not reflect the overall conclusions formed by NCAT and the models of care proposed. The Committee questions why the two NCAT reports are different when produced only three years apart. The answer is that much has changed both nationally and locally since 2010 – both in terms of clinical practice, quality governance, NHS finances and public expectations of performance. In particular, the 2010 report recognised that immediate changes to services should be considered, following which the overall strategic context for acute services has substantially changed. The 2010 report was, in effect, the trigger for the development of the MtC proposals as it identified where work was needed to ensure a service configuration was developed which delivered safe, clinically appropriate, viable and sustainable services for patients.

Committee comments
Reference to the NCAT reports of 2010 and 2013. The arguments around viability of the MLUs are the same now as they were in 2010 – nothing has changed in that respect. The general comments about much as changed nationally and locally since 2010 are accepted.

The proposals outlined in the MtC proposals in 2013 take into account these strategic changes and NCAT findings as well as examples of system failure which have been highlighted from a national regulatory perspective. We would ask that the Committee recognises these changes over the three year period and focuses on the implications of the 2013 report which has also been supported with additional assurance from NCAT. The 2013 report and further assurances represent the most recent, current sources of clinical evidence.

We would also like to assure the Committee that whenever any evidence and/or serious challenge to the clinical case for change was put to us, we referred it to NCAT for an independent view. All of this evidence was provided to the Committee but we note that it was not mentioned in your report. NCAT is acknowledged to be the national expert clinical body on health service models and configurations. NCAT's view is that the clinical case for change is substantial and the MtC proposals will deliver services which are in the interests of patients and local residents.

This view is further substantiated by the NHS SCAPand the Department of Health's Gateway Reviews conducted in advance of the the consultation. We feel that the report would benefit by reflecting these key aspects on NHS assurance. All these documents are publically available on the MtC website and were provided to the Committee.**Approach taken on the use of evidence**

We have highlighted above some of our concerns about the way in which our evidence has been reflected in the draft report. We have a number of examples, which are set out in detail in the annex. In particular, the Committee cited partial evidence from the Consultation Institute and we feel that there is more in the information provided by them which is relevant. For example, the positive statement made by the Institute's Managing Director, Rhion Jones, about the scrutiny process is highlighted in the report but no reference is made to the overall assessment of the consultation which the Institute judged to be good. We would suggest that a fuller recognition of the Institute's view would strengthen the report and overall quality of the Committee's evidence gathering process.

Committee comments

The Committee has agreed to expand this paragraph to provide a more balanced view.

In its draft report the Committee places substantial emphasis on a submission from Mike Wood MP. We submitted this to NCAT who independently reviewed it and concluded that this evidence did not change their opinion about the strength of the clinical case for change. The Committee did not refer to a formal response to the consultation from Simon Reevel MP which was broadly in favour of our proposals. We respectfully suggest that if MPs' views are being taken into account then it is in the public interest that all opinions expressed by local MPs are reflected in the report.

Committee comments

Mike Wood MP attended the Committee to present his submission, which is reflected in the report. Simon Reeval MP was invited to attend the Joint Committee to give evidence and did not take up the offer to do so. There is a misunderstanding of the scrutiny process – members primarily reference evidence presented to the Committee not necessarily to the consultation. All MPs were invited to submit views to the Committee. However, the Committee will amend this section to reference Simon Reeval's summary and reference to Yvette Cooper and Jon Tricket's petition.

We note that the draft report does not fully reference research papers provided as evidence. We believe this has the potential to give readers of the report the impression that the references used are the only evidence relevant to particular issues.We would draw your attention to the independent analysis report of the consultation output produced by the Campaign Company which we believe is a key document and which is not listed amongst your sources of reference.

Committee comments

The Joint Committee has agreed to amend this paragraph and make reference to the Campaign Company's report.

In the early stages of the evidence gathering sessions, we ensured that various health agencies prepared introductory presentations to help Committee members have a full understanding of the clinical evidence supporting the case for change. In this way, we sought to provide a logical and structured approach to our presentation of evidence. However, the Committee's preferred style of working during these sessions placed less emphasis on these presentations and sought a different route to securing the required evidence. It is, of course, entirely for the Committee to decide how it wishes to operate, and

we were happy to respond to your lines of enquiry, supplementing our responses with written materials and key fact/data sheets, national and international clinical evidence.

However, this seems to have given the impression to Committee members that the evidence presented to them was selective and/or incomplete. Perhaps the learning from this is that we should, in the future and as part of the planning stage, agree how the sessions should be structured beforehand. We would, of course, be happy to revisit any areas of evidence with you and/or to resubmit any evidence provided earlier. A list of the documented evidence – including presentation slides, data sheets and other material – is included at the end of our annotated comments contained within the lengthier annex enclosed.

Committee comments
All the evidence produced by the NHS is supportive of the proposals – there is evidence which would be more challenging which was not cited.

OTHER ISSUES

A key area of concern raised by the Committee is that the development of the care outside hospital programme (Care Closer to Home – CC2H) was not sufficiently developed to allow the changes to hospital services to proceed. We noted your lack of confidence in this programme of work and your doubts that it would come into effect quickly enough to comprehensively support implementation of the MtC proposals. In response, our view is that we have explained to the Committee on several occasions that development of CC2H is making progress, albeit at a different pace to the MtC proposals.

All partners recognise that full implementation of the MtC proposals will not take effect until 2016/17 by which time the various components of CC2H will be in place. We have explained that an outline business case for CC2H is being developed now with completion scheduled for the end of 2013. The plan is to roll out elements of the CC2H programme over the coming months and years and well before the MtC proposals are fully implemented. We have made it a condition of our decision to proceed to commission the services set out in the MtC proposals that the CC2H programme must be in place. No significant changes to hospital services will be possible or commissioned by us until CC2H is sufficiently developed and in place to support them.

Committee comments
The timetable proposed is questionable and is it affordable? Can commissioners substantially develop CC2H whilst maintaining hospital services?

As we progress, we will be presenting the detail to our Health and Wellbeing Boards and to the Joint Health Scrutiny Committee and seeking to assure you of the robustness of our plans and delivery.

Two other important areas which are highlighted within the Committee's draft report may benefit from further clarification These relate to concerns about whether the implications of the proposed changes have been taken into consideration in terms of future capacity - particularly at Pinderfields Hospital - and that this takes into consideration of future changes in patient flows.

We understand the Committee's concerns that modelling for future hospital capacity takes into account a wide range of factors which could impact on future requirements. We have therefore presented information on the comprehensive activity and capacity modelling which has been undertaken at various evidence gathering sessions and have also provided further evidence, particularly in relation to a dedicated report explaining the impact on patient flows.

Committee comments
No specific detail has been provided to the Joint Committee – there are a number of statements and general assumptions in relation to modelling and sensitivity analysis – not a dedicated report on patient flows as indicated.

This modelling takes into account a range of assumptions including growth in demand, efficiency, use of resources and changes in patient flows. The output of this modelling has been presented in the context of the proposed changes and a sensitivity analysis has also been undertaken to identify the level of risk associated with demand and patient flows. This work on capacity modelling will continue throughout the planning and implementation phase to ensure any changes are identified and addressed.

In a number of sections the draft report refers to inconsistent information on transfer times between hospital sites which we are happy to clarify. Information on travel times has been provided to the Committee in two formats. The information included in MYHT's Outline Business Case which was prepared in November 2012 prior to detailed work with Yorkshire Ambulance Services. At this stage the information on travel times was taken from a national route/journey planning source. This data set therefore refers to the time taken from one location to another based on average road conditions.

A second evaluation of travel times was therefore developed in conjunction with Yorkshire Ambulance Service which included time taken to retrieve the patient and handover to the receiving department. Evaluation of this transfer time was tested through a simulation exercise which also identified areas where this time could be reduced through improved operational policies.

A further key area of concern highlighted by the Committee is the perceived negative impact the proposals would have on residents in North Kirklees. As stated above, we were very aware of this throughout the consultation process. The independent body (the Campaign Company) regularly briefed us on emerging views and findings. This impact is acknowledged within the Integrated Impact Assessment (IIA) produced and made available in the early stages of the consultation and later reinforced in the analysis of the consultation outcome. We would draw your attention to the following:

- The IAA is a living document which is a vital form of reference for us as commissioners and to MYHT The IAA is being refreshed as part of the process of developing a full business case for the MtC proposals and will continue to be regularly updated over time to account for changing circumstances. The IAA will be extended to the wider Transformation Programme.

- We have responded to the outcome of the consultation process by setting out a number of important conditions linked to our decision in relation to commissioning future services. These widen and strengthen the range of services available in North Kirklees – both at Dewsbury & District Hospital and in the community – to mitigate against the negative impact on local residents. Our expectation is that more clinical services including outpatient appointments will be provided locally for North Kirklees patients than is the case now. These changes were discussed with the committee on 1 July and are reflected in the recommendations approved by our two CCG governing bodies on 25 July 2013. We recognise that although we discussed these changes with you on 1 July 2013, these recommendations were not available to you when you produced this draft report and would encourage you to include them in your final report to provide balance and a full record of the outcome for the public's attention.

- We considered that the draft report focused very strongly on the perceived impact for residents of North Kirklees with less emphasisabout the impact for Wakefield and Pontefract residents. The proposals, as you know, cover this wider population. We would ask the Committee to consider therefore the benefits for the majority of the 600,000+ population of North Kirklees and Wakefield District, in terms of protecting and improving local services which will save more lives and provide better outcomes and services for local people.

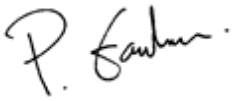
Committee comments Response to the outcome of the consultation – linked conditions to the decision - It is noted that these are to 'mitigate against the negative impact on local residents'. The Committee will include reference to the additional recommendations as suggested.

We hope you find these comments helpful. We have a number of more detailed and/or specific comments to make about the contents of the draft report which are annotated in blue within the annexed report of the Committee.

In summary, both our CCGs believe that the decision we took on 25 July 2013 will lead to improved efficiency and clinical quality of services for our local communities in the future. That means more lives will be saved. In addition, the changes will ensure that we maintain a thriving network of local acute hospitals which will service patients into the future.

If the Committee wishes, we are both very happy to continue to work with you in any way you wish to help to refine your report. We also look forward to working closely with the Committee throughout the next stages of implementation of the MtC proposals and the wider Mid Yorkshire NHS and Social Care Transformation Programme.

Best Wishes



Dr Phil Earnshaw
Chair
NHS Wakefield CCG

Chris Dowse
Chief Officer
NHS North Kirklees CCG

(On behalf of Jo Webster
Chief Officer of NHS Wakefield CCG
and Senior Responsible Officer for
'Meeting the Challenge'

Summary Findings

The Consultation and Engagement Process

There had been extensive engagement in the pre-consultation phase which had secured an understanding of the issues that must be addressed and the need for change, and which provided a good platform to move forward to consultation. However, notwithstanding this level of engagement **the Joint Committee was concerned that only one option has been put forward for consultation.**

NHS Response
The process of developing and refining options for hospital service configuration was initiated in 2010 following the report produced by NCAT in June of that year based on its assessment of the proposed reconfiguration associated with the opening of the new PFI hospitals which was due to come into effect in February 2011.

This report concluded that whilst the proposals were clinically safe in the short term, further changes would be necessary to ensure the continued clinical sustainability of services. The NCAT report, a copy of which has previously been shared with the Committee, made particular reference to the four clinical service areas which are the focus of the MtC consultation.

You will recall that we requested in 2010 that the Joint OSC should not be disestablished so that we could continue to engage with the Committee as options were developed and refined.

From an initial scoping of potential configuration options, five emerged as being clinically deliverable taking into account necessary co-adjacencies and these were made public in autumn 2011.

Subsequent to this, the scale of the financial challenge became apparent and it was agreed that more radical proposals were required to deliver a service model which was clinically *and* financially sustainable. A significant pre-consultation engagement exercise was undertaken during this period including a stakeholder deliberative event to agree the scope of the consultation and an options appraisal scoring exercise involving members of the public. It was through this process that the options were refined from five to two. Based on the outcome of the scoring exercise and subsequent financial and risk analysis, the Cluster Board agreed at its meeting on January 10th 2013 to proceed to consultation on one option.

The process by which the option was arrived at has been subject to internal and external assurance, including clinical assessment by NCAT and the NHS North of England's Service Change and Assurance Process and the Department of Health's Gateway process. The JOSC were fully engaged throughout this period and the issue of whether consultation on a single option was acceptable was further explored during the Committee's evidence gathering sessions during consultation. The draft consultation document was discussed in detail with the Committee on 15 February 2013 where we felt that any concerns about a single option had been addressed.

The Consultation Institute has also confirmed that it is appropriate and lawful to consult on a single option, particularly where alternative options are not viable in reality.

As was discussed with the Committee in February 2013, it would also be inappropriate to formally consult on a proposal that was not clinically sustainable and therefore could not be implemented.

Committee comments (see summary findings)

The Committee was aware that many members of the public had decided not to participate in a process where decisions could be influenced by how the choices were presented.

NHS Response
This is an assertion which conflicts directly with the view of the independent national experts on consultation processes (the Consultation Institute) who have overseen the consultation exercise since before it began on 4 March 2013. The Institute has since awarded the consultation its Certificate of Compliance with the best practice standards as set out in The Consultation Charter. Although 'owned' by the CCGs, the questions were developed in partnership with the Public and Patient Advisory Group and were shared with the Committee before consultation began. The Committee's comments were reflected in changes to the final consultation materials. The questions were also scrutinised by the independent analysts – the Campaign Company.

We cannot therefore accept that there is any evidence that substantiates the assertion that there was 'manipulation' of consultation questions and we would therefore be grateful if you would consider removing this assertion from your final report.

Committee Comments
This wording is lifted directly from the Joint Committee minutes of the 3 May 2013 – the NHS did not raise their concerns at that time. The minutes are also reproduced on page 134 of the Campaign Company's final Report on the public consultation, which is a public document. The NHS now subsequently asks the Joint Committee to remove this assertion from their final report.

The Joint Committee would make it clear that in no way was there any intention to suggest the deliberate manipulation of the consultation questions in the way it is suggested. The Consultation Institute indicate that they were aware of 'technical' drawbacks to the phraseology used in some of the questions. The issue is does the Joint Committee feel these 'technical' drawbacks had a significant influence on the outcome of the consultation. There is at least an element of 'nudge' – or choice architecture in the way decisions may and can be influenced by how the choices are presented in order to influence the outcome. Val Barker, former Director of Public Health, makes the same point in her eveidence to the consultation.

The Joint Committee has agreed to withdraw the reference to the word manipulation and re-word this paragraph **"The Joint Committee believed some of the consultation questions appeared to be structured in such a way as to induce a preferred response"**

It was accepted that there would not be detailed implementation plans at this stage but a robust description of services was required so the public could understand how the whole system fits together and the new ways in which services will be delivered in their locality. **The Committee was concerned that the consultation document did not contain specific proposals about the primary, community and social care services that will need to be put in place alongside the acute changes.**

NHS Response
The consultation was about changes to hospital services. However, the consultation document contains a substantial chapter on plans for the further development of CC2H giving several examples of current schemes that the CCGs aim to roll out across both districts. It was also explained to the Committee during evidence sessions that the process of developing CC2H was moving at a different pace and had only recently reached the stage where a Strategic Outline Case had been produced. A separate OBC and, later an FBC, will be produced by commissioners in partnership with other partners (local authorities, community services providers, third sector etc), in due course.

Committee comments
The public were consulted on plans to develop CC2H = Question 5 A & B "Meeting the Challenge"

The Committee believes the consultation document and presentations should have emphasised the whole system nature of the transformation programme. **The Committee is not convinced this happened in sufficient detail in order for the public to make an informed choice and the lack of detail may have led to bias in their decision-making.**

NHS Response
The interdependencies of the various work streams of the transformation programme are clearly referenced in the consultation documents. The need to develop CC2H in particular before significant changes are made to hospital services has been a repeated theme in meetings/discussions throughout the consultation.

Overall the Committee believes the consultation process aimed to follow recognised and accepted best practice. However, inevitably there have been gaps. Members were also disappointed at the low participation rate. **The Committee's view is that the consultation outcome is inconclusive and far from ideal as a basis on which to make significant and major decisions on local health services.**

NHS Response
The participation rate was broadly in line with other similar public sector consultations. At the evidence session of 3 May 2013, the Consultation Institute explained that the effectiveness of the consultation should not be judged by the numbers who take part, but the quality of the engagement that takes place. A wide variety of techniques were used to encourage people to take part and to engage with patients and the public. The independent analysis undertaken by the Campaign Company was credible, good quality and complies with Market Research Society

guidelines (even though the consultation was not a research exercise). The CCGs and MYHT do not consider that the results were inconclusive – they were simply a fair, comprehensive and independently reported reflection of what people said and what their views are. The Consultation Institute also explained the need to take account of the consultation activity as a whole and consider whether or not people had been given the opportunity to contribute. They concluded that people had been given that opportunity and that a low response rate is not indicative of a poor quality of response or poor quality process.

Committee comments
The numbers involved must reflect in some way the quality of the consultation

It is very clear however, that a very large proportion of residents in North Kirklees have expressed significant concerns regarding particular elements of the proposals, including A&E, maternity and children's services, through a petition containing 30,000 signatures. **Whilst this expression of public interest is parallel to the consultation it would be unwise to ignore this level of concern and it should be given appropriate weighting in the decision-making process.**

NHS Response
The CCGs and MYHT have made repeated references to the petition and have never had any intention of ignoring it. It was taken into account by the Joint Advisory and Review Group and the two CCG Boards in reaching their decisions. It is clear that there is some misunderstanding of the impact the proposals will have in North Kirklees and that more work to promote better understanding of how the reconfigured health system would work in reality is required.

Committee comments
This response supports the Committee's view that the consultation has not sufficiently informed the public regarding the impact of the changes and more needs to be done to promote a better understanding of how the reconfigured health system would work in reality.

What level of weighting was given to the petition by the Joint Advisory Review Group (JARG) when reaching their decision? It is suggested that there is some misunderstanding of the impact of the proposals and that more work needs to be done to promote better understanding – The way in which the clinical case for change is presented, and the evidence used to support it, is a key factor in making the case for change – one of the Secretary of State's 4 key tests – This statement suggests an element of doubt that this test has been achieved.

The Committee had some concerns regarding the lack of detail underpinning the clinical services strategy and analysis of the arguments for change. **The evidence supporting the proposals was limited, variable and in some cases selective.**

NHS Response
For each of the proposed service changes, the Committee was provided with an evidence pack containing details of current service provision, proposed model, case for change (including NCAT conclusions), benefits, assumptions, scenarios describing the potential changes to patient pathways and reference materials.

A wealth of comprehensive information and evidence (including the NCAT report, SCAP and Gateway reviews) was presented to the Committee and to stakeholders and the public during the consultation. These are listed in full at the end of this document. The MtC website has a substantial section containing local and national/international evidence. If the Committee felt the clinical evidence presented – much of which was also verified by external experts – required further challenge, it would have been helpful for them to have called independent clinical witnesses to do that or to provide an alternative/contrary view. The CCGs and MYHT would be happy to resubmit information and provide further clinical support/information, if required.

Committee Comments
The SCAP and the Gateway Reviews were not made directly available to the Joint Committee.

The primary role of the Joint Committee is to articulate the views, concerns and aspirations of the public through a process of challenge that is both inquisitive and progressive. Members are not passive recipients of information but they are expected to challenge what is presented. It should be noted they are not clinical experts and do not readily have access to independent clinical expertise or advice. However, the Joint Committee would point to the opinion of the Consultation Institute. *"The Overview and Scrutiny Committee is one of the best safeguards to ensure everything is done transparently and to best practice standards. The meeting I attended on Friday was a classic example of democracy in action, with Councillors taking a very reasonable approach to what is, by any standard a difficult set of questions.."*

R Jones Consultation Institute

The Committee is concerned that the financial implications have not been resolved and many questions remain unanswered.

It is an inconvenient truth that any further reductions in services will have to come from Dewsbury, since it is the only substantial unit that is not encumbered by a hefty PFI unitary charge. **Whilst these issues go unresolved the Trust is open to the charge that Dewsbury will become unsustainable in the longer term.**

NHS Response
Both CCGs and the Trust have given repeated assurances about the future of DDH as a vital and vibrant part of the local health system with a significantly increased range of non-specialist services available including more elective surgical specialties, outpatient and day case activity. It would not be possible to realise the MtC proposals and wider transformation programme without development of Dewsbury & District Hospital. The whole basis of the MtC proposals is that the three hospitals should be seen together as integral parts of a whole service provider. The geography also mitigates against Dewsbury being a specialist centre – even if it were part of Calderdale & Huddersfield NHS Foundation Trust, Leeds or Bradford NHS Trusts, all of which already has a major hospital providing acute and complex care.. A financial viability report was produced in 2012, details of which were presented and discussed with the Committee on 8 March 2013. This presentation

confirmed that the three hospitals were each making a loss and would not be sustainable in their own right. The PFI charge is therefore not relevant in this context. What is relevant is clinical configuration, ie the adjacency of interdependent services. It is anticipated that under the proposals, the financial viability of Dewsbury will be improved by increasing the provision of elective and outpatient services. In addition, the CCGs and MYHT have made strenuous efforts to emphasise that the key drivers for the MtC proposals are clinical rather than financial.

Committee comments
The Joint Committee's views have been taken out of context. The current proposals utilising and developing all 3 sites is welcomed. The Committee welcomes the commitment that Dewsbury is a vital and vibrant part of the local health system. The concern is that if these proposals have to be revisited in the future because of an escalating rather than deceasing financial shortfall, one option would be to consider reducing services at Dewsbury as a result of the current PFI position.

Notwithstanding the assurances given by the Trust Development Agency regarding system wide support up and until 2017, the planning process is dependent upon a fragile promise of support.

NHS Response
The CCGs and MYHT do not consider that there is evidence to support this statement – the Trust is only dependent on the TDA for transitional support to reach a balanced financial position and for capital funding. The Committee is urged to recognise the FBC development and assurance processes which will be critical to securing wider external support.

Committee comments
It could be argued that the proposals are not financially viable if there remains a short fall of £4.6m (Revised) – There is evidence of concerns from CCG in a letter to Angela Monaghan , Chair CKW Cluster 9 January 2013 and elsewhere in relation to OBC

Travel and Transport

It is clear from the consultation response that travel and transport are a key concern to the public and this was reflected through the Joint Committee's findings. A Travel Advisory Group had been established to consider proposals that would mitigate against any potential travel disruption.

The Committee had some concerns around the analysis and the assumptions used in the modelling. It was not clear to the Joint Committee what information had been used to determine travel times.

NHS Response
Travel and transport issues were discussed in detail at the evidence sessions on

Travel and Transport on 12 April 2013 and on emergency transport on 24 May 2013, in additional to the discussion that took place at individual service specific sessions.

The final report of the Travel Advisory Group (TAG) contains this information. It was made available to the Committee for the session on 12 April 2013 and to the public via the MtC website. At the session on 12 April 2013, the Committee was given information about assumptions regarding patient flows and impact on travel times. The Committee was also given detailed information about the work of the Travel Advisory Group that had been established prior to the consultation and the potential solutions developed by that group which formed the basis of consultation questions. At the session on 24 May 2013, Yorkshire Ambulance Service (YAS) provided detailed information about transfer times and the anticipated volume of transfers based on their own data sources. Any differences in transfer times were explained fully in terms of clarifying the data definitions for transfer, including handover process, traffic conditions and times of day.

Committee comments
The Committee had questioned how travel times had been determined and in particular if any of the TAG members had actually undertaken any specific journeys to help provide a realistic picture. The Committee was informed that no such journeys had been undertaken.

Examples of patients being discharged in unsociable hours was raised and the Committee were assured that the Hospital would do all they could to help to arrange transport. **There is a duty of care placed on the Trust, particularly in respect of vulnerable patients.**

NHS Response
MYHT concurs with the comment regarding duty of care and has described how this would be discharged during the various evidence sessions. However, the examples mentioned were actually people who attended A&E at night and were allowed home after treatment – **not** discharged from an inpatient bed.

Committee comments
The Committee agrees the examples were discharge from A&E

The Joint Committee questioned the pre-engagement activity in relation to transport and travel and wondered why this had not been reflected more in the consultation document. It was suggested that further work would be required as clinical models emerge. **The Joint Committee believes this information and analysis should have been available prior to public consultation, in order to help the public make more informed decisions.**

NHS Response
The final report of the TAG has been publicly available since 22 March 2013 and was posted on the MtC website on 10 April 2013. It was explained to the Committee at the meeting on 12 April 2013 that the questions relating to transport in the consultation document had been derived from the proposed solutions put forward by the TAG. The reason transport featured so prominently in the consultation materials and activity was because it emerged as a critical issue in this pre-consultation work.

Committee comments
The comment is in relation to further work being required as clinical models emerge – not the TAG

Input from Metro highlighted the lack of direct services between the three trust sites and the difficulties that many residents of the Wakefield District and North Kirklees area would have travelling to more distant sites by public transport. **In particular, it was stressed that cost and travel time could be a real issue for some communities. It was stressed that given the locations of the three sites, a direct public transport link between them would not be a viable, commercial solution.**

This is acknowledged but the footfall survey undertaken at the three hospitals indicated that more than 70% of patients arrived by private care.

In terms of any subsidy, **It was noted that given current budget constraints, Metro would not be in a position to provide financial support to any public transport actions contained within the TAG group's action plan.**

Members were informed that the TAG group will support the development of detailed proposals for implementation of the solutions, including costing and identifying sources of funding and potential suppliers of transport solutions so that these could be implemented as soon as required and prior to services being reorganised across the sites. **However, no details of these initiatives were provided during the consultation.**

NHS Response
The consultation documents clearly list the possible ways patients could be helped with travel difficulties. These are included in the presentation to the committee on 12 April 2013. Work on costing was not completed until after 31 May 2013. However, the assurance that final travel solutions would be implemented before significant changes to hospital services are made still stands and is central to the recommendations agreed by the CCG Boards.

Committee comments
The consultation document does list several ways in which patients could be helped but provides no detail.

There appears to have been little consideration on the impact of patients from Wakefield who may have to travel to Pontefract or Dewsbury for their planned operation.

NHS Response
This is contained both in the TAG final report and the IIA. Both were publicly available throughout the consultation. In addition, MYHT has had no complaints in this regard from elective orthopaedic patients who now go to Pontefract for treatment. Also, the shuttle service runs in both directions.

Committee comments
The point here is that numbers will significantly increase.

The Joint Committee was told that it is a minimum of 3 bus journeys from Dewsbury to Pinderfields on a timetable that doesn't link up and often means lengthy delays between each journey. **Local taxis fares are prohibitive, particularly on low income families and in an emergency reliance on public transport would neither be practical or safe.**

NHS Response This assumes people use buses in an emergency, rather than ambulances

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The National Clinical Advisory Team's (NCAT) report suggests that on balance travel times are acceptable from a clinical standpoint and that the benefits the public will have from the reconfiguration outweigh this inconvenience. **This has to be a subjective view and not based on public opinion.**

NHS Response NCAT are independent, national clinical experts whose advice must be considered as both authoritative and objective. The CCGs and MYHT feel that, overall, the clinical benefits of the MtC proposals outweigh the inconvenience to some patients, taking into consideration the distances involved. Committee comments The Committee has agreed to re-word this to say "**This is a clinical view which at this stage in not fully supported by public opinion".**

In order to properly evaluate trade-offs between location and outcomes would require a conjoint analysis specifically designed to look at the impact of different attributes on the overall benefit obtained from the proposals. **The Joint Committee has seen no evidence to suggest this has happened.**

NHS Response MYHT has made a commitment to re-profile services (particularly for Dewsbury residents) where a net increase in attendances at Dewsbury & District Hospital is seen. Figures on this have been provided for outpatient, elective inpatient and day case surgery.

The Joint Committee has previously recommended to the Trust that they should have developed a trust wide travel plan as far back as 2009. **It is disappointing to note that despite assurances at the time, this has not been implemented and brings into question present day assurances that travel and transport are being taken seriously enough in order to mitigate public concern.**

NHS Response The CCGs (or predecessor PCTs) have implemented a three site shuttle bus for staff and patients with plans now to extend its availability.

In any area, the greatest disadvantage is likely to be experienced by individuals without access to a car (Including members of one-car households without daytime access). Although car ownership is relatively high, rates for the poor, the elderly and for women are far lower than the average.

NHS Response
A survey was carried out in September 2012 as part of the integrated impact assessment which was provided to the Committee as part of the evidence pack for the meeting on 12 April 2013. Table 247 in the 'Extract from the IIA – Travel survey analysis' document shows that only 2.96% travelled to hospital by bus. More than 50% travelled by car. Table 248 indicates a slight increase in the proportion of people who would travel by bus (6.58%) if the proposed changes went ahead and a similar proportion of people expecting to travel by car (53.62%). Since this survey was undertaken, the 111 bus service from Wakefield bus station to Pinderfields has been established which improves access by public transport.

Committee comments
The Committee's view that the greatest disadvantage is likely to be experienced by individuals without access to a car is supported by the survey carried out in September 2012.

The Clinical Services Strategy and the "Meeting the Challenge" consultation have highlighted tensions between the perceived safety, effectiveness and efficiency of larger specialist centres and the demand for more geographically accessible local care. **However, geographical access – the distance which must be travelled in order to use the health service – is one aspect of access which is often overlooked but which presents barriers of cost, time and inconvenience.**

NHS Response
The Committee has been provided with considerable evidence about this and the CCGs believe that been far from overlooked. Indeed, it has been considered in detail and been an important factor in the way some service changes have been designed – particularly the model for emergency day care. Transport/travel emerged as a key issue for patients and the public well before consultation began. This is why the TAG was established to develop potential solutions prior to consultation ad their findings and proposed solutions were presented to the Committee on 12 April 2013. Travel and access are also an important aspect of the IIA. The Committee was given evidence which shows that there would be an overall net reduction in patient journeys.

Committee comments
The Joint Committee accepts that the CCGs have not overlooked this issue and would agree to re-word the sentence to "is one aspect of access which **can** be overlooked".

Care Closer to Home

The Joint Committee was advised that Wakefield and North Kirklees were working closely together to get the greatest benefit from the community pathways. They were reflecting on where investments had done well for each side.

The Joint Committee questioned possible pressures in the system around capacity and finance.
In particular, whether wider system support would be required and how this was being addressed. **It was noted that the OBC recognises that even upon completion of Option 2, an annual structural subsidy in the order of £10m will still be require**d. It was suggested that this position could not be a long-term solution and transitional support had been recognised by the Trust Development Agency (TDA). Further clarity on this was not available at this stage.

NHS Response
All partners are committed to identifying further opportunities to reduce the £10 million shortfall in required resources as more detailed models and implementation plans are developed. The Committee is asked to note that when this this discussion took place, the proposal was at an early stage in the development of an outline business case.

