IRP

Independent Reconfiguration Panel

ADVICE ON PROPOSALS FOR CHANGES TO MATERNITY SERVICES IN CALDERDALE AND HUDDERSFIELD

Submitted to the Secretary of State for Health

31 August 2006

IRP

Independent Reconfiguration Panel

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CONTENTS

EXECUTIVE SUMMARY

1. **Overall, the Panel agrees that the proposals as set out in Option G3 of the consultation document (see para 4.6.2) represent the most appropriate way to deliver safe, effective and accessible maternity services for the 21st century.**

2. **The reconfiguration of services in Calderdale and Huddersfield has already agreed that paediatrics, including neonatology, should be centred on the Calderdale Royal Hospital (CRH) site. It follows, on grounds of safety, that consultant-led maternity services should also be sited at CRH.**

3. **The new Yorkshire Ambulance Service must be a key partner in the implementation of the changes to maternity services so that the Service can ensure it plays a full part in the success of the changes.**

4. **Midwife-led units should be available on both the Huddersfield Royal Infirmary (HRI) and the CRH sites. Home births should also be available to all local mothers where appropriate.**

5. **The transition to the new service models should proceed over a maximum of two years and be fully implemented by the end of that period.**

6. **Greater priority should be given to providing more antenatal, outpatient and postnatal care in the community with all midwives working in teams and their work involving both hospital and community work. Children's Centres are an ideal location for the provision of community maternity services and the number of Centres should be increased locally in line with existing plans.**

7. Improvements to midwifery in a community setting in Huddersfield are vital to address the needs of the most deprived women. These improvements should not be dependent on funding arising from the acquisition of CNST standards but should be given priority at the earliest stages of implementation.

8. Transport is a vital component in a successful local NHS. A regular bus service available to patients, visitors and staff should run between HRI and CRH. The local NHS and the two metropolitan councils should consider how they can further improve transport links for the benefit of service users and families.

9. The changes to local health services will free up accommodation enabling a number of clinical services to work in improved accommodation. Full advantage should be taken of these opportunities to the benefit of patients.

10. With the Calderdale and Huddersfield NHS Trust having now achieved Foundation Status it will be vital that the Board and the membership of the Foundation Trust, key community leaders and stakeholders give their full support to the successful implementation of the proposals.

OUR REMIT

What was asked of us

1.1 The Independent Reconfiguration Panel's (IRP) general terms of reference are included in Appendix One.

1.2 On 19 April 2006, Councillor Peter Coles, Chair, Calderdale and Kirklees Joint Health Overview and Scrutiny Committee (HOSC), wrote to the Secretary of State for Health, Patricia Hewitt, exercising powers of referral under the Local Authority (Overview and Scrutiny Committees Health Scrutiny Functions) Regulations 2002. The referral concerned proposals developed by the Calderdale and Huddersfield PCTs for changes to maternity services provided by the Calderdale and Huddersfield NHS Trust. The Secretary of State responded to Councillor Coles on 1 June informing him that she had asked the IRP to undertake a review of the proposals. Draft terms of reference were set out in a letter from the Department of Health to the IRP Chair, Dr Peter Barrett and these were subsequently agreed. Copies of correspondence are included in Appendices Two to Five.

1.3 The Panel was asked to advise:

a) Whether it is of the opinion that the proposals for changes to maternity services set out in the decision of 22 March 2006 [made by a joint committee of the Calderdale, Huddersfield Central and South Huddersfield Primary Care Trusts] *(Option G3 of "Looking to the future…your chance to have your say") will ensure the provision of safe, effective and accessible maternity services for the people of Calderdale and Huddersfield. And if not, why not;*

b) On any other observations the Panel may wish to make in relation to the proposals for changes to maternity services and implications for any other clinical services; and

c) In the light of a) and b) above, on the Panel's advice on how to proceed in the best interests of local people.

It is understood that in formulating its advice the Panel will pay due regard to the principles set out in paragraph A2 of its general terms of reference.

1.4 The advice offered in this report relates only to the provision of maternity services and not to proposals for changes to any other services agreed on 22 March. The consultation process conducted by the PCTs under sections 7 and 11 of the Health and Social Care Act 2001 was also outside the Panel's remit as the Joint HOSC had indicated that it was satisfied that it was adequate.

OUR PROCESS

How we approached the task

2.1 The West Yorkshire Strategic Health Authority (which became part of the Yorkshire and Humber Strategic Health Authority on 1 July 2006) was asked to provide the Panel with relevant documentation, and to arrange site visits, meetings and interviews with interested parties. The SHA, in conjunction with the relevant PCTs and the NHS Trust, completed the Panel's standard information template. This can be accessed through the IRP website (www.irpanel.org.uk).

2.2 The Calderdale Metropolitan Council and Kirklees Metropolitan Council Joint Health Overview and Scrutiny Committee was also invited to submit documentation and suggest other parties to be included in meetings and interviews.

2.3 Panel members visited Calderdale Royal Hospital (CRH) and Huddersfield Royal Infirmary (HRI) on three occasions. Initially, Nicky Hayes, Nick Naftalin and Gina Tiller visited on Friday 7 July. Peter Barrett, Mark Santer and Gina Tiller visited on Tuesday 11 July. Tony Shaw and Martin Houghton accompanied members on both visits. Details of the people seen on these visits are included at Appendix 8.

2.4 The Panel Chair, Dr Peter Barrett, wrote an open letter to editors of local newspapers on 27 June informing them of our involvement (see Appendix 6). The letter invited people who felt they had new evidence to offer or who felt their views had not been heard adequately during the formal consultation process to contact the Panel.

2.5 175 people contacted the enquiry line (see Appendix 7) and consequently Peter Barrett, Paul Roberts, Ray Powles and Tony Shaw made a further visit to Calderdale and Huddersfield on Monday 7 August to meet some of those who responded. They also visited the special care baby units (SCBU) at both sites.

2.6 Meetings were held with five local MPs – Linda Riordon (MP for Halifax) and Christine McCafferty (Calder Valley) on 12 July, Kali Mountford (Colne Valley) and

Barry Sheerman (Huddersfield) on 2 August and Mary Creagh (Wakefield) on 8 August.

2.7 A number of other visits and meetings were held. Peter Barrett, Nicky Hayes, Paul Roberts, Tony Shaw and Martin Houghton visited Bournemouth Maternity Unit on 17 August. Peter Barrett met representatives of the Royal College of Midwives on 23 August. Tony Shaw held a telephone discussion with Mary Newburn, Head of Policy Research at the National Childbirth Trust on 23 August. Peter Barrett and Tony Shaw met representatives of the Royal College of Obstetricians and Gynaecologists on 25 August. Peter Barrett and Tony Shaw visited Helme Chase Maternity Hospital, Kendal on 29 August.

2.8 A list of all the written evidence received – from the SHA, PCTs, Joint HOSC and all other interested parties - is contained in Appendix 7. The Panel considers that the documentation received, together with the public responses to the Chair's letter to local newspapers, provides a fair representation of the views from all perspectives.

2.9 The Panel reviewed a draft report on 8 August 2006. The advice contained in this report was agreed following that meeting.

2.10 Throughout our consideration of these proposals, our aim has been to consider the needs of patients, public and staff taking into account the issues of safety, access and effectiveness as set out in our terms of reference.

2.11 The Panel wishes to record its thanks to all those who contributed to this process. We also wish to thank all those who gave up their valuable time to present evidence to the Panel and to everyone who contacted us offering views.

2.12 The advice contained in this report represents the unanimous view of the Chair and members of the IRP.

THE CONTEXT

A brief overview

3.1 The proposals for maternity services under consideration in this report form just one part of a package of proposals for changes to services provided by Calderdale and Huddersfield NHS Trust which had been developed by the Calderdale, Huddersfield Central and South Huddersfield Primary Care Trusts in collaboration with the NHS Trust.

3.2 This is the second time in six years that local health organisations have consulted on maternity services. In 1998, the then Calderdale and Kirklees Health Authority held a series of workshops with obstetricians and paediatricians from the separate district general hospitals providing services to the Calderdale and south Kirklees communities. The sessions concluded that to continue providing safe, high quality and sustainable services in paediatrics and consultant-led maternity care these services would need to be reconfigured onto a single hospital site. A consultation on proposals to centralise consultant-led maternity services, along with proposals for changes to other services, was held in 1999/2000. While a number of the proposals were agreed by the health authority in 2000, including the decision to reconfigure inpatient paediatrics onto the CRH site, the proposal for maternity services was not supported. This presented significant challenges to implementing the agreement to centralise neonatal intensive care and inpatient paediatric care at CRH and consequently these were not implemented.

3.3 The NHS Trust then undertook further work to consider how a two site consultant-led maternity service could be sustained while reconfiguring paediatrics. Proposals for a paediatric rota to support consultant-led maternity services at HRI were explored but were not considered viable in light of the implementation of the European Working Time Directive (EWTD)[1]. Attempts were also made to train advanced neonatal nurse practitioners (ANNPs) to provide paediatric cover at HRI but the nature of the training and intensity of post-training support made securing sufficient numbers difficult.

3.4 In May 2005, the PCTs and the NHS Trust began a process of public engagement with the establishment of six service improvement groups and a series of stakeholder, service

[1] The EWTD currently limits junior doctors' hours to 58 hours per week, further reducing to 48 hours in 2009.

user and public workshops to examine the current configuration of clinical services. This led to a formal public consultation exercise *"Looking to the future…your chance to have your say",* held between 6 October 2005 and 30 January 2006[2], which included proposals for the development of surgical services, children's and women's services as well as expanding services in the community. A simultaneous consultation exercise *Moving Forward* considered services provided by the South West Yorkshire Mental Health Trust (SWYMHT).

3.5 In accordance with section 7 of the Health and Social Care Act 2001, Calderdale and Kirklees health overview and scrutiny committees were formally consulted and a joint HOSC was formed to respond to the proposals. The Joint HOSC responded in January 2006 indicating its support for the majority of the proposals with the exception of proposals relating to maternity services.

3.6 A joint committee of the PCTs met on 22 March 2006 to consider the outcome of the two consultation processes. The Joint Committee agreed the following:

3.6.1 *To develop a broader range of services in the community thereby providing improved access to appropriate care closer to people's homes by shifting resources from secondary to primary care*

3.6.2 *With regard to services currently located at St Luke's Hospital, Huddersfield, provided by the South West Yorkshire Mental Health Trust and the Calderdale and Huddersfield NHS Trust:*

- *Inpatient services for working age adults and older people with acute mental health problems to be relocated to the HRI site*
- *Inpatient services currently provided at the Castle Hill and New Haven Units, for people needing low secure care, to be relocated to the Fieldhead Hospital site in Wakefield*
- *Those mental health services that need to be provided within an acute hospital setting to be relocated to the HRI site or Acre Mill site*
- *Those general health services that can be appropriately provided in a community setting to be relocated into the community along with their underpinning resources*

[2] The original end of consultation on 16 January 2006 was extended to 30 January at the request of the Joint HOSC to allow more time for analysis of responses.

