

Oxfordshire Joint Health Overview & Scrutiny Committee Monday, 7 August 2017

ADDENDA

4. Oxfordshire Big Health and Care Transformation - Phase 1 (Pages 1 - 366)

Since the Agenda despatch the approximated timings for this meeting have been revised to the following:

- 10.00 – 10.45 – Clinical Commissioning Group
- 10.45 – 12:05 – Speakers
- 12:05 – 12:15 – break
- 12:15 – 13:30 – Questions from the Committee
- 13:30 – 14:30 – Committee Lunch
- 14:30 – Committee comments and recommendations

The following reports are now attached:

- OTP – Decisions on Phase 1 consultation – HOSC covering paper;
- OTP – Phase 1 Decision Making Business Case – OCCG covering paper;
- OTP – Decision Making Business Case (Phase 1);
- The draft Minutes of the OCCG Board meeting held on 20 June 2017 at which the Phase 1 consultation outcomes were examined;
- The results of the OCCG commissioned Integrated Impact Assessment for Phase 1, including a travel and access analysis;
- The results of an OCCG commissioned parking survey at the John Radcliffe and Horton General Hospital sites undertaken by Mott McDonald; and
- The results of an OCCG commissioned qualitative survey undertaken by Healthwatch Oxfordshire capturing patient experiences of travelling and parking at Oxford University Hospitals NHS Trust sites hospital sites.

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Oxfordshire Joint Health and Overview Scrutiny Committee

Date of Meeting:

Monday 7 August 2017

Title of Paper:

Oxfordshire Transformation Programme – Decisions on Phase One Consultation

Purpose:

OCCG representatives have been invited to share the Decision Making Business Case and highlight how comments and concerns raised during the consultation have been addressed.

Senior Responsible Officer:

David Smith, Chief Executive, Oxfordshire Clinical Commissioning Group and
Catherine Mountford, Director of Governance

Oxfordshire Transformation Programme – Decisions on Phase One Consultation

Oxfordshire Clinical Commissioning Group has published the final recommendations on the proposals in Phase One of the Oxfordshire Transformation Plan. These recommendations will be discussed at the OCCG Board meeting on 10 August.

The main paper that has been published for the OCCG Board meeting is the Decision-Making Business Case (DMBC) which sets out the response to the consultation and the recommendations for decisions.

The following appendices to the DMBC have also been published:

- The Integrated Impact Assessment that sets out an analysis of the potential impact of the changes proposed.
- The Healthwatch report on a travel survey of patients attending the four acute hospital sites in Oxford and Banbury.
- The Motts MacDonald report on parking at the John Radcliffe and Horton Hospitals.

The public consultation has closed and no further responses can be accepted by the OCCG. However, at the request of Oxfordshire HOSC, OCCG representatives will be attending the HOSC meeting on 7 August to listen to any further comments and concerns of members to inform the Board discussion.

Where possible, their questions will be answered; however, it is important to note that no decisions have yet been made, and will not be made, until the OCCG Board meeting on 10 August.

Oxfordshire Clinical Commissioning Group Board Meeting

Date of Meeting: 10 August 2017

Paper No: 17/57

Title of Paper: Phase One of the Oxfordshire Transformation Programme –
Decision Making Business Case

Paper is for:

(please delete tick as appropriate)

Discussion

Decision

✓

Information

Purpose and Executive Summary:

The attached paper is the Decision Making Business Case for Phase One of the Oxfordshire Transformation Programme. It updates the information in the Pre Consultation Business Case including:

- details of the final proposals;
- the outcomes of the public consultation and how the views captured by the consultation were taken into account; and
- the findings of the formal impact assessments, additional work requested by the Board and the proposed mitigations that will be put in place to address any issues raised

It also demonstrates that the final proposals are sustainable in service, economic and financial terms and can be delivered within the planned capital spend.

