Calderdale and Kirklees 999 Call for the NHS

Report for the Independent Reconfiguration Panel

Reconfiguration of Calderdale and Huddersfield NHS Foundation Trust Hospital Services Full Business Case

September 21st 2017

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INTRODUCTION

The proposed reconfiguration of Calderdale and Greater Huddersfield NHS is huge and has taken three years to get to the Full Business Case.

It has been staunchly resisted all along the way by thousands of members of the public who value our Calderdale and Huddersfield District General Hospitals (each with a full 24/7 bluelight A&E), and are not prepared to see them dismantled.

The public consultation outcome was a decisive NO to the Right Care Right Time Right Place reconfiguration propoals.

Throughout the past three years, at every step of the way, we have carefully examined evidence for the proposals and have found it wanting. We - and our elected Councillors on the Joint Health Scrutiny Committee - have been patronised, belittled, dismissed and hoodwinked by managers in both CCGs and the Hospitals Trust.

Now that Calderdale and Kirklees Joint Health Scrutiny Committee have referred the Calderdale and Greater Huddersfield Right Care Right Time Right Place reconfiguration proposals to the Secretary of State for Health, we ask you to carry out a full review based on a thorough visit to Calderdale and Kirklees, so you can listen to everyone who has something they want you to hear.

We also ask you to investigate the wider context and drivers for the Right Care Right Time Right Place reconfiguration plans - namely:

- the government's "austerity" policy and its effects on the NHS and social care; and
- the Sustainability and Transformation Partnership that the RCRTRP plans are a key part of

Both of these issues surface in the Full Business Case for the Right Care Right Time Right Place reconfiguration, particularly in The Economic Case for Change and in The Strategic Context, respectively.

There are many aspects of the proposals that we could draw to your attention, but in this report we focus on the Full Business Case as this has not been publicly scrutinized. The Trust refused to release it to the Joint Health Scrutiny Committee in time for its July meeting, which took place shortly before the Board had approved it and decided to publish it.

We find the Full Business Case to be largely un-evidenced and deeply flawed. It also includes proposals that have not been consulted on.

In analysing the Full Business Case, we have considered it in terms of how it affects people - patients, the public and NHS staff; and how it affects things - money and buildings.

We hope this will help you with your thorough review of the referred reconfiguration proposals.

999 Call for the NHS (Calderdale and Kirklees) 27 September 2017

SUMMARY

The national failure to fund the NHS properly and to carry out adequate workforce planning are the root causes of the decision to reconfigure Calderdale and Greater Huddersfield NHS and social care services. This is clear from the National Clinical Advisory Team report in 2013 that underpinned the Strategic Review - published to general public outrage in early 2014.

We have no confidence that government decisions to under-fund the NHS and national NHS workforce planning failures are appropriate reasons for reconfiguring our NHS and social care services; we ask you to consider this when reviewing the Right Care Right Time Right Place proposals, as set out in the Full Business Case.

Equally, we have no confidence in the clinical case for change and its modelling, and neither has the Clinical Senate. We ask you to investigate this in considering the Clinical Case for Change.

The Clinical Senate has made it clear that the Right Care Right Place Right Time plans are based on nationally generated models with no significant local input.[1]

They found no evidence that local clinical staff had been asked about either the [2]hospital model or the model of [3]community care.

[4]They could not certify that the proposed models would generate the required quality of care.

So we can have no confidence in plans for the workforce and how patients would access and experience health and social care, since these depend on the clinical case for change.

We ask you to investigate the following issues when you review the Right Care Right Time Right Place plans that Calderdale and Kirklees Joint Health Scrutiny Committee have referred to the Secretary of State for Health.

[1,2,3,4] Please see End Notes to the Summary (p. 10)

1. NATIONAL FAILURE TO FUND THE NHS PROPERLY AND TO CARRY OUT ADEQUATE WORKFORCE PLANNING

We ask you to investigate:

- Whether it was appropriate that all the NHS and hospital reconfiguration options put forward for consideration and consultation took as their starting point an acceptance of the dire consequences of national failure to fund the NHS properly and to have any kind of adequate workforce planning.

- Why the NHS organisations did not demand a solution to these problems and develop a case for change based on assumptions that the government could do its job of proving adequate funding, effective workforce planning and an appropriate legislative framework that would enable the NHS to operate according to its core founding principles.

2. FAILURE TO CONSULT ON THE WEST YORKSHIRE AND HARROGATE SUSTAINABILITY AND TRANSFORMATION PLAN

We ask you to investigate the secretive operations of the West Yorkshire and Harrogate Sustainability and Transformation Plan (now Partnership) - which this reconfiguration proposal is seen as a key part of - particularly:

- the failure to consult on three proposed West Yorkshire and Harrogate Sustainability and Transformation Plan schemes for CHFT (two for planned care and one for vascular services)

- the failure to consult on merging local services into accountable care systems

- whether this new business model for the NHS is compatible with the core NHS principle of providing comprehensive healthcare for all who have a clinical need, free at the point of need.

- the failure to consult on radical changes to hospital services through the West Yorkshire Association of Acute Hospitals' "Collaborative Programme" approach

3. PROJECTED SHORTAGE OF CLINICAL INCOME

We ask you to investigate the effect of the projected shortage of clinical income on the ability of all patients to access the hospital treatment/s they have a clinical need of, free at the point of need. Particularly:

- The effects on patients of the “commissioner affordablity gap” - ie the fact that the Clinical Commissioning Groups do not have enough money to pay for the services CHFT thinks it needs to provide.

- The effect on CHFT and patients of Calderdale Clinical Commissioning Group’s intention of providing Community Services (aka “Care Closer to Home”) on the basis of a capitated budget, via an Accountable Care Organisation.

4. OPENNESS AND ACCOUNTABILITY OF STAKEHOLDER GROUPS, AND CHFT’S RELATIONSHIPS WITH THE PUBLIC, JOINT HEALTH SCRUTINY COMMITTEE AND NHS COMMISSIONERS.

We ask you to investigate:

- Whether the proposed Governance arrangements to communicate with and involve all the groups and organisations affected by the hospitals reconfiguration would help to dissolve the justified distrust, frustration and disgust that have built up among members of the public who have tried in good faith to scrutinise the proposals and take part in the public consultation.

- Whether in future they would enable clear open and honest multi-directional communication between all involved.

- Whether and how it is possible for all the Stakeholder groups in the Management and Governance structure/process to be open, honest and accountable. Or,

- Whether that has been rendered impossible by the fact that NHS institutions, as currently constituted by the 2012 HSCA and various subsequent statutory instruments that have modified these organisations and their relationships without Parliamentary scrutiny, have been designed by stealth to bring in the market and force through the “ reconfiguration “ of healthcare to that end.

5. TRUST BOARD

With regard to the Trust Board, we ask you to investigate:

- Membership Council governors’ awareness of their statutory roles and responsibilities and additional powers.

- Whether and how they have exercised them during the last few years when the reconfiguration proposals have been in development.

- How their exercise of their roles, responsibilities and additional powers could be improved.

6. WORKFORCE PLAN

We ask you to investigate and establish:

- The reason/s for near-total absence of a community services workforce plan from the Workforce Plan in the Full Business Case.

- The community workforce requirements of the Calderdale Care Closer to Home scheme.

- The local community service staff training needs for both Calderdale and Greater Huddersfield.

- The lack of a primary care strategy that has GPs' and other primary care staff backing.

- The claim (p74) that the proposed reconfiguration will improve recruitment and retention of clinical staff within key hospital and community specialties.

- The workforce planning assumption that an outpatient services review will help deliver new models of care and reduce follow-up appointments for existing patients with long-term conditions, while CHFT works with mental health, primary and social care and other local provider services to "develop efficiencies in service provision." FBC p 76)

7. HOSPITAL BED CUTS

We ask you to investigate:

- Whether cutting 105 hospital beds is feasible (which would account for 150 WTE job losses, or 22%) and find out why the hospitals Trust have not provided the necessary evidence to support their bed cuts plan.

- The hugely optimistic assumption of a 6% reduction in emergency admissions every year for 5 years. Just for comparison, over the same period, the West Yorkshire Sustainabilility and Transformation Partnership overall is only planning a 4% reduction in emergency admissions in total by 2020/1 (p57, West Yorkshire & Harrogate Sustainability and Transformation Plan).

- Whether the Care Closer to Home patients would pay for community support using means-tested personal social care budgets as well as non-means tested personal health budgets/continuing health care payments.

- The basis for any judgement about what part of Care Closer to Home patients' community support would be subject to means-tested social care, on the basis that it was personal social care, not NHS care.

8. REVIEWED SKILLS MIX/NEW PROFESSIONAL ROLES

We ask you to investigate the high risk that the reviewed skills mix/ new professional roles are unlikely to provide good quality, safe patient care.

9. JOB EVALUATION

We ask you to review how to make sure that nursing remains an art that involves nursing the whole person, whatever their needs - particularly since nurses whom we have spoken to say that the proposed job evaluation will destroy everything that epitomises nursing: that is, to provide all nursing care from basic care upwards.

10. INCREASED USE OF VOLUNTEERS AND COMMUNITY GROUPS IN THE NEW PLANNED AND UNPLANNED CARE HOSPITALS

We ask you to investigate:

- The appropriateness of increased use of voluntary work and community involvement in both hospitals, which is part of the workforce plan.

- Which and how many hospital jobs CHFT envisages giving to volunteers.

- What about patient safety?

- The ethics of undermining properly waged jobs carried out by trained, qualified and unionised staff, by replacing them with third sector organisations who may or may not pay those who are carrying out this work.

11. PLANNED CARE HOSPITAL - SIGNIFICANT DIFFERENCE BETWEEN THE FULL BUSINESS CASE AND THE PUBLIC CONSULTATION DOCUMENT.

We ask you to investigate the reasons for the difference between the Full Business Case and the public consultation document, with regard to the planned care hospital bed numbers.

12. PF2

We ask you to investigate whether the Trust's withholding of information during the public consultation, that PF2 is the only available source of capital funding, may invalidate the consultation.

13. ENFORCED EFFICIENCY CUTS AND DELAPIDATION OF HRI

In the context of this proposed reconfiguration, we ask you to investigate whether the 2011-2015 £20bn "efficiency cuts" required by the Nicholson Challenge and the further £22bn+ cuts required by Sustainability and Transformation Plans make any kind of economic sense - particularly since they are directly responsible for the alleged "time-expired" state of Huddersfield Royal Infirmary, due it falling into such a state of disrepair because the Trust had no money to maintain it properly.

14. LENDLEASE CONFLICT OF INTEREST

We ask you to investigate whether CHFT acted improperly, unethically and carelessly in giving Lendlease Consulting the 2015 contract to update the 2013 NIFES report on the state of the Huddersfield Royal Infirmary building, at a time when Lendlease Corporation had a vested interest in Calderdale Royal Hospital Special Purpose Vehicle and stood to profit from the decision to make Calderdale Royal Hospital the preferred Acute and Emergency hospital.