3.6.3 *That the Calderdale and Huddersfield NHS Trust should continue to provide the broadest range of safe, high quality and sustainable local hospital services from two hospital sites, including two fully functioning A&E departments.*

3.6.4 *In order to provide safe, high quality and sustainable inpatient services that ensure the best use of resources, and build on the provision of paediatric inpatient care, neonatal intensive care agreed in 2000:*

- *Planned inpatient orthopaedic and planned inpatient general surgery, including breast surgery and all in patient gynaecology should be provided at CRH*
- *All emergency inpatient orthopaedics and emergency general surgery, complex planned surgery and emergency paediatric surgery should be provided at HRI*
- *A 24-hour paediatric assessment and observation unit able to accommodate children requiring a short term stay should be provided at HRI*
- *All inpatient obstetrics and services for babies needing special care should be provided at CRH*

3.6.5 *The joint committee resolved to retain a midwife-led unit at CRH and develop a clear transition plan to include:*

- *A full obstetric service at both HRI and CRH for a minimum of 12 months while establishing a midwife led unit at HRI*
- *Once established the midwife led unit to run alongside the Huddersfield obstetric unit for a maximum period of six months during which training protocols are developed and confidence established*
- *Increase the provision of community midwifery*

3.6.6 *Calderdale, Huddersfield Central and South Huddersfield PCTs to work with partners within Calderdale and Kirklees to improve access and transport links to support the service changes to mitigate any detrimental effects on service users as a result of these service changes.*

3.7 The joint committee of the PCTs wrote to the Joint HOSC on 5 April 2006 responding to concerns raised in the Joint HOSC's report. The Joint HOSC wrote to the Secretary of State on 19 April advising that:

- The Committee was satisfied that the consultation had been handled in line with sections 7 and 11 of the Health and Social Care Act 2001
- It was content with the majority of the proposals contained in the consultation
- One aspect of the proposals – the option for maternity services – was felt to be not in the best interest of the local population (these concerns are outlined in Chapter Four)

3.8 On 1 June 2006, the Secretary of State for Health, Patricia Hewitt, advised Cllr Peter Coles, Chair of the Joint HOSC that she had asked the IRP to undertake a review of proposals for maternity services across Calderdale and Huddersfield.

INFORMATION

What we found

4.1 A vast amount of written and oral evidence was submitted to the Panel. We are grateful to all those who took the time to offer their views and information. The evidence put to us is summarised below – firstly general background information followed by views in support of the proposals and specific concerns expressed to us and finally other evidence gathered.

4.2 **Services Provided and Activity**

4.2.1 The Calderdale and Huddersfield NHS Trust (CHT) is the main provider of hospital services in the Calderdale and Huddersfield areas. The Trust has two main hospitals, Calderdale Royal Hospital in Halifax with 480 beds and Huddersfield Royal Infirmary with 450 beds. Services are commissioned by the Calderdale, Huddersfield Central and South Huddersfield PCTs[3].

4.2.2 Calderdale and Huddersfield NHS Trust employs 4,564 Whole Time Equivalent (WTE) staff. This includes 162 WTE consultants, 158 WTE junior doctors, 78 WTE other medical grades, 1,405 WTE nurses and midwives and 313 WTE ancillary and estates staff.

4.2.3 The current vacancy rate is 1.87%. The main recruitment problems are with technicians, occupational therapists and senior physiotherapists.

4.2.4 The NHS Trust provides consultant-led maternity care and an adjacent midwife-led unit at CRH. Consultant-led maternity care only is currently provided at HRI. In 2005/06, 2,752 deliveries took place at CRH and 2,617 at HRI (2,728 and 2,622 respectively in 2004/05).

[3] Huddersfield Central, South Huddersfield and North Kirklees PCTs are due to merge on 1 October 2006 to form Kirklees PCT.

4.3 **Geography, Demography, Access and Transport**

4.3.1 There are two local authorities relating to the NHS Trust's catchment area, both unitary metropolitan districts: Calderdale with a population of 192,405 and Kirklees with a population of 388,567 (but see para 4.3.2 below). The largest towns are Halifax (pop. 82,506) in Calderdale, and Huddersfield (pop. 146,234) in Kirklees.

Area covered by Calderdale, Huddersfield Central and South Huddersfield PCTs

4.3.2 CHT provides services to Calderdale, Huddersfield and south Kirklees – including the Holme Valley. Services for the remainder of the Kirklees population are commissioned by the North Kirklees PCT whose principal communities include Dewsbury, Batley and Cleckheaton. Residents of that part of Kirklees generally receive acute services from the Mid-Yorkshire Hospitals NHS Trust. Data on patient flows indicate that, at present, there is relatively little flow between HRI and Dewsbury Hospital's (part of the Mid-Yorkshire Hospitals NHS Trust) catchment areas for maternity services.

4.3.3 Between May 2001 and May 2006 the registered population of the PCTs increased by 2.9% in Calderdale, 2.7% in South Huddersfield and 4.8% in Huddersfield Central. The average growth across the health community was 3.2%.

4.3.4 Calderdale has a 7% Black and Minority Ethnic share of the population. Within Kirklees, the Black and Minority ethnic share of the population is 17.5% in Huddersfield Central and 2% in South Huddersfield.

4.3.5 Areas of relative deprivation include Exley, Halifax Central, Mixenden and Illingworth in Halifax and Dalton, Deighton, Thornton Lodge, Newsome, Crosland Moor and Birkby in Huddersfield.

4.3.6 CRH and HRI are 5.14 miles apart, connected by the A629. The M62 motorway runs east-west between the two towns. The journey time by car between the HRI and CRH is around 15 minutes though it can take up to 30 minutes in rush hour or if serious traffic problems are occurring.

4.3.7 An analysis of 255 journeys undertaken by ambulance found the average journey time to be 16 minutes. This includes *non-blue light* as well as *blue light* transfers. The shortest journey time was 10 minutes and the West Yorkshire Metropolitan Ambulance Service (now part of the Yorkshire Ambulance Service) considered that 10-12[4] minutes for a blue light ambulance was a reasonable assumption.

4.4 Estate

4.4.1 The current condition of the estate occupied by maternity services is:

- CRH is condition B - a requirement of the Private Finance Initiative (PFI) concession means the hospital must be maintained at this level
- HRI is condition B - a substantial refurbishment project was completed in 2004

4.5 NHS Star Ratings and organisational status

4.5.1 CHT received a three star rating in 2004/05, two stars in 2003/04 and three stars in 2002/03. The Trust was licensed as a Foundation Trust by Monitor on 1 August 2006.

[4] These figures relate only to time spent in the ambulance and do not include other time associated with transfer at both ends

4.6 **The proposals for maternity services**

4.6.1 At present, there are consultant-led maternity units at both CRH and the HRI. A midwife-led unit adjoins the obstetric unit at CRH. The majority of rooms at CRH are "LDRP" (labour, delivery, recovery, postpartum) rooms that enable mothers to deliver their baby and have any necessary postnatal care within the same room.

4.6.2 **The PCTs' preferred option (Option G3 as described in *Looking to the future…your chance to have your say*) would see inpatient consultant-led maternity care centred on the Calderdale site together with an "alongside" midwife-led unit. A standalone midwife-led unit would be provided at HRI. This option would allow a shift of investment away from acute settings and into the community.**

4.6.3 The arguments put forward in support of this model of care are described in detail in *Looking to the future…your chance to have your say* and are summarised briefly below.

Appropriate childbirth settings for healthy women

- The desire to move away from providing acute hospital care for well women
- Women to be cared for by midwives who are trained to support normal birth - providing improved continuity of care (including one-to-one care during labour)

Improving health outcomes for women and their babies

- Positive outcomes can be achieved from care for women in labour provided in non-medicalised environments
- Improvements in community midwifery and antenatal care will lead to better outcomes
- Improved outcomes arising from midwives working with women with specific social or clinical needs such as teenage mothers, women requiring language support or women with disabilities
- Greater engagement with women and families earlier on through Sure Start Centres and successor children's centres

Safety issues

- Safety of arrangements for neonatal care – the maintenance of the current level of neonatal facilities within the health community cannot be sustained in the future unless this service is reconfigured onto a single site

- Safety of arrangements for maternity care – better cover can be provided on a single site ensuring compliance with national targets for 40/60 hour consultant delivery suite cover, and requirements for medical training and accreditation
- Safety of arrangements for maternity care – an improved anaesthetic service could be provided with a single consultant-led unit through the employment of anaesthetists specialising in obstetric work

4.7 **Concerns raised**

4.7.1 *Issues raised by the Joint HOSC*

In referring the matter to the Secretary of State for Health (see Appendix Two), the Joint HOSC stated that in its view Option G3 was not in the best interests of the local population. It suggested that the NHS Trust should maintain maternity services on both hospital sites for the following reasons

Strategic planning

- "The committee is concerned that there needs to be broader, strategic planning at a regional level about the type and location of maternity service provision"

Investment in community midwifery and health needs of disadvantaged groups

- "The committee accept that there are compelling clinical and policy drivers for change and that "no change" is not an option. They also accept that resources need to be shifted away from hospital provision and towards community midwifery provision if the significant differences in health inequalities, particularly for more disadvantaged groups, are to be addressed. The massive variations in rates of infant mortality and low birth-weight babies, for example, will not be tackled purely by investing in hospital provision"

The MLU concept

- "The committee are supportive of midwife-led care and the principle of midwife-led units. They are sceptical, however, about the sustainability of the one being proposed for Huddersfield at this point in time and feel that more needs to be done across the local health system to better support the normality of childbirth"
- "Members do not consider that the relatively short transition period proposed is sufficient to address the current lack of local confidence in the proposed stand alone midwife-led unit" [for Huddersfield]

Social implications

- "While the committee have found many of the medical and clinical arguments to be compelling, there are also [in the Committee's view] compelling social implications of the proposed model"

4.7.2 These issues are considered in detail in the Joint HOSC's response to the *Looking to the Future* consultation on proposals for future health services in Calderdale and Huddersfield.

4.7.3 In the course of our consideration of this case, a number of views and issues were presented to us from a variety of sources. These are summarised briefly below and are discussed more fully in the next chapter together with our recommendations.

Safety issues

- The perceived risk of giving birth in a midwife-led unit without the availability of obstetric cover on the same site should it be required
- Transfer times for women in labour requiring obstetric care and concern about the ability of the ambulance service to handle transfers (in view of the general performance of the former West Yorkshire Metropolitan Ambulance Service)
- Lack (of awareness) of work undertaken by the consulting bodies on risk and transport assessments

The MLU concept

- Long term viability in view of:
  - (possible) closures elsewhere in the country
  - concern whether enough women will use the unit

Investment in community midwifery and health needs of disadvantaged groups

- Belief that removing consultant-led maternity care from Huddersfield would deprive the most needy of that option of care during birth [in Huddersfield]
- Concern that the Trust will not achieve the CNST[5] level 2 standards required to free up funds for expanded community care

Social implications

- The right to be born in Huddersfield

[5] Clinical Negligence Scheme for Trusts – see discussion in Chapter 5

- Difficulties in getting to Halifax for relatives and friends and problems with parking once there
- Services required in Huddersfield to cope with the expanding population of the town

Estate

- Services being relocated to CRH to protect the PFI - *"what's in it for HRI?"*
- Capacity issues around the ability of CRH to handle the proposed additional numbers of births

Strategic planning

- The need for a Yorkshire-wide consideration of service provision rather than individual proposals for neighbouring localities – as highlighted by
  - The separate service reconfiguration programme in North Kirklees and Wakefield looking at options for services provided by the Mid-Yorkshire Hospitals NHS Trust at the Dewsbury and District Hospital and in Wakefield and Pontefract
  - The possibility of a review of services provided at Barnsley NHS Foundation Trust

4.8 **Other evidence**

4.8.1 *Midwife-led units*

Some concerns were expressed to the Panel about the viability of midwife-led units and we therefore arranged to see examples of good practice.