Financial Implications of Paper:

The first Phase of the Oxfordshire Transformation Programme was focused on changes required to some clinical services for safety reasons and to improve outcomes for patients. In line with the guidance, the NHS England assurance process confirmed that the proposals outlined in the pre-consultation business case should be affordable in capital and revenue terms.

Action Required:

The OCCG Board is asked to consider five individual recommendations as a result of Phase One to address the need to provide high quality, safe and sustainable services. These are summarised below:

1. Critical Care

Move to a single Level 3 Critical Care Unit (CCU) for patients within Oxfordshire (and its neighbouring areas), located at the Oxford University Hospital (OUH) Oxford sites. The CCU at the HGH would become a Level 2 Centre, working in conjunction with the major centre in Oxford.

2. Acute Stroke Services

Secure an improvement in outcomes for stroke patients through direct conveyance of all patients where stroke is suspected from Oxfordshire (and its neighbouring areas) to the Hyper Acute Stroke Unit (HASU) at the John Radcliffe Hospital (JRH) in Oxford. This will be supported by the roll out of countywide Early Supported Discharge (ESD) (already available in two localities) to improve rehabilitation and outcomes.

3. Changes to Acute Bed Numbers

Agree to make permanent the planned closure of 146 acute beds thereby formalising the temporary changes made as part of the 'Rebalancing the System' delayed transfer project that has been running since November 2015. The implementation of this will be staged:

- 110 beds are already closed and will remain so and enable the investment in alternative services to be made permanent;
- The additional 36 beds will only be permanently closed when the system has made significant progress in reducing the numbers of delayed transfers of care. Any further planned closures will need to be reviewed by Thames Valley Clinical Senate and assured by NHS England.

4. Planned Care Services at the Horton General Hospital

Separate elective from emergency interventions at the HGH and localise care through the development of a new 21st century Diagnostic and Outpatient Facility; an Advanced Pre-operative Assessment Unit; and a reconfiguration of existing theatre space to act as a Co-ordinated Theatre Complex to improve elective services.

5. Maternity Services

Create a single specialist obstetric unit for Oxfordshire (and its neighbouring areas) at the JRH and establish a permanent Midwife Led Unit (MLU) at the HGH.

OCCG Priorities Supported (please delete tick as appropriate)

✓	Operational Delivery
✓	Transforming Health and Care
✓	Devolution and Integration

✓	Empowering Patients
✓	Engaging Communities
✓	System Leadership

Equality Analysis Outcome: An Integrated Impact Assessment is in progress.

Link to Risk:

AF21: Transformational Change

Author: Catherine Mountford, Director of Governance on behalf of the Transformation Programme Team

Clinical / Executive Lead: Dr Joe McManners, Clinical Chair and David Smith, Chief Executive

Date of Paper: 2 August 2017

Phase 1 of the Oxfordshire Transformation Programme – Decision Making Business Case

1. Introduction

Following OCCG Board agreement and NHSE England assurance of the Pre-consultation Business Case (PCBC) the public consultation on proposed changes to some health services in Oxfordshire took place between 16 January and 9 April 2017. It focussed on improving quality of services and making permanent some temporary changes made in 2016. This Phase One consultation was seeking views on:

- Changing the use of acute hospital beds across Oxfordshire
- Planned care services at the Horton General Hospital, Banbury
- Stroke services across Oxfordshire
- Critical care services at the Horton General Hospital, Banbury
- Maternity services, including obstetrics, special care baby unit and emergency gynaecology services at the Horton General Hospital, Banbury

This consultation was phase one of a two phase process. The plan for a split consultation and the plan for delivering the consultation were agreed with Oxfordshire Health Overview and Scrutiny Committee (HOSC) in November 2016.

The Board received the report of the consultation at its meeting on 20 June 2017 when it was

- Agreed it was assured on the consultation process
- Received the report on the consultation and noted the findings
- Noted the work being commissioned to ensure sufficient information would be available for the decision-making meeting on 10 August 2017
- Identified areas where additional information was required prior to decision-making.

The final step in the process is for the Board to receive the Decision Making Business Case (DMBC).