The proposed model indicated a reduction of 200 beds. The Joint Committee were seeking assurances around the modelling particularly around acute activity and bed requirements which would need to be robust and flexible enough to meet variation in demand.

NHS Response
Detailed information on assumptions and modelling have been provided, including use of benchmarking (comparison of lengths of stay against a peer group of hospitals) and sensitivity analysis.

Committee comments
The detail on assumptions and modelling have not been provided to the Joint Committee

Members recognised the arguments being articulated that the NHS would restructure itself around community services and deliver transformational change. The Joint Committee is mindful that this would not be a simple 'reduce hospital costs; invest in community and primary care' equation. **There is as much, if not more, of a challenge facing community health services and general practice, whose models of care have not yet faced the scrutiny and modernisation experienced by most hospital trusts in recent years.**
The Joint Committee remains to be convinced that the 'Care Closer to Home' programme will result in the successful delivery of the Mid Yorkshire Clinical Services Strategy.

NHS Response
The CCGs would welcome an opportunity to provide further information about this. The outline business case will be completed by the end of October 2013.

The Joint Committee believes the cost effectiveness of Care Closer to Home has not been thoroughly evaluated in the proposals and has seen no clear evidence that CCH services will produce any cost savings to the NHS.

The Joint Committee was informed that delayed transfers of care were minimal, however this is not reflected in anecdotal evidence to local members regarding the experience of their constituents in relation to delayed discharge.

NHS Response
It is difficult for the CCGs and MYHT to respond to anecdotal evidence. We have provided information about work on plans to avoid unnecessary hospital admissions and reliance on hospital care.

The Joint Committee is concerned that the proposals in relation to community based health care are not underpinned by any detailed plans and there is no evidence of resources being identified.

NHS Response
The commissioners have given repeated assurances about their commitment to this. Plans are being developed to a different timescale to the MtC proposals and a Strategic Outline Case has been produced. The timeframe for the development of CC2H was explained to the Committee in its evidence sessions.

Committee comments
No detailed plans or resources have been identified at this stage.

The change proposals accept that there will be a requirement to invest in reformed community services but provides no detail. There is a worrying lack of evidence to support the proposals. Integrated care pathways have yet to be developed and agreed yet the clinical services strategy is dependent upon sufficient investment in community provision.

On balance the Joint Committee is of the view that insufficient detail has been provided to support the proposals on care closer to home, which is a key dependency of the Clinical Services Strategy.

NHS Response
As above.

Emergency care

The Committee's key line of inquiry regarding urgent care services is: will there be sufficient capacity and capability- particularly within the emergency departments at Pinderfields and Dewsbury within the new model? If patients have to be admitted

will there be sufficient beds at the Pinderfields unit to accommodate the acute activity without impinging on other specialist services or surgery

It was reported that the Commissioners' vision aims to reduce A&E attendances and emergency admissions by increasing capacity in primary care in areas such as long term condition care planning. The target is to reduce A&E attendances by 8% over a twelve month period which equates to 9,317 attendances.

These proposals have yet to be finalised and the Committee has expressed concerns at the lack of detail regarding implementation or finance

The Trust have indicated that last year the commissioners invested in reducing the number of admissions, targeting around 5% of resources.

It would seem that this has had little impact on reducing admissions to date which over the last year have increased by 10%. This would imply either interventions are not effective or considerably more resources are required, which will have to be taken from existing budgets.

NHS Response
The Committee was provided with a summary document entitled 'Emergency Care' . Section 1.1 provides a summary of attendances, admissions and conversion rates which shows an increase in admissions from 47,858 in 2010/11 to 49,062 in 2011/12 – an increase of 2.5%. The document goes on to describe the proposed introduction of ambulatory emergency care and the volume of patients for whom admission would be avoided as a result of the additional measures being developed in primary care.

Committee comments
The response cites figures from 2010/11 and 2011/12 being an increase of 2.5%. The current increase in emergency / urgent care (and cited in the Joint Committee's report is 10% (2012/13) as indicated in the emergency / urgent care data sheet presented to the Committee on the 10 May 2013.

It would have been useful to have seen financial projections aligned to the proposals to give some indication of the costs involved. Without this and a clear commitment to invest there can be little confidence in reducing the bed base at a time of unprecedented demand.

NHS Response
The proposed changes include development of CC2H which will reduce demand. There will also be changes in the way patients are assessed and treatment started on an ambulatory care basis (emergency day care). Data has been presented on conveyance rates, attendances and a conversion profile for MYHT which shows substantial opportunities exist to reduce reliance on hospital admissions.

The Joint Committee was told that ambulance arrivals at Mid Yorkshire (currently 210 per day) were to be offset by reductions in delayed hand overs. However the recent performance of the Trust is disappointing.

NHS Response
The Trust's recent performance against the four hour waiting time target is good, despite a profile of rising demand. An operational delivery plan for handover is already in place.

Delays not only indicate inefficiencies in the system, but have the potential to negatively impact on patient outcomes and result in a poor experience of care. An assumption underpinning the proposals for change is that the Trust's performance is within the upper quartile – it is clear significant improvement is required in this key area of activity.

There seems to be a significant discrepancy in the calculation being put forward in terms of reduced A&E attendances. Commissioners envisage a reduction of 8%, by increasing capacity in primary care (although the Joint Committee has seen no evidence to support this), whilst the Trust are reporting an increase of 9% over the last 12 months**. It would seem that even if all the proposals for improved primary care are implemented and actually work, there will still be a net increase of 1% in A&E attendances. Or in other words no change to the present position – this is simply not sustainable, affordable or safe.**

NHS Response
The activity analysis and capacity planning assumptions for the future take into consideration both A&E attendances and emergency admissions. The assumption relating to A&E attendances is that the current growth rate, which has been 8% in the last 12 months, can be realigned to the growth rates experienced in similar health economies including neighbouring Trusts. The future demand trends for emergency admissions have been modelled at 3% overall (to reflect the average growth over the past three years) of which 2% will be accommodated through community and primary care developments with the remainder (1%) expected to result in increased demand on hospital services.

Committee comments
it is suggested that current growth rate can be aligned to growth rates in similar health economies including neighbouring trusts – however Mid Yorkshire is the highest in the North of England for attendances at Emergency Departments and the second highest for admissions and is an outlier compared to neighbouring trusts.

On balance the Joint Committee believes there is conflicting evidence, unidentified resource issues, implications in terms of access and equality, negative public opinion, questionable sustainability and affordability, and perhaps most telling, a lack of confidence in primary care.

NHS Response
These different issues would benefit from further explanation and the CCGs and MYHT would be happy to provide further information as required.

The Committee had asked what travel time analysis had been used to assess the ambulance patient impacts for affected patients and had travel times been calibrated against actual journey times achieved by YAS crews travelling at non-blue light speeds. **It was reported that inter-facility transfer was between 17-25 minutes, maternity 30 minutes. The Committee had previously been informed that the average was 15 minutes – the quickest time now being reported was 16 minutes.** (This was considered further by the Joint Committee in relation to Maternity Services)
The Committee made reference to the quantity, quality and content of some of the supporting information provided to members.

The controversial 'right place, first time' argument for closing departments and/or concentrating A&E services has been challenged by one of the UK's most distinguished experts.

Jon Nicholl, Professor of Health Services Research at Sheffield University, co-wrote a four-year study of more than 10,000 'Category A' emergency cases. The research, which was published in the Journal of Emergency Medicine, found that longer A&E journeys led to 'an increased risk of death' The research found that overall, each extra 10km (6.2) miles travelled to A&E will increase the proportion of patients who die by 20 per cent.

NHS Response
This study cannot be applied directly to the proposed model and could cause unwarranted concern to patients and the public if not explained in more detail. The study was based on data for activity between 1997 and 1999 – prior to the introduction of highly skilled paramedics – and practice has changed substantially in the past 14-16 years, particularly in respect of stroke and trauma services. The most serious cardiac patients are already taken to Leeds. The study was looking at transfers between comparable units (ie ones that did the same thing) whereas the future scenario would be between two very different kinds of A&E units – one without specialist presence and one with. The Nicholls report indicates a correlational link, not a causal one. The Committee was provided with details of other research evidence which is not referenced in its response.

Committee comments
The Nichol Study was published in 2007 and is only cited to balance the evidence presented to the Committee. Conversely one of the key drivers for change in the clinical services strategy is to save more lives – the inference being if the public don't accept these proposals more people will die as a result – could this cause unwarranted public concern?

Maternity Services

The Joint Committee was seeking assurances that the proposals were safe and sustainable. Members closely examined the projected improvements in patient outcomes and potential risks to delivery, including the likely impact on patients and their families (in the short, medium and long term) in particular in terms of access to services and travel times (Dewsbury in particular).

It was explained that at the time of booking, 60% of women would be classified as 'low risk'. Of these, quite a number would then move to 'high risk' during the course of their pregnancy. A significant number would also choose not to give birth in a Midwife Led Unit (MLU).

NHS Response
Out of the 3,583 low risk bookings at MYHT in 2012/13 645 were classed as high risk at the end of the antenatal period. This means 18% of low risk women become high risk throughout the pregnancy,

The Committee was informed that all antenatal and postnatal care would continue to be delivered locally.

It was explained that MLUs were as safe for low risk births and could provide a better experience.

At Pinderfields, the proposed changes would see consultant presence increase from 60 hours per week to 168 hours per week. Activity was estimated at 6000 births per annum.

Members were given an outline of the transfer procedure from an MLU. It was estimated that 20% of women in labour in Dewsbury would need transfer to Pinderfields. Overall approximately 35% of women would need to transfer, including after the baby was born. The majority of transfers would not be for life threatening events, and the ambulance travel time was under 15 minutes. (This time has subsequently been amended – average time was 20 minutes, with transfer between maternity units being 34 minutes) Paramedic teams could commence treatment, and the receiving hospital would be preparing.

In Pontefract during 2010/11, 86 in labour transfers were made to Pinderfields, of which 8 were emergencies. All had positive outcomes.

NHS Response
It would be helpful if this could be clarified. Section 3.2 of the supporting evidence provided to the Committee makes clear that 77% of these transfers were before birth. The Committee was told there had been eight emergency transfers from the Pontefract midwife-led unit (MLU) in 2010/11 and that most in-labour transfers are for women requiring epidurals for pain relief rather than for critical emergencies such as a rapid deterioration in the baby's heart rate or excessive bleeding.

16 consultants were currently in post, and 24 would be needed to staff the new proposals. This would increase to 32 if consultant-led units were at both Pinderfields and Dewsbury. There is a national shortage of consultants.

NHS Response
This actually brings the case for change into focus as it reaffirms that having two consultant-led units would not be possible. The benefits of providing 24/7 consultant-led care for high risk pregnancies are clear and substantial. The proposals meet

Royal College and other national standards.

The Committee expressed concern at the lack of detail on how it was proposed to address the risks or barriers that the proposals could create.

The Committee suggested that there must be an increased level of risk if there were an increased numbers of transfers irrespective of ambulance capacity.

NHS Response
It would be helpful to see the evidence to support this suggestion as the Pontefract experience, where the operational model is already working well.. A key aspect of the MtC proposals is to ensure that women are carefully assessed throughout their pregnancy so that they can be referred to (or choose to go to) the most appropriate service setting according to how much risk is associated with their pregnancy/labour. As explained in the two evidence sessions on this subject, women receive continuous risk assessment during pregnancy and clear criteria for transfer have been agreed with YAS.

Committee comments
The Committee's view that there must be an increased level of risk by virtue of increased numbers is a logical assumption to make on the basis that there will be some risk involved in transfer and this will be multiplied by increased frequency – conversely the NHS provided no evidence to suggest there was no risk.

It was explained that there was good evidence from the national survey of over 80,000 women, that there was no difference in the outcome depending on where the mother gave birth. The evidence suggested that 98% of low risk women giving birth at home had a normal delivery; this dropped to 80% in a midwife led unit; 65% in an alongside unit; and 58% in a consultant led unit.

NHS Response
All women will have three choices about their place of delivery – home birth, midwife-led or consultant-led, subject to appropriate clinical protocols.

In response to a question from Members, Dr Mahmood, a GP in north Kirklees, explained that the changes would not affect the procedure followed at a GP surgery if a women presented in labour. **Dr Mahmood acknowledged that travelling times was the key issue for patients in north Kirklees, with some patients already choosing to give birth in Calderdale or Bradford.**

Members of the Committee sought clarification on how the issue of infant mortality in north Kirklees was being addressed by the proposals. Dr Hooper, Director of Public Health for Kirklees and Chair of the Maternity Workstream, confirmed that research supported that the site of delivery had little impact in terms of infant mortality. The work carried out in north Kirklees saw much more integration between community midwives and other sectors, and there was a desire to see greater integration with children's centres and support services such as Auntie

Pam's. An enhanced community midwife service was essential to the success of the proposals.

Members sought clarification on how community midwifery would be improved, and questioned if there was a shortage of midwives. The Joint Committee was advised that there was no local shortage in numbers of midwives and that there was a good ratio of 1 midwife to 31 women. It was explained that ensuring the right professional was in the right place was critical.

Members of the Committee questioned the rationale for deciding to have the consultant led unit at Pinderfields and not Dewsbury. The Joint Committee was advised that the Neonatal Intensive Care Unit and neonatal services were at Pinderfields, and a consultant led unit would need those support services on site.

The Committee expressed concern regarding specific problems around infant mortality which had been attached to North Kirklees in the past. The Joint Committee was advised that there were a number of studies looking at infant mortality rate in general and assured them that the Trust were confident that the place of birth had no impact on any complications following the birth.
Following a request for further clarification on transfer times It was reported that a practice run had been held to measure the emergency transfer time from Dewsbury & District Hospital to Pinderfields Hospital. Although the transfer time between hospitals was 20 minutes, the transfer time between the two maternity units was 34 minutes.
It was reported that advice had been sought from the Clinical Advisory Team. The transfer time was acceptable as long as appropriate stabilisation of the mother and baby had taken place.

NHS Response
The advice goes on to say that appropriate protocols need to be in place (and followed) and the right level of clinical presence available before, during and after emergency transfer. The reconfigured model is geared to ensuring exactly that – in particular, 24/7 consultant availability with appropriate back-up (NICU, SCBU etc). The Committee was told that the Dewsbury MLU would operate to the same protocols as the existing Pontefract service, which already meets these criteria. It is also important to note that the transfer time from hospital bed to hospital bed between Dewsbury and Pinderfields is almost the same as the call-in time for a consultant on-call (30 minutes).

Committee comments
The Joint Committee was told that it was not possible to compare the transfer time from a hospital bed between Dewsbury and Pinderfields with the 30 minutes call-in time for a consultant.

It was suggested that the proposed changes will not increase reliance on community midwifery services as ante natal and post natal care is already carried out locally and this arrangement will not change.

Members were told that the Trust are confident that the capacity plan for the midwifery unit at Dewsbury is robust and allows for future growth as the model becomes established.

NHS Response
The plan also covers Pontefract.

Members are mindful of comments made by NCAT in January 2013 regarding the expected number of births at Dewsbury:

"It is expected that the number of births in the standalone unit at Dewsbury will be about 500 births a year. This is an ambitious target and our experience nationwide has been that over time the numbers of mothers choosing to use a standalone unit tend to fall. Many successful units are delivering about 350 births a year. Any lower figure than this does challenge the affordability of such units"

NHS Response
Overall, the NCAT report confirms it has given its support to the creation of a MLU in Dewsbury.

It is interesting to contrast NCAT comments made in 2010:

"The aim is that the midwifery led unit at Pontefract will have 500 births a year and it will be important that this figure is achieved, in order to ensure the viability of that unit and to ensure that capacity changes do not emerge at Pinderfields".

NHS Response
The evidence provided to the Committee in the summary document sets out the number of birthing rooms currently and proposed and how these will ensure adequate capacity at Pinderfields – now and in the future – to accommodate a transfer of activity from Dewsbury and/or Pontefract, through patient choice or clinical need..

Births at Pontefract in 2011 were 265, and in 2012 they were 303, which supports NCAT's view that the 500 birth target at Dewsbury is ambitious and may bring into question the sustainability and affordability of that unit going forward.

Responding to the Joint Committee's concerns about sustainability of the MLU at Dewsbury, the CCG indicated "…the NCAT data uses 350 births as a minimum number for a viable midwifery unit and we have therefore checked local activity data and national assumptions to ensure the assumption of 500 births is realistic".

Given the example of Pontefract above the Joint Committee as serious doubts that Dewsbury's proposed midwife-led unit will be sustainable and affordable in the long term.

Further extracts from NCAT's 2010 report make interesting reading:

"it is also worth commenting that the option of creating a single maternity inpatient unit across the three hospitals (which is suggested by some) is unlikely to be either acceptable to the public or warranted from a clinical safety perspective, provided sufficient emphasis is placed on maintaining high quality inpatient services at Pinderfields and Dewsbury"

The report goes on to say:

"For maternity services, however, we are not at this stage convinced of the merits of developing a single inpatient unit and would suggest that emphasis is placed on maintaining two separate but linked inpatient obstetric units, together with the midwifery led birthing unit at Pontefract"

The Joint Committee would question what has significantly changed in the last 3 years to justify NCATs current assessment of the proposals.

NHS Response
The summary document provided to the Committee sets out the evidence that guidance has changed markedly since 2010 and refers to the National Birthplace Study (available on the MtC website throughout consultation) which was published in 2011. Given the focus of the CSS, the plans for maternity services are now in a different context including consolidation of acute anaesthetic and operative resources at Pinderfields.
The NCAT report of January 2013 draws on current guidelines and evidence and states:

"The proposed model of care for maternity and children's services can be strongly supported. It is important that the children's inpatient services are brought together on one site as soon as possible and this will have immediate implications for the obstetrics services. Merging the obstetric units onto one site alongside the paediatric services has advantages for improving availability of consultant obstetrician time on the labour unit and will improve overall sustainability. These plans will require evaluation of demand and capacity to ensure that the appropriate number of beds are available for the unit and there is clear planning for each of the maternity led birthing units. The model of midwife led birthing units can be strongly supported, both the standalone units at Dewsbury and Pontefract, and the alongside unit at Pinderfields Hospital. Working collaboratively, the MLBUs should lead to a reduction of overall demand within the system for consultant obstetrician led management of labour"

Committee comments
"The Joint Committee would question what has changed in the last 3 years" is a question that is answered to some extent in the response.

The Joint Committee supports the view that the potential loss of any form of maternity provision at Dewsbury will exacerbate health inequalities and would have a huge impact on deprived communities in North Kirklees, who will find it difficult to access maternity care outside of their local community.

There is no doubt that the Trust faces a challenge in medically staffing two consultant-led obstetric units and the proposals will go some way to ease the current pressures but it is difficult to see how the proposals will improve access and choice – in this regard the Trust has failed to make out a compelling case for change.

NHS Response
The cover that will be offered to those booked into the obstetric unit will be 24/7 instead of 60 hours per week; hence will provide safer cover than at present at either of the consultant led units. The clinical case for change is compelling and has been supported by NCAT and passed various tests/reviews.

Surgery

Members noted that the transfer of all acute services to Pinderfields was not without risk. Unless the demand and capacity modelling is correct there will be a significant impact on other services.
The Committee expressed concern over part of the NCAT report that stated that surgery could risk being pushed out by lack of beds and loss of medical staff.

NHS Response
The summary document and presentation provided to the Committee on 10 May 2013 shows that the acute/elective split will improve the situation and make it less likely that acute cases will take up elective beds.

It was explained that although a few consultants had left, they were in the process of filling vacancies and despite rumours, the staff losses were not due to the proposed changes. Each employee had been through an 'exit interview' and although there were concerns from some with regard to the changes, this was not felt to be a reason for resignations.

NHS Response
This discussion was in relation to emergency doctors and not surgical consultants.

Committee comments
Reference was made to this in the NCAT report

The Committee noted that some operations require post-operative HDU support and it would not be appropriate to operate on an elective site.

NHS Response
The materials provided to the evidence session on 10 May 2013 provide assurance about the clinical assessment process to determine which patients/conditions that would require surgery at Pinderfields.

It was explained that day case surgery and pre and post-operative care would be available on all 3 sites. The more acute and complex surgery would be centralised at Pinderfields. Planned and non-complex surgery would take place at Dewsbury and

Pontefract. There would be increase in the range of specialties at Dewsbury and surgery requiring access to critical care was 40% at Pinderfields.

The shift in acute care will only work if MYHT ensures that as many patients as possible are treated on the Dewsbury site by appropriate risk assessment and providing post-operative care which is of a high standard.
The NCAT report suggests that "Whilst it may not be possible to put in place, or continue with, a high dependency unit or intensive care facility at the Dewsbury site for reasons of cost and sustainability, there are other models which can enhance post-operative recovery and enable the elective site to carry out operations on a wider group of patients".

This statement raises a number of issues: It would seem that ideally Dewsbury would benefit from a high dependency unit or an intensive care facility if not prohibited on cost and sustainability grounds. Secondly, it is suggested other models are available which can enhance post-operative recovery and enable the elective site to carry out operations on a wider group of patients but provides no details of what they are or evidence on improved outcomes. Finally, the statement would imply an element of risk which appears not to have been identified in terms of what elective procedures can be safely carried out on the elective site. Because critical care and some medical support will no longer be available it will need to be clear exactly which groups of patients can be safely managed at Dewsbury in future.

NHS Response
There are three levels of Critical Care 3 = ICU, 2 = HDU & 1 = Level 1. An ITU at Dewsbury will not be sustainable but it is likely that MYHT will be able to have Level 1 unit(s) at Pontefract and Dewsbury to increase the number of elective operations on these sites. It is acknowledged this information was not available to the Committee at the time of producing their report.
The document provided to the Committee on 10 May 2013 sets out which patient groups would not be suitable for elective surgery at Dewsbury if the critical care model across the three hospitals is as proposed in the OBC. This is defined through the pre-assessment process such as that used for orthopaedic elective revision cases.

It was explained that the average length of stay after surgery was 3.4 days. This had decreased greatly over the last few years. Members were drawn to the NCAT statement **"**Generally MYHT is doing well with gradually reducing the length of stay thus the stated average length of stay (ALOS) should be achievable. However the threat to achieving this is a change in case mix. As hospitals deal with ever more complex patients who are elderly and have multiple co-morbidities, it will become more challenging to discharge safely. Thus if the community and primary care is treating the easier cases, the hospital will be left with more difficult cases and this will prove challenging to the downward pressure on ALOS".

The Joint Committee has some concerns in relation to this. It is clear that increasing numbers of challenging and complex cases will become more prevalent, particularly in terms of elderly patients, which can be attributed to increased pressure on A&E departments and higher admissions. This cohort of patients not only account for the increasing numbers of admissions, but by

their very nature are more difficult to discharge and it is questionable if there is sufficient intermediate care provision to offset this.

The NCAT statement goes on to say "Involvement of specialists in elderly medicine and rehabilitation is important. Whilst there will be no specific medical cover out of hours for these patients, they can be managed safely if there are appropriate protocols in place with escalation policies if transfer is required".
It is suggested that out of hours clinical cover at the Dewsbury site will be provided by advanced care nurse practitioners with anaesthetic support. Whilst this is likely to be a safe model, MYHT will need to put in place clinical protocols to ensure only appropriate patients are cared for on the Dewsbury site and that escalation policies are in place if patients deteriorate.

The view of NCAT "Whilst this is likely to be a safe model" implies an element of risk. Clearly without appropriate protocols and escalation policies there is a risk to patient safety. The Joint Committee would like further assurances on this.

NHS Response
The document provided to the Committee on 10 May 2013 describes arrangements for consultant cover across the three sites and 24 hour on-site presence of anaesthetists and advanced nurse practitioners to review patients and respond to deterioration at Pontefract and Dewsbury. This model already operates at Pontefract and is consistent with the model of care in stand-alone elective treatment centres operated by the NHS and independent sector. The clinicians attending the session on 10 May 2013 provided further detail of how this would operate in practice.

The Choose and Book system had been a step forward although only 57% of activity was represented on it and there had been some issues with the generated letters.

The Joint Committee was advised that elective surgery would be carried out over evenings and weekends and the sessions would be longer than 9am to 5pm.
There were 5688 elective inpatients at Pinderfields in 2011/12. These patients will in future not have access to their local hospital for elective surgery but will have to travel to Dewsbury or Pontefract, or another provider out of the District. **It could be argued that this does little to extend patient choice but in fact restricts local access for local people.**

NHS Response
A proportion of patients will not, but 40% will still access Pinderfields along with all day case elective patients.

The Joint Committee is worried about the reduction in bed numbers and shares the concerns expressed by Mike Wood MP and others. It is suggested in the consultation document that that bed numbers have been "rigorously tested the assumptions about the number of beds required, looking at how the length of stay in hospital can be further reduced in the future" **It is disappointing that none of the evidence used in this testing process has been published.**

The Joint Committee recognise that whilst there are some significant concerns in terms of these proposals they do bring with them clear benefits which have been outlined in MYHT local challenges and case for change. However, the key question remains: will there be sufficient capacity and capability to deliver the proposed model – sufficient doubts exist to warrant at least further examination prior to implementation, should there be a decision to proceed.

Paediatric Services

The proposal is that paediatric assessment facilities and outpatient care would be provided on all sites, supported by dedicated paediatric short stay units on both Pinderfields and Dewsbury sites, separate from the main paediatric ward. There would be no change to children's surgery which would be delivered from Pinderfields.

NHS Response
This is not the case as there would be some children's day surgery at Dewsbury & District Hospital.

Committee comments
"There would be no change to children's surgery which would be delivered from Pinderfields" – This statement is lifted directly from the evidence pack tabled by the NHS on the 10 May 2013.

It was suggested that the proposal addresses staffing difficulties anticipated by NCAT in 2010 due to the anticipated reduction in specialist doctors being trained.

The Joint Committee was advised that Mid-Yorks were the first Trust to provide 24/7 RSCNs (Registered Sick Children's Nurse) who would be available on all sites. In Pinderfields there would be 24/7 consultant delivered care for complex and acute cases, Pontefract would have consultant delivered care 9am to 5pm and Dewsbury would have consultant delivered care from 9am to 9pm, with the ability to flex where necessary. It was suggested that most children present within this timeframe.

The Committee expressed concern regarding the reduction in beds; however, Members were assured that the expectation was not to need as many beds because of the increased speed of assessment and emergency day care. There would also be retention of local access to day case and out-patient care and community care would be strengthened.

NHS Response
This relates to the global position on beds, not paediatric beds. The paediatric capacity model is based on 70% bed occupancy and data has been provided on overnight admissions and emergency transfers

Committee comments
The Joint Committee accepts this relates to the global position on beds

The Committee requested information on patient flow. Members were advised that the information could be distributed; however, support from the Trust would be

needed to explain the data as the layout would be somewhat complex. The Joint Committee was advised that under the changes there would be an impact on patient flow around West Yorkshire; however, at this stage it was not possible to say how or where.

NHS Response
This issue appears to relate to all services – not just paediatrics. This information can be made available and the offer to do so was made during the relevant evidence session. MYHT would be happy to provide more specific information, if requested.

Committee comments
The Joint Committee accepts this relates to all services – not just paediatrics

The Committee expressed concern that paediatric services may be transferred to Leeds. Members were advised that the Trust wanted a specialist children's centre in the area and to preserve all the existing services. It was stated that the Trust believed they had taken all situations into account and that the CCG was constantly monitoring capacity. To stay as they had been doing was unaffordable and new models had had to be created.

The Committee had some concerns regarding after hours provision. It was reported that there would be flex of time and a natural overlap period, plus transfer by ambulance, where necessary.

In terms of general bed numbers the Committee wanted to know how the capacity modelling had been undertaken. Consideration had been given to reductions of acute beds at Dewsbury, maximising surgery and ambulatory care. It was acknowledged that the majority of reductions would be a Dewsbury. 50 new beds would be created at Pinderfields. It was emphasised that there was no reduction in service.

NHS Response
This paragraph relates to the global position on beds, not paediatric beds.

The Joint Committee has noted that there is significant public concern within the Dewsbury area regarding paediatric services, particularly that inpatient medical care would be centralised at Pinderfields.

These concerns centre on local access but specifically on the extra strain put on parents and carers in terms of travel and transport. **In any reconfiguration of a service, some local areas will experience change and this will inevitably stimulate opposition. Given the perceived benefits outlined in the MYHT case for change, the question must be posed as to whether the clinical case has been convincingly described or promoted.**

NHS Response
NCAT is clear that the clinical case for change has been made. It is accepted that the NHS and its partners has more to do to make people fully aware of the implications for patients, the benefits the changes will bring and the integrated nature of the wider transformation programme. This was a key outcome from a stakeholder deliberative event held on 2 July 2013. The recommendations from that event are reflected in those which were accepted at the joint meeting of the two CCG

governing bodies on 25 July 2013.

Committee Comments
It is suggested that NCAT have clearly made the case for change – however, the statement goes on to say that the NHS and its partners has more to do to make people fully aware of the implications for patients, the benefits the changes will bring and the integrated nature of the wider transformation programme. **This is one of the Secretary of State's four tests – The way in which the clinical case for change is presented, and the evidence used to support it, is a key factor in making the case for change.**

Mental Health

The proposals for major change to local NHS services will have system wide implications. Running alongside the service strategy in Mid Yorkshire Hospitals are other transformation programmes, such a mental health and learning disabilities. Interdependencies within schemes were explored by the Joint Committee to ascertain whether any issues or risks associated with the delivery of the clinical service strategy have been identified.

Members were concerned that associated programmes were running at a different pace and scale and there was a lack of detail underpinning the programme, The Joint Committee was asked to take into consideration that the proposals were still at Outline Business case stage at that time and therefore modelling will continue as an iterative process.

At the moment people can access any of the Trust's Emergency Departments for this help, as all can refer patients to local mental health services such as Crisis Response & Intensive Home Treatment Teams or contact the Local Authorities to request Mental Health Act assessments if it is believed the patient may require detention in hospital for treatment. **This provision will not change as a result of the reconfiguration as a result of the Clinical Services Strategy. People wanting or needing this sort of response will still receive it from all three EDs.**

People with an LD or with on-going MH problems who need help for another acute health problem will be treated as appropriate for these needs. Depending on the assessment by the GP, paramedic or other health worker they will be taken to or it will be recommended that they attend the most appropriate site for assessment and treatment of the acute health need. **The presence of an LD or an on-going MH problem will not make this decision different to that made for someone with a similar acute health need who does not have an LD or a MH problem.**

Some people who are more familiar with one of the other hospitals may find this change difficult and require specific support. People should be given reassurance by others involved in their care.