15. CLAIM THAT HUDDERSFIELD ROYAL INFIRMARY IS TIME-EXPIRED

We ask you to investigate the credibility of the Full Business Case's claim that Huddersfield Royal Infirmary is time expired, with no more than 10 years of life left, even if all the backlog maintenance tasks identified in the 2015 update to the 2013 NIFES report were carried out. This is not what CHFT said in the Pre-Consultation Business Case and public consultation.

END NOTES

[1] The Clinical Senate review of the hospital services model (Pages 159 and 163) states:

> "...the standards proposed in the documentation ... are taken from a variety of national documents... The standards are very generic, however, and could largely apply to any Trust, which left the Senate with questions about their deliverability.

> Commissioners are recommended to include more detail about the level of local clinical engagement in agreeing how deliverable these standards are..."

[2] The Clinical Senate review of the hospital services model (Page163)

> "The documentation does not give a sense... of what local clinical discussions there have been in agreeing how achievable these standards are locally. From the information provided, we could not have confidence that the model would guarantee performance in the absence of clarity on the other key factors including staffing levels, which the Senate agreed are crucial to the delivery of these standards."

[3] The Clinical Senate Review of Community Services Specifications for Calderdale, Greater Huddersfield and North Kirklees CCGs (PCBC p 137) says that these Specifications contain no evidence to support commissioners' claims of "extensive engagement with staff" over the last two years.

It considers it "likely that there would be workforce issues during such a large scale transformation" and recommends further work on how " risks to patient care can be mitigated during the transition period", that would result from current CHFT "workforce issues getting worse as the morale and motivation of clinicians continues to deteriorate". This is identified as a "Principal risk".

It also says that there will be "resistance and refusal to change" in primary care.

[4].The Clinical Senate Review says (p164) that it can't tell how "achievable" the hospital services clinical model's "aspirations" are, because there isn't enough clarity about the more centralised model of care, and there is a lack of operational detail - particularly the workforce model, including recruitment and retention.

The Clinical Senate review of the hospital services model says (p159) that:

"The lack of detail at this stage left the Senate with questions regarding the ability of this model to deliver the standards proposed."

As for the community services/Care Closer to Home model, the Clinical Senate Review of Community Services Specifications for Calderdale, Greater Huddersfield and North Kirklees CCGs says:

> "...the visionary style of the documents...has compromised our ability to assess if the risks have been addressed."

DETAILED INFORMATION

This section provides full information about the issues we ask you to investigate.

1. NATIONAL FAILURE TO FUND THE NHS PROPERLY AND TO CARRY OUT ADEQUATE WORKFORCE PLANNING

We ask you to investigate whether it was appropriate that all the NHS and hospital reconfiguration options put forward for consideration and consultation took as their starting point an acceptance of the dire consequences of national failure to fund the NHS properly and to have any kind of adequate workforce planning.

We ask you to investigate why the NHS organisations did not demand a solution to these problems and develop a case for change based on assumptions that the government could do its job of proving adequate funding, effective workforce planning and an appropriate legislative framework that would enable the NHS to operate according to its core founding principles.

Background: "The question is whether democracy can prevail and the public can make its demands for proper funding and public provision undeniable by any government." (Stephen Hawking)

We are making our demands for proper funding and resourcing, so that both Huddersfield and Calderdale District General Hospitals complete with 24/7 Type 1 A&Es, can stay open and meet all required standards of patient care and staff terms and conditions of work.

Once that is guaranteed we can begin to look at ways of improving and modernising the NHS and social care.

The NHS is not failing, it is being failed.

We urge you to tell the Secretary of State to properly fund and resource the NHS so that our District General Hospitals can stay open and meet all required standards of patient care and staff terms and conditions of work.

Once that is guaranteed we can begin to look at ways of improving and modernising the NHS and social care.

The Full Business Case refers to national lack of adequate NHS funding and workforce planning as "the strategic context". It describes the funding shortage in these terms:

- The Nov 2016 National Audit Office report on NHS Financial Sustainability indicated the NHS is financially unsustainable (in other words, the government isn't funding it properly);
- The Full Business Case is a key part of the West Yorkshire and Harrogate Sustainability and Transformation Plan (which has to cut over £1bn NHS and social care costs by 2020/21, compared to current funding levels);
- CHFT relies on the Dept of Health for cash to pay creditors and staff and the Clinical Commissioning Groups can't afford the cost of commissioning services.

It says despite all this CHFT has done well in maintaining access to services but due to its problems recruiting and retaining staff, this depends on high agency staff costs – £20m in 2016/7.

The solution to a shortage of A&E and paediatric consultants is not to close an entire District General Hospital and turn it into a small planned care clinic with an urgent care centre and outpatients - it is to demand an adequate national workforce plan and decent pay and conditions, and to identify a meanwhile solution until the national workforce plan is in place and taking effect.

In our area, multiple NHS organizations are "failing" their inspections by the Care Quality Commission and NHS England; perhaps this has a bigger meaning. Maybe it becomes impossible to provide decent and safe care when staff and services are being cut because of a shrinking budget.

Clifton House and Nook Group Practice in Huddersfield has just joined both our hospitals Trust and the Kirklees community services provider Locala in receiving a Care Quality Commission judgment of "requires improvement" – while both Greater Huddersfield and Calderdale Clinical Commissioning Groups have been put in special measures by NHS England because of their inability to meet its harsh financial targets.

CHFT nods towards the true source of these problems in the Full Business Case summary of the Clinical Case for Change, which says that CHFT can't meet national guidelines for clinical standards regarding staffing and building standards without

> *"a major injection of permanent staffing and financial resources beyond that which is known to be available from government."*

In other words, if there weren't massive PFI debt, a national NHS staff shortage and a mean government, both District General Hospitals could continue, each with their own 24/7 type 1A&E.

Those are the real reasons for the "reconfiguration". And this is why we cannot accept the reconfiguration, because it will not solve these problems – it just normalises and accepts

dysfunctional “austerity” economics, making us all accept these problems and the Full Business Case “solutions” as inevitable.

We do not, and they are not – they are the result of the government’s political decisions, which we contest on the basis of solid economic arguments and values of social and environmental justice.

But all the NHS organisations involved in this reconfiguration proposal set out to remake the Calderdale and Greater Huddersfield NHS as a straitened service defined by those shortcomings.

As a key part of West Yorkshire and Harrogate Sustainability and Transformation Plan (STP), the reconfiguration proposals are *“merely the vehicle for delivering cuts to services that the government’s ongoing underfunding of the NHS has made inevitable”* - as Unison has described the STPs.

A big cause of the NHS funding shortfall is the huge waste of money (estimated at between £4.5bn/year and £30bn/year) that comes from running the NHS like a market and privatising its services.

The solution to this is not recourse to Sustainability and Transformation Partnerships, but legislative change through the NHS Reinstatement Bill, to undo the damage done over virtually the whole course of the current century, through NHS privatising legislation introduced by successive governments, culminating in the completely undemocratic 2012 Health and Social Care Act that was not in any party’s 2010 manifesto.

But the Full Business Case normalises and accepts the government’s “austerity” economic policy – its economically illiterate, socially and environmentally punitive dogma that public spending cuts are good for the economy. More info here and here.

National Treasure and brainbox scientist Professor Stephen Hawking recently wrote

> *“There is overwhelming evidence that NHS funding and the numbers of doctors and nurses are inadequate, and it is getting worse. The NHS had a £2.4bn shortfall in funding in 2015-16, bigger than ever before. NHS spending per person will go down in 2018-19. According to the Red Cross, the NHS is facing a humanitarian crisis. There is a staff recruitment crisis. The BBC reported that on 1 December 2015 there were 23,443 nursing vacancies, and a 50% increase in vacancies from 2013 to 2015. The Guardian reported in May that the number of nursing vacancies had risen further to 40,000. There are increasing numbers of doctor vacancies and increasing waiting times for GP appointments, treatment and surgery.”*

This is the true strategic context and nature of the problems that need solving. The proposed Right Care Right Time Rght Place reconfiguration is not going to solve these

problems, it is just going to enable and acquiesce in the government's inadequate resourcing of the NHS and hasten its dismantling.

2. FAILURE TO CONSULT ON THE WEST YORKSHIRE AND HARROGATE SUSTAINABILITY AND TRANSFORMATION PLAN

We ask you to investigate the secretive operations of the West Yorkshire and Harrogate Sustainability and Transformation Plan (now Partnership) - which this reconfiguration proposal is seen as a key part of - particularly:

- *the failure to consult on three proposed West Yorkshire and Harrogate Sustainability and Transformation Plan schemes for CHFT (two for planned care and one for vascular servces)*
- *the failure to consult on merging local services into accountable care systems*
- *whether this new business model for the NHS is compatible with the core NHS principle of providing comprehensive healthcare for all who have a clinical need, free at the point of need.*
- *the failure to consult on radical changes to hospital services through the West Yorkshire Association of Acute Hospitals' "Collaborative Programme" approach*

Background: The Sustainability and Transformation Plan elements of the Full Business Case have not been consulted on with the public nor has there been consultation on them with the West Yorkshure and Harrogate Joint Health Overview Scrutiny Committee

The Full Business Case includes two different Sustainability and Transformation Plan/West Yorkshire Association of Acute Trust proposals for planned care, that have not been consulted on or scrutinised by Councillors, and that seem to be contradictory in their implications for workforce and other resources.

The third West Yorkshire and Harrogate Sustainability and Transformation Plan scheme that has not been consulted on, is about vascular services.

The Full Business Case section 3.4 on the West Yorkshire and Harrogate Sustainability and Transformation Plan contains proposals for merging local services into accountable care systems and for radical changes to hospital services through the West Yorkshire Association of Acute Hospitals' "Collaborative Programme" approach, which were not included in the public consultation.

The place for scrutinizing these plans is the West Yorkshure and Harrogate Joint Health Overview Scrutiny Committee, which has been asleep on its watch. It has met only 3 times, most recently in March 2017, and when contacted a couple of months ago, the responsible Scrutiny Officer said there is no date for the next meeting.

West Yorkshire and Harrogate Sustainability and Transformation Plan - vascular services.

The Full Business Case says it includes the additional capacity requirements if CHFT were to be chosen as the second vascular arterial site for the West Yorkshire and Harrogate Sustainability and Transformation Partnership - but the table of “Change in Whole time Equivalent Headcount” (FBC p77) shows a reduction of 14 WTE staff due to West Yorks Vascular collaboration.

This doesn’t make sense, unless it means that CHFT thinks it will lose its existing specialised arterial vascular service in the West Yorkshire Association of Acute Hospitals (WYAAT) reorganisation of the service, which aims to reduce the number of hospitals providing it to 2 ‘hubs’. If this were to happen, CHFT would provide “a fully integrated spoke service.” (FBC, p61.) We have no idea what any of this means.

Additional elective surgery, at an elective “hub” site

Increasing numbers of planned care patients in Calderale and Greater Huddersfield are using private hospitals - either deciding to go private because of delays and restrictions to elective treatments in CHFT, or by CHFT referring patients to local private hospitals because they can’t keep up with patients’ need for operations.