2. Decision Making Business Case

The attached report has been designed to act as the formal 'Decision Making Business Case' (DMBC) for the Oxfordshire Transformation Programme. It updates the information in the PCBC including:

- details of the final proposals;
- the outcomes of the public consultation and how the views captured by the consultation were taken into account; and
- the findings of the formal impact assessments and additional work requested by the Board and the proposed mitigations that will be put in place to address any issues raised

It also demonstrates that the final proposals are sustainable in service, economic and financial terms and can be delivered within the planned capital spend.

Further detail supporting this DMBC is available in a series of documents that the Oxfordshire Clinical Commissioning Group Board has previously considered as well as a small number of additional documents that have been produced to ensure the Board is fully informed. These documents are referenced throughout the DMBC and listed in Appendix A: copies have been made available to all Board members and published on the Transformation Programme website.

3. Acute Hospital Beds

Section 9 of the DMBC outlines the proposals for the permanent closure of hospital beds and development of community and ambulatory services to support the reduction in delayed transfers of care. These proposals have been considered retrospectively against the requirements of the NHS England Bed test and the outcome of this is included in the DMBC.

All acute hospitals have to manage their bed stock on a daily basis in line with operational service needs and safe staffing. This leads to some temporary beds closures and these are not part of the DMBC. Through ongoing work with the OUHFT and as part of the contract discussions we are aware that due to nurse staffing difficulties they have had temporary closures of beds across different areas of the Trust.

The Board of the Oxford University Hospitals NHS Foundation Trust considered contingency planning necessitating the potential emergency temporary closure of additional beds for patient safety reasons. In line with all other NHS organisations, the Trust has been undertaking a survey of its estate in the light of the Grenfell Tower fire. Information received by the Board on 27 July 2017 has identified the need to undertake urgent remedial works on its Trauma Unit on the John Radcliffe site. This will necessitate the reprovision of 52 beds.

The OCCG Chief Operating Officer continues to work with OUHFT and other partners to mitigate the impact of these operational pressures.

4. Current status of Legal Challenges and Referrals to Secretary of State

As the Board is aware there are challenges being pursued through judicial review and referral to Secretary of State for Health. These challenges will need to be addressed through the proper processes and this may take time. The current status of these is summarised below:

4.1 Application for Judicial review

In April 2017 Cherwell District Council, South Northamptonshire District Council, Stratford-on-Avon District Council and Banbury Town Council made an application for a judicial review of the consultation process.

We have received notification from the Court that the application for permission has now been considered on the papers and permission has not been granted.

The Claimants may apply for reconsideration of the application for permission at an oral hearing. The Claimant has 7 days from the date of receipt of the order to make such an application. The Court will rise for the summer recess from 31 July 2017 so we do not know when a hearing might be listed.

4.2 Referrals to the Secretary of State

There are two outstanding referrals to the Secretary of State

- Referral (14 February 2017) by Oxfordshire Joint Health Overview and Scrutiny Committee of OUHFT's temporary closure of the consultant-led maternity services at the Horton General Hospital.

We have received confirmation that the Secretary of State referred this to Independent Reconfiguration Panel on 1 August 2017 for an initial assessment. The IRP have been asked to respond by 1 September 2017.

- Referral (25 April 2017) by Stratford-on-Avon District Council regarding the adequacy of the consultation on the proposed changes

We have been informed that the Secretary of State has requested further information from the council.

5. Recommendations to the Board

The OCCG Board is asked to consider five individual recommendations as a result of Phase One to address the need to provide high quality, safe and sustainable services. These are summarised below:

1. Critical Care

Move to a single Level 3 Critical Care Unit (CCU) for patients within Oxfordshire (and its neighbouring areas), located at the Oxford University Hospital (OUH) Oxford sites. The CCU at the HGH would become a Level 2 Centre, working in conjunction with the major centre in Oxford.