There may be an issue of inter-service communication for people who are actively receiving care for their LD and/or MH needs, due to the way that MH and LD services are configured within SWYPFT. Currently SWYPFT have Business Development Units (BDUs) which are co-terminus with Local Authority boundaries. Therefore a person receiving on-going care from an LD or MH service in

Kirklees could be taken to Pinderfields Hospital and then referred for an assessment to a Wakefield service. SWYPFT have a single Patient Administration System, called RiO, so the Wakefield service should be able to identify that the person is an active patient in the Kirklees area and so ensure that there is no duplication of effort and the patient benefits from some level of continuity.

In summary representatives of both SWYPFT and MYHT do not believe there is any differential impact of the Clinical Services Strategy on people with a Learning Disability and/or a mental health problem.

The Joint Committee is aware that some of the timescales involved go beyond the decision date following consultation therefore members were not able to fully consider this work in any detail.

Evidence and Findings

The Consultation and Engagement Process

Engaging patients and the public

One of the responsibilities of the joint health scrutiny committee was to reach a view on whether the consultation process undertaken by the NHS was developed and undertaken in accordance with the legal duty on the NHS to involve and consult patients and the public. The duty to involve and consult means that the NHS should discuss with patients and the public their ideas and plans for change and reasons for these changes. The NHS also has a statutory duty to consult the relevant overview and scrutiny committee (the Joint Committee) regarding changes to health services within the local area.

The consultation focused on specific changes in secondary care provision across North Kirklees and Wakefield District – specifically:

- Surgery
- Inpatient children's services
- Maternity Services
- Emergency care

Summary outcome of consultation

The *Meeting the Challenge* Consultation took various forms, including a postal and online consultation, public meetings, discussion groups and other submissions including; road shows, stakeholder feedback and letters.

The consultation document was mailed to 241,303 households using Royal Mail, with a *Freepost* return address for respondents to use when returning the feedback contained within the summary document. The consultation document was also available online, in GP surgeries and other accessible locations. The feedback form asked a combination of closed questions (where respondents are offered a series of options) and open questions (where respondents can offer any view). There were 2091 respondents to the main consultation either by post or online from across the postcode areas covered by the consultation.

As well as 8 public meetings there were 9 discussion groups and a total of 47 community and stakeholder groups. In addition, a phone poll of 1,013 residents was carried out which was based on strict quotas and tolerances by age, gender, geography and ethnicity (the Joint Committee received a breakdown and some areas were still not covered).

Level of awareness was measured by the phone poll that was conducted towards the end of the consultation period. Respondents were asked whether they had heard about the *Meeting the Challenge* consultation. A quarter of people (25%) had heard about it (256 out of 1013 polled).

Analysis of the qualitative data from postal and web respondents shows that the three main areas of concern **access to care, transport** and **specific hospitals.**

Key broader concerns raised in public meetings included:

- A view that Pinderfields hospital PFI had "saddled" the hospital with debt
- The historic merger of the three hospitals into a single trust had resulted in **Dewsbury hospital 'taking on Pinderfields debt'**
- The financial motive for changes
- Whether attendees would really be listened to
- Specific concerns about the current appointment system

In addition, there were clear differences in both the levels of concern and specific concerns based on geography, with residents in North Kirklees exhibiting higher levels of anxiety about the proposed changes. It was noted that the IIA showed that proposals would impact more on this area.

The consultation methods took into account through a set of equalities questions.

Phone Poll: Black, Minority and Ethnic (BME) respondents were more concerned about the proposals with 73% showing some level of concern compared to 60% overall.

Transport was an issue for multiple groups; it was however more of an issue for the oldest and youngest age groups as well as the BME community

In addition, the BME community were more concerned keeping maternity services local than the overall response.

Residents who actively engaged in the consultation process were evenly divided on whether they thought the proposals would achieve their aims and generally supportive in principle of specialising care. But consistent concerns were raised about the specific proposals. In particular, these focused on the impact of changes to Dewsbury and District Hospital in North Kirklees. The main concerns highlighted were:

- *Transport and Travel* –the centralisation of a number of specialist services that would impact on journey times and travel accessibility across the area.
- *Access to care* – centralising services at one hospital would impact on the availability of local appointments and access to emergency care
- *Specific hospitals* – centralising some services at Pinderfields raises issues about capacity in that hospital and concerns about the long term viability of Dewsbury hospital.

Committee discussions

There had been extensive engagement in the pre-consultation phase which had secured an understanding of the issues that must be addressed and the need for change, and which provided a good platform to move forward to formal consultation.

Notwithstanding this level of engagement **the Committee was concerned that only one option was being put forward for public consultation.** The Consultation Institute had also sought assurances that the process leading up to the decision to use a single option was robust and fair. In addition the Strategic Health Authority's Health Gateway Review had raised similar concerns "Perhaps, most significantly we received a clear message that if only one proposal is being consulted upon it is essential to describe and outline to the public why other options are not viable and the appraisal process undertaken"[2] It went on to say "There is also a general consensus on the need to include some proposals or areas where no decision has been taken and the public can exercise choice to influence the implementation of proposals.

The Consultation Institute indicated that whilst it would have been preferable to proceed to consultation with more than a single option, it was lawful to do so. They were also relaxed about relatively low numbers provided that there was good qualitative information and there was sufficient evidence that all views have been adequately expressed.

NHS Response The above is not reflected in the summary findings section

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However, **the Committee remained concerned with regard to the receipt of the posted consultation as it appeared that there were people who hadn't received this.** The Trust asked that a note was made of where these residents lived and the details passed to them. The Committee questioned if the consultation was getting to the right people, maternity was cited as an example. Members also questioned why an 'easy read' version of the consultation document had only just been produced some way into the consultation period.

NHS Response When the MtC team became aware that Royal Mail had been unable to deliver to some sub postcode areas, they mitigated by making (several thousand) additional copies available in GP surgeries, pharmacies, children's centres, libraries, community venues and council offices. Students were used to deliver hundreds of summary documents door-to-door over a weekend. Copies were also posted to people who requested them. All this was stated during the evidence session on 10 May 2013. Committee comments The evidence session was the 3 May 2013 not the 10 May As stated in the response.

The Committee had raised some concerns with regard to the roadshows both in terms of location and purpose. Members highlighted a number of locations where they felt the roadshow was not in the right location, or should have been located in an area that was not well covered by other consultation activities, i.e. public meetings etc.. This led on to concerns regarding purpose. **Members believed the Roadshows were more aligned to advocating the proposals rather than being genuinely open to reciprocal inquiry.** The Trust advised that although they were for information only, they attempted to send along a Consultant or Doctor

[2] Health Gateway Review – The Mid Yorkshire Clinical Strategy Reconfiguration 30/01/2013

where possible. The Trust would put as much effort into the remaining roadshows as possible.

NHS Response
There is no evidence of the roadshows being used principally to advocate for the proposals. The staff on the roadshows did not have sufficient knowledge to do so, nor to engage in reciprocal debate. The roadshows were for information giving and to encourage people to take part in the consultation and/or fill in feedback forms. The function of the roadshows was explained to the Committee during the evidence session on this subject.

Committee comments
"the roadshows were for information giving" – which promoted the case for change

The Committee understood that details of the consultation were in hospital foyers, however, they felt that this needed to be more prominent with perhaps the inclusion of screens. The Trust advised they would identify televisions that consultation information could be shown on.

The Joint Committee believed some of the consultation questions were structured in such a way as to induce a preferred response.

The Committee was aware that many members of the public had decided not to participate in a process where decisions could be influenced by how the choices were presented in order to influence the outcome. It was acknowledged that the questions could have been better but it was emphasised that they were devised in conjunction with the Patient Reference Group.

In terms of attendance at Area Committees it was disputed by the Committee that invitations had been sent to all Area Committees. Clarification on this was requested by members and further information and clarity on numbers attending.

The Consultation Institute were pleased with the level of scrutiny the Joint Committee was undertaking in relation to the consultation process. They indicate that It was easy to see why elected members and community groups are anxious about the changes to NHS services and that an effective Overview and Scrutiny Committee is one of the best safeguards they can have to ensure that everything is done transparently and to best practice standards. It was suggested that the acid test in terms of the outcome of the consultation was "did I have the opportunity to express my view"

The Committee emphasised the need to refresh the publicity around the consultation and it was indicated this was being planned with various media activities arranged.
The Committee raised concerns that the consultation document did not contain specific proposals about the primary, community and social care services that will need to be put in place alongside the acute changes.

NHS Response
The documents contain substantial sections on CC2H and it has been clearly stated that developing care in the community/outside hospital is a prerequisite for the clinical changes.

Committee comments

No specific details were presented.

It was accepted that there would not be detailed implementation plans at this stage but a robust description of services was required so that the public could understand how the whole system fits together and the new ways in which services will be delivered in their locality. It was felt that this should be agreed prior to consultation and included in the documents and presentations to emphasise the whole system nature of the transformation programme. **The Committee is not convinced this happened in sufficient detail in order for the public to make an informed choice and the lack of detail may have led to bias in their decision-making.**

NHS Response
A clear outcome from consultation feedback was the lack of confidence that CC2H will be/is sufficiently developed. This was reflected at the stakeholder deliberative event and is acknowledged by the commissioners – not least in the recommendations as amended and approved on 25 July.

Committee comments
"A clear outcome from the consultation feedback was a lack of confidence that CC2H will be/is sufficiently developed" – This supports the Committee's view that there is a lack of confidence that CC2H is sufficiently developed to underpin the clinical case for change.

Health care is characterised by an asymmetry of information. The public know relatively little about the complexities of health care. Health care professionals have much better information on the relationship between health care and other determinants of health. Therefore there is an in-balance and this is exploited in the consultation questions which lead the public to make decisions based on imperfect information.

Overall the Committee believes the consultation process has aimed to follow recognised and accepted best practice.

NHS Response
The Certificate of Compliance and sign-off letter from the Consultation Institute shows that we did achieve that.

Committee comments
The Joint Committee acknowledges that the Consultation Institute has signed off the consultation, which meets their expected level of best practice.

However, inevitably there have been gaps. Members are also disappointed at the low participation rate. It would be folly for commissioners to presume that the silent majority were either in favour or indeed against the proposals. However, it is not safe to assume that because a particular perspective has not been heard, it doesn't exist. It is important not to mistake absence of evidence for evidence of absence. Assumptions that people only participate in consultations when they wish to oppose something are also fragile given that we can't be sure the message has reached the larger audience. **The Committee's view is that the consultation outcome is inconclusive and far from ideal as a basis on which to make significant and major decisions on local health services**.
It is very clear however, that a very large proportion of residents in North Kirklees have expressed significant concerns regarding particular elements of the proposals,

including A&E, maternity and children's services, through a petition containing 30,000 signatures. In addition a template email campaign attracting 1290 responses in opposition to the proposals was also received by the Clinical Commissioning Groups. **Whilst this expression of public interest is parallel to the consultation it would be unwise to ignore this level of concern and it should be given appropriate weighting in the decision-making process.**

Consultation with the Joint Committee

In accordance with their statutory obligations, the NHS has consulted the Joint Committee prior to and during the consultation period and has responded to the Joint Committee's requests for information.

Evidence Gathering Sessions

"it is easy to see why elected members and community groups are anxious about changes to the NHS and an effective Overview and Scrutiny Committee is one of the best safeguards they can have to ensure everything is done transparently and to best practice standards. The meeting I attended on Friday was a classic example of democracy in action, with Councillors taking a very reasonable approach to what is, by any standard a difficult set of decisions that Clinical Commissioning Groups will have to take. I'd love to see more O&S Committees take this level of interest rather than sit back until a consultation has ended – and then complain about it".

Rhion Jones, Consultation Institute

NHS Response
The committee has relied on elements of the Consultation Institute evidence in compiling its response but has not included reference to the positive views expressed in relation to the consultation process.

Committee comments
It is accepted that there are positive elements of the Consultation Institute evidence not referenced in Joint Committee's report, however, this is clearly referred to in the particular evidence session held on the 3 May 2013 and is reflected in those minutes.

The Joint Committee held 6 evidence gathering sessions on the following dates:
12 April 2013
24 April 2013
03 May 2013
10 May 2013
24 May 2013
01 July 2013

NHS Response
It is suggested that the session on 8 March 2013 at which the financial position was discussed in detail is also referenced here.

Committee comments
In addition to the specific evidence sessions referred to above, the Joint Committee held a session on the 8 March 2013 to discuss the financial position of the Trust.

In addition, the Joint Committee received a substantial amount of written material from stakeholders, letters and e-mails from members of the public, together with a number of public deputations. Members of the Committee held public drop-in sessions and attended various public meetings and roadshows, as observers organised by the "Meeting the Challenge" team.

At an early stage in the evidence gathering sessions, **the Committee had some concerns regarding the lack of detail underpinning the clinical services strategy and analysis of the arguments for change**. The general thrust was that it was felt not enough supporting information was being provided to allow members the opportunity to effectively scrutinise the proposals.

The CCG responded positively to this feedback. The Committee was asked to take into consideration that the proposals are still at Outline Business Case stage and therefore modelling will continue as an iterative process involving testing, challenging and refining assumptions and models across hospital and community services. It was suggested that this period of development is to be expected to continue throughout the planning process and includes taking into account the comments received through the consultation process, for implementation over a three year period. Assurances were given that, where more detailed information is available, this will be presented to the Committee to maximise the effectiveness of the evidence gathering process to enable members to fulfil their responsibility to assess the validity of the consultation process.

However, although the Committee subsequently received a plethora of information and data **much of the evidence supporting the proposals was limited, variable and in some cases selective.**

NHS Response
The CCGs and MYHT made available the most up to date, accurate and comprehensive evidence/information available to them. In their view, the format of the sessions may have mitigated against evidence being presented in a way which may have been clearer and more helpful.

Committee comments
The Joint Committee reminded the NHS on several occasions that much of the information being presented was already in the public domain and it would be a more useful and productive use of time to deal with the specific elements of the clinical proposals. The Committee would suggest that some action learning and reflection would benefit the process in future.

The Committee would have liked to have seen a more balanced presentation of the evidence, where this exists. For example, Mike Wood MP rightly cites Shaun D'Souza (specialist registrar) and Sunka Guptha (consultant physician for older people) in an editorial for the 'British Medical Journal' published on 20 May 2013. That:

"There is no evidence that enhancing community care for frail older people will reduce hospital admissions, and demands on secondary care will probably continue to rise. There has been a sustained reduction in the number of acute beds over the past few decades, and most hospitals now average over 90% bed occupancy. A further reduction in beds based on the vain hope that enhancing community services will reduce admissions could be potentially dangerous to patient care. It would be

more sensible to evaluate the effects of enhancing community services before making decisions to cut more acute beds" (BMJ 2013;346; f3186).

NHS Response
This study has led to considerable debate amongst geriatricians and other professionals and should not be relied upon without reference to that. Many commentators seem to accept the basic premise that doing more work outside hospital does not, in itself, necessarily reduce acute admissions of older people. However, the debate is much wider and deeper than this. Most experts seem to agree that CC2H does have considerable benefits for patients (eg East Devon), is desirable and popular with patients. A common view put forward is that it is too simplistic to look at the various factors relevant to a whole system approach to care of older people in isolation. When CC2H is rolled out as an integrated whole system model, there is a strong body of opinion which suggests it would have a positive impact on hospital admissions.

Committee comments
"When CC2H is rolled out as an integrated whole system model, there is a strong body of opinion which suggests it would have a positive impact on hospital admissions". – Although no supporting evidence is cited there is evidence to contradict this view (Nuffield Trust, Royal College of Physicians**)**

The Committee was asked to take into consideration a response from UNISON Mid Yorkshire Hospitals Branch to the consultation.

The central thrust of their arguments focused on the belief that services were being planned in response to financial pressures, not patient need or clinical requirements, because of the high costs of the PFI hospital scheme, and as such is disproportionately impacting on Dewsbury Hospital. **This is a view shared by others and one which the Trust has failed to address sufficiently in the consultation to counter this argument.** This was not helped by the refusal of the Trust to release publicly a report by Ernst and Young which considered the financial viability of the Trust and which is perceived to have unduly influenced the outcome of the clinical services strategy. **Non-disclosure is premised on the basis of commercial confidentiality, but this argument has lost its shield given the level of public mistrust, whether or not this is real or perceived.**

NHS Response
The headlines of the financial viability report were presented to the Committee on 8 March 2013. An offer was made following the session on 1 July 2013 to share and go through that document with Committee members in private which has so far not been taken up although the CCGs and MYHT would be happy to progress this as necessary.

Clearly there is some recognition of the financial viability of the proposals and this is recognised more prominently in the Outline Business Case. Part of the Overview and Scrutiny role is to have regard to the financial implications of any reconfiguration proposals and this element was challenged throughout the consultation.

The Committee is concerned that the financial implications have not been resolved and many questions remain unanswered. The proposals will require

£38m capital investment of which £30m is dependent on Department of Health funding. The Committee is reminded of a previous reconfiguration of services at Mid Yorkshire hospitals which fell through following public consultation because the identified capital investment was not secured. Furthermore, the Committee is conscious that if the proposals are implemented there will still be an annual deficit of £10 million.

NHS Response Recent capital and revenue analysis prepared by MYHT has revised these estimates to a more favourable position.

These concerns have also been expressed by both Clinical Commissioning Groups prior to the consultation. "*The OBC sets out that even upon completion of option 2, an annual structural subsidy in the order of £10m will still be required. This position cannot be a long-term solution and I would like to stress that our CCG have not made any commitment thus far*"

It is an inconvenient truth that any further reductions in services will have to come from Dewsbury, since it is the only substantial unit that is not encumbered by a hefty PFI unitary charge. Whilst these issues go unresolved the Trust is open to the charge that Dewsbury will become unsustainable in the longer term.

There are serious doubts regarding the affordability of the proposals as currently set out which question sustainability going forward. **Notwithstanding the assurances given by the Trust Development Agency regarding system wide support up and until 2017, the planning process is dependent upon a fragile promise of support.**

Travel and Transport

Overview

Local people rightly want to know how their travel and transport arrangements would be affected under the proposed changes to health and community care services in the Mid Yorkshire Hospitals footprint. Pre-consultation feedback highlighted the issue was of grave concern to many, especially in the North Kirklees area.

Consideration of other local reconfiguration and stakeholder surveys highlighted similar concerns and the interim integrated impact assessment (IAA) helped identify the populations who would have to travel further.

As a result of this and to mitigate against any potential travel disruption, a Travel Advisory Group (TAG) was set up in December 2012 to:

- Consider the information and feedback about the concerns patients; staff, the public and stakeholders had about the impact of the proposed changes on travel and transport.

- Consider specific issues for and feedback from those groups identified in the interim IAA as being adversely affected by the proposals

- Identify and address any gaps in information, linking to other groups and organisations that could support this area of work.

- Make representations to the Mid Yorkshire Health and Social Care Programme executive on the potential actions necessary to improve travel arrangements and mitigate travel disruption for those affected by the proposed changes.

Membership of the TAG included patients, representatives from Mid Yorkshire NHS Trust, Clinical Commissioning Groups, public health, communications and engagement, LINKS, local authority and local transport provider (Metro). A North Kirklees non-executive director chaired the group.

Headlines

- It has always been apparent that travel and transport would be a significant concern for patients and visitors (this was clearly borne out in the consultation).

- It is suggested that overall, fewer people will need to travel as far or as often as they do now as more services will be provided in local hospitals and closer to home

- It is accepted that a minority of patients will have more complex travel arrangements

Travel group – options for consideration/consultation

The following options were being considered:

- More flexible appointment times
- Training staff to give better information
- Extending the frequency and availability of the shuttle bus and route 111 bus
- Bookable community transport for some patients
- Support to get home for patients arriving by emergency ambulance
- Free Metro cards for A&E patients with no alternative
- Better travel information
- Travel helpline
- Travel information with outpatient appointment letters

Committee Discussions

On the 12 April 2013 the Joint Committee received a presentation on transport and travel arrangements and how they would be affected under the proposed changes in the Mid Yorkshire Hospitals.

Analysis from the 2012 Travel Survey, of which 68% of the respondents were hospital patients, was discussed. A Travel Advisory Group (TAG) had been set up in December 2012 and included patients, Clinical Commissioning Groups, LINKS, Metro and representatives from Mid-Yorkshire NHS Trust. The Group considered information and feedback from patients and aimed to learn from other reconfiguration projects.

Members were told that travel was always at the head of priorities when reconfiguration took place. Under the new proposals it was hoped that fewer people would need to travel to hospital and any travelling would also be less often. Wakefield CCG had produced detailed analysis of patient shuttle bus usage which had increased slightly since its introduction in January 2011.

Some suggestions for going forward that had been discussed at the TAG included extending the frequency and availability of buses, free metro cards for A&E patients, travel helplines, subsidised taxis, subsidised parking, later appointments, improved community transport and better travel information.

It was explained that clinical models had been created in order to understand impact on future hospital journeys using analysis for the past 5 years and inputting challenges into the system, also considering aspects such as the placement of diagnostic equipment. **It was thought that there would be 15,000 less journeys by 2016/17 under the new proposals because of locally based care.**

It was suggested that a more flexible appointments system would help in terms of transport to and from hospital. **Members indicated that this had been proposed by scrutiny some time ago and was something that should happen irrespective of the clinical services strategy.** It was noted that a review of the appointments system was underway. In relation to in-patient surgery and the more complex cases being undertaken at Pinderfields, questions were raised as to how elderly people, for example, would be able to attend for 7.00am or earlier. This had not yet been considered. However, it was reported that the net impact was positive for planned services.

NHS Response

This work is ongoing and is separate to the MtC proposals.

It was explained that 'choose and book' was now used for around 60% of first appointments and all but 8 services operated this system. The Trust would let the Committee know which services they were. The 'choose and book' facility had not yet been looked at in terms of a 24/7 service.

The Travel Advisory Group had so far had five meetings at various locations throughout the District. A community hub was to be created in Wakefield which would include voluntary groups, Patient Transport Services and the Trust. This was also being discussed as a way forward in Kirklees. **Concern was expressed that Members had not been invited to input into the TAG, particularly through Metro**. This would be would be fed back at the next TAG meeting.

Examples of patients being discharged in unsociable hours was raised and the Committee were reassured that the Hospitals would do all they could to help to arrange for transport home. There is a duty of care placed on the Trust, particularly in respect of vulnerable patients. It was reported that a clear procedure was now in place in respect of vulnerable people being discharged out of hours. The Committee requested a copy of this procedure.

It was suggested ambulances, social workers and occupational therapists were also able to take patients home if they were available. The Joint Committee felt this should be more widely publicised. Questions were raised around the eligibility criteria. Members also questioned if the travel helpline was a free phone number. It was not clear whether this was the case. **It was also suggested that in terms of first appointments more information should be available in GP surgeries and information on transport and travel should be available at the booking stage.**

Significant drive time analysis had been collected and included in the survey, including travel time data which had been put through clinical modules. **The Committee had some concerns around the analysis and the assumptions used in the modelling. It was not clear to the Joint Committee what information had been used to determine travel times – if post codes had been used for example.**

The Joint Committee asked if the travel times had been calibrated against actual journey times, and if members of the TAG had personally undertaken any journey's to reassure themselves that the times were realistic and achievable. It was reported that this type of analysis had not been undertaken.

It was explained that the CCG was currently working with Metro and the shuttle bus between the three sites had already been improved. The timetable had been modified and there were extra pick up points. A stock of Metro Cards were available at each hospital for those who were entitled to use them. The Committee questions how this would work and who would be entitled and how people would know this was available.

Additionally, the use of ambulances was being studied and ways that the service could be improved. Their usage was said to be significant. A review was taking place of the standby points (areas of high demand), rotas and revenue over the next 9 months.

T**he Joint Committee questioned the pre-engagement activity in relation to transport and travel and wondered why this had not been reflected more in the consultation document.** Members felt strongly that further work was required and questioned why the TAG had concluded its work at such an early stage. It was reported that the TAG could be reconvened if required. (The group had subsequently been reconvened).

The Joint Committee considered a summary of the Integrated Impact Assessment and requested further information on the analytical and modelling techniques used in the development of the proposals in relation to travel and transport. It was reported that clinical pathways were being developed to ensure the best possible patient options, however this was an on-going and clinicians were being challenged through the process.

The Joint Committee questioned the impact on Yorkshire Ambulance Service (YAS) both in terms of Patient Transport Services (PTS) and emergency ambulances. It was reported that protocols were in place and work was on-going with the CCGs. **It was suggested that further work would be required as clinical models emerge. Members suggested that this information and analysis should have been available prior to public consultation, in order to help the public make more informed decisions**. The Joint Committee questioned any budget implications arising from the proposals and whether these had been factored in to the equation. Discussions would take place with commissioners and it was noted that YAS was undertaking its own transformation programme with proposed changes to working patterns.

NHS Response It would be unrealistic to have detailed analysis, costings, strategies, action plans and answers for queries about all aspects of the wider transformation programme available before consultation began. Committee comments Some level of detail should have been provided.

Input from Metro highlighted the lack of direct services between the three trust sites and the difficulties that many residents of the Wakefield District and North Kirklees area would have travelling to more distant sites by public transport –either to access appointments or to visit inpatients at the hospitals. **In particular, it was stressed that cost and travel time could be a real issue for some communities.**

It was stressed that given the locations of the three sites, a direct public transport link between them would not be a viable, commercial solution. Members were informed of the early success of the new 111 bus, which has been funded by Metro. The service provides a direct link from Wakefield bus station to Pinderfields, providing improved interchange and links for people travelling into Wakefield and onward to Pinderfields.

It was noted that given current budget constraints, **Metro would not be in a position to provide financial support to any public transport actions contained within the TAG group's action plan, other than those which could be provided through existing resources i.e. improved timetable information provision in hospital reception areas.**

The Joint Committee had raised some concerns regarding the level of detail underpinning the travel and transport proposals being put forward by the TAG.

Members were informed that the Travel Group had been re-established and would focus on developing options that require minimum investment – such as better travel information and more flexible appointment times for early implementation (on the basis these will have benefits for patients irrespective of whether service configuration changes) **The Joint Committee welcomes this but believes these measures should already be in place.**

Members were informed that the group will support development of detailed proposals for implementation of potential solutions, including costing and identifying sources of funding and potential suppliers of transport solutions so that these can be implemented as soon as required and prior to services being reorganised across the sites. **However, no details of these initiatives were provided during the consultation.**

There appears to have been little consideration on the impact of patients from Wakefield who may have to travel to Pontefract or Dewsbury for their planned operation.

The Joint Committee received many concerns from the public in relation to travel and transport, particularly from the North Kirklees area. Members of the Joint Committee held a series of public drop-in sessions where members of the public could express their views.

"Travel on public transport may be possible from the centre of Dewsbury to Pinderfields, but for most areas in North Kirklees, would require at least two bus journeys. Residents in some areas would be far more likely to access services in Bradford or Leeds, as these are more easily accessible". Local resident Dewsbury Customer Service Centre

"Would be three buses for visitors to get to Pinderfields from most locations, and the cost implications for someone visiting over a period of days or weeks would be significant". Local resident Cleckheaton Library

"The buses from local areas (Thornhill) can be full, and people have to wait for the next one" Local resident Cleckheaton Library

Members were told that parking was very difficult at Pinderfields – an example was given of someone who had driven round for a number of hours.

"There are very few disabled parking spaces at Pinderfields, and these are always full". Local resident Cleckheaton Library

The Joint Committee was told that it is a minimum of 3 bus journeys from Dewsbury to Pinderfields on a timetable that doesn't link up and often means lengthy delays between each journey. There is an option of using a local taxi service but a taxi fare costs at least £15 each way. It has been suggested that in an emergency, public transport would be neither be practical or safe and the financial impact on low income families would probably mean that many simply would not be able to afford to make the journey by taxi regardless of how great their need was. The natural alternative will be that more people will be compelled to ring 999 for an ambulance in

these emergency situations, thus putting more pressure on an ambulance service that is already stretched to capacity and has no plans for expansion.

"An out-patients appointment at Pinderfields for a patient from Batley means a 4 hours or more round trip by public transport – I know this from personal experience, having suffered a slight stroke last November" Kirklees Councillor

The Joint Committee is aware of a previous public transport mapping exercise carried out by Metro in 2009, which illustrated that **for some people an off peak journey to access services or visit patients may take up to two hours**. It was also stated that there are significant changes to bus timetables after 6.00pm and in some cases bus services do not run in the evening. '*Your Hospitals, Your Say – Consultation on proposals to develop specialist hospital services in Mid Yorkshire'.* 2009.

It is suggested that 'trade offs' are inevitable in the planning and provision of health care. For example, the NCAT report suggests "*We think on balance that travel times are acceptable from a clinical standpoint and will not affect outcomes. The benefits the public will have from the reconfiguration outweigh this inconvenience".*

This has to be a subjective view and not based on public opinion. In order to properly evaluate trade offs between location and outcomes would require a conjoint analysis specifically designed to look at the impact of different attributes on the overall benefit obtained from the proposal. **The Joint Committee has seen no evidence to suggest this has happened.**

Better measures of geographical access, which integrate public and private transport availability with distance and time, are required if an accurate reflection of the experience of those without their own transport is to be obtained.

The report goes on to say that *"nevertheless the Trust, local authorities and transport companies should do all they can, following analysis of patient flows, to improve the public transport between all three sites".* **It is clear from evidence provided by Metro that this seems unlikely to happen**.

NHS Response
The CCGs would be interested to know what evidence Metro provided ashey were not present at the evidence session on this subject. The improvements required to help people with increased travel problems do not all depend on Metro. A number of recommendations to put measures in place to help people with travel problems were approved by the two CCG governing bodies on 25 July 2013 and include a commitment to extend the hours and days of operation of the shuttle bus.

Committee comments
Evidence from Metro was submitted in writing (via e-mail)

Members were concerned that in terms of a more centralised approach to planned admissions patients were usually required to present at 7.00am – this would cause considerable travel difficulties for many patients, particularly the elderly.

Travel and transport are nearly always at the forefront of public concern when service reconfigurations are being proposed. In 2009, a public consultation 'your hospitals, your say' was held on proposals to develop specialist hospital services in

Mid Yorkshire. As a result of this, in March 2009 Steer Davis Gleave, Transport Consultants, were commissioned by the then NHS Wakefield District to undertake a Transport Options Review of the three main hospital sites in the Mid Yorkshire Hospital sites. The proposals were also the subject of formal public consultation and a Joint HOSC was set up between Kirklees and Wakefield Councils

The Joint HOSC made a number of recommendations at that time including:

"*The Committee recommends the development of a Trust wide travel plan that links to a regional transport strategy to the specialist facilities. Connectivity needs to be about neighbourhoods and not just hospital to hospital connections. The Committee supports the travel consultant's recommendation that a travel plan co-ordinator is appointed".*

It is disappointing to note that despite assurances at the time, this has not been implemented and brings into question present day reassurances that travel and transport are being taken seriously enough in order to mitigate public concerns.

It is clear from the consultation outcomes that concerns about transport and travel are significant including the centralisation of a number of specialist services that would impact on journey times and travel accessibility across the area.