In recognition of this, the Full Business Case includes a new Sustainability and Transformation Plan/ West Yorkshire Association of Acute Trusts (WYAAT) proposal for delivery of additional elective surgery at an elective “hub” site, that aims at:

> “releasing WYAAT providers capacity to undertake additional elective activity that is currently contracted to the private sector...” (FBC, p 61)

This would be done by “using estate and workforce in a flexible model across the WYAAT footprint.” (FBC p133).

The planned care hospital could take this additional elective work (repatriated from the private sector and out of area) by “optimising utilisation of the planned care facilities out of hours and at weekends.”

The Financial Case Upside Sensitivities Table (FBC p 141) seems to show that this additional elective work would be done for private patients, as it is listed as Independent Sector Patient Income, and the notes say that

> “Changes to Commissioning clinical thresholds, growth in regional and national waiting lists is [sic] likely to have an impact on the demand for independent healthcare. The Trust would seek to maximise utilisation of existing resources to

> meet the anticipated growth in independent sector patient income...with this work being delivered through utilising three session days and 7-day services."

The "Change in Whole time Equivalent Headcount" Table shows this additional elective work would require an additional 80 staff. (FBC, p77) The Income and Expenditure table shows that it would generate income of £0.1m in FY19, rising to £1.5m by FY27 and £2.9m in FY42.

Is this a plan to set up a Private Patient Unit? Or would the private patients just use the same wards as NHS patients, at times when NHS patients were not using them, out of hours and at weekends?

The usual justification that trusts provide for establishing a private patient unit is that the income from the unit will benefit NHS patients. However, there is ample evidence that this is not the case and that to generate more revenue most District General Hospitals would be better increasing the numbers of NHS patients they treat rather than establish a more capital intensive PPU.

This needs scrutiny by both Councillors and the public. The public has all along suspected that the Planned Care Hospital would be used for private patients and this cannot go ahead by stealth through the notoriously secretive Sustainability and Transformation Partnership.

West Yorkshire and Harrogate Sustainability and Transformation Plan - standardisation of elective surgery

A new Sustainability and Transformation Partnership/ West Yorkshire Association of Acute Trusts (WYAAT) proposal for standardisation of elective surgery (associated with collaboration with other hospitals) aims to cut costs (FBC p133) as it may enable efficiencies such as reduced length of stay to be delivered and could reduce the workforce required. (FBC, p 61)

The anticipated WTE reduction is 10 in each of years 3, 4 and 5.

The first elective service to get the standardised operating procedure is orthopoedics. The aim is to increase operations and reduce subcontracting to NHS providers, while reducing the total cost of orthopoedic services by between £4.2m and £9m through reducing the total workforce and use of bank and agency staff.

How are they going to do more operations with fewer staff? A look at the Getting It Right First Time (GRIFT) scheme, that this proposal is based on, shows that these standardisation schemes are based on econometric measurements of value for money,

not patients' clinical needs. (Report on the Value Challenge Pilot, HFMA/Healthcare Costing for Value Institute, May 2017)

This raises the question of what happens to patients whose treatment would not represent value for money - that might use more resources than the standardisation scheme allows for.

And if the elective hub goes ahead, using the planned care facilities and staff out of hours and at at weekends for private patients and patients from other areas, it looks as if the planned care hospital could be under a lot of pressure.

Orthopoedics is listed in the Full Business Case as an inpatient service. The Full Business Case doesn't seem to say how many bed days are assumed for orthopoedic patients. But all day case activity in the planned care hospital has been assessed at 0.5 of a bed day for each day case (with the exception of Oncology and Haematology day cases where assessed a 0). This is potentially problematic. An Advanced Nurse Practitioner points out,

> "Haematology patients can become unwell quite quickly so although we did use to take day case patients you may end up needing to find them a bed - so a hospital without capacity for spare beds is a risky business.
>
> Haematology / oncology day case cannot be a flat 0 beds? People do react to chemo and to blood and folk do take unexpected turns for the worse."

Patients would be travelling from the far end of Calderdale to the Huddersfield planned care hospital and if they were to be turfed out without any chance of even a half day in bed to recover, that could be very difficult for them.

Merging local services into accountable care systems

There has been NO public consultation on this proposal.

Accountable Care Systems are a new business model for the NHS and social care in England that is explicitly designed to "manage demand", through the use of fixed capitated budgets that will be insufficient to meet the public's needs and will force the NHS to behave like an insurance company. This will lead to cherrypicking patients by restricting services to patients who offer the best value for money.
This would decisively end the NHS as a comprehensive service for everyone who needs health care. The result will be a limited menu of NHS treatments (just like NHS dentistry.)

Top-up payments and insurance will become essential - but only the relatively wealthy and healthy will be able to afford them. The rest of us will have a second class public safety net like the USA medicare/medicaid system.

This is already starting under STP funding cuts pressures. An Advanced Nurse Practitioner said,

> *"I'm unsure what on earth I can do to reverse the fact that some day soon I'm going to be facing a choice between continuing in health care or saying goodbye to my duty of care & principles. Unless things change soon I know this is a realistic fear, I didn't read that BMA article about controlling demand but as soon as I saw the headline I thought that title is not wrong, people really really can't access the care they need because of ridiculous control mechanisms that just keep coming - it's not clear cut, it's calculated and very complicated."*

Private health care companies and their lobbying organisation the NHS Partners Network explicitly see Accountable Care Organisations as a route to increased NHS privatisation and, as the 2015 Spending Review for the NHS stated, the government is committed to ACOs as means of long term partnerships with private sector (although NHS England keeps quiet about this).

The government's 2015 Spending Review settlement for the NHS committed the government to encouraging long-term partnerships with the private sector in a number of key areas including:

- development of new models of care including Accountable Care Organisations
- the upgrade of diagnostic capabilities
- hospital groups and acute care collaborations.

The NHS and social care will open even wider to privatisation and corporate control, increasing costs, extracting profits and worsening working terms and conditions for staff. The end of fair and equal health care for all will tear apart the social fabric of our country.

The care models and "modern workforce" that ACSs/ACOs will deliver are unevidenced and not in the public interest or the interest of the NHS - as the referral of the Right Care Right Time Right Plance proposals to Sec of State show.

STP- wide commissioning decisions about cuts and centralisation and networking of hospital clinical and non-clinical services are to be taken by a Joint Clinical Commissioning Committee that can force binding decisions on individual CCGs; and despite the fact that CCGs and Local Authorities are meant to run integrated commissioning, the Joint Clinical Commissioning Committee excludes local authorities.

A recent local government association survey showed that there is no agreement between local authorities and the NHS about STPs. Given this, how can STPs set up ACSs that are to include both LAs and CCGs that will have responsibility for delivering all the community/ social care/public/primary health services for their area and apparently the hospital services too?

The shortcomings of local authorities when charged with delivering public private partnerships are evident in massive social housing failures. This bodes ill for how they will deliver public private partnerships for health and social care.

Radical changes to hospital services through the West Yorkshire Association of Acute Hospitals' "Collaborative Programme" approach

These proposals came like a bolt from the blue to most members of the public - basically to everyone who doesn't spend time poring over CHFT Board papers and minutes. We still have not been able to get our heads round them.

The proposed changes seem massive. They include five key areas of work.

One is "developing a **'Centres of Excellence'** approach to higher acuity specialties e.g. hyper-acute stroke, neurology, cancer, vascular, ENT, eliminating avoidable cost of duplication and driving standardisation." (Full Business Case, p28)

We don't really know what a Centres of Excellence approach is, although Leeds Teaching Hospitals Centre of Excellence webpage says http://www.leedsth.nhs.uk/about-us/our-services-and-specialities/centre-of-excellence/ Centres of Excellence provide specialist services commissioned by NHS England.

However the Full Business Case seems to say (p28) that from April 2017 NHS England wants to hand over specialist commissioning to STPs. Since STPs don't actually exist as an entity, being a network of relationships between NHS organisations and local authorities, it is hard to see which of these organisations would be responsible for commissioning specialist health services.

A clue may be offered by the Naylor Review, which states that the creation of Accountable Care Organisations (ACOs) responsible for all health care for a given population would overcome the conflicts of interest that currently exist between the "advisory" role of STPs and the statutory responsibilities of NHS provider trusts. An ACO would incentivise acute providers to invest property assets in primary, community and mental health services, alongside private investors, and so enable more patients to be treated closer to home in line with the 5 Year Forward View.

As an ACO becomes a stand-alone, standardised, "public-private partnership", we will have lost the sense of any National Health Service. With Naylor, we will lose a lot of our public assets and public wealth into private pockets. I guess that's the point.

What effects would a Centres of Excellence approach have on CHFT, which currently provides a number of specialist services including vascular surgery and vascular interventional radiology services, neonatal intensive care, HIV, chemotherapy, bone anchored hearing aids (BAHA), cardiac MRI, and implantable cardiac devices? Would

those services be lost, so patients and families had to travel out of the area to Leeds, Bradford or Wakefield, which as the biggest WYH hopsitals would be most likely to be a Centres of Excellence?

We are worried to see that - as the £1bn funding hole opens up in the West Yorkshire and Harrogate NHS and social care services - a Centre of Excellence like Leeds Teaching Hospitals is boosting its private practice and taking funding from an American-owned private care company.

Already Leeds Teaching Hospitals Cancer Centre has a "partnership" with an American-owned private health company, to provide private cancer care in its hospital. https://finder.bupa.co.uk/Hospital/view/90768/nova_healthcare_limited

In August it was forced to apologise for sending terminally ill cancer patients adverts for the "latest technologies" available through the private Novacare cancer clinic, that suggested they would get better treatment there than on the NHS. http://www.independent.co.uk/news/health/nhs-sends-terminally-ill-cancer-patients-adverts-for-private-care-leeds-teaching-hospitals-trust-a7879151.html

Leeds Teaching Hospitals also offers a new private prostrate cancer service at the Leeds Prostate Centre, which provides advanced robotic surgery for private patients. http://www.htieu.com/news-articles/4-cancer-care-specialists-unveil-plans-for-growth-after-leeds-deal?lightbox%5Biframe%5D=true&lightbox%5Bwidth%5D=720&lightbox%5Bheight%5D=560 This discovery prompted a Kirklees nurse to ask

> *"I've never known such appointments being offered for prostate before. Have you? I wonder if we are losing NHS services by stealth? In view of this super prostate hospital. I thought Bradford was the specialist in prostectomy(robotic surgery) etc not Leeds?"*

As mentioned in the previous section, the government's 2015 Spending Review settlement for the NHS committed the government to encouraging long-term partnerships with the private sector in hospital groups and acute care collaborations. We find it very worrying that this is not mentioned in the Full Business Case section on the West Yorkshire Association of Acute Hospitals' "Collaborative Programme" approach.

A second key work area for the West Yorkshire Association of Acute Hospitals' "Collaborative Programme" is "Developing West Yorkshire and Harrogate **standardised operating procedures and pathways across services**, building on current best practice and using "Getting it Right First Time" (GIRFT) to drive out variations in quality as well as operational efficiency and facilitating safer free movement of bank staff across providers."