4.8.2 *Bournemouth Royal Hospital*

One such example was the well-established unit at Bournemouth Royal Hospital which last year dealt with about 550 births including 100 home births. There was strict adherence to selection guidelines in assessing the suitability of the patient for a midwife-led birth. A consultant obstetric-led service is based in Poole, about 8 miles away and though roads are often very congested no significant incidents have occurred when transfers from the unit have been required. The atmosphere on the unit was calm and welcoming. The midwife team was enthusiastic, skilled and highly motivated – key factors in the unit's success. The midwives' attachment to the unit was strong with some choosing to commute long distances to work there. They covered both home and MLU deliveries and derived much satisfaction from seeing women and their families through the whole birth experience.

The unit enjoys considerable support from local people - women and their families greatly appreciated seeing someone they knew and trusted and a high proportion of mothers chose the unit again for subsequent deliveries.

4.8.3 *Helme Chase Maternity Hospital*

We also visited the standalone midwife-led maternity unit at Helme Chase which opened in September 2001. The Unit specialises in water births and other forms of active birth, encouraging women to have normal physiological births without the need for intervention. Women also transfer back from consultant-led units after more complicated births (the nearest consultant-led unit is 23 miles away in Lancaster). The unit provides antenatal and postnatal care for local mothers as well as a maternity ultrasound service. All patients registered with Helme Chase are offered ultrasound at 12 and 20 weeks gestation.

4.8.4 *Royal College of Midwives (RCM)*

Having heard the views of midwives' representatives locally in the NHS Trust, we wanted to get a national perspective.

4.8.5 The Royal College of Midwives' representatives were very supportive of midwife-led units provided there was strict application of selection criteria to ensure that only those patients with uncomplicated pregnancies and medical histories were accepted. They reported that the level of complications and untoward incidents throughout the country was very low. The development of midwife-led units supported the direction of travel outlined in the maternity standard of the National Service Framework (NSF) for Children, Young People and Maternity and increased patient choice. There was good evidence of increased job satisfaction amongst midwives who had made the transition to work in such environments. Patients who gave birth in a midwife-led unit were likely to opt for similar care for subsequent deliveries.

The RCM recognised the concerns of the existing workforce, in particular being asked to perform tasks which they currently felt beyond their level of competence. However, with good leadership, training and support and an opportunity to reflect on their practice, they felt that these problems could be overcome. Midwives could rediscover *"what midwifery was all about"* as has happened in other areas of the country.

4.8.6 *National Childbirth Trust*

The National Childbirth Trust is a leading charity offering information and support on pregnancy, birth and parenting. The Trust is supportive of midwife-led units because

- They are close to where women live and enable local services to be maintained, for example when medical services are reconfigured
- Care is generally of high quality, including a personalised woman-centred approach with a focus on facilitating normal birth and breastfeeding
- They usually have well thought through protocols for booking and transfer
- Staff within the unit work well together as a team

4.8.7 The NCT prefers midwives to be based in the community (so mainly working in the communities where women live) and going into a midwife-led unit or hospital when mothers need care there. The NCT considers that it cannot be justified for a low risk mother to be required to give birth in a consultant-led unit. Such mothers should be offered the options of a home birth or giving birth in a midwife-led unit. They see the main restriction on the freedom of choice for mothers being the use of interventions and consider that the "onus of proof" should be with those who suggest the intervention.

4.8.8 A good relationship between a standalone midwife-led unit and a consultant-led unit is essential, as is a good relationship with the ambulance service.

OUR ADVICE
Adding value

5.1 Introduction

5.1.1 The Secretary of State for Health asked the Panel to consider the proposals for maternity services developed by the Calderdale and Huddersfield PCTs. This is just one part of a much larger package of proposals for service changes proposed for CRH and HRI. In 2005/06 the health community held two consultations, covering acute services and mental health services. The Joint HOSC has agreed that both consultation processes met the requirements of sections 7 and 11 of the Health and Social Care Act 2001[6]. The Joint HOSC has also accepted the majority of the changes proposed. It has, for example, accepted the proposed changes covering emergency surgery, accident and emergency services, paediatrics and gynaecology as well as the changes proposed for St. Luke's Hospital – including its eventual closure. Only one aspect of the acute services consultation, involving maternity services, was referred to the Secretary of State.

5.1.2 It is worth stating here that the main driver behind these changes is not *existing* financial pressures but the desire to provide modern and sustainable services for the future. Bearing in mind staffing, training and accreditation issues, the viability of a range of clinical services often means that they have to be organised for a wider population. The PCTs and the NHS Trust have faced up to these issues and it is a great credit to them that it was possible to agree the majority of the proposals in the package. The Joint HOSC is also to be applauded for the very thorough way in which it has conducted its analysis of the proposals and for the quality of its response to the formal consultation.

5.1.3 Concerns have been expressed by those opposed to the proposals about the lack of alternative options presented. The consultation document, *Looking to the Future…your chance to have your say,* lists five options – each with unwelcome consequences for some of the population involved. But whatever the views expressed on the five options, two points seem clear: first, that maintenance of the status quo is not an option and secondly that no *other* realistic option has since emerged.

[6] The Health and Social Care Act 2001 places specific duties on NHS bodies in relation to consultation with overview and scrutiny committees and with the public. Further information can be found on the IRP website www.irpanel.org.uk

5.1.4 It is entirely understandable that people should be concerned about proposals for maternity services that would see consultant-led maternity services based at CRH with midwife-led units on both sites. For the people of Huddersfield and surrounding area, the loss of a consultant-led maternity service at HRI is a particular concern in view of perceived transport difficulties between CRH and HRI for women transferring during labour due to complications.

5.1.5 The Panel does not underestimate this concern and fully recognises the strength of public feeling on the issue. However, the appropriate provision of maternity services needs to take account of the "whole journey of childbirth". The current configuration of maternity services does not, in our view, provide either an optimum service for all women across Calderdale and Huddersfield or represent a sustainable model for the future.

5.1.6 **Recommendation One**

Overall, the Panel agrees that the proposals as set out in Option G3 of the consultation document (as described in para 4.6.2) represent the most appropriate way to deliver safe, effective and accessible maternity services for the 21st century.

5.1.7 While the issue of transfer between the two sites during labour is clearly a significant concern, other factors around safety have also to be borne in mind.

5.2 Safety issues

5.2.1 *Obstetrics*

NHS organisations have a statutory responsibility in relation to the standard of clinical care they provide. The Panel heard evidence about the need to meet standards set by national regulatory and accrediting bodies. The Royal College of Obstetricians and Gynaecologists (RCOG) is responsible for maintaining and improving standards in the practice of obstetrics and gynaecology. It also develops standards for education and training in obstetrics and gynaecology and its work informs other national bodies such as the NHS Litigation Authority (see paras 5.4.4 to 5.4.10).

5.2.2 The RCOG's standard for labour wards requires that dedicated consultant cover should be available for a minimum of 40 hours during the working week. This standard specifies

a minimum of 60 hours consultant cover per week by the end of 2008. The College also approves junior doctors' posts subject to compliance with appropriate training and supervisory standards. The Calderdale and Huddersfield Trust, in common with any other Trust providing consultant-led maternity services, is subject to review by the Postgraduate Medical Education and Training Board (PMETB). The NHS Trust's current training accreditation is conditional on achieving the 40 hour target. The withdrawal of support for training posts would have a severe impact on the ability of the Trust to recruit and retain staff.

5.2.3 Such national standards are developed for good reason – they enhance the safety of services. The maintenance of two consultant-led maternity units that do not meet modern standards is not acceptable. It has been suggested that both units could be maintained, at the required standards, by recruiting additional consultants. However, this ignores both the extra investment that would be needed to fund additional posts and the insufficient "throughput" of cases that would be required for consultants and junior staff to acquire and maintain specialist skills.

5.2.4 *Dedicated obstetric anaesthetists*

The Panel heard much about the importance of employing anaesthetists that specialise in obstetrics and that this would only be possible if the consultant-led maternity service was centralised in a single location. We tested this view with a range of professionals and the responses consistently supported this requirement. We were also told that, in this age of specialist anaesthetists, should the need arise for an anaesthetist during a birth, it is essential to be able to call upon someone with specialist obstetric skills. Trained obstetric anaesthetists are needed for the provision of an epidural service, elective Caesarean section lists and the antenatal and peripartum management of sick obstetric patients.

5.2.5 *Paediatrics and neonatal intensive care*

Agreement has already been reached that specialist neonatal and paediatric services will be sited at CRH with a paediatric assessment service retained at HRI. The Panel heard that there were good reasons for centralising neonatal services and that the regional neonatal network advised that for safety reasons a specialist neonatologist should not cover more than one site when on call. The current arrangements for providing neonatal support to Huddersfield are not sustainable as the paediatric rotas to cover both sites

could not be adequately staffed in the future due to changes in the maximum working hours arising from the EWTD, nor would the workload and case mix sustain adequate experience and training for junior staff.

5.2.6 The Panel supports the agreed approach. Centralising neonatal services will allow the maintenance of a "level 1" special care baby unit (SCBU), providing the basic level of care to less dependent babies and also a "level 2" high dependency neonatal service that can safely support those infants who are in need of more care. The most dependent babies will still need to be transferred to "level 3" neonatal intensive care services at Leeds, Bradford or Hull[7].

5.2.7 The Panel recognised the high level of dedication and loyalty in the SCBU staff at HRI but noted that maintaining adequate cover with such a small pool of trained staff was often dependent on goodwill. Consultant obstetric-led maternity services are by selection likely to include those women whose labour is more complicated. As a result, their babies are more likely to require neonatal support. If neonatal and paediatric services are to be situated at CRH then it follows that consultant-led maternity services should be sited there also.

5.2.8

Recommendation Two

The reconfiguration of services in Calderdale and Huddersfield has already agreed that paediatrics, including neonatology, should be centred on the CRH site. It follows, on grounds of safety, that consultant-led maternity services should also be sited at CRH.

5.2.9 Increasing the scale of the consultant-led maternity unit will present planning and management challenges that need to be carefully anticipated and should not be underestimated. Running a unit of this size is a quite different concept and lessons should be learned from units of a similar size working successfully elsewhere in the country.

[7] Units providing care for new-born babies fall into three categories from level 1 providing routine and special care to level 3 providing the most specialised intensive neonatal care. Report of the Neonatal Intensive Care Services Review Group, Department of Health April 2003

5.2.10 *Transfers between the two sites*

Widespread concern was expressed about transport issues though, inevitably, at times there was some confusion about the type of journey being undertaken. While many of those who gave evidence to us were also concerned about the difficulty of travelling between home and the consultant-led maternity unit at CRH, the major concern is around hospital to hospital transfer – when complications arise during labour.

5.2.11 Panel members undertook the journey between the two hospital sites on several occasions without any apparent difficulty. We recognise, though, that bottlenecks do occur particularly during the rush hour and when emergencies arise on the motorway. Members of the Joint HOSC that we met had accepted assurances from the ambulance service about target times for transfer and were content that ambulances could get through the traffic in an emergency.

5.2.12 We heard that the ambulance service and local NHS have held discussions about the arrangements needed to support the proposed changes to maternity services. Extending the availability of qualified paramedical staff in the ambulance service would be consistent with the changes. The PCTs will need to ensure that the plans and protocols drawn up for the service to be commissioned from the ambulance service are shared with the Joint HOSC and wider public.