The Clinical Services Strategy and the "Meeting the Challenge" consultation have highlighted tensions between the perceived safety, effectiveness and efficiency of larger specialist centres and the demand for more geographically accessible local care. However, geographical access – the distance which must be travelled in order to use the health services – is one aspect of access which is often overlooked but which presents barriers of cost, time and inconvenience.

In any area, the greatest disadvantage is likely to be experienced by individuals without access to a car (including members of one-car households without daytime access). Although care ownership is relatively high, rates for the poor, the elderly and for women are far lower than the average.

Care Closer to Home

Overview

The care closer to home programme is part of the wider Mid Yorkshire Health and Social Care Transformation Programme and plays a major role in the successful delivery of the proposed changes surrounding the Mid Yorkshire Clinical Services Strategy.

Five key areas have been identified to help keep more people out of hospital and more care delivered locally. These include:

a) **Easy access to high quality emergency care** with longer opening hours for GPs.
b) **Simpler scheduled care pathways for surgery** with specialists available to give advice, more clinics in the community for common health issues and patients able to have simple operations without needing to go to hospital.

c) **Quick response to urgent care problems** by setting up services in each area to prevent patients from having to go to hospital unless clinically necessary.
d) **Coordinated care for people with a long-term condition/frail/elderly** by setting up multi-disciplinary health and social care team covering the whole of North Kirklees and Wakefield District. This will mean people with a long-term condition will have a personal care plan.
e) **Less time spent in hospital** because care providers will know when someone is in hospital and will make sure services are in place for them to leave hospital as soon as they can.

Two key areas have been identified:

a) Slowing down or reducing the number of frail and / or elderly admissions occurring unnecessarily known as *'Admissions Avoidance"*
b) Supporting patients' discharge from hospital as soon as they no longer require hospital care known as '*Discharge to Assess"*

The proposed service model has been developed through extensive engagement with primary, community, secondary, social care and the voluntary sector and is based on national practice as well as need rather than what already exists.

Local health and social care partners agree that an integrated care team (ICT) approach spanning all three key areas below will ensure a fully-integrated service delivery:

- **Proactive care**- what can be done 'closer to home' to manage people's health and prevent them from needing to go into hospital especially those with long-term conditions and elderly/frail
- **Crisis intervention** – what can be done 'closer to home' for people who need regular access to specialist care so that a rapid response can be provided in the community
- **Early supported hospital discharge** – what can be done 'closer to home' to enable people to be realised home as soon as possible with the right support and care in place.

Estimated potential impact of proposed changes

The Summary Outline Business Case has modelled the estimated impact of the service model and these are summarised below. These estimates are based on national practice. It has also modelled the overall results under three scenarios of low, medium and high to illustrate potential levels of savings for each health and social care partner.

Table: Estimated potential impact of proposed model

Proactive care impact	Crisis intervention impact	Admission avoidance impact	Supported discharge impact
Reduction in A&E attendance by up to 2.5%.	**Reduction in A&E attendance** by up to 10%.	Circa 10% reduction in number of **avoidable admission rates** will be delivered through more proactive crisis	**Reduction in the existing average length of stay** by up to three days for the target population
Reduction in hospital admissions by up to	**Reduction in hospital admissions** of between		

5%. **Reduction in spend on nursing/residential homes/domiciliary care.**	15-20%. **Reduction in spend on nursing/residential homes/domiciliary care.**	prevention work and better long-term condition management.	group.

High level financial indicators
The proposed service model offers a sustainable solution by:

- Reducing the cost to commissioners for A&E attendances and hospital admissions.
- Reducing the levels of nursing and residential care due to increased domiciliary care.
- Reducing ambulance conveyance.
- Ensuring patients have a supported discharge therefore reducing length of stay in hospital.

In a 'medium' case scenario, the net benefit to Wakefield CCG could be in the region of a £8.7m saving and for North Kirklees CCG, a £0.1m saving respectively. There would also be opportunities for both Wakefield MDC and Kirklees MBC to reduce costs.

Potential reduction in hospital (acute) beds
In addition to the service model creating a more sustainable solution, it is likely that the Mid Yorkshire NHS Hospitals Trust would accrue savings from reduced length of stays and admission avoidance. Mid Yorkshire assume a total of 132 beds to be reduced through Admission Avoidance (58 beds) and Early Supported Discharge (74 beds).

CCG	
Wakefield	Between 68 and 179 beds
North Kirklees	Between 30 and 80 beds

Committee Discussions

On the 12 April 2013 the Joint Committee received a presentation on Care Closer to Home.

It was explained that the idea of the project was to stem unnecessary admissions and treat patients in their own home where possible. If a hospital admission was required then patients would stay only as long as clinically necessary. People were now living longer with one in five of the population classed as elderly. **44% of all hospital admissions were patients over 65 and it was felt that 40% of these admissions could be treated elsewhere.** A multi-disciplinary health and social care team would be created which would cover North Kirklees and Wakefield to provide care for the elderly and those with long term illness.

NHS Response Dr Foster data for 2011/12 and 2012/13 shows 34% of admissions were for over 65 year olds.

Evidence showed that care in the home aided recovery and improved the patients' outcome. Treatments that had originally been carried out in hospital were now able to be undertaken at home or in GPs clinics or health centres. This would

benefit the long term conditions such as COPD (Chronic Obstructive Pulmonary Disease) and strokes.
A new strategic vision had been created which consisted of five strands – improve access to high quality primary care, rapid response to urgent needs, providers working together, simplified planned care pathways and appropriate time in hospital. Ambulance personnel and paramedics would be able to do a lot more in the community when they assessed the patient. There was a pilot scheme in place in Kirklees and Wakefield was hoping to follow their lead. Making services accessible 24 hours a day was at the forefront of the changes.

There would be improved use of planned care and pathways with better telephone access. There were already 2000 'carephones' which were available for use and this would be expanded.

Emphasis would be placed on early supported hospital discharge. At present time there had been negative feedback concerning delays in the discharge of patients. A team would be organised to go walkabout into wards and 'pull out' patients for discharge. A proposed model had been created for the discharge lounge and there would be discharge teams. The Committee expressed concern over the terms 'push and pull' with regard to the discharge of patients. It was suggested that the term could be reconsidered.

Around 15 community teams across West Yorkshire had been created 18 months ago. They were mobile workforces who would have access to health records (hospital and GP records) and would know when a patient was leaving hospital and would therefore be able to support them with planned care.

Intermediate care beds had been put in place, 35 in North Kirklees and 78 in Wakefield. These were intended to make transition from hospital smoother.
A series of meetings had taken place with stakeholders and there was now a summary outline business case included in the report which showed potential reductions. The model showed the estimated potential impact of the proposed model under low, medium and high results of savings for each health and social care partner.

The Joint Committee was advised that Wakefield and North Kirklees Clinical Commissioning Groups were working closely together to get the greatest benefit from the community pathways. They were reflecting on where investments had done well for each side, although the finances were better in Wakefield. The CCG was encouraging Mid-Yorks Trust to set up a community task force.

The Joint Committee was advised that there would be a link between Adult Social Care and NHS Community Services. This would improve outcomes for residents across the District and would offer a more streamlined appropriate service with better value for money, and care closer to home. Integrated service delivery was a key priority and joint commissioning arrangements were well established.

The Committee were pleased that the hospital discharge issue was being overhauled. The Trust reassured the Committee that the problem of waiting for discharge would be eradicated and quicker assessments would help overcome this.

It was explained that CCG were waiting for some guidance from Government on what 24/7 care entailed. It was possible that the 24 hour service would be operated from Pontefract Hospital and the pilot was would be signed off very soon.
The Trust assured the Committee that there was a system in place to monitor the changes.

The Joint Committee questioned possible pressures in the system around capacity and finance.

In particular, whether wider system support would be required and how this was being addressed. **It was noted that the OBC recognises that even upon completion of Option 2, an annual structural subsidy in the order of £10m will still be require**d. It was suggested that this position could not be a long-term solution and transitional support had been recognised by the Trust Development Agency (TDA). Further clarity on this was not available at this stage.

NHS Response This relates to the MYHT OBC not the OBC for Care Closer to Home. Committee comments The Joint Committee would suggest both the MYHT OBC and the OBC for CC2H are connected. The reference here is in relation to pressures elsewhere in the system i.e. social care if the structural subsidy was not addressed. Which reemphasises the view expressed by the Committee that the MYHT OBC and the CC2H OBC are inextricably linked.

The proposed model indicated a reduction of 200 beds. The Joint Committee were seeking assurances around the modelling particularly around acute activity and bed requirements which would need to be robust and flexible enough to meet variation in demand.

The Joint Committee question proposals for future domiciliary care pathways and eligibility criteria. Members suggested that better integration of social care data with health will be vital – social care information will be a good indicator of future issues for health.

NHS Response The capacity model has been assured by the Public Health Observatory. It does rely on certain assumptions around length of stay, demand, achievement of Government Quality, Innovation Productivity and Prevention (QIPP) targets and occupancy.

Members recognised the arguments being articulated that the NHS would restructure itself around community services and deliver transformational change. The Joint Committee is mindful that this would not be a simple 'reduce hospital costs; invest in community and primary care' equation. **There is as much, if not more, of a challenge facing community health services and general practice, whose models of care have not yet faced the scrutiny and modernisation experienced by most hospital trusts in recent years.**

Similarly, the case for vertical integration of community and acute services is a pressing one – **real quality and productivity gains are at the interface of**

secondary and primary acre, at the interface between NHS and social care. **There is potential for efficiency gains and improved services within the Care Closer to Home proposals but the evidence for this appears limited.**

Policy Context

'Care Closer to Home' (CCH) is not a novel concept. As far back as the National Beds Inquiry[3] and the NHS Plan[4] in 2000, the health service was intended to be redesigned around the patient. A new range of intermediate care services were meant to build a bridge between hospital and home with more specialist care provided closer to people's homes, in response to demographics, attitudes and technology. Rapid response and 'Hospital-at-home' teams were introduced to work on an integrated basis with GPs, community nurses, physiotherapists and social care staff to make sure that people received the active support they needed to remain independent at home.

The theme of CCH continued to be developed in subsequent years, with the aims of improving access and convenience of patients, and potentially reducing the high demands for hospital care in response to an aging population and an increasing number of people with one or more long-term conditions. In England, the white paper, *Our health, our care, our say'*[5] announced the launch of six 'Shifting care closer to home' demonstration sites, to provide frontline evidence about moving services to community settings.

The emphasis on bringing care closer to home was a key theme in the *NHS next stage review* and has been further developed in the Health and Social Care Act 2012.

Thirteen years on from the NHS Plan it would appear many of these initiatives have failed to meet the objectives set in offsetting in sufficient numbers the increasing demand on hospital services and delivering care closer to home.

The Joint Committee remains to be convinced that the 'Care Closer to Home' programme will result in the successful delivery of the Mid Yorkshire Clinical Services Strategy.

Overall, the evidence base for safety, clinical-and cost-effectiveness in transferring secondary care into the community is thin, but conversely there is no evidence base to suggest that specialist care is better delivered in hospital. CCH services significantly improve patients' satisfaction with healthcare services, as well as improving their attitudes to and knowledge of their individual conditions and treatment.

NHS Response

This is not the case – the CC2H programme has undertaken a quality impact assessment which demonstrates a convincing evidence base for the clinical and cost benefits of transferring care to settings outside hospitals.

[3] Department of Health. *Shaping the Future NHS: Long term planning for hospitals and related services: Consultation document on the findings of the National Beds Inquiry,* London, 2000

[4] Department of Health. *The NHS Plan.A Plan for Investment, a plan for reform.* London, TSO, 2000

[5] Department of Health. *Our health, our care, our say: A new direction for Community Services.* London, TSO, 2006

Committee comments
The evidence base for safety, clinical and cost-effectiveness in transferring secondary care into the community is thin. It is suggested this is not the case – the CC2H programme has undertaken a quality impact assessment which demonstrates a convincing evidence base for the clinical and cost benefits of transferring care to settings outside hospitals – there is no evidence provided to this effect and there is contradictory evidence as cited by the Joint Committee and in addition the Nuffield Trust and the Royal College of Physicians

The Joint Committee believes the cost effectiveness of Care Closer to Home has not been thoroughly evaluated in the proposals and has seen no clear evidence that CCH services will produce any cost savings to the NHS.

The evidence suggests that for community health and social care services, focussing on facilitated discharge, rather than preventing admission, has a greater impact on creating flow of patients through services and reduces the likelihood of problems in emergency departments.

Surveys conducted by the King's Fund have found that delayed transfers of care are a concern for many NHS organisations. However, more investigation is needed to discover why, despite these concerns, official statistics show a relatively stable picture on delays. Discussion with directors of acute hospitals strongly suggest that the official data for delayed transfers of care do not accurately reflect the number of patients who are delayed and waiting for discharge[6]

The Joint Committee was informed that delayed transfers of care were minimal, however this is not reflected in anecdotal evidence to local members regarding the experience of their constituents in relation to delayed discharge.

Community services can be complex and hard to navigate for emergency care staff, meaning that it can be easier to admit a patient than find suitable support in the community at short notice.

Timely access to social care services is also critical. Both local authorities are trying to protect social care budgets, but net expenditure on adult social care has fallen in real terms for the past two years. Nationally, the number of people receiving publicly funded social care through local authorities has also continued to fall – by 7 per cent in 2011/12 and by 17 per cent since 2006/7. Over the same period, the number of people aged 85 years and over has risen by more than 20 per cent. A recent survey of Directors of Adult Social Services by the King's Fund found that transferred NHS money is being used to promote the closer integration of care but in many cases it is being used to offset general service pressures and councils are finding it much harder to find savings that do not impact on the quality or quantity of care.

There is limited evidence that community-based interventions have been able to reduce admissions at a large enough scale to make an impact on the operation of hospitals. Schemes aimed at avoiding admissions and A&E attendance are

[6] Appleby J, Humphries R, ThompsonJ, Galea A (forthcoming). *How is the health and social care system performing?* Quarterly monitoring report 2013.

generally very poorly evaluated, too small to make much impact, hard to manage and prone to creating additional demand[7]

NHS Response
What is known to work (evidence based) forms part of the integrated care team approach and includes self-management of conditions, health and social care response in a crisis and specialist geriatrician assessment. The Torbay model is a good example.

The evidence that does exist suggests that successful examples are likely to be large scale and integrated with other services. The integrated service in Torbay remains the best example of community interventions that have reduced emergency admissions to hospital. **(This model was cited in evidence to the Joint Committee)**

Much attention has been paid to problems in access to primary care services, particularly out-of-hours. There seems to be an inconsistency in the number of emergency appointments that are available and how many might be needed. No data or evidence has been produced to illustrate this.

As indicated earlier, there have been many attempts to divert people from A&E services over many years by providing alternative primary care type services. These schemes appear mainly to increase overall demand, particularly for minor injury and illness, and have also had the effect of creating a highly fragmented system which generates confusion among GPs and other referrers about how and where to access care. There is anecdotal evidence that patients are also confused and turn to A&E services as they have confidence in them and find them easy to access[8]

As with community health and social care services, the evidence base for interventions that can help to prevent hospital admissions is patchy[9]

Nursing and residential homes are an integral part of the care system and are caring for increasingly frail patients. Improving the management of nursing and residential home patients is an important task for primary care in order to prevent unnecessary admission to hospital.

The Joint Committee is concerned that the proposals in relation to community based health care are not underpinned by any detailed plans and there is no evidence of resources being identified.

Concerns in this regard were raised by NCAT prior to consultation:

"Predicted activity is predicated on other work streams being implemented; ie the community care strategy, which includes admissions avoidance and improved discharge planning. The acute care strategy needs to be integrated with these strategies. It would be advantageous for these plans to be implemented and

[7] Purdy S (2010). *Avoiding Hospital Admissions. What does the research evidence say?* London: The King's Fund.
[8] The Kings Fund, *Evidence to Health Select Committee* 2013
[9] Purdy S (2010) *Avoiding Hospital Admissions*

evidenced so that they are having the predicted effect on hospital attendance, average length of stay and bed occupancy before the full reconfiguration of services takes place. Otherwise there will be a risk that there will be intolerable demand placed upon the planned acute medical unit"

Responding to concerns expressed by the Joint Committee the NHS Wakefield Clinical Commission Group said:

"However, it is important to note that the timeline for implementation is to deliver the proposed changes in community services before 2016 which allows time for these developments to have an impact on demand for hospital beds in advance of the hospital reconfiguration".

Unison, the public Services Union has raised concerns around the allocation of resources to fund expanded community services:

All these are complex and demanding services to organise, and this will not happen without proper allocation of money and managerial resources. None of this is outlined in the document, leaving the proposals as aspirations and wishful thinking, but with little credibility as a practical plan".

Mike Wood MP has also raised significant concerns around the provision of community services:

"Significantly, the Trust's centralisation of A&E and acute medicine at Pinderfields and bed reduction at Dewsbury rests on the delusional premise that major improvements in primary care/community care will reduce the need for acute hospital admissions….there is no evidence within the reconfiguration proposal that the Trust has any concrete 'admission avoidance schemes' in place to take up the vastly increased throughput needed"

Mike Wood MP also cites evidence to suggest that reducing beds based on enhanced community services could be potentially dangerous to patient care.[10]

The change proposals accept that there will be a requirement to invest in reformed community services but provides no detail. There is a worry lack of evidence to support the proposals. Integrated care pathways have yet to be developed and agreed yet the clinical services strategy is dependent upon sufficient investment in community provision.

Members questioned what assurances can be given to the Joint Committee and the public that these proposals are not simply aspirational?

NHS Response The Public Health Departments have supported a programme to gain greater understanding of the evidence base to support modelling. The current assumptions, based on more recent analysis, are more favourable than the original activity assumptions considered by the Committee. Committee comments The Joint Committee has not seen the more recent analysis.

[10] D'Souza,S, Guptha,S (BMJ 2013;346:f3186)

Overall there is a concern that various transformation programmes are becoming fragmented and are working at different pace and scale all of which have interdependencies with the clinical services strategy.

On balance the Joint Committee is of the view that insufficient detail has been provided to support the proposals on care closer to home.

Social care

Overview

The proposed changes to hospital services are set in the context of a wider health and social care transformation agenda. Joint integrated working arrangements will be crucial to the success of the clinical services strategy, particularly in relation to the admission avoidance model and average length of stay.

In both of the above the Joint Committee has sought assurances that associated transformation programmes will help prevent attendance and admission to hospital, particularly for people requiring urgent care, older people and people with long term conditions.

In addition, improvements in discharge and community support will be required in order to reduce reliance on acute hospital beds by creating new pathways and models of care in out of acute hospital settings, particularly in relation to Dementia, and to develop and improve End of Life care programmes to further reduce reliance on acute settings wherever possible. The Committee therefore welcomed the further information on the transformation of Adult Social Care and progression of the integration with the health agenda, which have obvious implications for the clinical services strategy.

The Joint Committee has sought assurances that the proposals for integrated care are genuinely person-centred – bringing together formally fragmented and sub-optimal services to significantly improve the quality and care to individuals. Research shows there are many different ways of doing this, and that, where implemented appropriately – patient experience and outcomes can improve significantly.

An emphasis on prevention and wellbeing reflects changing demographic patters in which active older people become a focus for priority attention in order to prevent or delay future service use (in this case acute admissions to hospital). The Joint Committee was keen to know how public health and social care policies will contribute to this agenda in the context of a population in which the burden of disease is growing.

Members wanted to know if there is flexibility to take forward different approaches in different areas (both within and across Wakefield and North Kirklees) and how the impact will be evaluated, with the emphasis being on people with complex needs.

Collectively, the local health economy will have to deliver a sustainable health care system in the most challenging financial circumstances and at a time of significant organisational upheaval. The Joint Committee wanted to know what risks are

associated with system wide transformation, particularly shifting the burden of care (in terms or resources and finance) disproportionately to any singe organisation (in particular the local authority).

The Chancellor has recently announced plans to more than treble the amount of NHS funding transferred to social care in 2015/16. However, a portion of areas' funding will not be paid up front. It will be realised only if clinical commissioning groups and councils can demonstrate their investments have resulted in improved outcomes, such as reductions in the proportion of patients with long-term conditions requiring emergency admissions to hospital.

Committee discussions

The Joint Committee received a briefing on the 24 April 2013 regarding the implications for social care arising from the Mid Yorkshire Clinical Services Strategy.

Written reports had been circulated in advance of the meeting by both local authorities in respect of social care.

Mrs Richards, Assistant Director: Well-Being & Integration at Kirklees Council, advised that the Council was engaging with the transformation agenda across the Mid Yorkshire footprint and responding to the Clinical Services Strategy as part of this wider transformation programme.

Mrs Richards highlighted a number of challenges for social care and Kirklees, as a result of the transformation programme:

- Negotiations around future models should be predicated on a radical conversation about money flow around the system – the money should follow the individual rather than remain within organisational silos. All organisations were facing financial pressures.
- Options for change should not inadvertently create volume pressures elsewhere in the system.
- Capacity to deliver the new model should be sustainable.
- The impact on Kirklees of a similar programme across Calderdale & Huddersfield;
- New models should be sustainable across the whole Kirklees geography.

Mrs Richards emphasised the role of Health & Well-Being Boards in maintaining an overview.

Kirklees currently provided 20 intermediate care beds at Ings Grove in Mirfield and 20 beds at Moorlands in Netherton. Due to hospital pressures, a further 13 transitional intermediate beds were provided across Kirklees. Additional beds were also commissioned by the CCGs and Locala.

Mrs Richards went on to outline the effect of blue light admissions advising that there was potential for a shift in people from North Kirklees being taken to Huddersfield Royal Infirmary, which had been modelled at 50 per day. The Hospital Avoidance Teams worked in A & E and there would be a shift in demand, requiring an additional service at Pinderfields. The Hospital Intake Team currently had 2 link workers who travelled to Pinderfields each day, and this would be likely to increase.

Mr Smith, Assistant Director: Personalisation & Commissioning at Kirklees Council, outlined the work the Council had already implemented on prevention and early intervention.

Mr Crook, Director of Family Services at Wakefield Council, explained that the measures set out in the report circulated prior to the meeting would still have been required irrespective of the Clinical Services Strategy. He expressed confidence that the measures the Council were taking would mitigate the risks of the review in respect of social care. The Council's approach was focused on supporting people at home, and resources were being invested in prevention and early intervention. The Council's main response to the proposals was to move further towards integrated care. A joint appointment by the Council and Trust of a Director of Integrated Care had been approved on 16 April 2013. Approval had also been secured in January 2013 to a consolidation of Adult Social Care Services with the community services arm of Mid Yorkshire.

Mr Hurren, Service Director for Adults at Wakefield Council, advised that care pathways would need to be redesigned and that reablement was critical to the Council's plans. He emphasised the opportunities that an integrated agenda would provide.

Ms Curry, Service Director for Strategy & Commissioning at Wakefield Council, advised that as commissioners the Council would not dictate or design solutions, but would give providers the opportunity to be creative.

Members of the Committee observed that the Clinical Services Strategy envisaged shorter stays in hospital, and the importance of hospital avoidance and early discharge had been highlighted, **The Committee sought clarification of the financial impact and pressures of this on local authorities**. Mrs Richards advised that if savings were made within the acute trust, some would need to be reinvested. Many of these patients would need more complex packages of care than might currently be the case. It was explained that there was some precedent in Kirklees, due to the support for people upon discharge and use of transitional beds in care homes. Mr Hurren highlighted the need for clear pathways for convalescence.

The Committee asked if the two local authorities worked together, and Mr Smith advised that commissioners across Yorkshire and Humber met regularly. It was recognised that there would be differences of approach across local authorities as they were locally accountable and allocated funds differently. Mr Crook noted that consistency was important.

The Committee sought clarification on the decision for Wakefield Council and Mid Yorkshire to pool resources but not budgets. Mr Crook advised that the Council had to mitigate its own risks. Workforce and assets would be pooled.

The Committee questioned if the two local authorities had made Mid Yorkshire aware of their own financial constraints both currently and in the future. Mr Hurren confirmed that all organisations were in negotiation and needed to have a shared vision going forward. Mr Smith confirmed all partners were aware of the financial position and envisaged that as precise patient flows were detailed, further negotiation would take place.

The Committee expressed concern that throughout the evidence gathering session, it had repeatedly been said that the details were not yet available, and sought assurances as to how it was proposed to move forward with more clarity. Both local authorities confirmed that work was being undertaken and that the level of information was as expected at this stage of the process. Public consultation had to be undertaken at an early stage, but 2016 was the date for being operational. **The Committee repeated its concern that the vision being put forward in documentation created an impression that everything was in place, and did not suggest it was dependent on others having the necessary budgets and resources**.

Emergency Care

Overview

Current Service Provision
Local Challenges

The local shortage of ED doctors is similar to national and other multi site Trusts' challenges in delivering emergency care and vacancies cannot be filled.

As a result of these pressures Pontefract Emergency Department was closed overnight in November 2011. The department subsequently reopened in September 2012 with a different model of out of hours care; a GP service was implemented to run the department at night supported by resident anaesthetic cover.

The demand profile at Pinderfields and Pontefract has changed since the new hospitals were commissioned. Pinderfields is now seeing greater demand for non-elective services, while Pontefract is significantly reduced compared to expected levels (average of 13 patients per night at a cost of over £3k per night).

Activity

Summary of Attendances, Admissions and Conversion Rate to Admission

Year	Site	Attendances	Admissions	Conversion Rate
10/11	PGH	73,250	20,428	27.89%
	PGI	56,774	11,485	20.23%
	DDH	73,710	15,945	21.63%
	Trust-wide	203,734	47,858	23.49%
11/12	PGH	87,814	28,376	32.31%
	PGI	39,169	4,804	12.26%
	DDH	76,929	15,882	20.65%
	Trust-wide	203,912	49,062	24.06%
80% of people treated in Dewsbury A&E are not brought by ambulance. Of these 82% are discharged. Of the 20% of people who arrive by ambulance at Dewsbury, 50% are admitted				

Attendances in the Emergency Departments across Mid Yorkshire are increasing by 9% in the last year (the highest growth in North of England) and emergency admissions have increased by 10% in the same period which is the second highest in the area. This level of growth is not sustainable in terms of service capacity and delivery nor is it affordable for commissioners.

Local Challenges include:

- Heavy reliance on locum support due to staff shortages.
- Greater demand for acute services at MYHT compared to other Trusts in Yorkshire and Humber area.
- Greater demand for Elderly care.
- Running two emergency departments which dilutes resources for a population of half a million.

- Transferring and diverting patients between hospital sites.

Current Service Provision

The current configuration of Mid Yorkshire Emergency Departments is as follows:

- **Pinderfields –** the emergency department is open 24/7 and consists of separate adult and paediatric areas. Pinderfields receives unselected Trauma (other than patients who would go to the Trauma Centre in Leeds Teaching Hospital NHS Trust (Leeds), acute medicine and surgery.
- **Dewsbury –** the emergency department is open 24/7 and consists of separate adult and paediatric areas, with an assessment unit located with the Paediatric Ward. The Kirklees walk in centre is also co-located with the department. Dewsbury receives unselected acute medicine and surgery.
- **Pontefract –** the emergency department is open 24/7. The unit is staffed from 10pm to 8am by a team of GPs, on average the department sees around 13 patients a night. Pontefract receives selected self referrers in medicine and ambulance admissions by strict protocol. Typically around 11% of patients are transferred to Pinderfields.

The NHS Case for Change

- **There has been a year on year increase in demand for emergency care, which exceeds national trends**. The reconfiguration of the emergency departments must ensure continued safe and efficient services that are fit for purpose for the coming years.
- Current levels of activity can compromise the available medical and nursing workforce at both the Pinderfields and Dewsbury departments with the active number of patients in a department at any one time exceeding 50 at both the Pinderfields and Dewsbury sites as a daily average. This can result in delays in assessment and the inability of staff to effectively observe and treat this number of patients, which constitutes a clinical risk. Consequently, this is a risk on the risk register, with mitigations and controls identified.
- There has been a shift in patient presentation with the increased demand being felt through the evening and progressively later into the night. Regularly there are in excess of 20 new patients per hour booking in between 21:00 and 00:00 hours. This leads to longer waiting times over night and backlogs the following morning.
- **With the growth in attendances, there is also a growth in admissions**. With the volumes in the out of hours period growing, there is an increasing likelihood of admissions not seeing a consultant until morning. This is associated with increased morbidity, mortality and length of stay.
- **The current medical workforce is excessively reliant on expensive locum staff due to national shortages of appropriately skilled doctors**. For the last three years it has become increasingly difficult to recruit and retain specialist doctors to the middle grade tier outside specialist registrars on the training scheme. The fill rate for emergency medicine posts in Yorkshire is 50%.

Future Configuration

The future configuration of Mid Yorkshire Emergency Care Network is as follows:

- **Pinderfields** – will have an Emergency Care Centre (ECC) which will provide Consultant delivered 24/7 care with full resuscitation facilities, receiving critically ill and injured patients. Specialist rotas will support the emergency care centre providing specialist care for the severely ill patient. Paediatrics would be delivered in the current paediatric ED.
- **Pontefract** – will have an Emergency Care Unit. The service would be delivered between 8am and 10pm, although the exact model of care would need to be developed further with the CCGs. Similar model of care to the GP out of hours model could be employed.
- **Dewsbury** – will have an Emergency Care Unit to deliver a 24 hour / 7day per week service. There are opportunities for further integration with the Walk in Centre and the Local Care Direct GP's who provide services within the Dewsbury ED. A dedicated children's assessment unit will operate alongside the emergency care unit.

The medical staffing model would run the three departments with 24/7 consultant cover on the Pinderfields site, 9am to 8pm cover on the Dewsbury site and daytime cover (9am-5pm) at the Pontefract site with on call provided from Pinderfields.

Local Activity/Trends

MYHT:

- Attendance at A&E in year 2012/13 compared to previous year 2011/12 shows an 8% increase. This is higher than any other Acute Trust in the North of England.
- The increase in attendance has translated to a 10% increase in admissions which is the second highest in the North of England (Alder Hey Children's Hospital 18%).
- Kirklees PCT A&E attendance rate is significantly higher than the Yorkshire & Humber SHA average, with the majority of the higher rates in North Kirklees.

Site	Admissions < 2nights	2012/13 Attendances	2012/13 Admissions (conversion %)
Pontefract	60%	38,205	4,375 (12%)
Pinderfields	60%	95.535	31,318 (33%)
Dewsbury	60%	87,694	18,118 (21%)

1. Admission Profile:

- Dewsbury:

- Mondays and Thursdays are busiest days of the week.
- 77% of attendances are between 08:00 and 20:00.
- 50% of attendances are for the top 6 complaints.

- Pinderfields:
  - Sundays and Mondays are busiest days of the week.
  - 72% of attendances are between 08:00 and 20:00.
  - 46% of attendances are for the top 6 complaints.