As outlined in the section above on West Yorkshire and Harrogate Sustainability and Transformation Plan - standardisation of elective surgery, the Getting It Right First Time

(GRIFT) standardisation scheme is based on econometric measurements of value for money, not patients' clinical needs.

And what will bank staff feel about moving "freely" from Pinderfields to Harrogate or Halifax to Airedale?

The third key work area for the West Yorkshire Association of Acute Hospitals' "Collaborative Programme" is "developing develop clinical networks and creating alliances as a vehicle (e.g. hyper acute stroke, cancer etc.)...the model being based on the 'chain' concept."

We had to look up what a **hospital chain** is. It turns out to be big hospitals providing specialist services in smaller hospitals that are distant from the big hospital. Eventually it could lead to the takeover of smaller hospitals by larger ones. http://www.nationalhealthexecutive.com/News/four-foundation-trusts-to-begin-taking-lead-on-hospital-chains/148341 So far, NHS Improvement has given four hospitals trusts the power to take the lead on setting up hospital chains: Guy's and St Thomas', Northumbria Healthcare, Royal Free London and Salford Royal NHS FTs. The four trusts are trialling different methods of collaboration, including buddying, partnerships and federations, as well as more formal consolidation through mergers and acquisitions.

The implications of this seem pretty huge but there has been no consultation on it.

Let's just say the experience of academy chains doesn't set a good example.

3 .PROJECTED SHORTAGE OF CLINICAL INCOME

We ask you to investigate whether the clinical contracts would make it impossible for all patients to access treatments for which they have a clinical need, free at the point of need; - whether hospital- based services, or hospital services that have been moved into the "community".

Specifically:

- *The effects on patients of the "commissioner affordablity gap" - ie the fact that the Clinical Commissioning Groups do not have enough money to pay for the services CHFT thinks it needs to provide.*
- *The effect on CHFT and patients of Calderdale Clinical Commissioning Group's intention of providing Community Services (aka "Care Closer to Home") on the basis of a capitated budget, via an Accountable Care Organisation. (Slide 13, Calderdale Locality STP (October 2016) - which the Full Business Case doesn't mention, as far as we can see.*

Background: a "commissioner affordabilty gap" and Calderdale CCG's plan to provide community services through an Accountable Care Organisation both threaten the ability of patients in Calderdale and Kirklees to access the comprehensive range of NHS treatments and services

Clinical Commissioning Group's shortage of money

A shortage of clinical income is shown in the projected contracts between the Clinical Commissioning Groups and CHFT. The CCGs and the Trust are working on the basis of different figures for the hospital services contract for the five years to 2021/22. This is basically because the CCGs are broke and under special measures and are trying to cut their spending (which they call QIPP). CHFT is also broke and says they and the CCG have "different QIPP assumptions". It boils down to the CCGs trying to get CHFT to provide services for less, and CHFT trying to get enough money from the CCGs to keep hospital ship afloat.

The variance between what Calderdale CCG plans to spend and what CHFT wants to receive as clinical income from the CCG is: FY18 - £5.7m short; FY19, £8.5m short; FY20, £11.4m short; FY 21, £12.8m short; FY22, £12.0m.

The variance between the GH CCG and CHFT clinical income values is FY18 - £5.8m short; FY19, £8.6m short; FY20, £9.1m short; FY 21, £8.9m short; FY22, £6.5m.(FBC section 12.5.4 Commissioner Affordability, p124.)

The Full Business Case points out (p124) that the "commissioner affordability gap" grows by £7m between FY18 and FY22. It also says that CHFT is committed to cutting spending through QIPP (efficiency cuts) and that the £7m - which we would call underfunding - will be "resolved" by removing the costs that put CHFT out of kilter with its income from commissioners.

Well I think that's what the Explanation of Table of clinical income values per commissioner Table means. It is hard to understand the CHFT jargon.

healthcare sector. The following table sets out the clinical income values per commissioner over the five year period.

£m	FY17	FY18	FY19	FY20	FY21	FY22
Year	**Yr 0**	**Yr 1**	**Yr 2**	**Yr 3**	**Yr 4**	**Yr 5**
CHFT Greater Huddersfield CCG Income	123.7	124.4	125.2	125.5	126.9	125.4
CHFT Calderdale CCG Income	139.6	139.3	139.7	140.5	141.7	140.3
CHFT Clinical Income	**263.3**	**263.7**	**264.9**	**265.5**	**268.6**	**265.7**
Greater Huddersfield CCG	123.7	118.6	116.6	116.4	118.0	118.9
Calderdale CCG	139.6	133.6	131.2	128.6	128.9	128.3
CCG Clinical Income	**263.3**	**252.2**	**247.8**	**245.0**	**246.9**	**247.2**
Greater Huddersfield CCG variance	-	(5.8)	(8.6)	(9.1)	(8.9)	(6.5)
Calderdale CCG variance	-	(5.7)	(8.5)	(11.4)	(12.8)	(12.0)
Difference	**-**	**(11.5)**	**(17.1)**	**(20.5)**	**(21.7)**	**(18.5)**

FBC Explanation of Table of clinical income values per commissioner

For FY17 the Trust and Commissioners agreed a financial position for the year, reflecting the activity commissioned and provided for the year. The difference in assumptions between the Trust and its two main commissioners arise as a consequence of the financial constraints facing each of the commissioners. Each of the CCGs have QIPP plans to reduce activity for the Trust and drive down the overall cost of healthcare spend over the five year period. The Trust and commissioners have planned for different contract values in FY18 due to differences on QIPP assumptions. The financial impact of this difference is reflected throughout the five year period.

The Trust is committed to delivering a financially sustainable solution for the health sector in West Yorkshire. Through the Calderdale and Greater Huddersfield Transformation Group the Trust is working with commissioners to identify and deliver QIPP that delivers financial savings for the health system i.e. both the commissioners', and providers', expenditure is reduced through the delivery of the QIPP.

It is key to note that the commissioner affordability gap grows by £7m between FY18 and FY22. Over 50% of the overall affordability requires in year resolution. It is assumed that as the £7m is identified, costs will be removed at 100% rate.

Whether or not we have understood the detail, we have grasped the general point that there is a growing "commissioner affordability gap" (which we call government underfunding of the Clinical Commissioning Groups).

We fear the effects this would have on the basic principle that the NHS provides a comprehensive service to everyone who has a clinical need for treatment, free at the point of need.

Specifically, we fear that patients' access to hospital services will be reduced through a variety of means, including referral management services' elimination of many GP referrals, and the application of value for money assessments for treatments and the patients who are to receive them, based on systems used by American insurance companies and Accountable Care Organisations.

Effect On CHFT Of Calderdale CCG's Intention Of Providing Community Services (aka "Care Closer To Home") On The Basis Of A Capitated Budget, Via An Accountable Care Organisation

The Full Business Case financial case for changes makes no mention of the likely effect on CHFT of Calderdale CCG's intention of providing Community Services (aka "Care Closer to Home") on the basis of a capitated budget, via an Accountable Care Organisation. (Slide 13, Calderdale Locality STP (October 2016).

Since CHFT would be included in this Accountable Care Organisation, and would move many hospital services into the "community", we ask you to investigate the effects of this on CHFT's contracts, its financial case for change, and patients' access to both hospital care and hospital services that would be moved into the community.

4. OPENNESS AND ACCOUNTABILITY OF STAKEHOLDER GROUPS, AND CHFT'S RELATIONSHIPS WITH THE PUBLIC, JOINT HEALTH SCRUTINY COMMITTEE AND NHS COMMISSIONERS.

We ask you to investigate:

- *Whether the proposed Governance arrangements to communicate with and involve all the groups and organisations affected by the hospitals reconfiguration would help to dissolve the justified distrust, frustration and disgust that have built up among members of the public who have tried in good faith to scrutinise the proposals and take part in the public consultation.*
- *Whether in future they would enable clear open and honest multi-directional communication between all involved.*
- *Whether and how it is possible for all the Stakeholder groups in the Management and Governance structure/process to be open, honest and accountable. Or,*
- *Whether that has been rendered impossible by the fact that NHS institutions, as currently constituted by the 2012 HSCA and various subequent statutory instruments that have modified these organisations and their relationships without Parliamentary scrutiny, have been designed by stealth to bring in the market and force through the " reconfiguration " of healthcare to that end.*

Background: many failures of openness and honesty

Given the pressures from central government and its quangos, we cannot entirely blame the Trust for the many failures of openness and honesty in the process of developing and consulting on the reconfiguration plans, although they have not helped themselves much.

But the Trust has been less than open and honest with the public and our elected representatives on the Scrutiny Committee - although we welcome their decision to publish the unredacted Full Business Case (albeit too late for the Joint Health Scrutiny Committee meeting which referred the NHS reconfiguration plans to the Secretary of State). In the end, though, they are only the messenger.

As explained in Section 1, above, we reject the message - clouded by smoke and mirrors - that the Trust has felt compelled to obey: that the future of the NHS involves huge cuts and significant increases in privatisation; and that even the public bits of the NHS, like our hospitals, are set up as independent businesses and operate as if they were commercial entities, with the appeal to commercial confidentiality and lack of democratic accountability that this brings.

The urgent need is to restore adequate funding and reinstate the NHS as a fully publicly owned, run, funded and provided service, that is free at the point of need and provides the full range of evidence-based treatments to everyone with a clinical need; with all market

structures and processes removed from it, and with direct accountability to the Secretary of State, whose duty to promote and provide these services would be restored.

Until that happens, efforts to make sure that NHS organisations are democratically accountable, at national and local levels, and communicate and cooperate effectively with each other, staff unions. patients, public and our elected representatives, will only achieve partial success.