5.2.13

Recommendation Three

The new Yorkshire Ambulance Service must be a key partner in the implementation of the changes to maternity services so that the Service can ensure it plays a full part in the success of the changes.

5.2.14 Although a considerable amount of work has already been done by the NHS Trust and the PCTs on assessing transport issues – and indeed on risk assessment in general – it is unfortunate that there seems to be little public awareness of this work.

5.2.15 The midwife-led unit that we saw in Bournemouth faces similar transport issues to those in Calderdale and Huddersfield and has not experienced any critical incidents resulting from the transfer of women in labour. The Kendal midwife-led unit we visited is an

equally successful unit, situated some 23 miles from the consultant-led unit at Lancaster. The Panel has seen no clear evidence to suggest that siting consultant-led maternity services at CRH would increase the risk of perinatal mortality or other adverse outcome compared to the current situation.

5.3 The midwife-led unit concept

5.3.1 Pregnancy and childbirth is, for the majority of women, a normal physiological process in which clinical intervention should only be used where indicated. In most instances, women can be most appropriately cared for by a midwife.

5.3.2 The maternity standard of the National Service Framework (NSF) for Children, Young People and Maternity Services was published by the Department of Health in 2004. The overarching statement of the standard is that "women should have easy access to supportive, high quality maternity services, designed around their individual needs and those of their babies". The standard requires NHS maternity care providers and PCTs to ensure that the range of antenatal care, birth and postnatal care services available locally constitutes real choice for women (including home births) and that local options for midwife-led care include midwife-led units in the community or on a hospital site.

5.3.3

Recommendation Four

Midwife-led units should be available on both the HRI and the CRH sites. Home births should also be available to all local mothers where appropriate.

5.3.4 The proposed midwife-led unit at HRI is seen by many as a *sop* to the local population of Huddersfield. There is a good deal of suspicion about its safety and its long-term viability. However, there are examples of successful units in other areas of the country and with good leadership, training and support of midwives there is no reason why women in Huddersfield should not have the opportunity to choose a birth not involving clinical intervention. The Huddersfield MLU should be established fostering the best qualities of the existing excellent midwifery workforce such as hard work, dedication and a patient centred approach.

5.3.5 If the midwife-led unit is to succeed, it is vital first to create a unit that is the pride of its midwives arising from their own competence and confidence. Secondly, when this has been achieved, the unit needs to build up a reputation based on the support of local mothers that will generate greater public confidence in it. Careful selection of women for the Huddersfield MLU will be essential – with proper protocols in place. These protocols are well established and in other successful units have resulted in very low complication rates. Women are assessed in the early stages of pregnancy and again throughout the antenatal period. If at any time they do not meet the criteria for a midwife-led birth then they are transferred to a consultant-led unit. In some cases during labour, unexpected complications may occur and transfer to CRH will be required. The Panel heard from other units in the country that even at this stage significant adverse events are rare.

5.3.6 The enthusiasm and commitment expressed by the senior midwifery staff we met can do much to generate confidence. The views expressed by other midwives, particularly those currently working at HRI, were more cautious. This needs to be addressed through good support and leadership, training and refreshing of skills - building on the existing structure of clinical leadership in midwifery to strengthen workforce as well as public confidence.

5.3.7 Conversations with the Royal College of Midwives reported much increased job satisfaction amongst those midwives in other parts of the country who had made similar transitions. For example, the midwife-led unit at Bournemouth is integrated with community midwifery, rotating staff between attending deliveries at home and in the Unit. Midwives' skills are kept up-to-date as well as ensuring that parents have an appropriate choice.

5.3.8 The Panel, of course, cannot give any guarantees that a midwife-led unit at HRI will remain viable in years to come. It will be up to the residents of Huddersfield whether they embrace the modern midwife-led unit or not but evidence elsewhere suggests a high level of satisfaction with midwife-led services and a high level of rebooking in future pregnancies from women who have experienced the difference. The RCM estimates that a midwife-led unit can be economically viable if it deals with a minimum of 350 births a year. The population of Huddersfield should be more than able to sustain this number of

births but will need reassurance about its safety. This should be provided by thorough ongoing audit and monitoring of outcomes.

5.3.9 The health community (PCTs and NHS Trust) resolved at the meeting of 22 March 2006 that a full maternity service would be maintained at HRI for a minimum of 12 months before moves to centralise consultant-led maternity services commenced and that a midwife-led unit would operate alongside a consultant-led service at HRI for up to six months before centralisation is completed. Since 22 March, the local NHS has indicated that the overall implementation period could be in the region of 18-24 months from commencement. An implementation plan should be drawn up – with identifiable markers put in place against which to demonstrate progress – on a timescale not exceeding two years.

5.3.10

Recommendation Five

The transition to the new service models should proceed over a maximum of two years and be fully implemented by the end of that period.

5.3.11 While we were visiting Calderdale and Huddersfield, the National Institute for Health and Clinical Excellence (NICE) issued draft guidelines on *Intrapartum care: care of healthy women and their babies during childbirth*. We note that these guidelines have been issued for consultation and we sought an opinion from the RCM in the course of our meeting with them. The College expressed some reservations about the transferability of the Norwegian study quoted in the draft guidelines to maternity services in this country. For example, the study was based on geographical service provision not with comparable clinical care and excludes variables like smoking.

5.4 Investment in community midwifery and health needs for disadvantaged groups

5.4.1 The expansion of community midwifery services, notably in Huddersfield and surrounding area, is a key component of the proposals. Much concern was expressed to us that the proposals will deprive the most disadvantaged and needy of access to services. Yet expansion of community midwifery services, if successful, would do exactly the opposite. Improved antenatal care, that reaches disadvantaged women early on in their pregnancies, has the potential to improve health outcomes for these women greatly.

5.4.2 Our visit to a Children's Centre in Huddersfield - the Chestnut Centre in Thornton Lodge on 7 July - provided a clear example of how disadvantaged women can benefit from community midwifery services. Maternity services are integrated with other family centred services provided by health and other agencies using the Centre as the hub. The alternative for many women would be not to access services at all. The advantage of this approach is twofold – it provides opportunities for addressing issues around social deprivation as well as facilitating greater continuity of care during pregnancy which should be a basic expectation for all pregnant women. The Panel was encouraged to hear that plans to increase the number of Children's Centres in the Huddersfield area, as joint ventures between local authorities and the NHS, are already in development.

5.4.3

Recommendation Six

Greater priority should be given to providing more antenatal, outpatient and postnatal care in the community with all midwives working in teams and their work involving both hospital and community work. Children's Centres are an ideal location for the provision of community maternity services and the number of Centres should be increased locally in line with existing plans.

5.4.4 The opportunity for more investment in community midwifery is an aspect of the proposals that seems to have been largely overlooked in much of the debate. Where it has been discussed, there has been widespread scepticism about whether sufficient funding will be forthcoming from potential savings on insurance premiums through the Clinical Negligence Scheme for Trusts (CNST).

5.4.5 The NHS Litigation Authority (NHSLA) is a special health authority responsible for handling negligence claims made against NHS bodies in England. The Authority administers the CNST which provides a means for NHS trusts to fund the cost of clinical negligence litigation. Trusts are assessed against standards of care from Level 0 to level 3. Compliance at higher levels allows trusts to claim a discount on their scheme contributions.

5.4.6 The NHS Trust is currently assessed at Level 1 by the NHSLA. To achieve Level 2 (which would provide a 20% discount for the following three financial years) the Trust needs to provide dedicated anaesthetic support for obstetric services as well as achieving other standards. At the moment, obstetric services share anaesthetists with operating theatres, critical care and A&E. The Trust also needs to have consultant obstetricians dedicated to the delivery suite for at least 40 hours a week

5.4.7 As discussed in paras 5.2.1 to 5.2.4 above, standards are put in place for the good reason that they enhance safety. The requirements to have 40 hours consultant cover in delivery suites and dedicated anaesthetic support for obstetric services are worthwhile objectives in their own right, regardless of potential savings on insurance premiums.

5.4.8 Equally, the potential benefits arising from the increased investment in community midwifery are so significant that their implementation should be assured regardless of whether any savings can be acquired through reduced CNST premiums.

5.4.9

Recommendation Seven

Improvements to midwifery in a community setting in Huddersfield are vital to address the needs of the most deprived women. These improvements should not be dependent on funding arising from the acquisition of CNST standards but should be given priority at the earliest stages of implementation.

5.4.10 The Panel understands that these improvements are not solely dependent for funding on potential savings arising from reduced CNST premiums and that savings arising from other "economies of scale", including the reduced need for additional junior doctor posts and changes to midwifery working practices, will also contribute to the cost. This does not appear to be widely understood amongst the wider public of Calderdale and Huddersfield, reinforcing our view that the investment in community midwifery has been an overlooked aspect of the proposals for maternity care.

5.5 Social implications

5.5.1 Much of the debate has centred on the wishes of Huddersfield residents for their children to be born in the town. While this desire is understandable people also accept that, in

complex cases, care has to be provided in specialist units. Under these proposals, Huddersfield residents would still be able to give birth in Huddersfield at the MLU or at home. Opting to do so would greatly enhance the long-term viability and success of the unit. As the maternity standard of the Children's NSF recognises, *"for the majority of women, pregnancy and childbirth are normal life events"*. Midwife-led care should be the norm for the majority of women.

5.5.2 Concern has also been expressed about transport difficulties for families and friends and also parking problems at CRH. It should be remembered that transfers between the two hospitals already occur in both directions for a variety of services. Urology and haematology are examples of services already provided from a single site – in these cases at HRI. As such, it should be recognised that transport between the two hospital sites is a vital part of the daily running of the NHS Trust.

5.5.3 The NHS Trust currently operates a bus service between the two sites and we were told of plans to increase its use for patients and visitors. The local NHS needs to follow through on the agreement made by the PCT Boards on 22 March 2006 to work with partners to improve access and transport links. The two metropolitan councils, as key stakeholders, also need to play a full part in this work.

5.5.4

Recommendation Eight

Transport is a vital component in a successful local NHS. A regular bus service available to patients, visitors and staff should run between HRI and CRH. The local NHS and the two metropolitan councils should consider how they can further improve transport links for the benefit of service users and families.

5.5.5 The Panel heard evidence of possible increases in the population of Huddersfield. A figure of 22,000 additional homes to be built in the town was frequently quoted. While there was also some uncertainty about precisely where or when these homes would be built, the NHS locally needs to be watchful of future health service requirements.

5.6. **Estate issues**

5.6.1 The reorganisation of services across the NHS Trust is intended to ensure that the best possible use is made of accommodation at both the HRI and CRH sites – resulting in the maximum patient benefit. For example, the vacated maternity accommodation at HRI will be available for improved surgical and orthopaedic wards and the expansion of the consultant-led maternity unit at CRH will make it possible to have refurbished accommodation for the relocated midwife-led unit on that site. The Panel considered that the advantages to be gained by the changes on both sites had not been sufficiently explained to the local public and, as a result, people were unable to see the benefits to them personally.

5.6.2 Concerns were expressed to us about insufficient accommodation being available for the expanded consultant-led maternity unit at CRH. When we were shown the plans for the reuse of accommodation it became clear that these concerns were unjustified. However, detailed plans made available to the general public would have helped local confidence in the proposals.