NHS Proposed Key Benefits

Emergency day care has a very significant impact on bed capacity as it provides rapid assessment, diagnostics and access to specialist inputs on a day care basis (avoiding patient waiting in beds for diagnostic tests etc). In addition the patient will receive prompt assessment and appropriate treatment without the need to be admitted to a hospital bed.

The key benefits to the proposed changes are as follows:

- Separation of emergencies with more senior presence and specialist care on site.
- Maintains urgent care locally for majority of patients.
- Reduces admission rates.
- Reduces time to assessment and treatment for the severely ill patient.
- Streamlining of processes to allow lower acuity patients to be assessed and treated in a more efficient and timely manner.
- Minimises travelling for patients/relatives and reduced secondary transfers.
- Enhances development of “emergency day care” for current admissions with low Length of Stay.
- Addresses medical workforce issues.
- Greater integration with local primary and community services.

Assumptions used in the service model

The development of the service model will target the patients who stay less than 2 nights in hospital and the 49 emergency conditions which have established care pathways. The aim is to provide as much emergency care locally in Dewsbury and Pinderfields and significantly reduce patient flows out of areas predicted in the OBC inpatient capacity model and financial model.

The model assumes that:

- Protocols for emergency conditions are in place across all hospital sites including paramedical/ambulance services
- Appropriate access, turnaround and capacity is provided in diagnostics to support diagnostics
- Specialist rotas at Pinderfields provide real time advice and support for all sites
- Pathways are aligned to appropriate 24/7 urgent care services in the community including follow-up

- There is access to urgent clinic appointments for patients who require follow-up
- Direct communication between hospital consultant and GP to agree the care plan
- The service will be funded through a BPT for emergency day care reducing costs for both provider and commissioner.

Committee discussions

The Joint Committee considered emergency care at their meeting held on the 10 May 2013.

The Committee was informed that the proposed development of a network of emergency care services is designed to minimise the need for people with less complex needs to travel for treatment or to be admitted to hospital**. It is anticipated of the 80,000 attendances at Dewsbury A&E, around 55,000 would continue to be treated locally**. Of these approximately 10% would be managed through an ambulatory model where they would be allowed home after tests and initial treatment with follow up provided as an outpatient.

The Committee's key line of inquiry regarding urgent care services is: will there be sufficient capacity and capability- particularly within the emergency departments at Pinderfields and Dewsbury within the new model? If patients have to be admitted will there be sufficient beds at the Pinderfields unit to accommodate the acute activity without impinging on other specialist services or surgery?

NHS Response The current system causes capacity problems. Elective patients often have operations cancelled due to demand for acute beds. Committee comments Not sure how this links to the question.

Members were told that the unit at Dewsbury will change from an emergency department to one which has been defined as an emergency care unit. It is hoped that this unit will be able to deal with and retain 70% of overall activity presently attending Dewsbury A&E. **Presently Dewsbury A&E has substantial activity with around 80,000 attendees. To retain 70% of activity will mean that the competency base of the receiving staff must include the ability to deal with acutely ill patients, medically ill patients and most minor injuries. An urgent care facility run by general practitioners would not be able to deliver this. The evidence is that patients with primary care type problems usually seen by GPs compromise about 20% of overall activity attending the Emergency Department.** The Joint Committee will want to see modelling assumptions underpinning the new model, in particular assurances around capacity and capability.

It was explained that all three hospitals would have 24 hour cover. Pinderfields would be the critical, primary department. Seriously ill patients would be treated in A & E – there were 2 resuscitation bays and four major cubicles to cover any patients arriving from Dewsbury. The Dewsbury service would treat walk in patients and selected

ambulance attendees, whilst some of the cases would be transferred onto a second destination.

NHS Response
There are six resuscitation bays and 15+ major bays available for all patients who attend, regardless of where they come from.

Ambulatory Emergency Care (AEC) would be used alongside the A & E department and would reduce the number of admissions into hospital by using alternatives. It was felt that 10% of people admitted could be treated in AEC. Patients with problems such as the following could be treated in AEC on the same day with possible discharge and follow up at clinics outside. If the problem becomes serious they could be transferred to the Emergency Care Centre at Pinderfields.

- chest pain
- headache
- cellulitis
- asthma
- pulmonary embolism
- minor head injury
- deliberate self harm (overdose).

The emergency department at Pontefract would remain the same. At present there were transfers from Pontefract to Dewsbury taking place – under the new proposals this wouldn't happen, therefore freeing up more ambulances. **Although research showed that increased travel times could have an effect on mortality, the benefits of attending at a hospital with a better service outweigh the negative impact of the journey.**

The Committee asked the Trust to explain the difference between consultant led and consultant delivered. The Committee was advised that consultant led was where the consultant was physically seeing patients and consultant delivered was where they were available to be contacted for advice. It was reported that consultants' would be on site at Dewsbury from 9.00am to 8.00pm weekdays and 9.00am to 5.00pm Sat/Sun, as at present.

It was reported that the Commissioners' vision aims to reduce A&E attendances and emergency admissions by increasing capacity in primary care in areas such as long term condition care planning. The target is to reduce A&E attendances by 8% over a twelve month period which equates to 9,317 attendances.

The 8% reduction is to be achieved by:

- increased walk-in, early mornings, weekend appointments with GPs etc.
- Additional acute GP appointment slots made available for same day attendance
- Implementation of the 'Doctor First' Scheme; and
- Additional GP appointments slots to be directly booked by the ED.

These proposals have yet to be finalised and the Committee has expressed concerns at the lack of detail regarding implementation or finance

The Committee was advised that Mid-Yorks Trust was in the top 5 of the best performing Trusts in the country with regard to the 4 hour target and explained that there was some very detailed work going on. Specialists would be primarily at Pinderfields, however, surgeons would be transferred and times could be shifted to cover needs.

Yorkshire Ambulance Service advised that pathways and transfers to and from Hospitals were at present being investigated as was the repositioning of crews and capacity. A red warning plan had been created for true emergencies to which senior staff would respond.

The Committee asked if the walk in centre in Dewsbury was to close as there had been rumours in the community. The Trust advised that the centre would not be closing although it was part of the review so it could change.

The Trust summed up by saying that last year the commissioners invested in reducing the number of admissions, targeting around 5% of resources.

It would seem that this has had little impact on reducing admissions to date which over the last year have increased by 10%. This would imply either interventions are not effective or considerably more resources are required, which will have to be taken from existing budgets.
It would have been useful to have seen financial projections aligned to the proposals to give some indication of the costs involved. Without this and a clear commitment to invest there can be little confidence in reducing the bed base at a time of unprecedented demand.

There were specific patients who didn't need to be treated in A & E and could make use of ambulatory care.

It is clear that the pressures felt by A&E services are caused by issues across the health and social care system that prevent the flow of patients through the system.

The Joint Committee was told that key to preventing long waits in A&E is making sure that patients flow quickly through the hospital and are discharged rapidly. There are a number of factors that prevent this, including, **the misalignment of workflow between emergency departments and the rest of the hospital – The Trust operates largely on a five-day week for most of its activities which creates problems with the flow of patients – reduced diagnostic services during weekends and over lunchtimes etc.**

Clearly there needs to be significant changes in working patterns with the introduction of 24/7 accessible health services. Cultural change on this scale will require more than a leap of faith.

NHS Response

The consolidation of services will allow better cover out of hours and the JOSC was given assurance that the move to a 24/7 model of working in emergency medicine is supported by clinicians.

The Joint Committee was told that ambulance arrivals at Mid Yorkshire (currently 210 per day) were to be offset by reductions in delayed hand overs. However the recent performance of the Trust is disappointing. A 15-minute target is a new requirement imposed on hospital trusts by the government this year. It is expected that all hand overs between ambulance and Accident and Emergency services will take place within 15 minutes. In May 2013 there were 4,278 ambulance arrivals at Mid Yorkshire. Out of these arrivals, 844 waited in access of 15 minutes for responsibility to pass from ambulance to Trust staff. This is 19.7 per cent.

Delays not only indicate inefficiencies in the system, but have the potential to negatively impact on patient outcomes and result in a poor experience of care. An assumption underpinning the proposals for change is that the Trust's performance is within the upper quartile – it is clear significant improvement is required in this key area of activity.

NHS Response

The proposals will go a long way to improving this position. Having the right specialist teams on site at Pinderfields will improve the assessment process and make it more efficient.

Access to care including emergency care was a clear concern expressed throughout the consultation on "Meeting the Challenge". This was also prominent in representations made to the Joint Committee by members of the public, who raised access to emergency care as a key concern, particularly residents from Dewsbury. Other key stakeholders and respondents to the consultation have raised similar concerns.

There seems to be a significant discrepancy in the calculation being put forward in terms of reduced A&E attendances. Commissioners envisage a reduction of 8%, by increasing capacity in primary care (although the Joint Committee has seen no evidence to support this), whilst the Trust are reporting an increase of 9% over the last 12 months. It would seem that even if all the proposals for improved primary care are implemented and actually work, there will still be a net increase of 1% in A&E attendances. Or in other words no change to the present position – this is simply not sustainable, affordable or safe.

The clinical viability and safety of the proposals have also been questioned by Mike Wood MP. NCAT have subsequently responded to these concerns and reiterated their view that the emergency care model can be supported. However, it is suggested that the Trust should look again that the plans in place would be able to accommodate the predicted activity:

"*It is rightfully a key concern for local politicians and the public, and the Trust with the two CCGs must ensure there are robust plans to ensure that capacity at Pinderfields will cope with expected activity".* NCAT 18 June 2013

For the assumptions on expected activity to be realised demand and capacity must be in balance. On the evidence presented to the Joint Committee so far this is unlikely to happen.

On balance the Joint Committee believes there is conflicting evidence, unidentified resource issues, implications in terms of access and equality, negative public opinion, questionable sustainability and affordability, and perhaps most telling, a lack of confidence in primary care.

Yorkshire Ambulance Service

The Joint Committee considered implications arising out of the proposals on the Yorkshire Ambulance Service at their meeting held on the 24 May 2013

The Joint Committee had provided information on their key lines of inquiry prior to the session.
It was explained that YAS saw an increase of 5% in activity from 2011-12 and an average of 200 emergency calls were received every day in 2012-13.. There were around 70 Red 2 calls a day, these related mostly to RTAs (Road Traffic Accidents), shortness of breath and chest pain. Red 1 calls, which were the highest clinical priority, worked out at an average of 4 calls a day. In the district there were 4 ambulance stations and 15 strategic stand-by points. **Dewsbury accepted around 40 ambulances per day with 20 of those patients discharged 20 admitted, although probably not to Dewsbury Hospital (this was an assumption based on historical data).** There were 4 transfers per day at the moment which would drop to 2 after the changes had been put in place. The Emergency Day Care Model would manage some patients.

NHS Response
The Committee was informed that evidence suggests the EDC model could reduce admissions by up to 10%.

The challenges were outlined which included extended drive times (managing patients for longer periods of time); increased decision making; managing increasing demand; Ensuring clinical quality; hospital handover and turnaround times; and reducing unnecessary hospital attendances.

Information was provided on the potential North Kirklees impact on Mid Yorkshire Hospital Trust reconfiguration of services. Members questioned whether these were based on condition of the patient or geographical location. It was reported this included all incidents. **It was asked which part of Kirklees were the analysis drawn from as there were significant variations. It was reported that it was based on post-code analysis.**

The Committee was informed that clinical care was very important and added that now 'the hospital had been brought to the patient'. Once a call had been received, a Rapid Response Vehicle (RRV) would attend the scene; give the first stage of treatment and asses the patient with an ECG, possibly speaking to a Cardiac clinician on the phone if needed.

The Committee had asked what travel time analysis had been used to assess the ambulance patient impacts for affected patients and had travel times been calibrated against actual journey times achieved by YAS crews travelling at non-blue light speeds. It was reported that inter-facility transfer was between 17-25 minutes, maternity 30 minutes. The Committee had previously been informed that the average was 15 minutes – the quickest time now being reported was 16 minutes. (This was considered further by the Joint Committee in relation to Maternity Services)

Hospital turnaround times for 2013 were provided.

The Committee was advised that the response times for ambulances ranged from 8 minutes to 20 minutes, the latter of which was likely to be in the rush hour. There were targets for response times and Information on A&E Response Standards was provided.

YAS were at present reviewing all 2 year old rotas to take into account factors like population change and new housing developments. These would be ready towards the end of the year. Pathways had been put in place to stop people being admitted to A& E and deal with them using different methods.

The Committee asked that, if Dewsbury A&E were to close, which hospital patients would be taken to. The Committee was advised that this depended on the clinical need and the nearest specialist unit. It was also hoped that a patients past medical history would be discussed at the scene in order to obtain the best outcome. Once the ambulance or ambulances then arrived at the hospital, the patient or the patients would be medically assessed for a second time in order of priority or if they were deemed critically ill they would bypass this stage. The second assessment could be also be bypassed by prior calls to the hospital from the ambulance technician.
The Committee was advised that there was a review being undertaken of urgent care pathways and a business case would be written specifying 5/6 things that needed to be dealt with differently. Ambulatory care would make a lot of difference to the system.

The Committee asked if the first stage assessment was clinically driven, YAS advised that this was an appropriate action and had a positive effect on patient outcomes.

The Committee asked what the overall impact on YAS would be in terms clinical outcomes, staff and finance. It was reported that YAS was in the process of a wide ranging transformation programme which included and estates reconfiguration, £45 million of efficiency savings and the production of a 5 year workforce plan. This included the development of Emergency Care Assistants (ECAs). It was reported that there would be no cuts to front-line services.

Members questioned the skills mix of staff and the training of ECAs. It was reported the training for ECAs was robust which would consist of an assessment, four week driver training (under blue light conditions) and four weeks clinical training. A four week probationary period would follow. It was confirmed that the training programme would make the system more efficient.

Dependent upon the outcome of the consultation a 4 year implementation plan would be drawn up. It was stressed that the Trust would be under pressure for the

next 5-10 years and if it didn't change then it would not be able to deal with efficiency savings.
It was re-iterated that the figures given out in the presentation were 'worst case scenarios' and that the Trust did not believe these situations would transpire. Diverts had drastically reduced over the past 12 months and would continue to do so. Also anyone that was critically ill would not be diverted.

The response time given in the report was from when the call came in to when the crew got to the patient. The ambulance would then arrive at the hospital where the receiving area would be ready then a clinician would deal with the handover once assessed. (see reference to performance)

Reference was made to the NCAT Report (National Clinical Advisory Team). This stated that the services were clinically safe.

The Committee made reference to the quantity, quality and content of some of the supporting information provided to members. It was stated that the YAS data would be re-distributed with headings. The Committee also questioned the difference in response/handover times as this had been different in the previous presentation. The Trust would provide clarity of the times and also evidence of work done regarding the Mid Yorkshire Clinical Services Strategy i.e. work carried out with other agencies.

The controversial 'right place, first time' argument for closing departments and/or concentrating A&E services has been challenged by one of the UK's most distinguished experts.

Jon Nicholl, Professor of Health Services Research at Sheffield University, co-wrote a four-year study of more than 10,000 'Category A' emergency cases. The research, which was published in the Journal of Emergency Medicine, found that longer A&E journeys led to 'an increased risk of death' The research found that overall, each extra 10km (6.2) miles travelled to A&E will increase the proportion of patients who die by 20 per cent.

Maternity Services

Overview

National Context (Outcome & Quality)

Over the last decade there have been a number of government policy drivers which have impacted, and will continue to impact, on Maternity services. These include: the National Service Framework for Children, Young People and Maternity Services published in 2004 and Maternity Matters; Choice, access and continuity of care in a safe service published in 2007.

Maternity Matters includes the national 'choice guarantees' providing choice in:

- How to access maternity care
- Type of antenatal care
- Choice of place of birth
- Choice of postnatal care.

The Future Role of the Consultant (RCOG 2005) and Safer Childbirth (RCA, RCM, RCOG, RCPCH 2007) both recommend that for units delivering in excess of 6000 births and also units delivering between 5000 and 6000 births there should be 168 hours of consultant presence i.e. 24 hours a day 7 days a week consultant cover.

Local Challenges

The Trust faces a challenge in medically staffing two consultant led obstetric units.

Doctors in training and locums continue to provide the majority of out of hours care within the current model. The recent review of women's services highlighted that in 2010 168 weekend night shifts and 222 weekday nightshifts across the two units were staffed with locum doctors.

A single larger unit will reduce the workforce pressure on the Trust and it is estimated that in the proposed configuration the Trust will require 24 obstetric and gynaecology consultants, however to run two units would require 32 consultants. Currently there are 16 consultants in post.

The Trust faces a challenge to improve performance against a number of direct birth related outcomes as well as a number of other challenges locally including uptake and provision of ante-natal care, improving breastfeeding initiation and sustaining rates, smoking in pregnancy rates etc.

Current Configuration

Currently the Trust maternity model consists of:

- A consultant led unit at Dewsbury & District Hospital with 40 beds which also offers midwifery led delivery and handles approximately 2600 deliveries per year. The unit operates with 60 hours of Consultant presence on Labour Ward.
- A consultant led unit at Pinderfields Hospital with 49 beds which also offers midwifery led delivery and handles approximately 4000 deliveries per year. The unit operates with 60 hours of Consultant presence on Labour Ward.
- A free standing midwife led unit at Pontefract Hospital with 4 beds and handles approximately 250 deliveries per year

In addition the Community Midwifery service also supports home deliveries delivering approximately 50 deliveries per annum in the North Kirklees area and 150 deliveries in the Wakefield area.

Numbers

Bed numbers/delivery suites

	Dewsbury	Pinderfields	Pontefract
Ante-natal beds	**21 (total antenatal/postnatal flexi beds)**	**32 (total antenatal/postnatal flexi beds)**	**0**
Midwife led unit delivery rooms	**2**	**0**	**4**
Consultant led delivery rooms	**6**	**11**	**0**
Post natal	**21 (total antenatal/postnatal flexi beds)**	**32 (total antenatal/postnatal flexi beds)**	**0**
Total			

Births

	Dewsbury	Pinderfields	Pontefract
2011	**2770**	**3673**	**265**
2012	**2522**	**3892**	**303**

*** Home births = 98 Pinderfields and Pontefract**

= 56 Dewsbury

The NHS Case for Change

The Trust will become one of the first in the country to deliver 24/7 consultant cover to its maternity units under the new proposals.

There is evidence to suggest that resident obstetric consultants will:

- Reduce the numbers of cases of death or harm to the baby during childbirth due to lack of oxygen
- Reduce the number of claims for damages linked to maternity – 1 in 1000 births resulted in injuries leading to the NHS paying damages with a total compensation figure of £3.1 billion between 2000 and 2010. In a number of these cases junior doctors and inexperienced midwives were involved in the management of labour and there wasn't adequate assistance from senior clinicians.

- Improve access and choice for women to receive direct consultant care and improvements in patient perception of care
- Support efficiency improvements with studies reporting reduced lengths of stay with increased numbers of consultant ward rounds and faster turnaround of patients.
- Improve the training experience and decrease work pressures for junior doctors
- Provide senior leadership for inpatients particularly in emergencies
- Support other members of the clinical team including midwives, nurses, anaesthetists and neonatologists
- Reduce the reliance on locums improving quality and reducing cost

There has been a reduction in trainee posts within the Yorkshire and Humber region. The Trust in 2012 did not see a reduction in Obstetric and Gynaecology posts; however it is expected that there will be fewer trainees in the future in line with changes seen in Anaesthetics and Paediatrics. It is also becoming increasingly difficult to recruit to staff grade posts in Obstetrics as the workforce is not available for a number of reasons. A single unit will minimise the impact of all these workforce challenges.

A larger unit will also support the availability of consultant anaesthetists able to offer women choice of pain relief, the potential for the use of interventional radiologists for the management of severe post partum haemorrhage which is referenced in the RCOG guidelines for the management of post partum haemorrhage and could prevent women requiring hysterectomies as a result.

Operating a larger unit enables the use of new technologies to support improved clinical care of women. The current unit at Pinderfields has access to cell saver equipment in theatre which is not available in Dewsbury. This allows any blood a woman is losing during massive post partum haemorrhage to be collected and recycled to use their own blood for transfusion. This reduces the pressure on the regional blood bank, saves costs to the local health economy and could save lives for women with rare blood types or who are Jehovah's Witnesses.

Future Configuration

The proposed service model for the Trust will provide:

- A free standing midwife led unit at Pontefract Hospital with 4 beds with an initial expectation of c.250 deliveries per annum
- A free standing midwife led unit at Dewsbury & District Hospital with 6 beds with an initial expectation of c.500 deliveries per annum
- An obstetric consultant led unit at Pinderfields Hospital with 74 beds with an expectation of c.6500 deliveries per annum. The unit will operate with 168 hours of Consultant presence on Labour Ward. In addition there is the potential to deliver an adjacent Midwife Led Unit on site (activity and bed numbers have yet to be determined).

In addition the Community Midwifery service will support home deliveries in the North Kirklees and the Wakefield areas and will look at increasing the current home delivery rate. The number of home births in 2011/12 increased by approximately

3.5% compared to the previous year. Women will therefore have choice of a complete range of high quality maternity services

Bed numbers/delivery suites

	Dewsbury	Pinderfields	Pontefract
Post-natal beds	**0**	**54**	**0**
Ante-natal beds	**0**		**0**
Midwife led unit delivery beds	**6**	**17**	**4**
Consultant led delivery suites	**0**		**0**
Total	**6**	**71**	**4**

Deliveries – predicted by 2016/17

Dewsbury	Pinderfields	Pontefract
500	**6500**	**350**

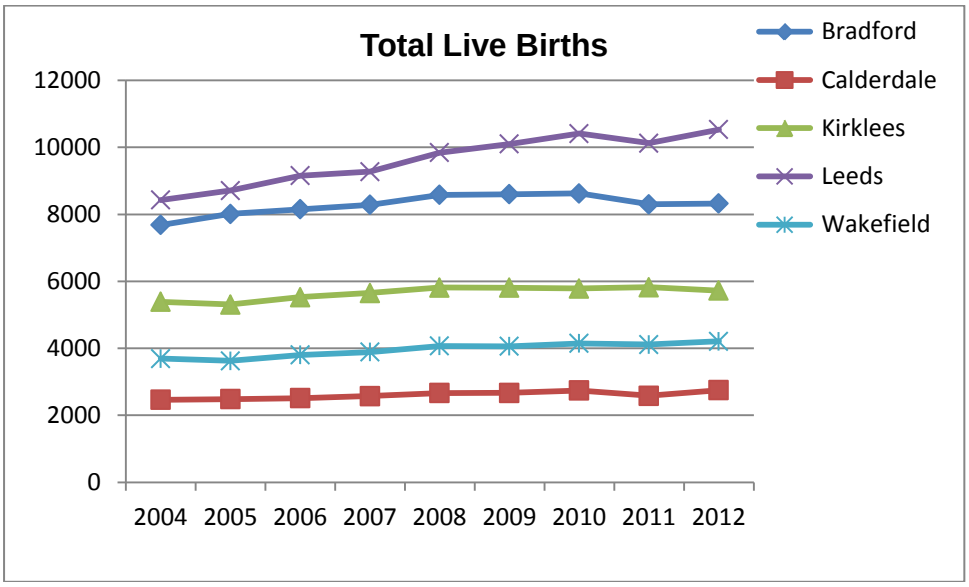
NHS Response

This is the capacity which is planned for. During the last three years demand has stayed constant at 6,800 deliveries. Therefore, it is expected that extra capacity for 500 births is made available at Pinderfields, which would cater for under-use of the Dewsbury and Pontefract sites should this occur.

Birth rates (Source Office for National Statistics)

Live births by single year and West Yorkshire local authority

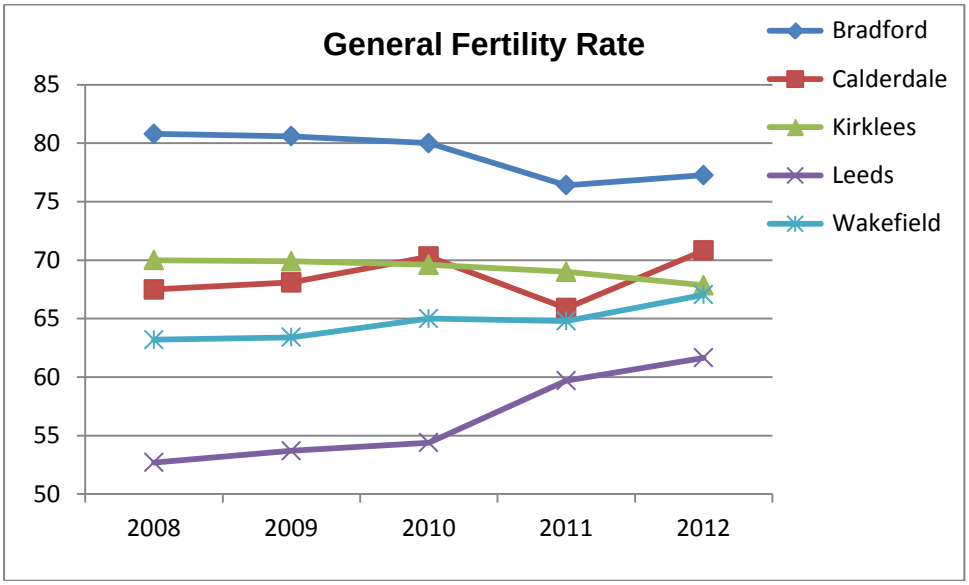
Total births	2004	2005	2006	2007	2008	2009	2010	2011	2012
Bradford	7686	8014	8153	8288	8580	8603	8627	8301	8322
Calderdale	2466	2486	2513	2573	2665	2671	2744	2584	2753
Kirklees	5389	5309	5530	5654	5814	5811	5784	5823	5725
Leeds	8431	8709	9155	9273	9844	10101	10412	10127	10533
Wakefield	3692	3624	3803	3889	4072	4061	4145	4113	4210



General Fertility Rate by single year and West Yorkshire local authority

General Fertility Rate is the number of live births per 1,000 women aged 15-44.

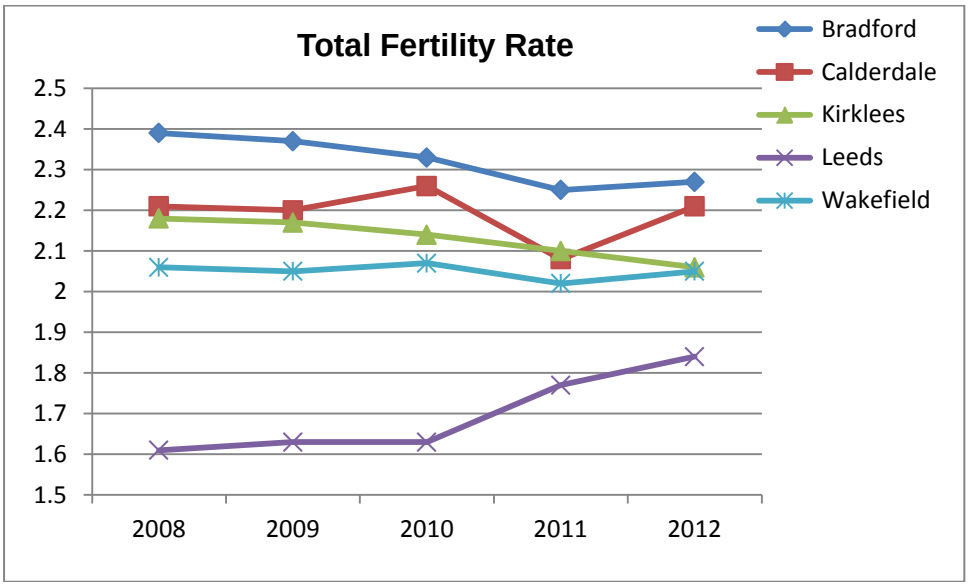
General Fertility Rate	2008	2009	2010	2011	2012
Bradford	80.8	80.6	80	76.4	77.3
Calderdale	67.5	68.1	70.3	65.9	70.8
Kirklees	70	69.9	69.6	69	67.8
Leeds	52.7	53.7	54.4	59.7	61.6
Wakefield	63.2	63.4	65	64.8	67.0



Total Fertility Rate by single year and West Yorkshire local authority

The Total Fertility Rate (TFR) is the average number of live children that a group of women would bear if they experienced rates of the calendar year in question throughout their childbearing lifespan.

Total Fertility Rate	2008	2009	2010	2011	2012
Bradford	2.39	2.37	2.33	2.25	2.27
Calderdale	2.21	2.2	2.26	2.08	2.21
Kirklees	2.18	2.17	2.14	2.1	2.06
Leeds	1.61	1.63	1.63	1.77	1.84
Wakefield	2.06	2.05	2.07	2.02	2.05



National Outcome Data

For women at low risk of birth complications, the incidence of serious adverse events during childbirth for the infant is low in all settings of maternity care.

The Birthplace in England study, conducted between 2008 and 2010 found no significant difference in the risk of a composite outcome of serious adverse events for the baby between births planned in free standing midwifery units and births planned in obstetric units.

The Birthplace study reported that 83% of women who planned birth in an FMU had a normal birth. For women whose planned place of birth was an obstetric unit only 58% had a normal birth.

The transfer rate for women in labour who planned birth in a free standing midwife led unit was 21.9%, over 77% of these transfers occurred before the birth. For first time mums the transfer rate was 36.3% and for women in their second or subsequent pregnancies the transfer rate was 9.4%.

For women in the study the average time of transfer from the midwife led unit was 35 minutes and transfer was predominantly by ambulance or private car.

Local Activity/Trends

- The birth rate for both North Kirklees and Wakefield is increasing by approximately 300 births per year.
- There is a slight increase in the numbers of births expected in the FMU at Pontefract this year by 50 from 250 to 300

There has been an increase in the number out of area births which have accounted for approx. 300 deliveries for Pinderfields, 100 for Dewsbury and less than 20 for Pontefract units. (The Joint Committee would have liked to have seen data on actual birth rates)

Proposed Key Benefits

- Enable consultant cover on the obstetric unit to meet expected standards
- Improve outcomes for mother and baby
- Improve childbirth experience
- Achieve CNST standards
- Enables the Trust to offer all possible choice
- Support 1:1 midwifery support during labour

Assumptions used in the service model

It is estimated that between 50% and 60% of women would be classed as low risk and therefore be clinically able to choose to have their baby at home or in a midwife led unit. The Trust is planning for approximately 7000 births per annum with around 500 of these taking place in the Dewsbury midwife-led unit and 500 at the Pontefract midwife-led unit. Of the 6000 births expected to take place at Pinderfields, the numbers using the midwife led unit have yet to be determined but could be in excess of 500 births per annum. Of these women who choose and are suitable for a midwife led unit the transfer rate in labour is about 8% for women having their second or subsequent birth and 30% for first time mothers with the vast majority of these transfers being for analgesia (epidurals) or slow progress in labour requiring medication under medical supervision. Many women assessed as low risk would still opt to use either the consultant or midwife-led units at Pinderfields (regardless of where they live) as they prefer the reassurance of consultant back-up being available on site should it be needed.