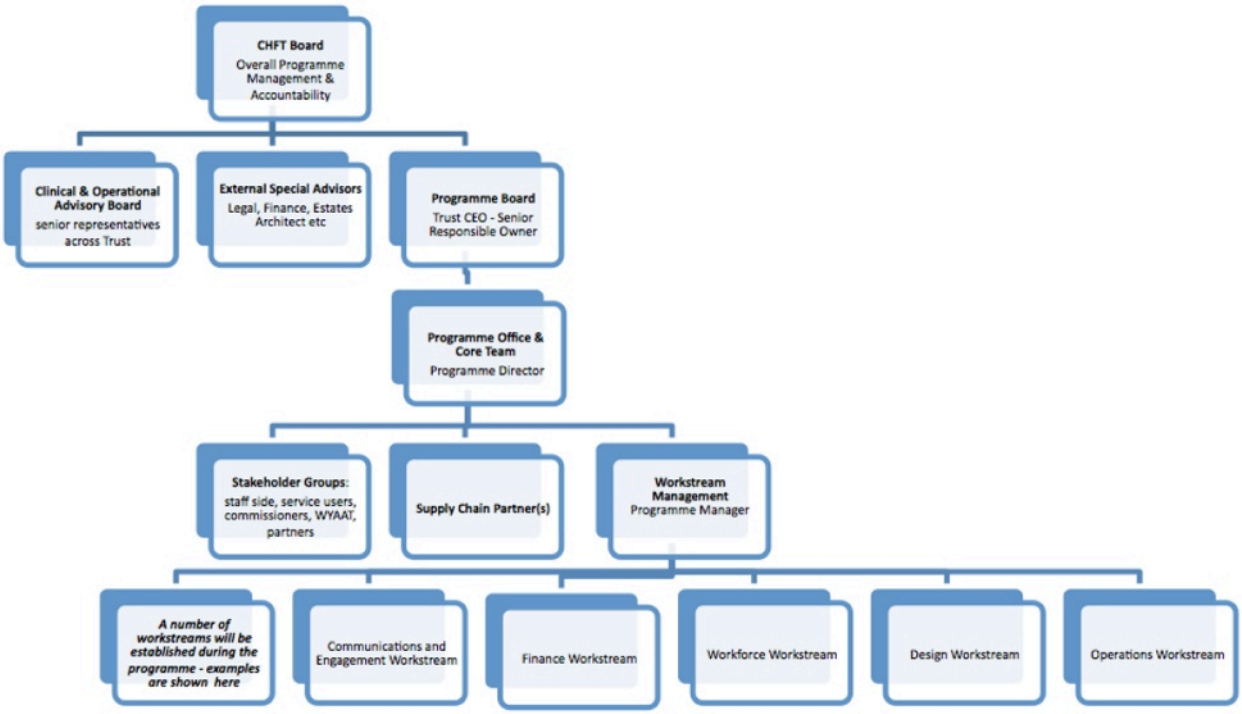
But partial success is better than outright failure and that is why we ask you to investigate Management and Governance arrangements, in particular the Stakeholder Groups arrangements.

Apart from staff-side groups, all the Stakeholder Group meetings shoud be held in public, including West Yorkshire Association of Acute Trust (WYAAT) meetings - even though the CHFT Secretary has said,

> *"I don't think we are yet in a position where decisions relating to acute care are being made regionally. It certainly feels like we still retain our own decision making powers as all decisions have to be ratified by individual Trust boards and WYAAT is not a legal entity. Anyone interested would only need to keep an eye on their own local Trust board as we all take the same information whether or not we approve it.*
>
> *I think the position is definitely different for commissioning where we are seeing more decisions being made on a regional basis – stroke being a good example. Clearly this may develop over time and obviously at that point, for good governance and transparency, we would want to reconsider our decision regarding meetings in public."*

The reason for nonetheless holding WYAAT meetings in public is that minutes of meetings and information distributed to individual Trust Boards are not the same as attending a meeting and making your own notes about who said what and what wasn't said. We know this from years of attending meeting and then reading the minutes.

A public group should be added to the Stakeholder Groups (see organisation chart, below).


CHFT Board
Overall Programme Management & Accountability
Clinical & Operational Advisory Board
senior representatives across Trust
External Special Advisors
Legal, Finance, Estates Architect etc
Programme Board
Trust CEO - Senior Responsible Owner
Programme Office & Core Team
Programme Director
Stakeholder Groups:
staff side, service users, commissioners, WYAAT, partners
Supply Chain Partner(s)
Workstream Management
Programme Manager
A number of workstreams will be established during the programme - examples are shown here
Communications and Engagement Workstream
Finance Workstream
Workforce Workstream
Design Workstream
Operations Workstream

5. TRUST BOARD

With regard to the Trust Board, we ask you to investigate:

- *Membership Council governors' awareness of their statutory roles and responsibilities and additional powers,*
- *whether and how they have exercised them during the last few years when the reconfiguration proposals have been in development, and*
- *how their exercise of their roles, responsibilities and additional powers could be improved.*

Background: At least some Membership Council governors seem to have been under the impression that they had no powers to do anything about the reconfiguration proposals. But when you look at the 2006 NHS Act and the 2012 Health & Social Care Act, they have what look like quite significant powers and responsibilities. They need to exercise them fully.

6. WORKFORCE PLAN

We ask you to investigate and establish:

- *the reason/s for near-total absence of a community services workforce plan from the Workforce Plan in the Full Business Case,*
- *the community workforce requirements of the Calderdale Care Closer to Home scheme*
- *the local community service staff training needs for both Calderdale and Greater Huddersfield*
- *the lack of a primary care strategy that has GPs' and other primary care staff backing*
- *the claim (p74) that the proposed reconfiguration will improve recruitment and retention of clinical staff within key hospital and community specialties;*
- *the workforce planning assumption that an outpatient services review will help deliver new models of care and reduce follow-up appointments for existing patients with long-term conditions, while CHFT works with mental health, primary and social care and other local provider services to "develop efficiencies in service provision." FBC p 76)*

Background: Workforce plan and implications

Monitor and PwC have told the Trust to tackle the high workforce spending required by two District General Hospitals (and also to deal with the massive PFI costs), by turning one DGH into a planned care hospital and the other into an acute and emergency hospital, while optimising the utilisation of the Trust's PFI and non-PFI estate.(FBC, p95)

CHFT's Full Business Case notes workforce "challenges" due to national staff shortages and NHS underfunding, but - in line with Monitor's and PvC's directions - misattributes the cause of their staff recruitment and retention problems to the fact that the Trust runs 2 DGHs each with a 24/7 Type 1 A&E.

As a result, their workforce plan is about controlling the symptoms, not tackling the cause of the disease of underfunding, stealth privatisation and a total lack of effective workforce strategy that that the government has inflicted on the NHS.

By workforce "challenges", they mean they haven't got enough staff, they have problems with recruitment and retention and they are spending A LOT on agency staff and have been told to cut that drastically starting this year.

The Workforce plan aims to solve the problem of not having enough staff and money by a 479 reduction in CHFT WTE staff over next 10 years, through natural turnover. This will save CHFT about £30m on its paybill.

It also states that recruitment and retention will be improved by dismantling the two DGHs and replacing them with one small planned care hospital with outpatients and urgent care centre and one acute and emergency hospital, as this will make CHFT a more attractive place for doctors to work.

But this has not been the case at Pinderfields Hospital in Wakefield, where the Mid Yorks Trust is a few years ahead of CHFT in a similar reconfiguration and is now "haemorrhaging" consultants, in the words of N Kirklees Support the NHS deputation to Calderdale and Kirklees Joint Health Scrutiny Committee (CKJHSC) at the July 21st 2017 meeting.

Other cost-cutting measures - including "delivery of skill mix" - in other words replacing highly qualified clinicians with new grades of less qualified staff - mean that workforce spending goes down year on year for the next 10 years and by 2042 is only slightly higher than it is now. (In contrast, the drugs bill more than doubles over the same period.)

479 is a lot less than the 966 wte reduction modelled in CHFT's 5 year strategic plan, and which is the number consulted on - this does make us wonder if they are just pulling figures out of a hat. Because what has happened to change the number of necessary staff, between now and the preparation of the 5 Year Strategic Plan last year?

CHFT's FBC proposes these measures to make it possible to do with 479 less staff than at present:

• service reconfiguration and redesign;
• recruitment and retention;
• new professional roles;
• job evaluation;
• staff utilisation and productivity.
(FBC pages 9 & 72)

There is next to nothing on community services workforce plan

Calderdale and Huddersfield NHS Foundation Trust (CHFT) is a hospital AND community services provider, but the workforce plan section of the Full Business Case says almost nothing about the community service workforce implications of the proposed reconfiguration.

The failure to include community service staff in the workforce plan is a gaping hole. Why? Particularly when we have come across this advice (that we think may be from the Independent Review Panel, although we did not remember to bookmark the link):

- The focus on acute care provision should not overshadow the need to strengthen primary care
- Local discussion often centres on beds as a representation of investment and capacity – the debate should focus more on creating a viable workforce for primary and community services

The omission is particularly dire given the overstretched and understaffed community services in both Greater Huddersfield - where Locala provides community health services that need improvement, according to the recent Care Quality Commission report - and in Calderdale.

District nurses need to account for every minute of their time – every activity is allotted time, from accessing notes to patient care and travel. It is demoralising and time consuming. Their laptops are poor and as they are out and about, the notes they are supposed to write end up as home work, with nurses reporting that they often are writing notes at 9.30pm.

Recently-retired Calderdale Community Matron Anne Marie Hutchinson said,

> "Working with vulnerable clients with inadequate resources is hell on earth. You cope initially by doing unpaid overtime then you burn out. I was lucky, my retirement date came and I took the opportunity to get out. Still feel guilty about those left behind!"

It is essential to have the right numbers of staff with the appropriate levels of training and skills in the community to care for sicker patients with more complex care needs. Qualified District Nurses need to be a key element in this work-force, co-ordinating and supervising other less qualified members of the Community Nursing Team.

Nationally, there are only half the number of District Nurses there were in 1997, and a third of those remaining are over 50 years old. The numbers being trained nationally are inadequate, and in 2016 12% of the training places were unfilled, with Health Education England citing "a reduced calibre of students and availability of placement capacity", presumably as a result of lack of Community Practice Teachers within the stripped down Community Nursing Teams. (Understanding Quality in District Nursing, King's Fund August 2016)

There is no evidence that CCGs have embarked on a locally-driven process of training up sufficient District Nurses to support the massive changes planned in the numbers of sicker patients in the Community. It will not be possible to attract ready-qualified District Nurses

from other areas – Calderdale and Greater Huddersfield will need to grow our own – and that takes time, so the gearing up needs to start now. But it doesn't seem to be.

Recently-retired CHFT consultant Colin Hutchinson told the Calderdale & Kirklees Joint Health Scrutiny Committee,

> "Do not be reassured that larger numbers of less qualified staff will make up for the shortage. There is very good evidence that the levels of qualified graduate nurses makes a very big difference to hospital death rates and to the speed of patient recovery, the most recent being published this month in the BMJ Quality and Safety, 'Nursing skill mix in European hospitals, by Aiken L.H. et al.. When such patients are being cared for in their own homes, there is every reason to believe that the close involvement of graduate nurses would be even more critical."

Disregarding these vital points, the Full Business Case limits itself to:

- a claim (p74) that the proposed reconfiguration will improve recruitment and retention of clinical staff within key hospital and community specialties; and
- a key workforce planning assumption that an outpatient services review will help deliver new models of care and reduce follow-up appointments for existing patients with long-term conditions, while CHFT works with mental health, primary and social care and other local provider services to "develop efficiencies in service provision." FBC p 76)

At the July 2017 meeting, the Calderdale and Kirklees Joint Health Scrutingy Committee rubbished the CCGs' lack of a primary care strategy and the Kirklees Local Medical Committee (LMC) secretary Dr Bert Jindal complained that the LMC had not been involved in any discussions about the reconfiguration proposals or the FBC. Among their many concerns, the LMC are worried about the impact of a greater workload on GP services and community nursing. There is a workforce crisis in General Pratice nationally and not enough staff to run existing GP services and primary care.