5.6.3 Concern was also expressed that the siting of the consultant-led maternity unit in CRH was, in some way, linked to the need to maintain the viability of the PFI build. We saw no evidence to support that view. Indeed, the overall proposals involve the relocation of a range of patient services and these will ensure the viability of both HRI and CRH sites to the benefit of local people in the future.

5.6.4

Recommendation Nine

The changes to local health services will free up accommodation enabling a number of clinical services to work in improved accommodation. Full advantage should be taken of these opportunities to the benefit of patients.

5.7 **Strategic planning**

5.7.1 The Panel noted evidence about maternity patient flows in and out of the Calderdale and Kirklees area. The data confirmed that Huddersfield and Calderdale were not greatly affected by neighbouring NHS facilities at present but that where necessary, as in the case of the neonatal network recommendations, strategic thinking had been appropriately applied.

5.7.2 We noted that work had been done by the former West Yorkshire SHA to promote the development of integrated service strategies in local communities. The new SHA for Yorkshire and the Humber will need to consider how HOSCs can be engaged in future work to complement the work done at local level.

5.8 **More widely**

5.8.1 It is clear from the views expressed to us that the process of public engagement and consultation did not entirely fulfil its purpose. Many members of the public felt that their comments had not been taken into account and there was a sense of unfairness, particularly amongst Huddersfield residents, about some of the decisions taken. But equally, it is true to say that NHS representatives felt a sense of frustration that sections of the local population appeared unwilling to recognise the need for service modernisation and planning for long-term sustainability of services that formed the main drivers for change.

5.8.2 It is not within the Panel's remit to advise on the process of engagement and consultation that took place since it was not part of the referral by the Joint HOSC. We would, however, make the comment that successful implementation of the proposals will only be achieved if key stakeholders now give their full support.

5.8.3

Recommendation Ten

With the Calderdale and Huddersfield NHS Trust having now achieved Foundation Status it will be vital that the Board and the membership of the Foundation Trust, key community leaders and stakeholders all give their full support to the successful implementation of the proposals.

SOME PERSONAL OBSERVATIONS

Dr Peter Barrett

I was extremely impressed by the mutual respect, diligence and mature debate on the part of the Joint HOSC and the NHS trusts. This has led to agreement about the majority of NHS service changes in the Calderdale and Huddersfield area; an achievement that should not be underestimated. Where there was remaining disagreement over maternity services this was approached with genuine concern, putting patients and their carers at the heart of the discussion. It seemed clear that, in this case, the proposed reconfiguration was not so much about money but more about the development of modern NHS services fit for the 21st century.

In approaching our task we kept to our remit of giving advice about the provision of safe, effective and accessible maternity services. There are inevitably strong emotions aroused when one community feels that part of their health service is being taken away and understandable fears for the viability of the services that remain. This is particularly true of maternity services and the feeling of being born into a particular community. Many feared this would be lost even if the journey to the nearest obstetric unit was just five miles away. There was also an attitude expressed that there should be the widest range of services in every community. Modern medicine cannot safely operate like this.

It depends on close co-operation between increasingly specialised consultant, nursing and support teams. This is especially true as regards maternity services. Midwives are the specialists in normal childbirth. When complications arise, a network of specialists including neonatologists, obstetricians and anaesthetists come together to provide leading edge services to those women who may require medical intervention. They are a limited resource and need to perform sufficient specialised work each year to maintain their skills and accreditation.

In the case of Calderdale and Huddersfield, combining the workload of the two obstetric units for those women needing specialist medical input during their pregnancies would provide sufficient work for training and recruitment and retention of consultants. It would also help provide for the increased demands in the future for better labour suite cover and the demands of the European Working Time Directive. Having decided this, it was a question of where to site the unit. Given agreement about the rest of the reconfiguration and the provision of anaesthetic and neonatal cover it is logical to place the obstetric-led maternity unit at Calderdale. This only

applied to those women requiring obstetric input into their labour and for many women with uncomplicated pregnancies the provision of midwife-led units in both Calderdale and Huddersfield will offer a more appropriate choice. A successful midwife-led unit builds on the notion that the birth of a child is essentially a normal procedure and that with the right advice, support, information and rigorous selection of mothers to be, it can offer an enhanced experience for the mother and the family. We visited examples of such units and I was impressed by the high levels of competence displayed by the staff and the absence of significant adverse outcomes during the years that they had been running. There are good examples of successful midwife-led units elsewhere in the country successfully maintaining their delivery rates. Those mothers that have used midwife-led units are likely to do so again.

Transport was one of the greatest concerns amongst the local Huddersfield people with fears expressed about the journey time between Huddersfield and Halifax. However, the distance of just over five miles between hospitals is much less than in many others in the country. Indeed the transfer of mothers from midwife-led units in other areas visited was not an issue despite greater distances involved and equally difficult traffic situations.

The ambulance service has given a commitment to meeting strict targets about transfer times and will need to be monitored closely to ensure that these are met. The need for transfer should be minimised by careful screening of patients in the antenatal period in accordance with national guidelines. There will be cases requiring emergency transfer during labour though a risk analysis has established the likely frequency of transfer to be low. Existing midwife-led units ensure the presence of a midwife in the ambulance during any such transfer.

For carers and family members, transport links should be expanded and attempts made to access funding to help with the cost of sustainable inter hospital transport. I was made aware of the deep levels of deprivation in certain areas of both communities. Huddersfield particularly suffered from low birth weight babies and increased perinatal mortality with an apparent reluctance of younger mothers to engage with health services. Continuing to do the same things in the same way as in the past will not produce the desired improvement in care. I welcome the community initiatives in reaching out to offer help and advice in a way that has not happened in the past. There is a unique opportunity for the people of Huddersfield to benefit from this innovative approach and lead the country in this development of health and social care but it needs a

guaranteed level of funding, independent of savings potentially made in other areas, adequate staffing and a clear strategy for the future.

In agreeing the shift of consultant-led maternity services to Calderdale, the people of Huddersfield must be reassured that what remains is safe and sustainable. This has to be linked to appropriate funding of first rate, innovative community women's and children's services, strict adherence to agreed transfer times by the ambulance service, appropriate training prior to any change in service, strict assessment of women in the antenatal period, and taking best practice from existing successful midwife-led units in other areas of the country.

List of abbreviations used

ANNP	Advanced neonatal nurse practitioner
CNST	Clinical Negligence Scheme for Trusts
CRH	Calderdale Royal Hospital
CHT	Calderdale and Huddersfield NHS Trust
EWTD	European Working Time Directive
HRI	Huddersfield Royal Infirmary
IRP	Independent Reconfiguration Panel
Joint HOSC	Calderdale and Kirklees Joint Health Overview and Scrutiny Committee
LDRP	Labour, delivery, recovery, postpartum
MLU	Midwife-led unit
NCT	National Childbirth Trust
NIC	Neonatal intensive care
NHSLA	National Health Service Litigation Authority
NSF	National Service Framework (in this case the Maternity standard of the NSF for Children, Young People and Maternity Services
PCTs	Calderdale, Huddersfield Central and South Huddersfield Primary Care Trusts
PFI	Private Finance Initiative
PMETB	Postgraduate Medical Education and Training Board
RCM	Royal College of Midwives
RCOG	Royal College of Obstetricians and Midwives
SCBU	Special care baby unit
SHA	West Yorkshire Strategic Health Authority (now part of Yorkshire and Humberside NHS)
SWYMHT	South West Yorkshire Mental Health Trust
WTE	Whole time equivalent

Appendix One

IRP general terms of reference

The Independent Reconfiguration Panel is an advisory non-departmental public body. Its terms of reference are:

A1. To provide expert advice on:

- Proposed NHS reconfigurations or significant service change;
- Options for NHS reconfigurations or significant service change;

referred to the Panel by Ministers.

A2. In providing advice, the Panel will take account of:

i. patient safety, clinical and service quality

ii. accessibility, service capacity and waiting times

iii. other national policies, for example, national service frameworks

iv. the rigour of consultation processes

v. the wider configuration of the NHS and other services locally, including likely future plans

vi. any other issues Ministers direct in relation to service reconfigurations generally or specific reconfigurations in particular.

A3. The advice will normally be developed by groups of experts not personally involved in the proposed reconfiguration or service change, the membership of which will be agreed formally with the Panel beforehand.

A4. The advice will be delivered within timescales agreed with the Panel by Ministers with a view to minimising delay and preventing disruption to services at local level.

B1. To offer *pre-formal consultation* generic advice and support to NHS and other interested bodies on the development of local proposals for reconfiguration or significant service change – including advice and support on methods for public engagement and formal public consultation.

C1. The effectiveness and operation of the Panel will be reviewed annually.

Appendix Two

Referral letter to Secretary of State for Health from Cllr Peter Coles

Please Contact: Geoff Ainsley
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Contact: John Heneghan
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Health and Social Care

Northgate House
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Date: 19th April 2006

Rt Hon Patricia Hewitt
Secretary of State for Health
Department of Health
Richmond House
79 Whitehall
London, SW1A 2NS

Dear Secretary of State,

REFERRAL TO THE SECRETARY OF STATE BY THE CALDERDALE AND KIRKLEES JOINT OVERVIEW AND SCRUTINY COMMITTEE

As you will be aware, in the case of formal consultations on proposals to significantly change local health services Overview and Scrutiny Committees have a power of referral to the Secretary of State.

Calderdale and Kirklees councils' overview and scrutiny functions have been formally consulted by the Calderdale and Huddersfield PCTs on proposals to reconfigure local health services. The proposals are contained in the consultation document - 'Looking to the future' - published October 2005, and the formal consultation took place between 6th October 2005 and 30th January 2006.

A joint committee of councillors from Calderdale and Kirklees councils was established to respond to the proposals, and a copy of their report is attached to this letter.

The joint committee has formally agreed that it is satisfied with the content and timing of the consultation and satisfied that the consultation process carried out by the Trust was adequate with regard to both Section 11 and Section 7 of the Health and Social Care Act 2001.

In its formal response to the consultation, the joint committee also made clear that it supported the majority of the proposals and felt them to be in the best interests of the local population.

However, the committee felt that one aspect of the proposals - option G3 for maternity services - was not in the best interests of the local population and agreed to refer ***this element*** of the proposals to the Secretary of State. The evidence to support this view is set out in committees'

final report, but the principle concerns are that the Trust should maintain obstetric cover on both hospital sites, for the following reasons:

- The committee is concerned that there needs to be broader, strategic planning at a regional level about the type and location of maternity provision.

- The committee accept that there are compelling clinical and policy drivers for change and that 'no change' is not an option. They also accept that resources need to be shifted away from hospital provision and towards community midwifery provision if the significant differences in health inequalities, particularly for more disadvantaged groups, are to be addressed. The massive variations in rates of infant mortality and low birth-weight babies for example, will not be tackled purely by investing in hospital provision.

- The committee are supportive of midwife-led care and the principle of midwife-led maternity units. They are sceptical, however, about the sustainability of the one being proposed for Huddersfield at this point in time, and feel that more needs to be done across the local health system to better support the normality of childbirth.

- While the committee have found many of the medical and clinical arguments to be compelling, there are also compelling social implications of the proposed model. The committee do not believe that the model for maternity services proposed in 'looking to the future' is in the best interests of the local population.