Committee discussions

The Joint Committee was seeking assurances that the proposals were safe and sustainable. Members closely examined the projected improvements in patient outcomes and potential risks to delivery, including the likely impact on patients and their families (in the short, medium and long term) in particular in terms of access to services and travel times (Dewsbury in particular).

The Joint Committee considered Maternity Services on the 24 April, 10 May and 1 July 2013.

Representatives attended from Mid Yorkshire Hospitals NHS Trust, Yorkshire Ambulance Service NHS Trust, Kirklees Council's Public Health Directorate, a North Kirklees GP, and Wakefield CCG

Dr Fishwick, Head of Women's Services at MYHT, delivered a slide presentation setting out the vision for maternity services as a part of the transformation programme.

It was explained that at the time of booking, 60% of women would be classified as 'low risk'. Of these, quite a number would then move to 'high risk' during the course of their pregnancy. A significant number would also choose not to give birth in a Midwife Led Unit (MLU).

Members were given an outline of current practice at all three sites. Women deemed to be 'low risk' could give birth at: home; at the MLU in Pontefract; midwife led at Dewsbury and Pinderfields; obstetric led at Dewsbury and Pinderfields; or another hospital of the woman's choice. A woman deemed 'high risk' could give birth at either Dewsbury or Pinderfields, or another appropriate hospital of their choice. The Neonatal Intensive Care Unit was at Pinderfields treating babies of 27 weeks gestation or more; if they were younger than this then treatment would be in Leeds. There was a Special Care Baby Unit at Pinderfields and Dewsbury.

The Committee was informed that all antenatal and postnatal care would continue to be delivered locally. Women at 'low risk' could give birth at: home; an MLU in Pontefract, Pinderfields or Dewsbury; the obstetric led unit at Pinderfields; or another hospital of their choice. A woman deemed to be 'high risk' could give birth either at Pinderfields' obstetric led unit or another appropriate hospital of their choice. Neonatal Intensive Care and the Special Care Baby Unit would only be available at Pinderfields.

It was explained that MLUs were as safe for low risk births and could provide a better experience. It also promoted more choice for mothers. Concentrating high risk births at Pinderfields would ensure that national recommendations for consultant presence were met, and this would increase safety. There would be more specialist obstetricians, as such a unit would be more attractive, and improve care for high risk births and sick babies. There would be more flexibility for women who needed a caesarean section.

The Committee was informed that there were currently approximately 2,600 births per year at Dewsbury, and that guidelines recommended that if the number fell below 2,500, only 40 hours of consultant presence was required per week. Current cover was 60 hours.

There would be an additional emphasis on community midwifery in Dewsbury, and more support for home births. The MLU would have 6 beds and initial activity was estimated at 500 births per annum.

At Pinderfields, the proposed changes would see consultant presence increase from 60 hours per week to 168 hours per week. Activity was estimated at 6000 births per annum.

Pontefract would continue with its 4 bed MLU.

Members were given an outline of the transfer procedure from an MLU. It was estimated that 20% of women in labour in Dewsbury would need transfer to Pinderfields. Overall approximately 35% of women would need to transfer, including

after the baby was born. The majority of transfers would not be for life threatening events, and the ambulance travel time was under 15 minutes.(This time has subsequently been amended – average time was 20 minutes, with transfer between maternity units being 34 minutes) Paramedic teams could commence treatment, and the receiving hospital would be preparing.

In Pontefract during 2010/11, 86 in labour transfers were made to Pinderfields, of which 8 were emergencies. All had positive outcomes.

16 consultants were currently in post, and 24 would be needed to staff the new proposals. This would increase to 32 if consultant-led units were at both Pinderfields and Dewsbury. There is a national shortage of consultants.

The Committee expressed concern at the lack of detail on how it was proposed to address the risks or barriers that the proposals could create.

Members of the Committee raised the issue of women in north Kirklees not attending ante-natal, and sought clarification on what would happen if a woman arrived at Dewsbury and was unknown. It was explained that if a woman was in labour, it would be usual to contact the midwife who would coordinate a response. However, if a woman arrived at Dewsbury, she would be triaged by midwives. If she was determined to be 'high risk', then she would be transferred to Pinderfields. If a woman had not attended any ante-natal, then she would automatically be deemed 'high risk'. This was not a regular occurrence.

If an interfacility transfer was required, a midwife would ring an ambulance and request an 8 minute response. Mrs Ali,YAS, advised that the level of midwifery activity at Dewsbury had not yet been mapped by YAS. **Members of the Committee expressed serious concern that the impact on YAS of the proposed changes had not been fully completed, as transport was a critical part of the Clinical Services Strategy changes.** YAS advised that information was being shared between Mid Yorkshire and YAS, but that the primary focus had been on A & E transfers. It was further stated that it would be in the region of 200 incidents per annum, and that YAS was confident it could respond.

The Committee questioned the anticipated transfer time between Dewsbury and Pinderfields of under 15 minutes. The Committee further questioned the robustness of the anticipated transfer figures, as these were based on experience at Pontefract, which it was felt had a different population demographic than Dewsbury.

Mrs Ward, Head of Midwifery at Mid Yorkshire, advised that the criteria for the MLU at Dewsbury was the same as at Pontefract, and they were therefore confident that the data could be extrapolated. The National Birthplace Study had also concluded that approximately 35% of women would transfer from an MLU, and of these 75-80% would be prior to birth.

Ms Griffiths, Interim Director of Corporate Planning and Projects explained the level of detail within the Outline Business Case and advised that a number of assumptions had been made in respect of transfers. However, data had been triangulated within a close level of confidence.

The Committee suggested that there must be an increased level of risk if there were an increased numbers of transfers irrespective of ambulance capacity.

It was explained that there was good evidence from the national survey of over 80,000 women, that there was no difference in the outcome depending on where the mother gave birth. The evidence suggested that 98% of low risk women giving birth at home had a normal delivery; this dropped to 80% in a midwife led unit; 65% in an alongside unit; and 58% in a consultant led unit.

In response to a question from Members, Dr Mahmood, a GP in north Kirklees, explained that the changes would not affect the procedure followed at a GP surgery if a women presented in labour. **Dr Mahmood acknowledged that travelling times was the key issue for patients in north Kirklees, with some patients already choosing to give birth in Calderdale or Bradford.**

Members of the Committee sought clarification on how the issue of infant mortality in north Kirklees was being addressed by the proposals. Dr Hooper, Director of Public Health for Kirklees and Chair of the Maternity Workstream, confirmed that research supported that the site of delivery had little impact in terms of infant mortality. The work carried out in north Kirklees saw much more integration between community midwives and other sectors, and there was a desire to see greater integration with children's centres and support services such as Auntie Pam's. An enhanced community midwife service was essential to the success of the proposals.

Members sought clarification on how community midwifery would be improved, and questioned if there was a shortage of midwives. Mrs Ward advised that there was no local shortage in numbers of midwives and that there was a good ratio of 1 midwife to 31 women. Ms Stacey, Nurse Consultant for Mid Yorkshire, explained that ensuring the right professional was in the right place was critical.

Ms Plachcinski advised that she worked in research for the National Childbirth Trust, and that research indicated that the transfer time did not present a difficulty.

Members of the Committee questioned the rationale for deciding to have the consultant led unit at Pinderfields and not Dewsbury. Ms Stone, Clinical Director for Integrated Care and Consultant Paediatrician at Mid Yorkshire, advised that the Neonatal Intensive Care Unit and neonatal services were at Pinderfields, and a consultant led unit would need those support services on site.

Dr Fishwick advised that if a woman had not attended any ante-natal care then presented at the Dewsbury or Pontefract in labour she would be deemed high risk and transferred to Pinderfields.
The figure for this was as low as around 20 women per year. Last year the Pontefract site had 303 deliveries, Dewsbury 2522 and Pinderfields 3892 last year. At booking in, 40% of these women were assessed as high risk, increasing to 60% becoming high risk.
Although a birth plan was put in place around 36 weeks into labour, this was a flexible system and factors could obviously develop after this had been created. Also things could change after the initial assessment of the woman in labour once presented at the hospital.

If a woman at Dewsbury or Pontefract was changed to high risk after presenting as low and a transfer was thought necessary, YAS would treat this as an emergency

response. This included slow progress of the birth, pain relief such as epidural needed, heart rate dropping, bleeding etc. Often the midwife would go with the patient and stay with her. Midwives in Pontefract and Dewsbury would be trained to the same level as the ones at Pinderfields.

In terms of transfer time, as opposed to journey time, the guidance was 30 minutes. All staff are trained in emergency response The Committee questioned the proposed capacity at Dewsbury in terms of bed numbers – the figure was quoted as 4 – 6 beds.

Further clarity was requested on how the plans would be implemented – it was reported that discussions were on going.

The Committee expressed concern regarding specific problems around infant mortality which had been attached to North Kirklees in the past. Dr Fishwick advised the Committee that there were a number of studies looking at infant mortality rate in general and assured them that the Trust were confident that the place of birth had no impact on any complications following the birth.

Infant mortality was attributed mostly to pre-pregnancy situations such as smoking, violence, stress, pre-term birth, drugs etc. Although doctors could not affect the way the patients lived their lives, they could optimise obstetric care and have a higher degree of neo-natal input. A high risk lifestyle, once recognised, would be flagged up on the patient's notes.

Ms Stacey advised that units with a high number of deliveries and special neo-natal care could decrease the mortality rate. Units that had a low number of births and therefore less neo-natal care, tended to have a higher mortality rate.
The Committee had requested more detail on the community midwifery service. It was reported that the community DNA rate was low. Further information would be sought from public health.

Angela Harris from the Yorkshire Ambulance Service explained to the Committee that **door to door Dewsbury to Pinderfields was timed at 15 minutes by ambulance.** (This figure has been subsequently amended see below). Research had been done into ambulance travel with hospitals all over Yorkshire to ensure the service was standardised and made safe. The improvements and changes were ongoing in the forms of rota reviews and 'system plan management' which identified hotspot areas for ambulance responders to be parked. Mr Eames assured the Committee that, with regard to the moving of patients and births, protocols were in place.

Finally, Mr. Eames advised that, if the plans for the Hospitals were implemented, Pinderfields would be the only unit outside London that would have 80 hours of cover, giving a significant improvement in the quality of care.

Following a request for further clarification on transfer times It was reported that a practice run had been held to measure the emergency transfer time from Dewsbury & District Hospital to Pinderfields Hospital. Although the transfer time between hospitals in light traffic was 20 minutes, the transfer time between the two maternity units was 34 minutes.

Ms Webster reported that advice had been sought from the Clinical Advisory Team. The transfer time was acceptable as long as appropriate stabilisation of the mother and baby had taken place. It was noted that the response time for a consultant to be available on site was 30 minutes. A very similar model was currently in place between Pontefract and Pinderfields Hospital which was operating safely.

A special care baby unit would still remain at Dewsbury Hospital but would be a transitional service in the postnatal ward. This would mean that babies who required only a small amount of intervention would be treated alongside their mothers. Babies with more complicated needs would be transferred to Pinderfields for more specific care.

NHS Response There will be no SCBU at DDH in future with that activity transferring to Pinderfields under the proposals. Committee comments This is accepted under the proposals however the reference is to a transitional service in the post-natal ward and would eventually transfer to Pinderfields.

The Joint Committee wanted to know more about the 'Safe and Healthy Pregnancy' – Mid Yorkshire Transformation Programme, and further information on community midwifery services. In addition, further clarity was being sought on a number of issues relating to maternity reconfiguration.

To facilitate this, a briefing was provided by Kirklees Public Health, along with Mid Yorkshire Hospitals, which provided details of the scope and progress so far in the transformation programme for maternity services arising from the implications of the MYHT Clinical Service Strategy.

Also provided was a response to the queries that the Joint Committee had in respect of the maternity reconfiguration and a list of issues relating to transfer of babies between Midwife Led Units (MLUs) and Obstetric Units (Ous). In addition, a brief summary of evidence regarding the safety and effectiveness of Midwife led units was provided.

The Joint Committee had raised some concerns around the underlying data underpinning the case for change. Clarification and reassurance was provided by Wakefield CCG .

It was suggested that the proposed changes will not increase reliance on community midwifery services as ante natal and post natal care is already carried out locally and this arrangement will not change.

The issue raised by members relates to ensuring there is sufficient capacity in the community midwifery service to take a more proactive approach to ensuring women access ante-natal care early in pregnancy and adopt lifestyle choices that improve the chances of having a healthy child. This is a wider public health issue that needs to be addressed irrespective of any proposed changes to hospital services and will be a major focus for the Transformation Programme. **Local data shows that the incidence of still birth at Dewsbury is slightly lower than in the rest of the district: 4.4 per 1000 in 2010/11 compared with 5.4 per 1000 for the whole Trust and 5.2 per 1000 compared to 5.9 per 1000 for the whole Trust**

Members were told that based on this data, it is projected that 500 women would choose to deliver at Dewsbury midwife led unit, although there is evidence that Asian women are less likely to request epidural or pain relief and therefore the number of women choosing to give birth in the midwife led unit may be higher. It was suggested the plan to provide six delivery suites would provide adequate capacity to accommodate a higher number of births if more women chose to deliver there. The capacity at Dewsbury allows for up to 700 births in the midwife led unit.

Local data was used to illustrate the fact that there are effective arrangements in place within Mid Yorkshire and that outcomes for mother and baby have been positive. The Joint Committee was informed that with substantial clinical experience and evidence based protocols which have been developed over the last 10 years the Trust will identify and select women in terms of clinical suitability for midwife led delivery at Dewsbury and ensure the arrangements for transfer reflect best practice.

Members were told that projections around numbers of women from North Kirklees who would require consultant led delivery or require transfer during labour were based on national studies referred to above, taking into account specific needs of the population of North Kirklees identified in the integrated impact assessment which shows that there is a marginally higher than national average proportion of women of child bearing age (20.5% compared with 20.1%) and a higher than national average proportion of non-white British women (18.8% compared with 13.2%).

The Joint Committee noted that the development of a MLU at DDH is dependent on a complementary offer from community maternity services. Members also requested information as to what level of evaluation of demand and capacity has been undertaken to ensure the proposals are both sustainable and affordable.

Members were told that the Trust are confident that the capacity plan for the midwifery unit at Dewsbury is robust and allows for future growth as the model becomes established.

Members are mindful of comments made by NCAT in January 2013 regarding the expected number of births at Dewsbury:

“It is expected that the number of births in the standalone unit at Dewsbury will be about 500 births a year. This is an ambitious target and our experience nationwide has been that over time the numbers of mothers choosing to use a standalone unit tend to fall. Many successful units are delivering about 350 births a year. Any lower figure than this does challenge the affordability of such units”

It is interesting to contrast NCAT comments made in 2010:

“The aim is that the midwifery led unit at Pontefract will have 500 births a year and it will be important that this figure is achieved, in order to ensure the viability of that unit and to ensure that capacity changes do not emerge at Pinderfields”.

Births at Pontefract in 2011 were 265, and in 2012 they were 303, which supports NCAT’s view that the 500 birth target at Dewsbury is ambitious and may bring into question the sustainability and affordability of that unit going forward.

Responding to the Joint Committee's concerns about sustainability of the MLU at Dewsbury, the CCG indicated "…the NCAT data uses 350 births as a minimum number for a viable midwifery unit and we have therefore checked local activity data and national assumptions to ensure the assumption of 500 births is realistic".

Given the example of Pontefract above the Joint Committee has serious doubts that Dewsbury's proposed midwife-led unit will be sustainable and affordable in the long term.

Further extracts from NCAT's 2010 report make interesting reading:

"it is also worth commenting that the option of creating a single maternity inpatient unit across the three hospitals (which is suggested by some) is unlikely to be either acceptable to the public or warranted from a clinical safety perspective, provided sufficient emphasis is placed on maintaining high quality inpatient services at Pinderfields and Dewsbury"

The report goes on to say:

"For maternity services, however, we are not at this stage convinced of the merits of developing a single inpatient unit and would suggest that emphasis is placed on maintaining two separate but linked inpatient obstetric units, together with the midwifery led birthing unit at Pontefract"

The Joint Committee would question what has significantly changed in the last 3 years to justify NCATs current assessment of the proposals.

The Joint Committee supports the view that the potential loss of any form of maternity provision at Dewsbury will exacerbate health inequalities and would have a huge impact on deprived communities in North Kirklees, who will find it difficult to access maternity care outside of their local community.

NHS Response

The proposal does not lead to the loss of all forms of maternity provision at Dewsbury. Under the proposals explained to the committee, all antenatal and postnatal care would continue to be provided in North Kirklees. The only part of the pregnancy that maybe delivered outside of North Kirklees is the delivery requiring obstetric consultant care. There will be increased access to consultant care for delivery from 60 hrs pw to 24/7, albeit on one site at PGH.

Committee comments

This comment relates specifically to obstetric consultant care.

There is no doubt that the Trust faces a challenge in medically staffing two consultant-led obstetric units and the proposals will go some way to ease the current pressures but it is difficult to see how the proposals will improve access and choice – in this regard the Trust has failed to make out a compelling case for change.

NHS Response
The only significant change in the maternity proposals is the site of delivery. The cover that will be offered to those booked into the obstetric unit will be 24/7 instead of 60 hours per week; hence will provide safer cover than at present in Dewsbury.

Surgery

Current provision

The Trust currently delivers acute and elective inpatient, day case and outpatient care in the following specialities:

- ENT
- Ophthalmology
- Oral and Maxillo Facial and Community Dentistry
- Trauma and Orthopaedics
- Plastic and Burns
- Urology
- Gynaecology
- Vascular Surgery
- Breast Surgery
- Colorectal Surgery
- General Surgery

Day case and outpatient sessions in all these specialities are currently offered at Dewsbury, Pontefract and Pinderfields Hospitals.

All acute inpatient surgery with the exception of Gynaecology, General and Colorectal Surgery are centralised at Pinderfields.

There is currently some short stay elective surgery at Pontefract. Dewsbury provides inpatient elective care in Bariatric, Colorectal, General and Orthopaedic Surgery.

Service changes were agreed in 2012 to create an elective orthopaedic inpatient facility at Pontefract for Wakefield and Pontefract patients (opened May 7 2013) and moved some adult ophthalmology services to Pontefract for patients from the Wakefield and Pontefract catchment area. Dewsbury provides elective orthopaedics and ophthalmology for the population of North Kirklees. Age Related Macular Disease Services for the whole district are centralised at Pinderfields.

The provision of acute general and colorectal inpatient services across two acute sites is becoming increasingly difficult for the following reasons:

The proposal

The proposal is that Trust would Pinderfields would become a centre for acute (emergency) surgery and the most complex elective surgery with other less complex surgery being undertaken at Pontefract and Dewsbury.

In the proposed model, Dewsbury would provide all surgical specialties where access to critical care is not required.

The following specialities would be treated at Pontefract:

- Orthopaedics
- Ophthalmology
- General Day case

All General and Colorectal acute inpatient surgery would centralise in Pinderfields with the majority of planned surgery being offered in Dewsbury or Pontefract. Critical Care would no longer be provided on the Dewsbury site and would be centralised at Pinderfields. The consequence of this would be that patients requiring access to Critical Care, either due to the complexity of the elective procedure they are undertaking or their underlying medical condition due to co-morbidities will have their surgery at Pinderfields.

A key feature of the preferred option is the separation of acute and complex activity in Pinderfields Hospital from elective activity in Dewsbury and Pontefract. The aim is to maximise the elective procedures undertaken at Dewsbury and Pontefract within the model of care that includes:

- Selected and protocolised takes through the Emergency Care Units;
- No critical care on those sites; and
- Cover provided by ANPs and RMOs.

The issues to consider include (a) presence/absence of Critical Care (b) facility for immediate/emergency return to operating theatre for post-op complications (c) level of medical care on the elective sites (seniority/specialist) and (d) provision of blood bank.

As acute general and colorectal surgery would be centralised at Pinderfields, the Trust would maintain two consultants on call and implement a Consultant level colorectal rota. The proposal would allow doctor rotas to be amalgamated on the Pinderfields site, which would enable the Trust to deal with the reduced volumes of training doctors who will be available to cover rotas.

Out of hours clinical cover for surgery at Pontefract and Dewsbury would be provided by 24/7 advanced nurse practitioner cover (ANP) and resident anaesthetists.

The split of acute work from elective would provide a protected elective bed base, reduce cancellations due to unavailability of beds, improve theatre utilisation, and create inpatient bed capacity at Pinderfields for increased acute workload.

Outpatient clinics before and after surgery will be offered on all three site.

Modelling

The capacity modelling undertaken at OBC stage was based on assumptions for;

- Future growth/demand (1.2% ONS)
- Bed occupancy of 85%
- Improving length of stay to in line with current performance of top ten percent of Trusts in peer group (by 2016/17)
- Changing patient flows (Drive Time) – no impact for surgery (assumes all patients in catchment area would continue to come to Mid Yorkshire services)

The precise calculation of the proportion of patients who could be safely provided on the Dewsbury sites is still being finalised with surgical consultants and anaesthetists. Currently about 14% of people who have had planned surgery are actually admitted to critical care (Level 1/HDU or ICU) after surgery. However, the capacity requirements need to be based on the volume of patients whose underlying health needs mean that they *might* need access to critical care post operatively rather than on the numbers that *actually require* critical care back up.

For the purposes of modelling it has been conservatively estimated that the Trust could carry out 60% of current activity at Dewsbury and Pinderfields on the

Dewsbury site (based on numbers where underlying conditions means surgery without access to critical care if required would present a risk.) In order to ensure sufficient bed capacity, it is assumed that no elective surgical work would be lost as a result of drive time. This is due to the fact that patients can be seen in Outpatients at any of the Trust three main sites and they would be more likely to have their operation at the Trust even if it meant them travelling to a site that wasn't their closest hospital for the inpatient element of their care. It is also assumed that by 2016/17 the Trust would have no reliance on the Independent sector and this work would be repatriated

MYHT Local Challenges and the Case for Change
Workforce Supply and Trends

There are two issues relating to workforce supply that will affect the future provision of surgical services:

- Reduction in doctor training numbers (Foundation Year 2's) – Currently the Yorkshire School of Surgery is reducing the number of surgical trainees throughout the Yorkshire region. In August 2011, General Surgery lost two Core Trainee posts. There was a further loss of three Core Trainee 1 and 2 training posts at MYHT in August 2012. The Division has already been notified of potential further loss of posts in 2013/14, which will severely impact on its ability to run two surgical takes.
- GI cover from a colorectal surgeon is required when a breast surgeon is on call at Pinderfields (at an additional cost). National Cancer guidance also suggests that all acute colorectal cancer cases should be treated by a colorectal surgeon. Due to numbers of available consultants and affordability, it is currently not possible to achieve this standard across two acute sites.

Clinical Safety, Best Practice, Clinical Guidelines and Pathways

There are three areas of clinical safety, best practice, clinical guidelines and pathways that will affect the future provision of surgical services:

Vascular surgeons already have a separate on-call rota and, in the future, it is likely that breast surgeons will establish a separate rota. This reduces the number of doctors available to provide on call cover for acute emergencies. To maintain two separate emergency surgery on-call rotas, the Trust will need a minimum of six surgeons on each rota. Currently, there are eight surgeons on the on-call rota at Pinderfields and six at Dewsbury. However, three of these are breast surgeons and one is a 'general' general surgeon. Therefore, the viability of two separate on call rotas is likely to be challenged in the next few years. This also needs to be viewed in the context of the reductions to junior doctor grades described above.

- Royal College Guidelines suggest that surgical teams should be consolidated on one site.
- Royal College of Surgeons/DH 'The Higher Risk General Surgical Patient: Towards Improved Care for a Forgotten Group' for managing acutely ill surgical patients recommends that all high risk surgical patients should have access to prompt senior review, CT scan, critical care beds and Emergency theatre. These drive consolidation of services onto one site.

Best practice

The current configuration of services prevents the Trust from separating out emergency from elective work. Separation of planned and unplanned surgery is identified nationally as best practice, reducing the risk of infection (including MRSA) and improving the overall effectiveness and efficiency of the services by reducing cancelled operations, delivering 18 week targets and reducing lengths of stay.

Performance

The increasing numbers of emergency admissions has an effect on the Trust's ability to deliver its elective work.

The Trust met the 18 week referral to treatment target for patients requiring admission in August 2012 across all specialties, but this has not remained consistent through the year and will not be sustainable without changing the way that services are delivered. An acute/elective split would support the Trust's ability to meet the targets of 18 weeks, cancelled operations not admitted within 28 days, elective length of stay targets and MRSA infection rates. In 2012/13 the Trust had 8 cases of MRSA infection against a target of 7 for the year.

Patient Experience

By keeping elective and emergency care separate, patients can be confident that their planned operations will take place as arranged and they will not experience the frustration, inconvenience and distress of a sudden cancellation. Furthermore, the clinical risk and cost to the health economy is reduced as fewer people remain unwell for longer than necessary, potentially becoming more ill while waiting for treatment.

Management of infectious diseases

Increasingly, patients coming into hospital for planned care are tested for MRSA and other highly infectious diseases, and should they test positive, they are treated before they receive their surgery, thus reducing the risk of spreading infection. However, this cannot be done for patients who need emergency treatment, mixing planned and emergency care in the same hospital or unit means the risk of spreading infection to a larger number of patients becomes higher. Those specialist hospitals where little or no emergency surgery is done, such as the Royal National Orthopaedic Hospital, have some of the lowest rates of hospital acquired infection.

In the proposed model all acute surgery and all surgery on patients requiring critical care back up would take place at Pinderfields.

Committee discussions

The Committee was informed that following the commissioning of the new hospitals at Pinderfields and Pontefract it has been increasingly difficult to provide the current range of acute and elective surgery across the Trust. Until recently utilisation of the theatre unit at Pontefract had been poor, with Pinderfields and the Trust as a whole seeing capacity problems in both acute and elective surgery.

Recent developments have had some success with improvements in performance against the 18 week target. However, it was suggested that these improvements are not sustainable in the longer term. Changes in guidance on clinical safety and best practice was another key driver for change. High demand for acute services at

Pinderfields has been to the detriment of elective services, leading to a high cancellation rate.

Members noted that the transfer of all acute services to Pinderfields was not without risk. Unless the demand and capacity modelling is correct there will be a significant impact on other services.
The Committee expressed concern over part of the NCAT report that stated that surgery could risk being pushed out by lack of beds and loss of medical staff. It was explained that although a few consultants had left, they were in the process of filling vacancies and despite rumours, the staff losses were not due to the proposed changes. Each employee had been through an 'exit interview' and although there were concerns from some with regard to the changes, this was not felt to be a reason for resignations.

The Committee noted that some operations require post-operative HDU support and it would not be appropriate to operate on an elective site.
It was explained that day case surgery and pre and post operative care would be available on all 3 sites. The more acute and complex surgery would be centralised at Pinderfields. Planned and non-complex surgery would take place at Dewsbury and Pontefract. There would be increase in the range of specialties at Dewsbury and surgery requiring access to critical care was 40% at Pinderfields.

The Committee questioned who would take the decision in terms of planned surgery at Dewsbury. The Committee was informed that the decision to put patients into HDU was taken before planned surgery in a pre-assessment clinic where their notes would be screened and they would be seen by a consultant. If patients were not pencilled in for HDU, however, their condition changed and they developed an intervening health issue, this would be the obvious exception. In the event of an emergency, the steps followed were: resuscitate, stabilise then drive (transport via ambulance).

The shift in acute care will only work if MYHT ensures that as many patients as possible are treated on the Dewsbury site by appropriate risk assessment and providing post-operative care which is of a high standard.

The NCAT report suggests that "Whilst it may not be possible to put in place, or continue with, a high dependency unit or intensive care facility at the Dewsbury site for reasons of cost and sustainability, there are other models which can enhance post-operative recovery and enable the elective site to carry out operations on a wider group of patients".

This statement raises a number of issues: It would seem that ideally Dewsbury would benefit from a high dependency unit or an intensive care facility if not prohibited on cost and sustainability grounds. Secondly, it is suggested other models are available which can enhance post-operative recovery and enable the elective site to carry out operations on a wider group of patients but provides no details of what they are or evidence on improved outcomes. Finally, the statement would imply an element of risk which appears not to have been identified in terms of what elective procedures can be safely carried out on the elective site. Because critical care and some medical support will no longer be available it will need to be clear exactly which groups of patients can be safely managed at Dewsbury in future.

It was explained that the average length of stay after surgery was 3.4 days. This had decreased greatly over the last few years. A lot of procedures were dealt with in places other than operating theatres, meaning fewer beds were needed. This also meant that a large volume of short stay work could be transferred to Dewsbury, including some urology, plastics, breast surgery, ophthalmology, Ear Nose and Throat, community dentistry, gynaecology and colorectal day surgery.
Members were drawn to the NCAT statement **"**Generally MYHT is doing well with gradually reducing the length of stay thus the stated average length of stay (ALOS) should be achievable. However the threat to achieving this is a change in case mix. As hospitals deal with ever more complex patients who are elderly and have multiple co-morbidities, it will become more challenging to discharge safely. Thus if the community and primary care is treating the easier cases, the hospital will be left with more difficult cases and this will prove challenging to the downward pressure on ALOS".

The Joint Committee has some concerns in relation to this. It is clear that increasing numbers of challenging and complex cases will become more prevalent, particularly in terms of elderly patients, which can be attributed to increased pressure on A&E departments and higher admissions. This cohort of patients not only account for the increasing numbers of admissions, but by their very nature are more difficult to discharge and it is questionable if there is sufficient intermediate care provision to offset this.

The NCAT statement goes on to say "Involvement of specialists in elderly medicine and rehabilitation is important. Whilst there will be no specific medical cover out of hours for these patients, they can be managed safely if there are appropriate protocols in place with escalation policies if transfer is required".
It is suggested that out of hours clinical cover at the Dewsbury site will be provided by advanced care nurse practitioners with anaesthetic support. Whilst this is likely to be a safe model, MYHT will need to put in place clinical protocols to ensure only appropriate patients are cared for on the Dewsbury site and that escalation policies are in place if patients deteriorate.

The view of NCAT "Whilst this is likely to be a safe model" implies an element of risk. Clearly without appropriate protocols and escalation policies there is a risk to patient safety. The Joint Committee would like further assurances on this.

The Committee referred to the NCAT statement and asked how the Trust managed parallel issues and patient experience. Members were advised that vascular surgery feedback was good with most of the patients having confidence in it. Patient notes had been an issue and were at present being transferred from paper to electronic records to enable them to be available with immediate access. There was still a lot of work to do around this but it was noted that Mid-Yorks were further ahead than some places in the country.

The Choose and Book system had been a step forward although only 57% of activity was represented on it and there had been some issues with the generated letters.