On top of all this, we are worried that the omission of community services workforce planning from the Full Business Case may mean that CHFT are assuming that they will lose the community services contract/s when the Calderdale Accountable Care System is set up (FBC p26; October 2016 Calderdale locality Sustainabiity and Transformation Plan)

7. HOSPITAL BED CUTS

We ask you to investigate:

- *Whether cutting 105 hospital beds is feasible (which would account for 150 WTE job losses, or 22%) and find out why the hospitals Trust have not provided the necessary evidence to support their bed cuts plan.*

- *The hugely optimistic assumption of a 6% reduction in emergency admissions every year for 5 years. Just for comparison, over the same period, the West Yorkshire Sustainabilility and Transformation Partnership overall is only planning a 4% reduction in emergency admissions in total by 2020/1 (p57, West Yorkshire & Harrogate Sustainability and Transformation Plan).*

- *Whether the Care Closer to Home patients would pay for community support using means-tested personal social care budgets as well as non-means tested personal health budgets/continuing health care payments.*

- *The basis for any judgement about what part of Care Closer to Home patients' community support would be subject to means-tested social care, on the basis that it was personal social care, not NHS care.*

Background: There is no evidence that cutting 105 hospital beds is feasible; past experience of hospital bed cuts suggests otherwise

The workforce capacity modelling in the Full Business Case takes account of a **105 bed reduction** by 2021/22 delivered by **improved pathways that enable admission avoidance and reduction in length of stay.** This would account for 150 of the WTE job losses (FBC p77).

The public consultation only identified 77 bed cuts - the difference is mostly accounted for by the reduction of planned care hospital beds to 64 in the Full Business Case.

The FBC has recourse to "belief" and likelihood" to justify the assumption that it can cut 105 hospital beds - it says (p 73) they BELIEVE that the proposed reconfiguration will "maximise" the opportunity to increase workforce efficiency and sustainability, so that CHFT can comply with workforce standards & be able to comply with 7 day working & deliver speciality rotas - particularly for ED, acute medicine, critical care, paediatrics and radiology. (FBC p75) This is "likely" to make it easier to recruit and retain staff, so reducing agency staffing/costs.

Belief and likelihood are not evidence - and it is not clear that there is any reliable evidence to support the assumption that the 105 bed reduction is safe or that new "pathways" will enable admission avoidance and reduction in length of stay.

The ability to cut 105 beds is based on a **hugely optimistic assumption of a 6% reduction in emergency admissions <u>every year</u> for 5 years**; this would have a cumulative effect of a 27% reduction over this period. Just for comparison, over the same period, the West Yorkshire STP overall is only planning a 4% reduction in emergency admissions in total.

Are the other areas of West Yorkshire simply lacking in ambition? Or are the plans for 105 bed cuts - more than the 77 bed cuts that were consulted on - going to place us from a state of intermittent crises to a situation of never-ending crisis?

Running hospital services with inadequate bed numbers is not efficient. It is not cost-efficient. It leads to staff wasting their time playing with the Rubik's Cube of moving patients around to try and find a bed - any bed - to accommodate their patients, rather than getting on with the business of caring for them.

It leads to ambulances and their crews backing up in hospital car-parks, rather than being out on the road attending to the next patient. It means that patients are admitted to inappropriate beds, remote from the medical teams that are caring for them, as the CQC noted in their report.

The Clinical Senate said the Care Closer to Home and hospital services reconfiguration proposals are aspirational and they cannot give any assurance that they will result in patient care of the required standard.

Unison's Sustainability and Transformation Plan Briefing points out that while moving care closer to home may have the potential to produce benefits for patients,

> "they have traditionally proved hard to deliver and are unlikely to produce substantial costs savings, even in the longer term."

The experience of the **NHS mental health trust (South West Yorkshire Partnership Foundation Trust) and Calderdale Council's Rehabilitation and Recovery Service is instructive**. They announced their aim to move patients out of rehab and recovery accommodation into their own homes, supported by *'a flexible community offer'* – whatever South West Yorkshire Partnership Foundation Trust might mean by this.

Calderdale Council proposed that mental health patients would pay for this community support using means-tested personal social care budgets and non-means tested personal health budgets

Is this what is going to happen to non-mental health patients under the Care Closer to Home scheme? That they will be made to pay for community support on the basis that it is personal social care, not NHS care?

A recent court case shows that the NHS is already trying to engineer this by saying that personal care is not a “nursing need”, so the NHS should not have to pay for this as a lower qualified assistant could do it.

Accessing the continuing care budget is already very difficult - one of our grandmas was all but dead by the time they decided her needs were "nursing". But more and more patients will come to rely on it as a result of cuts to hospital beds. We cannot accept this as a desirable direction of travel. It undermines patients’ free access to NHS services at the point of clinical need - as their needs are increasingly being redefined as “personal care”.

The Mid Yorks reconfiguration plan in 2014 included downgrades to Dewsbury District Hospital and its A&E, but the **Dewsbury hospital bed cuts plans have had to be shelved because they were unrealistic.** The Star Chamber recommendations say that this is “despite work to develop enhanced services outside hospital settings” – aka care closer to home.

The Mid Yorks plan was to reduce beds across the system from 1148 to 985 - but events have shown that the bed modelling was based on false assumptions, as the Mid Yorkshire Hospital Trust Chief Executive Officer admitted on 2 February 2017.

A recent review of the bed modelling has taken account of demand and capacity, length of stay and changes to the assumptions about drive time (where people picked up by ambulance would be conveyed) and concluded that 1118 beds are required - a reduction of 30, not 163 as planned in the Full Business Case.

The example of mental health trusts’ bed cuts some time ago does not inspire confidence either. They cut beds, then found they needed them, haven't got the money to reopen them or build new mental health hospitals, and so are increasingly reliant on private mental health hospitals and beds.

There is now a massive shortage of NHS beds for mental health patients in Calderdale and Greater Huddersfield. In financial year 2015/16, Calderdale CCG paid £1,612,525 to 5 private mental health companies for mental health hospital and care home services. Rosemary Hedges, a retired NHS mental health worker, comments:

> “These are truly shocking statistics. When Storthes Hall Mental Hospital in Huddersfield closed in 1989 the health authority reprovided 76 inpatient beds, a 14 bed rehab hostel and a 22 bed long stay facility. That was just for one health

district. By 2010 they had all gone. Now we pay through the nose to provide profits for private companies. It's a disgrace."

8. REVIEWED SKILLS MIX/NEW PROFESSIONAL ROLES

We ask you to investigate:

- *The high risk that the reviewed skills mix/ new professional roles are unlikely to provide good quality, safe patient care*
- *The appropriateness of increased use of voluntary work and community involvement in both hospitals, which is part of the workforce plan*

Background: The reviewed skills mix/ new professional roles are unlikely to provide good quality, safe patient care

All wards will have **minimum nurse to patient ratios** of 1:8 daytime and 1:10 night, with the exceptions of ITU; Level 2 = 1:2, Level 3 = 1:1 and Paediatric wards 1:4. However, the FBC Workplan does not say if these are all registered nurses or not. This is crucial to patient safety.

Recent research has found increased rates of patients' deaths in hospital following common surgical procedures, on wards with low numbers of registered nurses – where, as a result there is also a higher incidence of necessary but missed nursing care. A report in the International Journal of Nursing Studies (http://dx.doi.org/10.1016/j.ijnurstu.2017.08.004) concluded that analyses of data from the RN4CAST study (2009–2011) supported the hypothesis that missed nursing care is the reason why there is an increased risk of patient mortality on wards with low numbers of registered nurses.

But the FBC Workplan says use of a **reviewed skills mix** will be critical to the delivery of the new models of care across the planned and un-planned care sites. In other words, new grades of less qualified clinical staff will replace more highly qualified professionals.

12 x 2-year qualified-Physician Associates will be recruited for each of the next 3 – 4 years, if local higher education institutions can provide the training and the workforce can be released or recruited to fill these roles. The same goes for emergency care practitioners (ECP), operating department practitioners (ODP) and nurse associates and nursing assistants at band 4 - although these can be delivered internally as a personal development route for staff through apprenticeships. Altogether this adds up to around 192 lower qualified clinical staff/year or 768 over 4 years.

FBC p78/79 says

> "Skill mix / role improvements: the Advanced/Extended scope Practitioner role will be further refined and deployed in the Trust to reduce reliance on the middle-grade

> doctor workforce across many specialties including ED, acute medicine, and paediatrics."
>
> "There may also be opportunities to gain additional economies of scale in medical services where the use of advanced practitioners operating in new care pathways, can be used to fill difficult to recruit middle and junior grade doctors."

Nurses we have discussed this with are not happy about the idea of replacing middle and junior doctors with advanced practitioners. One Calderdale ANP said:

> "Advanced nurse practitioners are not doctors and we cannot be replacements for doctors but we can supplement the skill mix. Different nurses have different experience and some have been trained through the hospitals more recently so they have done the work of a junior house officer in rotation in some cases. We can independently see, diagnose and treat a range of undifferentiated conditions but still I don't believe we can replace.
>
> "Staffing the cold site urgent care centre with ANP's/ENP's who can only liase remotely with A&E on the hot site is a huge worry. When you read what they say will come through the doors of an urgent care centre it doesn't sound too much - but when a poorly person has the choice of making it to the closest place or not making it further, anything could and will walk through that door."

CHFT are saying the urgent care centre could be provided by another provider, and if it were, CHFT would lose 13 staff (FBC p77). Which 13 staff would that be? Plus, for two urgent care centres there is no way 13 staff is enough.

Each of the staff needs two days off and you need about 6 working each of the 7 days on an 8-8 service. Overnight they will need at least two overnight at each - and this is a very rough calculation based on walk in centre figures from wakefield with pinders A&E nearby.

9. JOB EVALUATION

We ask you to review how to make sure that nursing remains an art that involves nursing the whole person, whatever their needs - particularly since nurses whom we have spoken to say that the proposed job evaluation will destroy everything that epitomises nursing - that is, to provide all nursing care from basic care upwards.

Background: Job evaluation is likely to destroy everything that epitomises nursing

The FBC says that competency based job evaluation to ensure clinical staff are practicising to the full extent of their education and training and not doing jobs that could effectively be done by someone else will generate the opportunity for new roles to be created, enabling skill and grade mix workforce changes. (FBC p9). Job Evaluation would account for 136 of the lost WTE jobs. (FBC p77)

Nurses among us think this is a very bad idea. One said,

> "Not to be able to do things for patients that others on a lower grade can, destroys all that epitomises nursing - that is to provide all nursing care from basic care upwards. We nurse the whole person, whatever their needs. I simply hate this proposed idea that a nurse can be too well qualified to take a patient to the toilet or assist them to eat! You can be underqualified for tasks but not overqualified. I hate the way the NHS is going."