The committee is aware that the power of referral should not be used lightly and should only be used if attempts at local resolution are unsuccessful. The committee in their formal response to the consultation recommended that the Trust develop and discuss with the committee alternative models which would meet the required clinical criteria but also maintain obstetric cover on both hospital sites.

Dialogue between the committee and the PCTs and acute trust has taken place in this regard, including an informal meeting of the joint committee with senior managers and clinicians which took place on 27th February but attempts to find a local solution have proved unsuccessful, and the joint PCT board have now formally resolved (22 March) to approve their preferred option G3.

The committee have since received a formal response from the PCTs describing how they intend to meet the recommendations contained in the committees' report. The committee have considered this response and are grateful to the PCTs for their desire to address the committees' concerns. However, the committee still feel that, with regard to the proposals in respect of maternity services, the response does not address the fundamental concerns outlined above. In particular, members did not consider that the relatively short transition period proposed would be sufficient to address the current lack of local confidence in the proposed stand-alone, midwife-led unit.

The committee therefore believes there is no option other than to refer this element of the proposals and to request that the PCTs suspend the implementation plan for the service changes in relation to maternity services.

I look forward to your response to this referral and await your decision with interest.

Cllr Peter Coles
Chair

Appendix Three

Letter to Cllr Peter Coles from Secretary of State for Health

From the Rt Hon Patricia Hewitt MP
Secretary of State for Health

Richmond House
79 Whitehall
London
SW1A 2NS
Tel: 020 72103000

SofS 42504

Councillor Peter Coles
Chair
Calderdale and Kirklees Joint Overview and Scrutiny Committee
Northgate House
Halifax
HX11UN

01 JUN 2006

Dear Councillor Coles,

Thank you for your letter of 19 April.

I have reviewed your letter and the grounds for referral under the Local Authority (Overview & Scrutiny Committees Health and Scrutiny Functions) Regulations 2002, and have taken a view from the local NHS.

I have asked the Independent Reconfiguration Panel (IRP) to undertake a review of the issues raised over maternity services and to report back to me with their advice. I have asked my officials to liaise with the IRP to take this forward with the local NHS and the Joint Overview and Scrutiny Committee.

I am copying this to Margaret Edwards, Chief Executive, Yorkshire and the Humber SHA.

Yours sincerely,

PATRICIA HEWITT

Appendix Four

Letter to Dr Peter Barrett from Tim Young, Department of Health

Richmond House
79 Whitehall
London
SWIA 2NS
Tel: 020 7210 5783

Dr Peter Barrett
Chair
Independent Reconfiguration Panel
Kierran Cross
11 Strand
London WC2N 5HR

8 June 2006

Dear Peter

Referral to the Secretary of State for Health by the Calderdale and Kirklees Joint Overview and Scrutiny Committee

I am writing to you to confirm the request of the Secretary of State that the !RP provide her with advice in line with our agreed protocol on the reconfiguration of services issues referred to her recently by the joint Calderdale and Kirklees Councils' health overview and scrutiny committees (HOSC). I attach copies of her correspondence with the HOSC.

Background

Proposals to reconfigure local health services across Calderdale and Huddersfield have been developed by Calderdale, Huddersfield Central and South Huddersfield Primary Care Trusts. A public consultation exercise *"Looking to the Future...your chance to have your say"* was held between 6 October 2005 and 30 January 2006.

In accordance with Section 7 of the Health and Social Care Act 2001, Calderdale and Kirklees Councils' health overview and scrutiny committees (HOSC) were formally consulted and a joint HOSC was formed to respond to the proposals.

The Joint HOSC responded in January 2006 indicating its support for the majority of the proposals outlined in *"Looking to the Future...your chance to have your say"* with the exception of the proposals relating to maternity services.

At present, there are consultant-led obstetric units at both the Calderdale Royal Hospital and the Huddersfield Royal Infirmary. The PCTs' preferred option (Option G3) would see obstetric care centred on the Calderdale site together with an "alongside" midwife-led unit and a stand-alone midwife-led centre would be provided at the Huddersfield Royal Infirmary.

A joint committee of the Boards of Calderdale, Huddersfield Central and South Huddersfield PCTs met on 22 March 2006 and approved six resolutions, including the preferred option for maternity services. The Joint HOSC referred the decision relating to maternity services to the Secretary of State for Health on 19 April 2006.

The Joint HOSC has confirmed that it is satisfied with the content and timing of the consultation, and satisfied that the consultation process carried out by the Trusts was adequate with regard to both Section 7 and Section 11 of the Health and Social Care Act 2001.

Draft Terms of Referral to the IRP

I am arranging with the Secretary of State's office for you and Tony Shaw to have an opportunity to meet with her briefly later this month to discuss any particular issues you may wish to clarify from your initial work with the local NHS and other stakeholders, and to sign off agreed final terms of reference.

Initial terms of reference discussed with the Panel Secretariat are:

"The Panel is asked to advise the Secretary of State by 31 *August:*

a) Whether it is of the opinion that the proposals for changes to maternity services set out in the decision of 22 March 2006 (Option G3 *of "Looking to the Future...your chance to have your say") will ensure the provision of safe, effective and accessible maternity services for the people of Calderdale and Huddersfield. And if not, why not;*

b) On any other observations the Panel may wish to make in relation to the proposals for changes to maternity services and implications for any other clinical services; and

c) In the light of a) and b) above, on the Panel's advice on how to proceed in the best interests of local people.

It is understood that in formulating its advice the Panel will pay due regard to the principles set out in paragraph A2 of its general terms of reference. "

Best wishes

TIM YOUNG
RECOVERY AND SUPPORT UNIT

Appendix Five

Letter to Tim Young from Dr Peter Barrett

IRP

Kierran Cross
First Floor
11 Strand
London
WC2N 5HR

Tim Young
Recovery and Support Unit
Department of Health
79 Whitehall
London SWIA 2NS

4 July 2006

Dear Tim

Referral to the Secretary of State for Health by the Calderdale and Kirklees Joint Overview and Scrutiny Committee

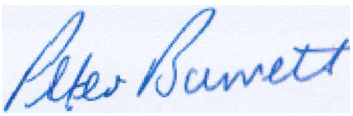
Thank you for your letter of 8 June about the above.

Following my meeting with the Secretary of State, I am happy to confirm that the Independent Reconfiguration Panel will provide advice in accordance with the terms of reference set out in your letter - and, as requested, by 31 August 2006. Specifically, we will offer advice on the proposals for changes to maternity services as agreed by the Boards of the Calderdale, Huddersfield Central and South Huddersfield PCTs at their meeting on 22 March 2006. The Panel's advice will *not* include consideration of proposals for changes to any other services agreed at the meeting of 22 March. The consultation process conducted by the Trusts under sections 7 and 11 of the Health and Social Care Act 2001 will also be outside our remit.

The process of calling for and reviewing evidence is already well advanced. Panel Members will be undertaking visits to Halifax (Calderdale) and Huddersfield shortly. We will be meeting people and hearing views from all sides of the debate.

As you know, in keeping with our commitment to open and transparent working, we will be publishing our advice on the IRP website. We would expect this to happen around four weeks after submission to the Secretary of State.

Yours sincerely



Dr Peter Barrett
Chair, Independent Reconfiguration Panel

Appendix Six

Letter to editors of local newspapers from Dr Peter Barrett, 27 June 2006

IRP

Kierran Cross
First Floor
11 Strand
London
WC2N 5HR

27 June 2006

For publication

Dear Editor

The Independent Reconfiguration Panel (IRP) has been asked by the Secretary of State for Health to review the maternity service proposals put forward by Calderdale, Huddersfield Central and South Huddersfield Primary Care Trusts. We are looking at whether their proposals will ensure the provision of safe, effective and accessible maternity services for the people of Calderdale and Huddersfield.

As part of our review, we are initially visiting Calderdale and Huddersfield on 7 and 11 July 2006 to talk to staff and patients and meet with people who believe they have new evidence that the panel should take into account. If you feel you have any new information, that was not submitted during the formal consultation, or feel you have not been heard we would like to hear from you. Please contact the communications team at West Yorkshire SHA at **sha.enquiries@westyorks.nhs.uk** or 0113 295 2141.

It is important that our review is open and accountable to the communities of Calderdale and Huddersfield. We will therefore publish our conclusions once they have been considered by the Secretary of State for Health.

Yours sincerely

Dr Peter Barrett CBE
Chair
Independent Reconfiguration Panel

Appendix Seven

Information made available to the Panel

Supporting papers

Paper	Title
1	Looking to the Future - Consultation Document
2	Looking to the Future – A Consultation Update
3	Joint PCT Paper - Approach to Analysing Responses
4	Joint PCT Paper - Option Appraisal Surgery for Women and Children
5	Joint PCT Paper – Role and Remit of the Joint Committee
6	Joint PCT Board Papers, 22 March 2006
7	Joint PCT Board Papers, 22 March 2006 – Supporting Papers Pack 1 and Pack 2
8	Joint PCT Board Minutes of Meeting, 22 March 2006
9	West Yorkshire Joint Health Scrutiny Committee Response to Consultation - Part A
10	West Yorkshire Joint Health Scrutiny Committee Response to Consultation - Part B appendices
11	West Yorkshire Joint Health Scrutiny Committee Response to Consultation - Referral Letter to Secretary of State for Health
12	PCTs' response to West Yorkshire Joint Health Scrutiny Committee
13	Letter - Kali Mountford MP to Secretary of State for Health
14	Letter - Secretary of State for Health to Kali Mountford MP
15	Letter - Secretary of State for Health to Peter Coles, HOSC Chair
16	Letter - Department of Health to Dr Peter Barrett, IRP Chair
17	IRP Background Template completed by West Yorkshire SHA
18	Calderdale and Huddersfield NHS Trust Workforce data
19	Calderdale and Huddersfield NHS Trust Star Ratings 2004/05 and Performance Summary
20	Calderdale and Huddersfield NHS Trust Service Listing
21	Calderdale & Huddersfield NHS Trust Paper – Decisions & Looking to the Future
22	Calderdale and Huddersfield NHS Trust – Links to Health Commission documents
23	West Yorkshire SHA Integrated Services Strategy: Maternity Services (working draft)
24	West Yorkshire SHA Integrated Services Strategy: National Drivers for change in maternity services
25	Children's Service Improvement Group – Submission to ISS Project Board
26	Women's Service Improvement Group – Submission to ISS Project Board
27	Department of Health Policy Advice
28	NICE draft guidelines for Intrapartum Care
29	Maternity Standard of the National Service Framework for Children, Young People and Maternity Services, September 2004
30	Random Survey of 30 Stand Alone Midwifery Led Units in England, Jan 2006
31	Maternity Services in the NHS, Reform, December 2005
32	Report on feasibility of maintaining a consultant-led obstetric service on Halifax and Huddersfield sites, Prof. J Thornton
33	PCTs' response to Prof. Thornton report
34	Annual Report of Director of Pubic Health for Huddersfield & District 2003
35	Annual Report of Director of Public Health for Huddersfield & District 2004/2005
36	Yorkshire Neonatal Network Business Plan
37	Letter – Mike Farrar, West Yorkshire SHA to Cllr Molly Walton
38	Letter – Margaret Edwards, West Yorkshire SHA to IRP
39	West Yorkshire SHA – Stocktake of Strategic Workforce
40	NHS Yorkshire and The Humber – briefing on maternity flows
41	Letter – Royal College of Obstetricians and Gynaecologists to Dr T Naeem, CRH
42	Letter - Huddersfield Patient & Public Involvement Forums to IRP
43	Letter - Letter from South Huddersfield PCT non executive directors