The Joint Committee was advised that elective surgery would be carried out over evenings and weekends and the sessions would be longer than 9am to 5pm.

There were 5688 elective inpatients at Pinderfields in 2011/12. These patients will in future not have access to their local hospital for elective surgery but will have to travel to Dewsbury or Pontefract, or another provider out of the District. **It could be argued that this does little to extend patient choice but in fact restricts local access for local people.**

Questions were raised around theatre capacity, robotic surgery and system one in primary care. It was reported that theatre capacity should improve and become more efficient as a result of the proposed changes, robotic surgery was expensive with similar outcomes and work was on going on compatibility of IT systems with primary and secondary care.
The Joint Committee is worried about the reduction in bed numbers and shares the concerns expressed by Mike Wood MP and others. It is suggested in the consultation document that that bed numbers have been "rigorously tested the assumptions about the number of beds required, looking at how the length of stay in hospital can be further reduced in the future" **It is disappointing that none of the evidence used in this testing process has been published.**

Mike Wood MP has said "the proposed reconfiguration of services will simply serve to transfer patient flows from Dewsbury to Pinderfields, leaving Pinderfields overwhelmed and Dewsbury depleted".

Unison, the Public Service Union have said "The reconfiguration plan is premised on a dangerous reduction of 200 beds within the Trust. These bed cuts have been planned at the very same time as Pinderfields hospital has been cramming extra beds into its bays to ease pressure on bed numbers. The Trust's OBC fails to offer a proper breakdown of the bed numbers or how this correlates –if at all- with local patterns of demand and health needs".

The Joint Committee recognise that whilst there are some significant concerns in terms of these proposals they do bring with them clear benefits which have been outlined in MYHT local challenges and case for change. However, the key question remains: will there be sufficient capacity and capability to deliver the proposed model – sufficient doubts exist to warrant at least further examination prior to implementation, should there be a decision to proceed.

Paediatric services

Current Service Provision

The Paediatric Service provides support to children up to the age of 16 across Wakefield and North Kirklees. This includes community paediatric services, out-patient clinics, paediatric assessment and medical and surgical inpatient care.

NB: Child and adolescent mental health services are not provided by Mid Yorkshire.

Children up to age 17 admitted through the Emergency Department by site

Pinderfields

	Attendances	Referred not Admitted	Admitted from Referral
2010/11	13982	495	1250
2011/12	19434	418	2209

Pontefract

	Attendances	Referred not Admitted	Admitted from Referral
2010/11	13031	232	1273
2011/12	10838	113	444

Dewsbury

	Attendances	Referred not Admitted	Admitted from Referral
2010/11	17671	90	2130
2011/12	20419	105	1964

Surgical admissions

There are approximately 2,600 surgical admissions from all parts of the district to Pinderfields each year.

Distribution of services

Pinderfields

Pinderfields has a children's inpatient ward currently staffed for 22 beds and admits both paediatric medicine and children's surgery. The bed base also provides 8 dedicated day surgical beds operating Monday to Friday, plus 5 beds dedicated to children's burn care. There is a separate 12 bedded Children's Assessment Unit co-located with the Children's Emergency Department.

Surgical specialties are all managed at Pinderfields and include General Surgery, Urology, ENT, Plastic Surgery, Ophthalmology and Orthopaedics. The Regional Spinal injury unit is located on site and has a specific children's pathway.

Dewsbury

Dewsbury provides a comprehensive outpatient service, inpatients for medical paediatrics and day surgery. The children's ward comprises 18 beds, which are mostly medical as day surgery is undertaken in the Boothroyd Centre. 8 beds are allocated to the assessment of paediatric referrals and there are plans to develop these as a dedicated paediatric short stay facility near the A&E department similar to the model at Pinderfields in the current year.

Pontefract

At Pontefract there are no inpatient facilities for children, but middle grade medical support is provided to support the ED Monday to Thursday 9:00 am – 5:00 pm and Friday 9:00 am – 1:00 pm.

Agreed protocols are in place for the transfer of children from Pontefract ED to Pinderfields.

Outpatients

Outpatient services are provided on all three sites: Pinderfields, Dewsbury and Pontefract and includes specialist asthma, endocrinology, diabetes, UTI, epilepsy, rheumatology, neonatal follow up, neurology, genetics and gastroenterology clinics.

Multi-disciplinary assessments are undertaken in the Children's Centre for neuro-disability and autistic spectrum disorder.

Outpatient attendances for 2012/13 were as follows:

Community paediatric services

For children in the Wakefield District the community paediatric service is provided by four consultant paediatricians, six associate specialists and two trainee specialist registrars. They fulfil all the statutory community paediatric roles (e.g. SUDIC paediatrician, looked after children etc) in addition to providing clinical services for neuro-disability, autism, ADHD, developmental delay, enuresis, bowel management, special school clinics, etc. Community paediatric clinics are provided in both Pinderfields and Pontefract children's outpatient departments as well as in community settings.

For North Kirklees children, child development/neuro-disability clinics are provided by the Dewsbury hospital paediatricians, including special school clinics. Children with ADHD and autism are managed by Children and Adolescent Mental Health Services (CAMHS) following an initial paediatric medical assessment by hospital paediatricians. Statutory roles are fulfilled for Kirklees commissioners by Calderdale and Huddersfield Foundation Trust. Community nursing and paediatric therapy provision is from Locala, a social enterprise which is the provider of community services in North Kirklees.

Neonates

The neonatal provision on the Pinderfields, Dewsbury and Pontefract sites are as follows:

- At Pinderfields there is a level 2 Neonatal Intensive Care Unit with 15 cots including 3 intensive care cots and 4 high dependency cots for high risk deliveries
- At Dewsbury there is a level 1 Neonatal Unit consisting of 12 Special Care Baby Unit cots.

- At Pontefract maternity care is available in the Midwife Led Unit located within the hospital but with no paediatric input.

Proposed model

The proposal is that paediatric assessment facilities and outpatient care would be provided on all sites, supported by dedicated paediatric short stay units on both Pinderfields and Dewsbury sites, separate from the main paediatric ward.

Inpatient medical care would be centralised at Pinderfields.

There would be no change to children's surgery which would be delivered from Pinderfields.

MYHT Local Challenges and the Case for Change

Clinical guidelines

The proposal is consistent with Royal College of Paediatricians recommendations (see below) to move towards fewer inpatient sites and increase short stay paediatric assessment and secures compliance with Royal College guidance on senior clinician assessment and review.

Creating a single centre for children requiring medical admission ensures better weekend and out of hours care for the most seriously ill children and allows more rapid turnaround for children requiring non-specialist care and intervention.
Outpatient care (10,000+ attendances a year) and urgent assessment will be retained on all three sites.

Provision of services across the whole Trust reduces variation in care provision.

The proposal addresses staffing difficulties anticipated by NCAT in 2010 due to the anticipated reduction on specialist doctors being trained.

The *Royal College of Paediatrics and Child health (RCPCH) Facing the Future: A review of Paediatric services (April 2011)* has reviewed the future provision of paediatrics. In summary, the report makes a series of recommendations to:

- Reduce the number of inpatient sites from 218 to approximately 170 with 32 new SSPAUs (short stay paediatric assessment units);
- Increase the number of consultants from 3,084 to 4,625 WTEs;
- Change working practices with increased use of resident consultants; and
- Expand significantly the number of advanced or enhanced neonatal nurse practitioners, the number of advanced children's nurse practitioners and the number of GPs trained in paediatrics, whilst decreasing the number of Specialist Trainees from 2,929 to 1720 WTEs.

The report also recommends 10 standards, which the RCPCH believes should be achieved by all acute general paediatric services:

1. Every child or young person who is admitted to a paediatric department with an acute medical problem should be seen by a paediatrician on the middle grade or Consultant rota within four hours of admission.

2. Every child or young person who is admitted to a paediatric department with an acute medical problem should be seen by a consultant paediatrician (or equivalent staff, specialty and associate specialist grade doctor who is trained and assessed as competent in acute paediatric care) within the first 24 hours.
3. Every child or young person with an acute medical problem who is referred for a paediatric opinion should be seen by, or have their case discussed with, a paediatrician on the consultant rota, a paediatrician on the middle grade rota or a registered children's nurse who has completed a recognised programme to be an advanced Practitioner.
4. All SSPAUs (Short Stay Paediatric Assessment Units) should have access to a paediatric consultant (or equivalent) opinion throughout all the hours they are open.
5. At least one medical handover in every 24 hours is led by a paediatric consultant (or equivalent).
6. A paediatric consultant (or equivalent) is present in the hospital during times of peak activity.
7. All general paediatric inpatient units adopt an attending consultant (or equivalent) system, most often in the form of the 'consultant of the week' system.
8. All general acute paediatric rotas are made up of at least ten WTEs, all of whom are Working Time Directive compliant.
9. Specialist paediatricians are available for immediate telephone advice for acute problems for all specialties, and for all paediatricians.
10. All children and young people, children's social care, police and health teams should have access to a paediatrician with child protection experience and skills (of at least Level 3 safeguarding competencies) available to provide immediate advice and subsequent assessment, if necessary, for children and young people under 18 years of age where there are child protection concerns. The requirement is for advice, clinical assessment and the timely provision of an appropriate medical opinion, supported with a written report.

In anticipation of this review, the NCAT carried out in 2010 recognised that the above concerns had been emerging and recommended that the Trust consider providing a single paediatric inpatient unit at Pinderfields. This would address the staffing difficulties, particularly at middle tier level, but also reflect the reduction in the number of children who need to stay overnight.

The setting up of rapid access/urgent appointment daily outpatient clinics on both the Pinderfields and Dewsbury sites would relieve some of the clinical pressures on the acute assessment units. Children seen in such a clinic include ward attendees for blood tests, neonatal jaundice screens and clinical review of recently discharged children. The clinics would also see any acute referrals needing a semi-urgent review, but unlikely to need admission, and have the ability to have a regular clinic opportunities for any urgent new patient referrals. The clinic also provides a more streamlined service for patients as children are not waiting for long periods whilst more urgent cases are dealt with. The clinic would be staffed by paediatric middle grade or consultant plus trained nurses.

The development of an integrated community paediatric service for North Kirklees would be similar to the service provided for Wakefield commissioners. This would provide a more joined up and holistic service for children with disability.

Workforce issues

The Royal College of Paediatricians identify a number of national workforce challenges in delivering the recommendations in the 2011 Facing the Future report referred to above: in particular, availability of consultants and the need to develop more specialist nursing roles. The Trust would need to increase the number of consultants to provide the increased levels of resident and on call consultant cover.

There is currently a national shortage of junior and middle grade doctors.

NCAT conclusions

The National Clinical Advisory Team which visited the Trust to assess the safety and sustainability of the service configuration associated with the opening of Pinderfields and Pontefract hospitals identified concerns with the future sustainability of a paediatric inpatient service delivered across two sites and the ability to comply with national guidelines.

The team concluded that the Trust should consider providing a single inpatient service at Pinderfields in anticipation of a reduction in the number of children requiring overnight admission and the availability of doctors in training to cover rotas across more than one site.

The National Clinical Advisory team review of the current proposals in January 2013, strongly supports the proposal to establish a single children's inpatient unit to serve the whole Mid Yorkshire area, concluding that this was consistent with national guidance and recommended that this element of the reconfiguration proposals should be implemented as soon as possible.

Key benefits

- Increased access to senior clinical opinion with specialist skills for all children, translating to better clinical outcomes.
- Separation of the sickest children from those with more minor illness so needs can be focussed and care provision more streamlined with timely review of all children and a quicker decision by a senior clinician.
- Enables greater subspecialisation.
- Maintains majority of Paediatric care at local hospitals.
- Addresses the national and local workforce supply issues and removes the current constant reliance on locums.

Modelling assumptions

The capacity modelling undertaken at OBC stage relating to children's services was based on the following assumptions;

- Future growth/demand (based on ONS 1.2%)
- Bed occupancy 80% for paediatrics
- Capacity at Pinderfields to relocate all inpatient beds from Dewsbury if required
- Length of stay aligned to current top ten percent in peer group (by 2016/17)
- No anticipated change due to 'drive time'

Committee discussions

The proposal is that paediatric assessment facilities and outpatient care would be provided on all sites, supported by dedicated paediatric short stay units on both Pinderfields and Dewsbury sites, separate from the main paediatric ward. There

would be no change to children's surgery which would be delivered from Pinderfields.

It was suggested that the proposal addresses staffing difficulties anticipated by NCAT in 2010 due to the anticipated reduction in specialist doctors being trained.
The Joint Committee was advised that Mid-Yorks were the first Trust to provide 24/7 RSCNs (Registered Sick Children's Nurse) who would be available on all sites. In Pinderfields there would be 24/7 consultant delivered care for complex and acute cases, Pontefract would have consultant delivered care 9am to 5pm and Dewsbury would have consultant delivered care from 9am to 9pm, with the ability to flex where necessary. It was suggested that most children present within this timeframe.

All would have walk in patient care with Pinderfields also having 24/7 ambulance arrivals. Pontefract and Dewsbury would have selected ambulance arrivals but would be covered by specialist out of hours/ on call advice. Also, ambulatory care would be used at Pinderfields and Dewsbury. It was suggested that the proposals are in concert with the national drive to improve standards by reducing the number of units from 218 to 170 and increasing paediatric assessment units, increasing the number of consultants, changing working practices, and expanding the number of advanced or enhanced neonatal nurse practitioners and the number of GPs trained in paediatrics. CCG Commissioners will commission to these standards.

It was suggested that the key benefits would be:

- Increased access to senior clinical opinion with specialist skills for all children, translating to better clinical outcomes
- Separation of the sickest children from those with more minor illness so needs can be focussed and care provision streamlined with timely review of all children and a quicker decision by a senior clinician
- Enables greater subspecialisation
- Maintains majority of Paediatric care at local hospitals
- Addresses the national and local workforce supply issues and removes the current reliance on locums.

The Trust advised of the peak times of admissions and stated that they felt they had this adequately covered; however, The Joint Committee was advised that these times were open to influence.

The Committee expressed concern regarding the reduction in beds; however, Members were assured that the expectation was not to need as many beds because of the increased speed of assessment and emergency day care. There would also be retention of local access to day case and out-patient care and community care would be strengthened.

The Committee requested information on patient flow. Members were advised that the information could be distributed; however, support from the Trust would be needed to explain the data as the layout would be somewhat complex. The Joint Committee was advised that under the changes there would be an impact on patient flow around West Yorkshire; however, at this stage it was not possible to say how or where.

The Committee expressed concern that paediatric services may be transferred to Leeds. Members were advised that the Trust wanted a specialist children's centre in the area and to preserve all the existing services. It was stated that the Trust believed they had taken all situations into account and that the CCG was constantly monitoring capacity. To stay as they had been doing was unaffordable and new models had had to be created.

The Committee had some concerns regarding after hours provision. It was reported that there would be flex of time and a natural overlap period, plus transfer by ambulance, where necessary.

It was suggested that previous changes at the Trust in relation to children's services had placed it in a good position which was 'sustainable'

In terms of general bed numbers the Committee wanted to know how the capacity modelling had been undertaken. Consideration had been given to reductions of acute beds at Dewsbury, maximising surgery and ambulatory care. It was acknowledged that the majority of reductions would be a Dewsbury. 50 new beds would be created at Pinderfields. It was emphasised that there was no reduction in service.

The Joint Committee has noted that there is significant public concern within the Dewsbury area regarding paediatric services, particularly that inpatient medical care would be centralised at Pinderfields.

These concerns centre on local access but specifically on the extra strain put on parents and carers in terms of travel and transport. **In any reconfiguration of a service, some local areas will experience change and this will inevitably stimulate opposition. Given the perceived benefits outlined in the MYHT case for change, the question must be posed as to whether the clinical case has been convincingly described or promoted.**

Mental Health

The proposals for major change to local NHS services will have system wide implications. Running alongside the service strategy in Mid Yorkshire Hospitals are other transformation programmes, such a mental health and learning disabilities. Interdependencies within schemes were explored by the Joint Committee to ascertain whether any issues or risks associated with the delivery of the clinical service strategy have been identified.

Committee discussions

The Joint Committee received a presentation on the Transforming Mental Health and Learning Disability Services on the 24 April 2013, as part of the Meeting the Challenge agenda.

Members were concerned that associated programmes were running at a different pace and scale and there was a lack of detail underpinning the programme, The Joint Committee was asked to take into consideration that the proposals were still at Outline Business case stage at that time and therefore modelling will continue as an iterative process.

The Joint HOSC's main concern was whether there was any differential impact on people with mental health problems and/or a Learning Disability as a result of the proposed reconfiguration of services across the Mid Yorkshire Hospitals Trust (MYHT) area. This was mainly in relation to possible changes in the Emergency Care Unit at Dewsbury & District Hospitals. Since the presentation on 24th April there has been further discussion between representatives of Mid Yorkshire Hospitals NHS Trust, including the Clinical Lead for Emergency Medicine, and South West Yorkshire Partnerships NHS Foundation Trust (SWYPFT) to explore the possible risks of the changes to people who live with a mental health problem or a learning disability.

Further information was subsequently provided:

Context

One way to broadly categorise the types of presentation to Emergency Departments by people with MH issues or a Learning Disability is the following:

1. People presenting for help primarily for their mental health problem – which may be new to them or part of a long-term condition

2. People with a Learning Disability or on-going MH problems presenting for help primarily for another health issue, which may or may not be related.

3. People presenting for help with both their MH problem and another health problem requiring hospital treatment. An example would be people with poor mental health who have serious injuries due to deliberate self harm.

People seeking help for their mental health problem

It is anticipated that the majority of people needing help for either a new or an on-going mental health problem will continue to access this help through community-based alternatives, such as their GP and SWYPFT's Single Point of Contact

services, as is currently the case. It is also acknowledged that some people with MH problems choose to access help through hospital Emergency Departments.

At the moment people can access any of the Trust's Emergency Departments for this help, as all can refer patients to local mental health services such as Crisis Response & Intensive Home Treatment Teams or contact the Local Authorities to request Mental Health Act assessments if it is believed the patient may require detention in hospital for treatment. This provision will **not** change as a result of the reconfiguration as a result of the Clinical Services Strategy. People wanting or needing this sort of response will still receive it from all three Eds.

People with an LD or an on-going MH problem wanting help for another health issue

People with an LD or with on-going MH problems who need help for another acute health problem will be treated as appropriate for these needs. Depending on the assessment by the GP, paramedic or other health worker they will be taken to or it will be recommended that they attend the most appropriate site for assessment and treatment of the acute health need. The presence of an LD or an on-going MH problem will not make this decision different to that made for someone with a similar acute health need who does not have an LD or a MH problem.

So in cases where the person with the LD or MH issue requires critical care or acute trauma services they will be taken to Pinderfields Hospital, as with all people who require these services. Some people who are more familiar with one of the other hospitals may find this change difficult and require specific support. People should be given reassurance by others involved in their care.

People needing help for both a MH issue and another acute health issue at same time

If it is determined that the person requires assessment at an acute hospital for the acute health issue, and will also need assessment for a possible MH problem, they will be taken to the most appropriate site for the acute health issue. This is because all three sites will be able to refer to mental health services, but not all three sites will be able to address all acute health problems equally.

There may be an issue of inter-service communication for people who are actively receiving care for their LD and/or MH needs, due to the way that MH and LD services are configured within SWYPFT. Currently SWYPFT have Business Development Units (BDUs) which are co-terminus with Local Authority boundaries. Therefore a person receiving on-going care from an LD or MH service in Kirklees could be taken to Pinderfields Hospital and then referred for an assessment to a Wakefield service. SWYPFT have a single Patient Administration System, called RiO, so the Wakefield service should be able to identify that the person is an active patient in the Kirklees area and so ensure that there is no duplication of effort and the patient benefits from some level of continuity.

In summary representatives of both SWYPFT and MYHT do not believe there is any differential impact of the Clinical Services Strategy on people with a Learning Disability and/or a mental health problem.

The Joint Committee is aware that some of the timescales for this work go beyond the decision date following consultation and therefore members were not able to fully consider this issue in any detail.

Glossary of Terms

Acute healthcare	Medical and surgical treatment usually provide in a hospital setting
Affordability	The ability to do something without incurring financial difficulty
A&E	Accident and Emergency Department
Clinical	Relating to patient care eg clinical evidence, clinical practice
Clinician	A health professional, such as a family doctor, consultant, psychiatrist, psychologist or nurse involved in clinical practice
CCG	Clinical Commissioning Group
Commission	To decide on behalf of local people what type and quality of services they require
Commissioner	The person or organisation who decides with, and on behalf of, local people what type, quality and quality of services they require
Community healthcare	NHS services provide outside a hospital, including district nurses, health visitor, community midwives, chiropodists and community psychiatric nurses
Complex/planned medicine or surgery	A planned operation or medical care where the patient may need to be in a high-dependency unit while recovering from the operation, either because their operation is complex or because they have other health problems
Configuration	The way a service is organised
Elective Care	Elective care is pre-arranged, non-emergency care that includes scheduled operations
Elective hospital	This is where patients go if they need an operation which is not urgent and can be planned in advance
Emergency care	Treatment for medical and surgical emergencies that are urgent and likely to need admission to hospital
Emergency department	Also known as 'Accident and Emergency' A service available 24 hours a day, seven days a week where people receive assessment, treatment and/or stabilisation for medical and surgical emergencies
Formal consultation	A formal, public programme for a set period designed to seek views from those who would be affected by, or those who have a particular interest in,

	proposed new services or changes in services
High Dependency Unit	Treats conditions that need intensive nursing support, such as people who are ill with pneumonia or who have had major surgery
Inpatient	A patient who is admitted for a stay in hospital for treatment or an operation
Inpatient paediatrics	These hospitals treat sick children who require a stay in hospital
Intensive care units	These units provide support for patients after complex surgery, or patients needing multiple organ support such as ventilation and dialysis
Intermediate care	A level of care and treatment which is outside the scope of most family doctors and can now be provided in settings outside large hospitals
Long-term conditions	A condition that cannot be cured but can be managed through medication and/or therapy.
Maternity	Relating to pregnancy, childbirth and immediately following childbirth
MLU	Midwife-led unit. A Pace where women assessed as being at low risk of complications can have their babies under the care of midwives without the need for a consultant to be present
MYHT	Mid Yorkshire Hospitals NHS Trust
National Clinical Advisory Team (NCAT)	The National Clinical Advisory Team provides a pool of clinical experts to support, advise and guide the local NHS on local service reconfiguration proposals to ensure safe, effective and accessible services for patients.
Neonatal	Relating to newborn infants
OBC	Outline Business case
Obstetrics and maternity unit	Where babies are delivered and women with complex pregnancies, such as expectant mothers with diabetes or heart disease or who are pregnant with triplets, are monitored
Outcome	The results that a patient gets from their treatment – in terms of how well they recover and how far it has been possible to cure their condition.
Outpatient	A patient who attends an appointment to receive treatment without needing to be admitted to hospital.
Overview and Scrutiny Committee (OSC/Health Overview and Scrutiny Committee (HOSC)	The committee of the relevant local authority, or group of local authorities, made up of councillors who are

	responsible for monitoring, and if necessary challenging, service change proposals
Paediatric services	This refers to healthcare services for babies, children and adolescents
Patient pathway or journey	This is a term used to describe the care a patient receives from start to finish of a set timescale, in different stages.
Public Finance Initiative	Schemes set up by the Government during the 1990s to help finance public sector projects including hospitals, roads, prisons and medical centres, through private sector funds
Planned care	Care – including operations and inpatient treatment – which is planned in advance rather than going to hospital as an emergency
Primary care	The first contact a patient has with local healthcare in their community, usually a GP, dentists, pharmacists or optician ie not secondary care, which is hospital based
Quality	The degree to which health services increase the likelihood of good health outcomes and are consistent with current professional knowledge.
Re-ablement	A new approach whereby a short-term intensive support programme is provided to help patients regain their independence after a debilitating illness or injury
Secondary care	Healthcare services delivered by medical or other specialists, usually in hospitals or clinics, that patients have been referred to by their GP or other primary care provider
Stakeholder	People and organisations with a shared interest in an issue, either because they may be affected by it or be able to affect a decision about it
Surgery/surgical	Clinical speciality which involves operations on particular parts of the body or to address specific injuries, diseases or degenerative conditions
Sustainability	Ensuring a service can operate properly, well into the future, in a way that is safe, of a high standard, appropriately staffed and which makes best use of the resources available.
Tertiary care	Highly specialised care which is only available in a small number of centres across the country

Trauma care	The care provided to people with serious and often multiple injuries eg major road accident victims
Trauma centre	This type of service treats major trauma patients who have complex injuries.
Trust Development Authority (TDA or NTDA)	A new NHS organisation that will monitor, oversee and support NHS trusts that are not yet NHS Foundation Trusts.
Unplanned care	Care which takes place without having being planned in advance and which usually means having an operation, urgent medical care and./or stay in hospital.
Urgent care	Care needed to treat a patient who suffers a sudden and unexpected health problem but not necessarily a life-threatening emergency

References

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Department of Health. *The NHS Plan. A Plan for Investment, a plan for reform.* London, TSO, 2000

Department of Health. *Our health, our care, our say: A new direction for Community Services.* London, TSO, 2006.

Appleby j, Humphries R, Thompson j, Galea (forthcoming). *How is the health and social care system performing?* Quarterly monitoring report 2013

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Nicholl J, West j, Goddacre S, Turner, J *The relationship between distance to hospital and patient mortality in emergencies: an observational study:* Emergency Medicine Journal 10/2007 24(p) 665-8

National Clinical Advisory Team – NCAT – Mid Yorkshire Hospitals NHS Trust Service Reconfiguration 28 June 2010

National Clinical Advisory Team – NCAT Mid Yorkshire Health and Social Care Clinical Services Strategy 14 January 2013

The Mid Yorkshire Hospitals NHS Trust Outline Business Case (OBC) Executive Summary – Public Document 24 December 2012

Below is a full list of the references that were brought to the attention of the Committee on the four specialities which would undergo reconfiguration under the MtC proposals:

Surgery

- NCAT report – 2010.
- Lord Darzi - Healthcare for London report – 2009.
- Royal College Guidance – minimum medical staffing levels.
- Productive Series, NHS Institute for Innovation and Improvement.
- NHS Outcome Framework, 2013/14.

- British Association of Daycase Surgery.
- 'The Higher Risk General Surgical Patient: Towards improved care for a forgotten group' The Royal College of Surgeons of England and Department of Health. Report on the peri-operative care of the higher risk general surgical patient 2011.

Emergency medicine

- Health Care Commission – not just a matter of time – 2008.
- NHS North of England – attendance and admission rates.
- NCAT Report 2010.
- NHS North of England – 4 hour target, attendance and admission rates.
- Dr Foster Hospital Guide 2012.
- Bright Approach to Fast Care, HSJ 9 August 2012.
- The NHS Institute for Innovation and Improvement *Directory of Ambulatory Emergency Care*.
- Adopt ambulatory emergency care to cut hospital admissions, Nursing Times 10 August 2012.
- Hospitals on the Edge, Royal College of Physicians 2012.
- Transforming the Delivery of Health and Social Care, Kings Fund 2012.
- 'Guidance for commissioning integrated urgent and emergency care: A whole system approach'. RCGP Centre for Commissioning. August 2011.
- 'Services for children in emergency departments' Report of the Intercollegiate Committee for services for Children in Emergency Departments. April 2007.
- NHS Institute – Delivering Ambulatory Emergency Care.
- College of Emergency medicine – Operational Handbook The Way Ahead.
- Primary Care and Emergency Departments Report from the Primary Care Foundation March 2010.
- Emergency Medicine Journal 2013: Article on impact on health outcomes of access to 24/7 consultant care.
- Emergency Medicine Journal 2007: Relationship between distance to hospital and mortality in emergencies: Jon Lovell et al.

Obstetrics

- The National Service Framework for Children, Young People and Maternity Services published in 2004.
- Maternity Matters; Choice, access and continuity of care in a safe service published in 2007.
- The Future Role of the Consultant (RCOG 2005).
- Safer Childbirth (RCA, RCM, RCOG, RCPCH 2007).
- NCAT Report MYHT Maternity Service Reconfiguration – 28 June 2010.
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- Birthplace in England Collaborative Group (2011) Perinatal and maternal outcomes by planned place of birth for healthy women with low risk pregnancies
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- Paula J. Laws, Sally K. Tracy, and Elizabeth A. Sullivan, (2010) Perinatal Outcomes of Women Intending to Give Birth in Birth Centers in Australia *Birth 37:1 pp28-36.*

Paediatrics

- The *Royal College of Paediatrics and Child health (RCPCH) Facing the Future: A review of Paediatric services (April 2011).*
- Royal College Guidance – minimum medical staffing levels.
- Productive Series, NHS Institute for Innovation and Improvement.
- Short Stay Paediatric Assessment Units (SSPAUs) – Advice for Commissioners and Providers – January.
- Royal College of Paediatrics and Child Health (RCPCH) guidance on the role of the consultant paediatrician in providing acute care in the hospital, May 2009.
- Consultant Delivered Care – An evaluation of new ways of working in Paediatrics (RCPCH) April 2012.
- Improving services for children in hospital, Healthcare Commission, 2007.
- DoH, Commissioning Safe and Sustainable Paediatric Services: A Framework for Critical Interdependencies, August 2008.
- Every Child Matters, 2003.
- Services for Children in Emergency Departments, RCPCH, 2007.
- Getting the right start: National Service Framework for Children, DH, 2003.
- NHS at Home: Community Children's Nursing Services, DH, March 2011.

List of evidence provided to the Wakefield and Kirklees Joint Health Scrutiny Committee

Date	Topic	Evidence provided
1 February 2013	Consultation arrangements	• Presentation setting out the proposed consultation arrangements
15 February 2013	Consultation arrangements	• Presentation setting out consultation plan • Copy of consultation plan • Draft consultation document
12 April 2013	Travel and transport	• Presentation • Extract from draft Integrated Impact Assessm • Final report of the Travel Advisory Group • Footfall survey questions • Transport briefing document
12 April 2013	Care closer to home	• Presentation • Care Closer to Home briefing document
24 April 2013	Mental health	• Presentation
24 April 2013	Maternity	• Presentation • Datasheet
3 May 2013	Consultation process and progress	• Presentation • Communications and engagement timeline • Consultation plan • Progress report on public consultation to date • Consultation process working plan

		• Media log • Meeting plan • Road show dates • Meeting the Challenge fortnightly highlight rep 1 & 2 (campaign company)
10 May 2013	Paediatrics	• Presentation summarising background and proposals and case for change • Briefing document summarising current and proposed service model, case for change, modelling assumptions and references
10 May 2013	Maternity (additional session)	• Presentation summarising background and proposals and case for change • Briefing document summarising current and proposed service model, case for change, modelling assumptions and references
10 May 2013	Surgery	• Presentation summarising background and proposals and case for change • Briefing document summarising current and proposed service model, case for change, modelling assumptions and references
10 May 2013	Emergency medicine	• Presentation summarising background and proposals and case for change • Briefing document summarising current and proposed service model, case for change, modelling assumptions and references
24 May 2013	Ambulance service impact	• Presentation • Briefing note explaining pack contents • Which patients go where paper • Calderdale, Kirklees and Wakefield cardiac arrests hospitals attended 2012 & map • Handover times 19th/20th May • May 2012 transfers to Dewsbury and Pontefra hospitals and drive times • Inter-facility transfers 2012/13 • Leeds and Wakefield LBU turnaround analysi from December 2011 • Monthly turnaround report April 2013-08-15 MYHT proposals impact on YAS of proposed arrangements for ambulatory pathways, mino injuries and cardiac arrest • Pontefract activity April 2011 to March 2012 • Briefing paper – What happens when you call for ambulance assistance • Yorkshire Turnaround agreement

Also provided

Meeting the Challenge Final Report – analysis of consultation responses by the Campaign Company (24 June 2013).