At least 136 Whole Time Equivalent jobs are due to go through Job Evaluation, although there are likely to be more. (The 136 figure comes from the Full Business Case table of "Change in Whole time Equivalent Headcount", which is for only years 3-10 and does not include figures for Years 1-2.) CHFT sent figures for Years 1-2 separately to NHS Improvement. The Full Business Case notes that WTE job losses in the workforce plan for the first two years are double the number for years 3-10. (Full Business Case, p77)

A Calderdale nurse said,

> "It sounds like everyone will be frightened for their job, needing to look important at all times and applying for their own job, if not their own job on a reduced grade.
>
> This is already happening. Often specialist nurses are on band 5 & 6 grades. Historically, specialist nurses like Macmillan nurses, pain specialist nurses or diabetic specialist nurses were at least a band 7 – most often band 8 (the old junior/ senior sister level).
>
> These same jobs are now sometimes advertised on a band 5 or a band 6 which is entry level staff nurse or Senior staff nurse level. But these specialist roles involve

independent work, advising a range of other professionals, lots of education and big case loads requiring lots of knowledge.

On a band 5 you wouldn't get interest from more experienced staff for that pay, so inexperienced nurses take the roles.

The palliative care nurse at work seemed worried at our last meeting, she said they were being asked to ensure their duties were appropriate to grade so she had to be doing more education and more delegation. We have been here a few times if you ask around – lots of managers in the community needed to reapply for jobs.

They will chop roles, reinvent a reduced number of new ones so 5 senior positions become 2 or 3 new positions and then they all have to apply for the remaining few jobs. All makes for unhappy staff."

Downgrading the profession

The entire definition of nursing has been called into question in a recent court case about who should fund the qualified nurses in Care homes and in the continuing care budget; it appears that the "NHS" argued that they don't need to fund the entire nurse pay if that nurse is doing "personal care."

This could be incredibly important for nursing and fuel the current agenda of downgrading the profession. If they can redefine what is a nursing need, they not only avoid the expense of many nursing home and hospital beds but take away the entire art of care side of nursing, leaving it as a clinical task orientated entity.

Calderdale and Huddersfield NHS Foundation Trust is desperately short of nurses and as a result has a lot of agency staff, which cost £20m in 2016/17.

Government must increase the number of nurses and bring in safe staffing laws

The solution is not to limit what nurses do in order that cheaper, less qualified staff can take over personal care tasks. The Government needs to increase the number of nurses as the shortage of nursing staff is putting patients at risk.

Data analysis by the Royal College of Nursing shows that 90% of England's largest NHS Hospitals are short of Nursing staff and supplementing them with unregistered staff.

Janet Davies from the Royal College of Nursing said,

"These startling figures show that, despite the Government's rhetoric, our largest hospitals still do not have enough nurses and that is putting patients at risk.

"In light of this, the Government must redouble its efforts to train and recruit more qualified nurses and stop haemorrhaging the experienced ones who are fed up, undervalued and burning out fast."

Janet Davies added that it is unreasonable to expect unregistered staff to fill staffing gaps, putting them in a situation they have not been trained to handle, and that,

> “Nurses have degrees and expert training and, to be blunt, the evidence shows patients stand a better chance of survival and recovery when there are more of them on the ward.”

10. INCREASED USE OF VOLUNTEERS AND COMMUNITY GROUPS IN THE NEW PLANNED AND UNPLANNED CARE HOSPITALS

We ask you to investigate:

- *Which and how many hospital jobs CHFT envisages giving to volunteers*
- *What about patient safety?*
- *What about the ethics of undermining properly waged jobs carried out by trained, qualified and unionised staff, by replacing them with third sector organisations who may or may not pay those who are carrying out this work?*

Background: We are gobsmacked.

We know increased use of volunteers in the NHS is part of the 5 Year Forward View, but there is no indication of the tasks will be handed to volunteers and community groups, or of the effect on trained, qualified and unionised staff, of replacing them with volunteers and community group members.

11. PLANNED CARE HOSPITAL - SIGNIFICANT DIFFERENCE BETWEEN THE FULL BUSINESS CASE AND THE PUBLIC CONSULTATION DOCUMENT.

We ask you to investigate the difference between the Full Business Case and the public consultation document, with regard to the planned care hospital bed numbers.

The planned care hospital bed numbers have been cut after the public consultation - the Full Business Case proposes 64 planned care beds, which is a considerable reduction from the number we were told in the public consultation.

12. PF2

We ask you to investigate whether the Trust's withholding of information during the public consultation, that PF2 is the only available source of capital funding, may invalidate the consultation.

Background: We find CHFT's subterfuge about PF2 during the consultation to be inexcusable. Since the Full Business Plan was published, we have found that CHFT must have already known when it prepared the Pre Consultation Business Case - and certainly during the public consultation - that PF2 was the only option.

A consultation is meant to be carried out on the basis of full and honest information, or it is deceitful and meaningless.

Although the Pre-Consultation Business Case referred to the possibility of PF2 as the source of finance for the new hospital buildings in Halifax and Huddersfield, this was presented as one of three possible options - the other two being a Treasury loan or a commercial loan.

This was also CHFT's position at a public consultation meeting when Owen WIlliams downplayed the likelihood of using a PF2 loan, in the face of angry public questions.

We were sceptical but took it on trust from Owen Williams that at least PF2 was not inevitable, as there were 3 options.

However, now that the Full Business Case unequivocally states that there is no other source of money for the new hospital buildings apart from PF2, we strongly suspect that during the consultation CHFT deliberately misled the public about the likelihood of being able to obtain money for the new buildings from sources other than PF2m, simply in order to avoid a public showdown about using PF2.

Since the Full Business Plan was published, we have found that CHFT must have already known when it prepared the Pre Consultation Business Case - and certainly during the public consultation - that PF2 was the only option, due to the government's incredibly tight Capital Development Expenditure Limit for the Dept of Health for Financial Years 2016/17 to 2020/21.

This was indicated in the July 2015 Spending Review document, that asked government departments to draw up plans for £20bn more cuts to public spending over the next four years.

The Dept of Health's resource and capital Departmental Expenditure Limit for Financial Years 2016/17 to 2020/21 were spelled out in the November 2015 Comprehensive Spending Review,https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/479749/52229_Blue_Book_PU1865_Web_Accessible.pdf which (p93) said:

> "The government has allocated £4.8 billion capital funding for health every year for the next 5 years. This includes funding for a shift in the way urgent and emergency care services are provided and improving out of hospital services to deliver more care closer to home. New investment of £1 billion in technology will support this transformation and integrate patient records across health and social care by 2020. Over the next 5 years, at least £500 million will be invested in building new hospitals."

Since it would cost over half of that £500m to build the new Huddersfield Planned care hospital (with urgent care centre and outpatients) and expand Calderdale Royal Hospital into an acute and emergency hospital for both areas, it must have been clear to CHFT when it wrote the Pre Consultation Business Case and carried out the Public Consultation, that the CDEL would rule out anything other than PF2. It should have made this clear in both the Pre Consultation Business Case and at public consultatoin meetings.

Because Calderdale Royal Hospital was built and now runs on the basis of one of the earliest, most costly and most notorious PFI deals in the country, the public has rightly been worried from the start of the consultation process, about the prospect of another PF deal to pay for the new buildings at both hospital sites.

The Full Business Case belittles the public's justified concerns (p99):

> *"...the public at large are skeptical about PFIs in this health economy because of the perceived impact of existing PFI arrangements."*

Throughout the whole whole four years this scheme has been lurching along, NHS have belittled and patronised the public. This does not reflect well on them. We are furious, not sceptical, because of the actual impact - not the perceived impact - of the CRH PFI deal.

Owen Williams himself, and other NHS management staff, told the public several times that the Calderdale Royal Hospital PFI debt was a significant reason why the Trust could not continue to run two District General Hospitals with full 24/7 A&Es and related acute services.

In a 2015 meeting with Green Party Parliamentary Candidates for Halifax and Calder Valley, Owen Williams said that CHFT had investigated whether it was possible to declare it an onerous debt.

Why then does CHFT patronise the public and deny the reality of the “impact of existing PFI arrangements”?

13. ENFORCED EFFICIENCY CUTS

In the context of this proposed reconfiguration, we ask you to investigate whether the 2011-2015 £20bn "efficiency cuts" required by the NIcholson Challenge and the further £22bn+ cuts required by Sustainability and Transformation Plans make any kind of economic sense - particularly since they are directly responsible for the alleged "time-expired" state of Huddersfield Royal Infirmary, due it falling into such a state of disrepair because the Trust had no money to maintain it properly.

Background: The effect of the 2011 to 2015 £20bn Nicholson challenge from on CHFT was to squeeze the hospitals to the pip, through having to make "efficiency" cuts that were incompatible with patient safety, as CHFT told Calderdale Council Adult Health and Scutiny Committee in 2014. Prioritising patient safety and refusing to impose all the required efficiency cuts forced the Trust first into deficit and then into financial special measures imposed by Monitor.

This is the context for the CHFT 5 Year Strategic Plan, drawn up by EY at a cost to the Trust of £500k. The plan provided the basis for the Pre Consultation Business Case.

Around the same time, NHS England produced Sustainability and Transformation Plan guidance that included harsh financial control totals and little funding carrots that depended on complying with the financial controls, and the prospect of a big financial stick if the financial controls and other targets were not met.

The targets are difficult if not impossible to reach with the shortage of money imposed by the government for years on end and designed to cut a further £22bn, at least, from the NHS spending compared to current levels by 2020/21.

CHFT's insistence on prioritising decent quality patient services left the Trust with next to no money keep up with the repair and maintenance needs of HRI. So the government's refusal to fund the maintenance of Huddersfield Royal Infirmary is responsible for its run down and proposed demolition.

How handy that this provides an opportunity for bankers and finance companies to profit nicely from the NHS cash cow through a new PF2 scheme.

14. LENDLEASE CONFLICT OF INTEREST

We ask you to investigate whether CHFT acted improperly, unethically and carelessly in giving Lendlease Consulting the 2015 contract to update the 2013 NIFES report on the state of the Huddersfield Royal Infirmary building, at a time when Lendlease Corporation had a vested interest in Calderdale Royal Hospital Special Purpose Vehicle and stood to profit from the decision to make Calderdale Royal Hospital the preferred Acute and Emergency hospital.

Background: Both the January 2016 Pre Consultation Business Case for the "reconfiguration" of Calderdale & Huddersfield hospitals – and now the Full Business Case – are based on advice from Lendlease Consulting. Lendlease Consulting is part of Lendlease Corporation, which until 2016 had a vested interest in Calderdale Royal Hospital. CHFT has not acknowledged this.

The Lendlease Consulting hospitals estate reconfiguration advice is contained in two reports: a 2015 report http://www.cht.nhs.uk/fileadmin/site_setup/contentUploads/6_Fact_Survey_Review.pdf that updated the 2013 NIFES survey of Huddersfield Royal Hospital and informed the Pre Consultation Business Case, and a 2017 update to the 2015 report, that fed into the Full Business Case

Lendlease Consulting is part of Lendlease Corporation, which until 2016 had a vested interest in Calderdale Royal Hospital through its subsidiary Lendlease PFI/PPP Infrastructure Consolidated Investment Holdings Ltd.