44	Letter - Calderdale and Huddersfield NHS Trust further Estates Information
45	West Yorkshire Joint Health Scrutiny Committee – list of written evidence considered
46	LAA Tracker Survey Indicators June 2006, Ipsos MORI
47	Infant Mortality Audit Protocol Data, Jorden & Varlow
48	Chronology re the Council's response to the proposals on maternity services (apart from the joint scrutiny process
49	Royal College of Midwives response to *Looking to the Future* Consultation
50	Letter – Carolyn Saville, RCM steward to Secretary of State for Health
51	Letter – Carolyn Saville, RCM steward to West Yorkshire Joint Health Scrutiny Committee
52	Note from local MPs on petitions
53	PCTs' briefing note on maternity service models
54	PCTs' briefing note – the next steps
55	Calderdale & Huddersfield NHS Trust – briefing note on NICE draft guidelines for Intrapartum Care
56	National Childbirth Trust - briefing on Midwife Led Units, Community Midwifery Units and Birth Centres
57	National Perinatal Epidemiology Unit - Birth Centre Review
58	National Childbirth Trust – Evidence based briefing: maternity care in birth centres
59	National Childbirth Trust – Reconfiguring Maternity Services: Views of User Representatives
60	Various articles from West Yorkshire regional press/BBC/Health Service Journal
61	*In good hands*, Royal Bournemouth Maternity Unit
62	*Birth, babies and beyond*, Royal Bournemouth Maternity Unit
63	The future role of the consultant: Setting standards to improve women's health, RCOG
64	Guidelines for the assessment and management of an impending birth in an ambulance setting, JRCALC
65	Investigation into 10 maternal deaths at Northwick Park Hospital, North West London Hospitals NHS Trust, Healthcare Commission
66	Towards Safer Childbirth: Minimum Standards for the Organisation of Labour Wards, 1999, Joint RCOG/RCM Working Party – currently being updated
67	*The place of birth: The Dutch midwifery system*, Beatrijs Smulders
68	Inclusion criteria for Home from Home Birth Centre, Guy's and St Thomas' Hospitals NHS Trust
69	Birth Centre Guidelines, The Mayday Healthcare NHS Trust
70	Acceptance Criteria for Midwifery-led Birth Centre Guidelines, CDDAH, County Durham
71	Birth Centre Admission Criteria, Dover and Canterbury Birth Centre
72	Maternity Services Booking Policy, West Wiltshire PCT
73	Guidelines for Maternity Care, Mid-Essex Hospital Services NHS Trust
74	Criteria for midwife-led care, Northern Devon Healthcare NHS Trust
75	Report of the Neonatal Intensive Care Services Review Group, DH April 2003

Correspondence submitted directly to IRP

1	Letter from Mrs K Elston, Huddersfield
2	Letter from C Herrero, Huddersfield
3	Letter from Sabrina Flack, Huddersfield
4	Letter from Mrs M Shaw, Huddersfield
5	Letter from John Smithson, Lib Dem Councillor for Almondbury Ward
6	Letter from C. A. Welburn, Huddersfield
7	Letter from Mr & Mrs Mellor, Huddersfield
8	Letter from Christine Hindle, Huddersfield
9	Letter from Mr & Mrs Martin, Huddersfield
10	Letter from Mrs Tindall, Huddersfield
11	Letter from Cllr Kath Pinnock, Lib Dem Leader in Kirklees
12	Letter from Arthur W Preston, Huddersfield
13	Letter from Mr & Mrs White, Huddersfield
14	Letter from K. A. Norcliffe, Huddersfield

15	Letter from Chris Taylor, Huddersfield
16	Letter from Nicola Cockcoft, Huddersfield
17	Letter from Cllr Nicola Turner, Lib Dem Councillor for Colne Valley Ward
18	Letter from Mrs C A Bradshaw, Huddersfield
19	Letter from B Cockcoft, Huddersfield
20	Letter from Mrs Barbara Farrand, Huddersfield
21	Letter from Bill Dicks, Huddersfield
22	Letter from Alex & Robert Law, Huddersfield
23	Letter from A Scott, Huddersfield
24	Letter from Carole Scott, Huddersfield
25	Letter from Fred Bradshaw & Cameron Boyd, Huddersfield
26	Letter from Dennis Hullock, Lib Dem Councillor for Dewsbury East Ward
27	Letter from Robert Iredale, Lib Dem Councillor for Golcar Ward
28	Email from Kirsty Tudor-McAdam (midwife)
29	Letter from Tony Woodhead, Lib Dem Councillor for Lindley Ward
30	Letter from Ann Denham, Lib Dem Councillor for Almondbury Ward
31	Letter from Margaret Dale, Non-exec Director, Huddersfield PCT
32	Email from Ruth Green (midwife at Huddersfield Royal Infirmary)
33	Letter from Adrian Murphy, Conservative Councillor for Kirkburton Ward
34	Letter from T Lloyd, Huddersfield
35	Emails from Carolyn Saville, RCM steward

Responses to the IRP Enquiry Line

1	Mrs Nicky Battye (phone + email x2)
2	Mrs J W Nicholson (phone)
3	Mrs Victoria Halstead (email)
4	Councillor Adrian Murphy (email)
5	Councillor Donald M Firth (email)
6	Ms Victoria Thornton (phone)
7	Miss Susan Harford (phone)
8	Miss Claire Kinder (phone + email)
9	Ms Debbie Hall (email)
10	Ms Laura Malik (email)
11	Ms Laura Malik (email)
12	Ms Patricia Parkin (phone)
13	Ms Annie Mosby (phone)
14	Ms Angela & Mr David Pogson (email)
15	Mr Ernie & Ms June Huby (email)
16	Ms Celia Morris (email)
17	Mrs Alison Simpson (email)
18	Ms Rachel & Mudiwa Zinyowera (email)
19	Ms Deborah Digman (email)
20	Mr R Morgan (email)
21	Ms Margaret Burgess (email)
22	Mr Matthew & Ms Laura Schofield (email)
23	Mr John Knox (email)
24	Aaron (email)
25	Mr John Penson (email)
26	Mrs Elaine Lockwood (phone)
27	Mrs Maureen Joyce Ward (phone)
28	Mrs Hilda Smith (phone)
29	Mr Carl Sykes (email)
30	Ms Helen Burrow (email)
31	Mrs Searby (phone)
32	Mr Paul Fahey (email)
33	Ms Annabel Herriott (email)

34	Mrs Karen Holroyd (phone)
35	Miss Kelly Gonsalves (email)
36	Dr Arthur Quarmby (email)
37	Mark Aylward (phone)
38	Ms Rachael Renton (email)
39	Mr Mark Branston (phone)
40	Mrs Betty Beecroft (phone)
41	Mrs Batty (phone)
42	Ms Moira Hannam (email)
43	Ms Marian Shaw (phone)
44	Mrs Adiba (phone)
45	Mrs Di Garrety (email)
46	Ms Rachel Cossey (email)
47	Ms Linda Dyson (email)
48	Mrs Margaret Hartley (email)
49	Ms Carol Wood (email)
50	Ms Helen Sykes (email)
51	Mr David Willis (email)
52	Mrs Kate England (email)
53	Ms Heather Fielden (phone)
54	Mrs Thelma Lloyd (phone)
55	Mr David Andrew Coldwell (phone)
56	MsMargaret Egglinton (phone)
57	Mrs Jennifer Coupland (phone)
58	MsJenny Burkinshaw (email)
59	Mrs Margaret Sharp (email)
60	Ms Joan M Colbeck (email)
61	Mr Rob & Ms Karen Heels (email)
62	Mrs Marcelle Jaggar (email)
63	Ms Carolyn Saville (email)
64	Ms Jayne Swaine (email)
65	Mr Bill Brown (phone)
66	Ms Christine Coe (phone)
67	Mrs Wait (phone)
68	Mrs Bretherick (phone)
69	Mr & Mrs JC Drury (phone)
70	Mrs Susan Buttle (phone)
71	Ms Lesley Earnshaw (email)
72	Christopher Sheard (email)
73	Mrs Phyllis Taylor (email)
74	Mrs Julie Yates (email)
75	Mr John Goodyear (email)
76	Anonymous (email)
77	Ms Jean and Mr John Hughes (email)
78	Ms Amy Davis (email)
79	Ms Diane DuQueno (email)
80	Ms Sue Kitching (email)
81	Ms Jan Boland (email)
82	Mr & Mrs S Townend (phone)
83	Ms Margaret Tiffany (email)
84	Sue Wood (email)
85	Ms Carol Paga (phone)
86	Mrs Manning (phone)
87	Ms Cheryl Lear (email)
88	Anonymous (email)
89	Chris Taylor (email)
90	Ms Kathleen and Mr Harry Stevens (email)
91	Mr Gordon Bray (email)

92	Ms Jackie Pearson (email)
93	Mr M D Hellawell (email)
94	P A Taylor (email)
95	Ms Helen Billingsley (phone)
96	Mr Shaukat (phone)
97	MsJane Freeth (phone)
98	Mr Saj (email)
99	Ms Joan Earnshaw (email)
100	Mrs June Hemingway (email)
101	Ms Mary Richards (email)
102	Mr Parr (phone)
103	Pat Kaye (phone)
104	Ms Carolyn North (email)
105	Ms Jacqueline Anne Fulton (email)
106	Ms Angela Langdon (email)
107	Mrs Vicki Stratford (email)
108	Ms Debbie Wadsworth (email)
109	Mr Jason Lear (email)
110	Mr Toni Mercer (email)
111	Mr David Osborne (email)
112	Ms Siobhan Beckwith (phone)
113	Ms Jane Horner (phone)
114	Ms Jean Moxon (phone)
115	Ms Fiona Weir (email)
116	Mr & Mrs Shahzad (email)
117	Mrs S Wilkinson (email)
118	Mr Alex Hutchinson (email)
119	Ms Joan Briggs (phone)
120	Mrs Doreen Blakeley (email)
121	Mr & Mrs Woodhead (email)
122	Ms Sheila Jaworski (email)
123	Mrs Brenda Whitaker (email)
124	Ms Kirsty Elston (email)
125	Mr Mark Hudson (email)
126	Mrs Jackie Kinder (email)
127	Mr Shaun Armstrong (email)
128	Ms Charlene Jones (email)
129	Ms Glynis Bellamy (phone)
130	Mr Alan Elston (email)
131	Ms Margaret Revitt (email)
132	Ms June Exley (phone)
133	JC Sandford (phone)
134	Mr Andrew Keith Sykes (phone)
135	Ms Tracey Hulsey (email)
136	Mr Alan Apps (email)
137	Miss Sarah Bretherick (email)
138	Ms Michele Hancock (email)
139	Ms Jean Ellis (phone)
140	Ms Rhoda Willoughby (email)
141	Mrs B Hinchcliffe (email)
142	Mrs Borg (email)
143	Dr Benster (phone)
144	Ms Judith O'Connor (email)
145	Ms Brenda Brown (phone)
146	Ms Lynda Firth (email)
147	Ms Sheila Taylor (email)
148	Mrs E Brown (email)
149	Ms Julia Skidmore (email)