Meeting the Challenge full consultation document.

Meeting the Challenge summary consultation document.

Letters from Dr Chris Clough, Chair of the National Clinical Advisory Team commenting on a submission by Mike Wood MP and information on emergency ambulance transfer times provided by Yorkshire Ambulance Service

APPENDIX A

MY Health and Social Care Transformation Partnership Programme

Meeting to consider the final report of the Wakefield and Kirklees Joint Health Scrutiny Committee on Proposals to Develop a Mid Yorkshire Hospitals NHS Trust Clinical Services Strategy

Additional information requested from the NHS for the meeting on September 16th 2013

Executive Summary

1.0 Purpose of this paper

This supplementary information addresses feedback from the Joint Health Scrutiny Committee on the Meeting the Challenge consultation on reconfiguration proposals for the Mid Yorkshire Hospitals NHS Trust.

The paper covers:

- Scope of Consultation
- Context
- Assurance
- Supplementary information

General issues identified in the JOSC response are addressed in the appendices.

2.0 Scope of the consultation

Section 242 (1B) of the National Health Service Act 2006 (as amended by the Local Government and Public Involvement in Health Act 2007) requires formal consultation to be undertaken where significant changes are proposed to health services.
The purpose of consultation was to seek public opinion on proposals to change the configuration of four specific aspects of delivery of hospital services:

- Emergency care
- Maternity – specifically births requiring consultant input
- Surgery
- Inpatient care for children

Whilst the purpose of the consultation was to consider these changes to hospital services and *not* on the detail of the proposals for care close to home, the consultation discussion and JOSC evidence gathering sessions also included reference to the wider transformation programme to ensure these proposals were not considered in isolation.

3.0 Context

This is a proposal for reconfiguration of hospital services in the North Kirklees and Wakefield area. The hospitals reconfiguration programme sits within the context of the wider health

and social care transformation programme which is being driven by the Health and Wellbeing Boards of Kirklees and Wakefield local authorities.
The whole system transformation promotes an integrated care system where care closer to home is the default position and hospital care offers the highest standard of clinical care to those with the most complex conditions. This approach is supported by commissioners and providers within the health and social care system as being the most effective way of ensuring high quality, accessible care and whole system sustainability.

3.1 Clinical sustainability and quality of care

Reconfiguration of hospital services in the North Kirklees and Wakefield patch is supported by a compelling clinical case for change, which is consistent with the national policy direction, and is essential to ensure sustainability of local acute services provision.

- Failure to reconfigure hospital services will have significant consequences for the quality and safety of care for the population of Wakefield and North Kirklees:
- Major impacts in A&E, obstetrics, paediatrics and acute surgery and medicine due to national shortages of clinicians in these specialties
- Less direct care by consultants for large groups of emergency patients
- Less hours of consultant resident care through the week and weekends
- No site able to offer 24/7 consultant care in A&E and Labour Ward
- The Trust will be less attractive to consultant staff leading to poor retention and recruitment
- Increased reliance on expensive and lower quality locum staff
- Risk of sudden unplanned service loss due to rota collapse or inability to deliver required quality
- Inability to meet national standards of quality
- Current models of care will not be able to deal with growth in demand
- Inability to deliver Francis/Keogh/Berwick recommendations
- Inconsistent with the national direction of travel for improving healthcare
- Contrary to the consensus view of local clinical experts
- Does not meet the recommendations of NCAT
- Less lives will be saved, more people admitted, longer hospital stays, more general and less specialist care.

The proposals secure a vibrant future for all three hospitals, in particular Dewsbury, which will undergo significant capital investment over the next three to four years.
For clarity, the JOSC refer to a comment in the NCAT report that doctors were leaving the Trust due to the proposals. It should be noted that this is a reference to anecdotal comments made on the day and was not a conclusion reached by NCAT. This was discussed with the committee. Substantial progress has been made since the NCAT visit in recruiting to posts which were previously covered by locum doctors

3.2 Financial sustainability

In addition to the clinical case for change, there is also a financial imperative due to the scale of the challenge facing the public sector. This has been considered by the Health and Wellbeing Boards to inform future planning.
The financial challenge facing the health and social care economy over the period to 2016/17 is:
Wakefield Council - £142m
Wakefield CCG - £48m
Kirklees Council - £50m to £70m
North Kirklees CCG - £20m

The Comprehensive Spending Review could lead to a further reduction in allocation of 10% to 13%. The only way in which the local system can address challenge on this scale is by integration and consolidation of services between health and social care.
For the purpose of clarification, the Committee's report contains an assumption that there will be a shortfall of £4.6m in the Trusts financial position following reconfiguration. Following further work on the Trust's financial plan we have developed a plan which achieves a financial surplus of £4.6m by 2017 not the deficit position stated in the Committee's report. As the Committee is aware substantial work is ongoing in the Trust and with local health and social care commissioners to ensure the local system across both health and social care is also financially viable, a major component of which is ensuring there is a financially viable acute provider.

4.0 Assurance

4.1 Ambitions and Conditions

The Governing Bodies of the North Kirklees and Wakefield CCGs approved the following ambitions and conditions, which have been accepted by the Mid Yorkshire Hospitals NHS Trust. Further detail is provided in Appendix 1.

To ensure that the health and social care system works together in an integrated way
• With support of our Health and Wellbeing Boards, the health and social care economies across Wakefield and North Kirklees will work in partnership to commission integrated services to deliver the objectives of the transformation programme.
• The Trust will implement fully the operational improvement programme and work in partnership with clinical commissioners and other providers to deliver a reduction in overall admissions - in accordance with the planning assumptions in the OBC and the SOBC for Care Closer to Home. • They will also implement the bed utilisation review recommendations and develop a scalable emergency day care activity treatment service (on agreed activity trajectories) and commence early implementation in Dewsbury District Hospital in autumn 2013 for some care pathways
• Both CCGs and the Trust will work with Yorkshire Ambulance Service to seek further assurance that the future operational model delivers the required change in operational performance required by the transformation programme for emergency and planned care and ensuring that services are fit-for-purpose on a sustainable basis.
To ensure that quality and safety are the key priorities and the commissioners' role is to assure themselves of this
• Mid Yorkshire Hospitals NHS Trust (MYHT) will achieve an average 85% bed occupancy target (adults) on an agreed trajectory for activity and provide an assurance process (including a quality impact assessment) to the CCGs on any proposed bed changes.
• The health and social care economies will work collaboratively to ensure that patients/ clients remain at the heart of our programme and that we will keep in prominent view through rigorous quality processes the impact on patient experience, quality and safety as we proceed with implementation.
• In order to improve outcomes, patient experience and service quality to deliver a successful transformation programme across North Kirklees and Wakefield, partners' ambitions are to employ digital solutions.
• All partners will continue to assess the impact of any change in services on patient equity and access including travel, particularly for our vulnerable communities. Where there is disproportionate impact, we will work with those communities to seek agreed solutions. Following the key themes emerging from the initial Integrated Impact Assessment around travel and taking into account the recommendations from the Joint Advisory Review Group and the Travel Advisory

Group.
To ensure that the proposals are affordable
• Partners will work to develop an outcome based contractual framework; recognising available resources and risk sharing which incentivise outcomes and promote quality and safety. All specific recommendations made by the CCGs which reflect the consultation output will be subject to a detailed clinical and financial sustainability assessment.
• Mid Yorkshire Hospitals NHS Trust will agree to protect the existing Wakefield community service resources at an agreed baseline (taking into account national and local efficiencies) as part of the future service transformation programme to be specified by Wakefield CCG to enable full transformation of the Wakefield Care Closer to Home model across the health and social care economy
• In line with previous commitments, the wider health-system will continue to provide system-financial support to ensure that the costs of workforce change, transitional support, technical and cash support and capital are available from NHS resources acknowledging that the local system will have finite resources to support the changes

4.1 Issues for consideration

Section 5.5 of the JOSC report asks the committee to consider whether they have received sufficient evidence in relation to ten key issues:

Adequacy of community and stakeholder engagement in the early stages of planning change.	The engagement and consultation process has been independently validated by the Consultation Institute. Appendix 2 describes changes made to address issues raised during pre-consultation engagement and during the formal consultation process.
Description and promotion of the clinical case	The clinical case for change was set out in the consultation materials and presentations. The clinical case is supported by NCAT and is further supported by more recent guidance including Royal College of Physicians guidance, Kings Fund and the NHS Confederation. Further detail on maternity services requested by the JOSC is provided in Appendix 3
Integration across sites and vision for the wider health community	The scope of the consultation is to consider proposals around four specific areas of hospital service delivery and these proposals are described fully in the consultation materials. Transformation of community services is not within the scope of the consultation but has been described to provide context. The local health economy is

	committed to having detailed plans in place by December 2013 with partial implementation by 2014 and full implementation by 2016/17, which is ahead of the timetable for proposed hospital service changes. The letter from NHS England and the Local Government Association setting out the timescale is attached in an Annex to Appendix 1, Commissioners' Ambitions and Conditions
Missing content	Additional information is provided in the appendices
Attention given to responses	The Consultation Institute has independently validated the adequacy of the consultation process. The Ambitions and Conditions agreed by the Governing Bodies demonstrate that the responses of the public have been taken into account.
Loss of services to communities	The proposal is to deliver safe, high quality care for the entire population of North Kirklees and Wakefield by re-shaping services across the three hospital sites. Appendix 4: Impact on Patient Flows between Dewsbury and Pinderfields demonstrates a net increase in provision of local care at Dewsbury and the conditions require retention of local care on all three sites wherever clinically possible.
Scepticism about local access to services	The Ambitions and Conditions agreed by the Governing Bodies require local access to be retained wherever clinically possible. Appendix 4: Impact on Patient Flows between Dewsbury and Pinderfields describes how local access will be achieved.
Potential for patients/visitors to be deterred from attending due to increased travel	The Ambitions and Conditions approved by the Governing Bodies required the recommendations from the Joint Advisory Review Group to support recommendations from the Travel Advisory Group with regard to travel solutions. These are contained in Appendix 5.
Ability of YAS to cope	The increase in patient journeys supported by YAS equates to 0.13% of their total patient transfers. YAS have provided assurance to the JOSC that this is deliverable. The Ambitions and Conditions agreed by the Governing Bodies commit the CCGs and the Trust to work with YAS to seek further assurance that the future operational

	model delivers the required change.
Extent to which account was taken of opposing views expressed during consultation	The Consultation Institute has independently validated the adequacy of the consultation process. The Ambitions and Conditions agreed by the Governing Bodies demonstrate that the responses of the public have been taken into account.

5.0 Supplementary information

The JOSC have asked for supplementary information in relation to the following areas;

- Capacity modelling for the hospital services;
- Impact on patient flows between Dewsbury and Pinderfields and whether Pinderfields can cope with the additional activity;
- Maternity
- Travel and transport

5.1 Capacity modelling

Recognised modelling tools are being used to assess future bed and theatre capacity requirements. This is an ongoing and iterative process involving commissioners and providers to ensure sufficient capacity across the whole system to support hospital realignment by 2016/17.

The modelling is based on 2011/12 full year data. Changes have been made to the modelling assumptions between Outline Business Case and Full Business Case development. These are detailed in Appendix 6.

5.2 Patient flows

The modelling indicates that there would be a net increase in the number of Dewsbury patients receiving local treatment from 128,000 to 137,000 episodes of care. These are detailed in Appendix 4.

5.3 Maternity

Further detail requested by the JOSC is provided in Appendix 3.

5.4 Travel and transport

Appendix 5 describes work undertaken by the Trust supported by commissioners to assist people in accessing hospital following previous hospital reconfiguration.

Appendix 1

Commissioners' ambitions and conditions

The commissioners' ambitions and conditions have arisen from the issues and concerns that arose from the consultation and demonstrate a desire to ensure:

- That the health and social care system works together in an integrated way;
- That quality and safety are the key priorities and the commissioners' role is to assure themselves of this; and
- That the proposals are affordable.

The two CCGs will work collaboratively and transparently with both Wakefield and Kirklees Councils to deliver the best possible integrated services for patients/ clients through a single approach to business. This will include pooling resources and sharing risk which will lead to integrated commissioning and agreed use of the Integration Transformation Fund.

The table blow lifts the ambitions and conditions that were contained in the Outcome of the Public Consultation on the Meeting the Challenge Strategy Proposals paper that formed the basis of the discussion at the Board Meetings of the two governing bodies held in public on 25th July:

Ambition and Condition	Why this was included	Assurance of implementation
To ensure that the health and social care system works together in an integrated way		
With support of the Health and Wellbeing Boards, to work in partnership to commission integrated services to deliver the objectives of the transformation programme.	To address the concern that there is lack of confidence in the health and social care system to deliver the changes, in particular to reduce the reliance on hospital services. This was highlighted as a key issue in the Deliberative Event.	The Health and Wellbeing Boards have a statutory responsibility to oversee the changes. Attached is a letter dated 8 August 2013 from Carolyn Downs, Chief Executive of the Local Government Association and Bill McCarthy, National Director: Policy for NHS England relating to a Statement on the health and social care Integration Transformation Fund. This follows the June Spending Round and demonstrates that transformational integration is national policy. The timeline required in Paragraph 5 is being met by the MY health and social care economy through the transformation programme. The Care Closer to Home Programme details plans for admission avoidance, support in time of crisis

		and supported early discharge. There are four years to deliver the implementation plan which will have clear measurements at each stage. Hospital services will not be reduced until the alternative is embedded in the community.
the Trust will implement fully the operational improvement programme and work in partnership with clinical commissioners and other providers to deliver a reduction in overall admissions - in accordance with the planning assumptions in the OBC and the SOBC for Care Closer to Home. They will also implement the bed utilisation review recommendations and develop a scalable emergency day care activity treatment service (on agreed activity trajectories) and commence early implementation in Dewsbury District Hospital in autumn 2013 for some care pathways.	As above, to address the concern that the bed reduction in the Trust will not be met by a corresponding increase in capacity in the community. To ensure that the Trust delivers services in a different way to enable more people to be cared for locally on a day treatment basis and that beds are utilised in the most efficient manner.	To continue to develop clear and robust plans for all four transformation programmes and test capacity achieved in the community against bed reductions in the hospitals. The commissioners and Trust have arrangements in place to ensure alignment in the delivery of service changes and the impact on hospital capacity delivered through each of the four programmes to hospital bed reduction. Capacity delivered by the four programmes is being analysed at whole programme level to avoid any double counting. Bed occupancy is an integral aspect of the Trust Integrated Performance Framework (IPF) and is subject to a quality impact process when demand exceeds activity assumptions. This system will also be used to assess the state of readiness for implementing any service changes and for evaluating the impact care close to home. The system is also aligned to

		CQC standards and requirements. Ensure that the findings of the bed utilisation review are implemented as appropriate. Pilots for Emergency Day Care are due to commence in Pinderfields from w/c September 16th and Dewsbury in October.
Both CCGs and the Trust will work with Yorkshire Ambulance Service to seek further assurance that the future operational model delivers the required change in operational performance required by the transformation programme for emergency and planned care and ensuring that services are fit-for-purpose on a sustainable basis.	To ensure that all organisations affected by the changes are engaged in the proposals. To ensure that the proposals are deliverable from the perspective of YAS.	Yorkshire Ambulance Service (YAS) is a key partner in operational Urgent Care planning and developing the detailed service models for these proposals. All aspects of developing future service plans will include YAS in the development of protocols, practice development, training and modelling patient flows.
To ensure that quality and safety are the key priorities and the commissioners' role is to assure themselves of this		
Mid Yorkshire Hospitals NHS Trust (MYHT) will achieve an average 85% bed occupancy target (adults) on an agreed trajectory for activity and provide an assurance process (including a quality impact assessment) to the CCGs on any proposed bed changes.	To address concerns around bed capacity and flexibility to deal with peak activity. To ensure that NCAT recommendations are met.	The modelling is now based on an average bed occupancy of 85% for adult medical and surgical patients and 70% for obstetrics and paediatrics in line with NCAT advice. This will be continually assessed and monitored through the Urgent Care Board. Bed reductions will not be made without QIAs being undertaken and mitigation demonstrated to ensure safe and quality care is

		maintained.
The health and social care economies will work collaboratively to ensure that patients/ clients remain at the heart of our programme and that we will keep in prominent view through rigorous quality processes the impact on patient experience, quality and safety as we proceed with implementation.	To address concerns that the proposals are primarily about financial stability and demonstrate that the commissioners' priorities are quality and safety. To demonstrate that the proposals for integrated health and social care would have gone ahead anyway because it is the right thing to do for our populations to meet national clinical guidance on quality and safe care. To ensure that patients and the public continue to be engaged on an on-going basis.	The MY Health and Social Care Transformation Partnership Programme oversees patient and public engagement so this is managed at the highest levels in each of the partner organisations. The implementation process will also be overseen by the MY Health and Social Care Transformation Partnership Programme and will ensure that patients are at the heart of the programme.
In order to improve outcomes, patient experience and service quality to deliver a successful transformation programme across North Kirklees and Wakefield, partners' ambitions are to employ digital solutions.	To ensure that services are leading edge and employ technologies that deliver efficient and streamlined services.	There is a MY health and social care economy wide group addressing IT and digital technology issues across the whole programme. An expert in IT solutions has been commissioned by the programme to advise on the implementation of digital solutions.
All partners will continue to assess the impact of any change in services on patient equity and access including travel, particularly for our vulnerable communities. Where there is disproportionate impact, we will work with those communities to seek agreed solutions. Following the key themes emerging from the initial Integrated Impact Assessment around travel and taking into account the	Access issues were one of the key concerns arising from the consultation. This had been anticipated and potential solutions put forward as part of the consultation. Recommendations were included in the Outcome of the Public Consultation on the Meeting the Challenge Strategy Proposals paper but there is a need to ensure that these are now taken forward and	The recommendations of the Travel Advisory Group are being taken forward through MYHT's Access Group and the original members of the Travel Advisory Group are now included in this Group. Delivery of the recommendations is being overseen by the MY Health and Social Care Transformation Partnership Group.

recommendations from the Joint Advisory Review Group and the Travel Advisory Group.	delivered. Travel and transport were one of the key concerns raised at the Deliberative Event. To address the recommendations of the Joint Advisory Review Group. There is a need to ensure that Equality and Travel Impact Assessments continue to be developed on an on-going basis.	
To ensure that the proposals are affordable		
Partners will work to develop an outcome based contractual framework; recognising available resources and risk sharing which incentivise outcomes and promote quality and safety. All specific recommendations made by the CCGs which reflect the consultation output will be subject to a detailed clinical and financial sustainability assessment.	To ensure that quality and safety remain at the centre of the proposals through the development of the transformation programme.	Produce in partnership an outcome based contractual framework in the development of care pathways to ensure quality and safety.
Mid Yorkshire Hospitals NHS Trust will agree to protect the existing Wakefield community service resources at an agreed baseline (taking into account national and local efficiencies) as part of the future service transformation programme to be specified by Wakefield CCG to enable full transformation of the Wakefield Care Closer to Home model across the health and social care economy.	To ensure that the Care Closer to Home Programme continues to be deliverable on an on-going basis.	Promote transparency across partner organisations in the cost base and commission resource envelopes.
In line with previous	To ensure that the financial implications of	This will be agreed by the

commitments, the wider health-system will continue to provide system-financial support to ensure that the costs of workforce change, transitional support, technical and cash support and capital are available from NHS resources acknowledging that the local system will have finite resources to support the changes.	the proposals are supported by the health system including the TDA and NHS England.	relevant partner organisations. Transitional arrangements will be agreed and monitored in terms of finance, capacity and quality. The use of non-recurrent funding will be deployed where appropriate.

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Date: 2 October 2013

Our ref: JOSC/Meeting the challenge /HWBletter

Cllr Betty Rhodes
Wakefield Council
Overview & Scrutiny Office
Room 53
County Hall
Wakefield
WF1 2QW

Dear Cllr Rhodes

I am writing on behalf of the Kirklees Health and Wellbeing Board following the recent request from yourself as chair of the Wakefield & Kirklees Joint Health Scrutiny.

The Joint Committee requested that the respective Health and Wellbeing Boards consider the Joint Committee's report and the additional information provided by the Clinical Commissioning Groups in response to your report. Specifically you asked if the Health and Wellbeing Board could indicate whether or not we still have confidence in moving to the Full Business Case, and whether or not any additional assurance is required from the CCGs and the Trust.

Having received your representation and having had further opportunity to debate with the Trust and North Kirklees CCG our position remains unchanged.

However for clarification I have attached the original letter that I wrote on behalf of the Kirklees Health and Wellbeing Board. As you will see from the letter the Board appreciated the context in which the proposed changes are taking place, but we had and continue to have specific areas where we require further reassurances. The Board continues to seek assurances on the areas outlined in the letter. It is the Boards view that the areas of concern will not be fully addressed until the full business case is complete and available to us. We believe that only then will we have a detailed picture of the level of likely investment and robust plans for implementation required.

As a Board we are keen to continue our dialogue with the Mid Yorkshire Clinical Service Strategy and the Transformation Programme in order to influence this significant change and ensure the best outcome for the people of North Kirklees.

Can I also take the opportunity to thank Cllr Smaje for taking the time to present the item.

Yours sincerely

Cllr Mehboob Khan
Chair of the Kirklees Health and Wellbeing Board

Enc Original HWB letter to North Kirklees CCG
Cc Dr David Kelly
Chris Dowse

Councillor Mehboob Khan

Leader of the Council

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Date: 2 October 2013

Our ref: Meeting the challenge /HWB letter

By Email:

Chris Dowse and Dr David Kelly
NHS North Kirklees CCG
Broad Lea House
Dyson Wood Way
Bradley
Huddersfield
HD2 1GZ

Dear Chris and David

On behalf of the Kirklees Health and Wellbeing Board can I thank you for co-ordinating the recent contribution at the Board on the Mid Yorkshire's "Meeting the Challenge " Clinical Services Strategy.

All Board members recognise the difficult challenges that the Health and Social Care system is facing in terms of:

- Demographic and volume pressures;
- The current financial climate and the need to deliver efficiency savings;
- The demands of delivering high quality, safe and sustainable services.

Which result in both health and local government facing some of our most challenging and difficult decisions in decades.

As an action the Kirklees Health and Wellbeing Board asked that in my role as chair is to comment on the Mid Yorkshire's "Meeting the Challenge " Clinical Services Strategy. I think it is important to reiterate that this letter is written solely in my role of chair and does not represent my view as Leader of the Council or the Labour Group.

The Health and Well Being Board understands the general direction of travel, that both you and your colleagues outlined and that you are working hard to address the concerns about the potential impact for both North Kirklees as a place and the people of North Kirklees who access their health care at Dewsbury District Hospital.

From our discussions at the Board, we appreciate that you have undertaken wide consultation with the public , partners and local politicians. As you know from previous Board discussion we have continued concerns around the Wakefield centric

focus of many of planned changes and are keen to see the proposals you outlined in response to the consultation about more people being treated locally in Dewsbury being implemented.

Whilst this is letter appreciates, the context in which the decisions need to be made, the Board would seek further reassurances. They are:

1. That the outlined enhancements proposed for treating more people locally are appropriately worked up. In particular given the current financial challenges how these can be effectively resourced and implemented. The Board would welcome an early and detailed conversation on these matters,

2. That as part of the ongoing communication and engagement work surrounding meeting the challenge you consider how best to address the point you raised about low public confidence in achieving your outcomes. In moving forward the public and in particular the people of North Kirklees will need to be assured their interests are being represented,

3. As you will know from our previous conversations at the Board, we are particularly keen to ensure close working relationship between this programme and the Calderdale and Huddersfield Health and Social Care Strategic Review. It would not be in the interests of the people of Kirklees or the wider Kirklees Health and Social Care economy for any planned changes either in Clinical reconfiguration or the wider transformation to have negative or unintended consequences for South Kirklees;

4. Both the Clinical Service Strategy and the Transformation Programme are inextricably linked and inevitably the Clinical Services Strategy can only be delivered if we have agreement on what and how the Transformation Programme will deliver. This will need to be predicated on an understanding on how we can take a more radical view on money flow around the economy to ensure the right investment in primary, community and social care provision (potentially in line with a community based budget approach) the Board would welcome an early discussion on this;

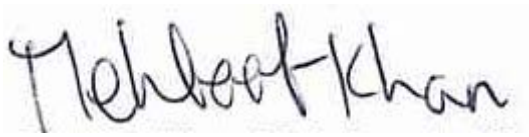
5. As part of agreeing what and how the work of " Meeting the challenge" is taken forward the Board would be keen to see detailed information on the mechanics of how and when key decisions will be made . A detailed plan and timetable for implementation to ensure there is appropriate lead in time to make the required investments and increased capacity, for example creating the future workforce required for the new operating models, in order that we can create a sustainable, high quality health and social care economy.

As with all large scale complex changes the devil is often in the detail, therefore the Health and Wellbeing Board would welcome having a more detailed conversation on the exact detail that sits behind each transformation work area, in order that as a Board we can get underneath the big picture we have had to date. In particular we would be keen to understand the current and predicted volume pressures around A&E, avoidable admissions and appropriate discharges, in order that we can fully appreciate the thinking behind future service reconfiguration.

The board would be keen to understand in detail the proposals going forward, the assumed benefits and perceived outcomes and be assured that we have considered the likely dependencies and the potential implications for the whole of the Kirklees Health and Social Care Economy.

In closing the Kirklees Health and Wellbeing Board continues to take a keen interest in maintaining its strategic oversight of the wellbeing of the people of Kirklees and the Health and Social Care Economy and therefore want to continue to be able to influence and shape the outcomes of this important piece of work.

Yours sincerely



Cllr Mehboob Khan
Chair of the Kirklees Health and Wellbeing Board

Councillor Pat Garbutt
Wakefield Town Hall
Wood Street
Wakefield
WF1 2HQ

7th October 2013

Dear Councillor Rhodes

Following the recent request from the Wakefield & Kirklees Joint Health Overview and Scrutiny Committee I am responding on behalf of the Health and Wellbeing Board for Wakefield. The Joint Committee asked the Health and Wellbeing Board to indicate whether we still have confidence in proceeding to a Full Business Case, following our consideration of the key areas of concern highlighted in the Joint Committee's report.

The Wakefield Health and Wellbeing Board have received regular updates on the progress of the Mid Yorkshire Health and Social Care Transformation Programme - Meeting the Challenge whilst in shadow form and latterly as a constituted board. These updates described the progress on External assurance, Consultation and programme development, giving the board the opportunity to consider, discuss and challenge. The Board has expressed its support for the overall direction of travel, whilst making recommendations that need to be considered going forward.

Having received your report and having had further opportunity to discuss and debate this with CCG and Trust representatives, we wish to indicate that Wakefield's Health and Wellbeing Board still supports the overall direction of travel and has confidence to proceed to a Full Business Case. In particular:

- Adequate community and stakeholder engagement - We had opportunities as a Health and Wellbeing Board to discuss and challenge the adequacy of community and stakeholder engagement. We are confident that the consultation process was robust. In particular, we note that NHS England was satisfied with the work undertaken and the CCG were given an award by the Consultation Institute for its approach to the consultation. Furthermore, the Board considered how they could contribute to taking the plans forward and highlighted a need for a clear narrative around the decisions taken and measures to address concerns raised during the engagement and consultation process.
- Description and promotion of the clinical case – The Board is satisfied that the clinical case for change has been sufficiently described, justified and are focussed on delivering safe and sustainable high quality care. We are also assured that the proposals have been independently reviewed by national experts.
- Integration across sites and vision for the wider health community - The Board recognise the vital role that integration of health and social care plays in delivering better outcomes to the people of the District. We will be progressing the development of plans on this agenda as one of the Board's key priorities over the next year and beyond. The Board commend the consultation process for providing context on the integration/transformation of health and social care services, whilst this was not within the scope of the Meeting the Challenge Consultation.
- Missing content – We are confident that the additional information provided by the CCG and Trust makes available any content that may have been missing from the reconfiguration plans.
- Attention given to consultation responses - We are confident that the consultation responses have informed the direction of travel and the ambitions and conditions agreed by the Governing Bodies. We note that the CCG were awarded by the

Consultation Institute for its approach to the consultation. Furthermore, the Board are satisfied with the measures put in place to address concerns raised during the engagement and consultation process.

- Loss of services to communities – The board are assured that the viability and quality of care could not be maintained with the current situation and that the conditions require retention of local care on all three sites wherever clinically possible. Furthermore, the proposals are focussed on delivering safe and sustainable high quality care and we are assured that quality, safety and effectiveness would be carefully monitored.
- Scepticism about local access to services - The Board has been assured that the conditions require retention of local care on all three sites wherever clinically possible and the proposals will provide an overall improvement in access. In particular, the investment plans for Dewsbury demonstrate an increase in provision of local care. Dewsbury will see an increase in patients and the Trust are working on optimising Pontefract Hospital.
- Potential for patients/visitors to be deterred from attending due to increased travel – The Board acknowledge that in order to mitigate any transport related issues that could affect access (from both patients and visitors) that the recommendations from the Travel Advisory Group with regard to travel solutions are supported.
- Ability of YAS to cope – The board are assured that the small increase in patient journeys that would be supported by YAS resulting from the proposals are deliverable.
- Extent to which account was taken of opposing views expressed during Consultation - We are confident that the consultation process was robust and note that the CCG were given an award by the Consultation Institute for its approach to the consultation and the Ambitions and Conditions agreed by the Governing Bodies demonstrate that the responses of the public have been taken into account.

Please be assured that as a Board we will continue to receive updates on the Mid Yorkshire Clinical Service Strategy and the Transformation Programme. This will enable us to influence the changes going forward and ensure the programme has the best outcome for the health and wellbeing of people living in the Wakefield District.

Yours sincerely

Councillor Pat Garbutt
Chair of the Wakefield Health and Wellbeing Board