This company had a 50% share in Consolidated Investment Holdings Ltd, the Calderdale Royal Hospital Special Purpose Vehicle's "ultimate parent undertaking" - according to Calderdale Hospital SPC Holdings Ltd's Annual Accounts made up to 31 December 2016.

When questioned during the public consultation about whether CHFT had considered Lendlease's conflict of interest when they decided to employ Lendlease Consulting to update the 2013 NIFES survey, a CHFT spokesperson said she couldn't answer that.

When I asked about this again (after the Full Business Case revealed that Lendlease's 2017 update report had identified that HRI was near the end of its life and could not be renovated in line with the clinical case for change), CHFT replied,

> *"Lendlease no longer have any interest in Calderdale Royal Hospital Special Purpose Vehicle. In addition, the maintenance section of Lendlease who previously provided service to the SPV via a formal contract was taken over by Cofely Ltd and subsequently by Engie. Lendlease therefore have no vested interest in CRH."*

This is true - but it was not true in 2015, when CHFT gave Lendlease Consulting the contract to update the 2013 NIFES update.

It was only in January 2016 that Lendlease Corporation sold its 50% share in Lendlease PFI/PPP Infrastructure Consolidated Investment Holdings Ltd to UK fund manager Dalmore Capital.

At the time it made the 2015 NIFES update Report, **Lendlease Consulting stood to directly profit from its advice**, that reversed the Trust's initial preference for Huddersfield as the acute and emergency site and Calderdale as the small planned care hospital.

This was made clear in Ernst & Young's 5 Year Strategic Plan for Calderdale and Huddersfield NHS Foundation Trust (CHFT), which outlined how the Calderdale Royal Hospital Special Purpose Vehicle stood to benefit financially from developing Calderdale Royal Hospital as the acute/emergency site.

The EY report says that any proposed capital works that fall within the Calderdale Royal Hospital PFI site that is owned by the PFI provider will be subject to their own procurement procedures that take longer and cost more: within the PFI contract there is an identifiable 12.5% overhead cost. Programme costs may also increase because of the longer period to procure the works. The type of contractors used may increase the tender prices. The capital cost at Calderdale Royal Hospital may be greater than at Huddersfield Royal Infirmary. Should the works at Calderdale Royal Hospital be added to the annual PFI costs, this will significantly increase the differential between Huddersfield Royal Infirmary and Calderdale Royal Hospital over the remaining 47 years of the PFI contract (Ps 226/7).

None of this information seems to have been carried through to the Full Business Case.

The advice that caused the flip in the preferred option for the hot and cold sites seems to have been the increased cost of maintenance work to bring HRI up to an acceptable standard, that Lendlease Consulting identified. The 2013 NIFES survey figure was £39m, in 2015 Lendlease raised it to £95m.

The £95m figure was used in the Trust's 5 Year strategic plan, drawn up by EY when it was parachuted into the hospital Trust by Monitor (now NHS Improvement) in the autumn of 2015, in order to impose huge cuts that the Trust had failed to make because they would have endangered patient safety.

On top of Lendlease's role in the Calderdale Royal Hospital PFI Special Purpose Vehicle, in 2012 CHFT appointed Lendlease as sole provider of Project Management, Quantity Surveying and CDM Coordinator services under a four-year agreement, after it had carried out numerous repeat commissions for CHFT since 2006. In their belated FOI reply, CHFT say that since 2012/13 to the end of 2016/17 financial year they have paid LendLease £1,842,869.

By 2016 Lend Lease had carried out £35m of capital and small works programmes at both Huddersfield Royal Infirmary and Calderdale Royal Hospital. These included the new £8m Pharmaceutical Manufacturing Unit (PMU) at Huddersfield Royal Infirmary, New Build Endoscopy Units at Huddersfield Royal Infirmary and Calderdale Royal Hospital as well as the new-build and refurbishment of infrastructure and engineering works.

So Lendlease gets to profit from £ms of work at Huddersfield Royal Infirmary and then to profit again from recommending that what it built is knocked down.

15. CLAIM THAT HUDDERSFIELD ROYAL INFIRMARY IS TIME-EXPIRED

We ask you to investigate the credibility of the Full Business Case's claim that Huddersfield Royal Infirmary is time expired, with no more than 10 years of life left, even if all the backlog maintenance tasks identified in the 2015 update to the 2013 NIFES report were carried out. This is not what CHFT said in the Pre-Consultation Business Case and public consultation.

Information we have gained from CHFT through a Freedom of Information request has aroused the suspicion that CHFT carefully controlled the information the public were fed during the consultation, in order to try and avoid public rejection of the hospitals reconfiguration. Not that that tactic worked. The public overwhelmingly rejected the proposals anyway.

In their reply to a recent Freedom of Information request, CHFT said that the 2013 and 2015 Reports are the basis for the Full Business Case conclusion that Huddersfield Royal Infirmary is time expired.

They had these Reports when they wrote the Pre Consultation Business Case and the public consultation documents, so why didn't they come to the same conclusion then?

The CHFT response to the Freedom of Information request said that

> *"Additional surveys and reports... undertaken in 2017 by Authorising Engineers and specialist consultants... support[s] the Trust's view that HRI is not financial [sic] viable to keep operational due to the significant capital investment required to keep the premises in a suitable condition to provide an effective health care service and support the requires [sic] clinical model."*

What was in those 2017 additional surveys and reports that shot Huddersfield Royal Infirmary from needing £95m capital spending on backlog maintenance in 2015, to being judged as time-expired in 2017?

In the Full Business Case, a new 2017 update from Lendlease states that the £95m capital investment in Huddersfield Royal Infirmary, that was proposed during the consultation, would not now solve the building's structural problems, because HRI's building, service infrastructure and space/functional suitability have now deteriorated to the point that in 10-15 years' time the hospital would have to be pulled down and rebuilt at a cost of £379.5m, even after the £95m investment in backlog maintenance.

We sent CHFT a Freedom of Information request to find out what this "further deterioration of the HRI estates building and service infrastructure and space/functional suitability" was.

We found CHFT's response to our FOI request to be muddled and self-contradictory. It said that the Full Business Case advice that HRI would be time expired after 10-15 years was derived from Lendlease's review of the 6 facet survey [ie the 2013 NIFES report] and the resulting 2015 shift statement provided by Lendlease.

CHFT's FOI response added that the 2015 report found that, although a number of elements within the 2013 6 facet survey were at condition B (ie sound, operationally safe and exhibits only minor deterioration), a significant amount of infrastructure elements e.g. electrical supplies, pipework, windows, building fabric, were at condition Cx (Operational) meaning replacement will be needed within three years for building elements and one year for engineering elements).

In other words, the Full Business case decision that HRI is time-limited is based on the 2013 and 2015 studies that were used in the Pre Consultation Business Case and Public Consultation. So why did CHFT not conclude then that HRI is time-limited?

CHFT's explanation in its FOI response was:

> *"The assumption behind declaring Huddersfield Royal Hospital to be time expired was that the required capital investment would not be available, so elements within the 6 facet survey would undoubtedly deteriorate further over the next 10-15 year period resulting in the majority being at condition CX or worse."*

Why didn't they say in the Pre-Consultation Business Case and the public consultation that the required capital investment would not be available? Has anything changed between 2015, when they wrote the Pre-Consultation Business Case, and 2017, when they wrote the Full Business Case, that means that the required capital investment would have been available then but now isn't? (See section 12, PF2, above.)

CHFT's FOI response added that HRI would be time - expired even if they did get their hands on the required capital investment because many of the required replacement schemes could not be carried out, either due to the live hospital environment or inability to access the works e.g. due to the presence of asbestos which cannot be removed in a safe and effective manner.

Again, why didn't CHFT make that point in the Pre-Consultation Business Case and public consultation? The live hospital environment is an obvious problem, and everyone has known about the asbestos for a long time. Why wait to dump it on the public out of the blue in the Full Business Case?

We can't see that the 2017 update report justifies CHFT's conclusion that HRI is time-expired.

In response to the FOI request, CHFT sent the following documents:

- CHFT BLM – Shift Statement 2015-11-30 Final
- AE Reports (2017)
- Concrete condition report (2017)
- Summary Window survey (2017)

These are the only additional surveys and work undertaken in 2017, following the 2015 Lendlease update of the 2013 NIFES report.

At least to the uninitiated, the 2017 technical reports on the state of Huddersfield Royal Infirmary don't seem to contain anything obvious to justify the claim that the hospital building will be time-expired in ten or fifteen years - although it is possible that the statement in The 2017 Method Statement for builder's [sic] work holes within an existing concrete structure, that alterations to any beams or columns are generally not permitted and a Structural Engineer should be consulted, could prevent the upgrade of HRI in line with contemporary clinical practices, as CHFT claims.

Here are the other main points in the 2017 technical reports, as we understand them.

The 2017 Electrical Systems Compliance Audit Report says that:

> *"The site remains effectively managed by competent and enthusiastic estates staff. There are no major concerns in terms of safety at the site but there are several areas that require reviewing and some actions to address..."*

The 2017 Window Survey Summary shows that the windows in 8 wards are of poor quality.

The 2017 Method Statement for builder's [sic] work holes within an existing concrete structure says that alterations to any beams or columns are generally not permitted. A Structural Engineer should be consulted. Other points include:

- Any alterations to the existing structure will weaken the structure and as such, works should be minimised.
- As a general rule, do not create new doorways or openings in shear walls. If openings are required then do not locate them at the end of the wall as this will have the greatest effect on integrity of the structure. A Structural Engineer must be consulted to review and approve the proposals.
- Do not locate openings adjacent to, above or below existing openings or features. Forces are concentrated around existing penetrations and the reinforcement is likely to have closer centres.

It gives a guide to the sequence for the routing of services/forming of holes and provides some general guidance to CHFT's Package Managers and Surveyors.

The 2017 Authorising Engineer Audit Report & Review of HRI Medical Gas Pipeline Systems recommends that non-compliances in existing plant, distribution system and wards/departments need to be corrected.They seem to be about fairly routine maintenance issues that are in hand. To the uninitiated at least nothing horrendously wrong seems to need fixing.

In comparison, the Full Business Case states that since the 1960s, when Huddersfield Royal Infirmary was designed, there has been greater demand on system capability at an acute hospital site, but any additional load resulting from extensions to the building would result in further pressure on the system infrastructure.

Examples include:

- Corroded service pipework could potentially fail – carrying out repairs could significantly disrupt patient services and care due to the location of asbestos in the building.
- Roof repairs are required throughout the building as water leaks into the building and patient areas including wards and treatment areas.
- Power supplies still require significant work despite improvements - (although the 2017 Electrical Systems Compliance Audit Report suggests at least to the uninitiated that these may not be major since it says "*There are no major concerns in terms of safety at the site but there are several areas that require reviewing and some actions to address...*"
- Fire safety has improved, but significant investment is still needed for compartmentation, fire detection and alarm systems. etc

It would be useful to hear informed views about whether there is a mismatch between statements in the Full Business Case and information in the 2017 technical reports.

We are suspicious that CHFT have been economical with the truth here. That is why we raise these points.