150	D A Haigh (email)
151	Ms Wendy Dey (email)
152	Ms Dawn Ollerenshaw (email)
153	Ms Paul Rowlands (email)
154	Ms Patricia Fleming (email)
155	Ms Lydia Ellis (email)
156	Mr John Troughton (email)
157	Ms Angi Williams (email)
158	Mrs Sandra Holloway (email)
159	Mr & Mrs Helm (email)
160	Ms Heather Daluz Vieira (email)
161	Ms Samantha Clegg (phone)
162	Ms Doreen Brown (phone)
163	Mr Greg Munday (phone)
164	Mrs E Straszynski (phone)
165	Ms Clementina Herrero (phone)
166	Miss Kate and Mrs Lynne Pogson (email)
167	Ms Emma Townsend (email)
168	Mr Andrew Collins (email)
169	Ms Sylvia Firth (via email)
170	Mr J &and Ms S Garside (letter)
171	Mr Garrick Graham (letter)
172	Ms Elizabeth Kendal/Hall (email)
173	Ms Eve Nicholls (email)
174	Mr Paul Rowlands (email)
175	Ms Sarah Amies (phone)

Appendix Eight

Site visits, meetings and conversations

Calderdale and Huddersfield NHS Trust
Friday 7 July 2006

Ms Diane Whittingham	Chief Executive, Calderdale and Huddersfield NHS Trust
Mr Kevin Holder	Chief Executive, Huddersfield Central and South Huddersfield PCTs
Dr Jo Bibby	Project Director, Calderdale and Huddersfield NHS Community
Dr Yvette Oade	Consultant Paediatrician, Divisional Director for Children's and Women's Services, Calderdale and Huddersfield NHS Trust
Ms Anne Render	Matron for Neonatal Intensive Care, Paediatric Unit, Calderdale and Huddersfield NHS Trust
Ms Pauline Pilcher	Trust union convenor and steward, UNISON
Mr Peter Bower	Vice-Chair, Huddersfield Central PPI Forum
Dr Bob Hayes	PPI Chair, Calderdale and Huddersfield NHS Trust
Mr Mike Snee	PPI Chair, Calderdale PCT
Mr John Darley	Operations Director, Yorkshire Ambulance Service
Ms Jacque Gerrard	Head of Midwifery, Calderdale and Huddersfield NHS Trust
Ms Alison Lovatt	Assistant Divisional Director, Children's and Women's Services, Calderdale and Huddersfield NHS Trust
Dr Tahira Naeem	Consultant Obstetrician, RCOG Local Representative
Mr Martin de Bono	Consultant Obstetrician and Gynaecologist, Clinical Director for Women's Services
Ms Helen Shallow	Consultant Midwife, Calderdale and Huddersfield NHS Trust
Mr James Campbell	Consultant Obstetrician, Calderdale and Huddersfield NHS Trust
Ms Linda Hill	Matron Community Midwifery, Calderdale and Huddersfield NHS Trust
Dr Sohail Bhatti	Director of Public Health, Huddersfield Central PCT
Dr Bert Jindall	GP, Secretary Huddersfield Local Medical Committee
Ms Lorraine Taylor	Lead Midwife for Substance Abuse, Calderdale and Huddersfield NHS Trust
Ms Alison Taylor	Public Health Midwife, Calderdale and Huddersfield NHS Trust
Dr David Anderson	GP, Professional Executive Committee Chair, Huddersfield Central PCT
Dr David Wild	GP, Co-PEC Chair, Calderdale PCT
Ms Sarah Antemes	Health Visitor, Co-PEC Chair, Calderdale PCT
Dr Graham Wardman	Director of Public Health, Calderdale PCT
Ms Helen Thompson	Director of Nursing and Clinical Development, Calderdale and Huddersfield NHS Trust
Ms Carolyn Saville	Midwife, RCM Local Steward
Ms Pat Gould	RCM Regional Manager North East

Ms Ruth Hanson	RCM Steward
Ms Gill Adjie	RCM Regional Officer Yorkshire
Mr Mark Brearley	Director of Finance, Calderdale and Huddersfield NHS Trust

Methodist Mission, Huddersfield and Calderdale and Huddersfield NHS Trust
Tuesday 11 July 2006

Mr Gordon McLean	Chair, Calderdale and Huddersfield NHS Trust
Mr Gareth Pratt	Non-Executive Director, Huddersfield Central PCT
Mr Stuart Le Pla	Non-Executive Director, Huddersfield Central PCT
Ms Helen McKinlay	Non-Executive Director, South Huddersfield PCT
Mr Bill Mayers	Chair, South Huddersfield PCT
Ms Hazel Wigmore	Non-Executive Director, Huddersfield Central PCT
Cllr Mehboob Khan	Non-Executive Director, Huddersfield Central PCT and Kirklees Council
Mr David Payne	Non-Executive Director, South Huddersfield PCT
Mr Rob Napier	Chair, Huddersfield Central PCT
Ms Angela Monaghan	Non-Executive Director, Calderdale PCT
Mr Alan Burnett	Vice Chair, Calderdale PCT
Mr Rob Cooper	Deputy Chief Executive, NHS Yorkshire and the Humber
Dr Sue Proctor	Director of Nursing and Patient Care, NHS Yorkshire and the Humber
Mr Colin McIlwain	Senior Portfolio Manager, NHS Yorkshire and the Humber
Mr Roy Wright	Editor, Huddersfield Examiner
Cllr Peter Coles	Calderdale Council, Chair, Calderdale and Kirklees Joint Overview and Scrutiny Committee
Cllr Molly Walton	Kirklees Council (Chair Health Overview and Scrutiny Committee) Calderdale and Kirklees Joint Overview and Scrutiny Committee
Cllr Ann Raistrick	Kirklees Council, Calderdale and Kirklees Joint Overview and Scrutiny Committee
Cllr Elizabeth Smaje	Kirklees Council, Calderdale and Kirklees Joint Overview and Scrutiny Committee
Cllr Julie Stewart-Turner	Kirklees Council, Calderdale and Kirklees Joint Overview and Scrutiny Committee
Mr John Heneghan	Overview and Scrutiny Team Leader, Kirklees Council
Mr Geoff Ainsley	Support Officer, Calderdale Council
Cllr John Ford	Calderdale Council
Cllr Patrick Phillips	Calderdale Council
Cllr Bob Metcalf	Calderdale Council
Mr Owen Williams	Deputy Chief Executive, Calderdale Council
Cllr Andrew Cooper	Kirklees Council
Cllr John Smithson	Kirklees Council
Cllr Linda Wilkinson	Kirklees Council
Cllr Adrian Murphy	Kirklees Council
Cllr Terry Lyons	Kirklees Council
Cllr Jackie Grunsell	GP and Kirklees Council
Mr Tony Hood	Director of Adult and Community Services, Kirklees Council

Ms Diane Whittingham	Chief Executive, Calderdale and Huddersfield NHS Trust
Mr Martyn Pritchard	Chief Executive, Calderdale PCT
Mr Kevin Holder	Chief Executive, Huddersfield Central and South Huddersfield PCTs
Dr Yvette Oade	Consultant Paediatrician, Divisional Director of Children's and Women's Services, Calderdale and Huddersfield NHS Trust
Ms Alison Lovatt	Assistant Divisional Director, Children's and Women's Services, Calderdale and Huddersfield NHS Trust
Mr Martin de Bono	Consultant Obstetrician and Gynaecologist, Clinical Director of Women's Services, Calderdale and Huddersfield NHS Trust
Ms Jacque Gerrard	Head of Midwifery, Calderdale and Huddersfield NHS Trust

Methodist Mission, Huddersfield and Calderdale and Huddersfield NHS Trust
Monday 7 August 2006

Capt. Jane and Capt. Ernie Huby	Salvation Army
Ms Jean Moxon and	
Mrs Alice Fozard	Acute Forum PPIH
Ms Judith O'Connor	Midwife, Huddersfield Royal Infirmary
Mr Garrick Graham	Former Chair, Huddersfield NHS Trust & former Consultant Surgeon
Dr Barry Benster	Former Consultant Obstetrician and Gynaecologist

Calderdale and Huddersfield NHS Trust, Special Care Baby Units, HRI and CRH
Monday 7 August 2006

Ms Jackie Ledger	Senior Sister, Special Care Baby Unit, HRI
Ms Janet Powell	Paediatric Matron, Calderdale and Huddersfield NHS Trust
Dr Gill Sharp	Consultant Paediatrician, Calderdale and Huddersfield NHS Trust

Meetings with Dr Peter Barrett, Chair IRP
Monday 12 July 2006

Ms Christine McCafferty MP	Member of Parliament for Calder Valley
Ms Linda Riordon MP	Member of Parliament for Halifax

Wednesday 2 August 2006

Mr Barry Sheerman MP	Member of Parliament for Huddersfield
Ms Kali Mountford MP	Member of Parliament for Colne Valley

Tuesday 8 August 2006

Mrs Mary Creagh MP	Member of Parliament for Wakefield

Visit to midwife-led unit, Bournemouth Royal Hospital
Thursday 17 August 2006

Ms Belinda Atkinson	Director of Nursing
Ms Pippa Knight	Head of Midwifery

Meeting with the Royal College of Midwives
Wednesday 23 August 2006

Anne Jackson-Baker	Director, RCM UK Board for England
Pat Gould	RCM Regional Manager North

Telephone Conversation with National Childbirth Trust
Wednesday 23 August 2006

Mary Newburn	Head of Policy Research, NCT

Telephone Conversation with Royal College of Obstetricians and Gynaecologists
Thursday 24 August

Prof. Allan Templeton	President, RCOG

Meeting with Royal College of Obstetricians and Gynaecologists
Friday 25 August 2006

Prof. Shaughn O'Brien	Vice President of Standards, RCOG
Mrs Charnjit Dhillon	Director of Standards, RCOG

Visit to midwife-led unit, Helme Chase Maternity Hospital, Kendal
Tuesday 29 August 2006

Angela Oxley	Modern Matron

Appendix Nine

Panel membership

Chair

Peter Barrett	Chair, Nottingham University Hospitals NHS Trust Former General Practitioner, Nottingham

Members

Sanjay Chadha	Trustee, Multiple Sclerosis (MS) Society Justice of the Peace
Nicky Hayes	Consultant Nurse for Older People at King's College Hospital NHS Trust Clinical Director of the Care Homes Support Team
Nick Naftalin	Emeritus Consultant in Obstetrics and Gynaecology at University Hospitals of Leicester NHS Trust Former member of the National Clinical Governance Support Team
Ray Powles	Emeritus Professor of Haematological Oncology Institute of Cancer Research Former Head of Haemato-oncology, the Royal Marsden Hospital
Paul Roberts	Chief Executive Plymouth Hospitals NHS Trust
Mark Santer	Former Bishop of Birmingham Non-executive member of University Hospital Birmingham NHS Trust Board
Gina Tiller	Tutor for the University of Northumbria and for the TUC Chair of Newcastle PCT and of the Newcastle Health Partnership

Administration

Tony Shaw	Chief Executive
Martin Houghton	Secretary

Appendix Ten

About the Independent Reconfiguration Panel

The Independent Reconfiguration Panel (IRP) offers advice to the Secretary of State for Health on contested proposals for NHS reconfigurations and service changes in England. It also offers informal support and generic advice to the NHS, local authorities and other interested bodies in the consideration of issues around NHS service reconfiguration.

The Panel consists of a Chair, Dr Peter Barrett, and members providing an equal balance of clinical, managerial and patient and citizen representation.

Further information about the Panel and its work can be found on the IRP Website:

www.irpanel.org.uk