2. Acute Stroke Services

Secure an improvement in outcomes for stroke patients through direct conveyance of all patients where stroke is suspected from Oxfordshire (and its neighbouring areas) to the Hyper Acute Stroke Unit (HASU) at the John Radcliffe Hospital (JRH) in Oxford. This will be supported by the roll out of countywide Early Supported Discharge (ESD) (already available in two localities) to improve rehabilitation and outcomes.

3. Changes to Acute Bed Numbers

Agree to make permanent the planned closure of 146 acute beds thereby formalising the temporary changes made as part of the 'Rebalancing the System' delayed transfer project that has been running since November 2015. The implementation of this will be staged:

- 110 beds are already closed and will remain so and enable the investment in alternative services to be made permanent;

- The additional 36 beds will only be permanently closed when the system has made significant progress in reducing the numbers of delayed transfers of care. Any further planned closures will need to be reviewed by Thames Valley Clinical Senate and assured by NHS England.
4. Planned Care Services at the Horton General Hospital
Separate elective from emergency interventions at the HGH and localise care through the development of a new 21st century Diagnostic and Outpatient Facility; an Advanced Pre-operative Assessment Unit; and a reconfiguration of existing theatre space to act as a Co-ordinated Theatre Complex to improve elective services.
 5. Maternity Services
Create a single specialist obstetric unit for Oxfordshire (and its neighbouring areas) at the JRH and establish a permanent Midwife Led Unit (MLU) at the HGH.

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Oxfordshire Transformation Programme

Decision Making Business Case (Phase One)

10 August 2017

Final

2 August 2017

Part One:

BACKGROUND AND CONTEXT

1. Introduction and Purpose

This report has been designed to act as the formal 'Decision Making Business Case' (DMBC) for the Oxfordshire Transformation Programme. It updates the information in the Pre-Consultation Business Case (PCBC) including:

- details of the final proposals;
- the outcomes of the public consultation and how the views captured by the consultation were taken into account; and
- *the findings of the formal impact assessments, additional work requested by the Board and the proposed mitigations that will be put in place to address any issues raised.*

It also demonstrates that the final proposals address key safety concerns, are sustainable in service, economic and financial terms and can be delivered within the planned capital spend.

Further detail supporting this DMBC is available in a series of documents that the Oxfordshire Clinical Commissioning Group (OCCG) Board has previously considered as well as a small number of additional documents that have been produced to ensure the Board is fully informed. These documents are referenced throughout this report and listed in Appendix A: copies have been made available to all Board members and published on the Oxfordshire Transformation Programme website.

2. Background

The Oxfordshire Transformation Programme was established to bring partners together to address the safety and sustainability challenges the health and social care system faces, including improving quality of service provision against a rising demand for services and budget pressures. More information on these challenges is available in the formal 'Case for Change'¹.

Changes to some services have already begun to be implemented. However, where proposals have the potential to result in significant change, they are being submitted to a two-stage NHS England assurance process and also shared with the public and stakeholders through a formal comprehensive consultation to obtain their views and feedback.

¹ The formal Case for Change is included in Chapter 4 of the *Pre-Consultation Business Case for Phase One (PCBC)*. This includes the overarching case for change for the Oxfordshire Transformation Programme and the detailed clinical case for change for each of the services within Phase One. This work built on the extensive public consultation and programme work undertaken during 2015 including the socialisation across the system of the 'Oxfordshire Storyboard' and the informal public and stakeholder consultation via 'The Big Conversation'.

2.1 A Phased Approach

The Oxfordshire Transformation Programme is taking a phased approach to developing, managing and consulting on its service change proposals.

The decision to split the Oxfordshire Transformation Programme into these two phases was taken based on advice from the Joint Health Overview and Scrutiny Committee (JHOSC).²

The first phase focused on those areas where there are the most pressing concerns about workforce, patient safety and healthcare (for example, where temporary changes have already had to be made) or where the proposed changes have been piloted. These included:

- **Critical Care at the Horton General Hospital;**
- **Acute Stroke services across Oxfordshire;**
- **Maternity services** - including obstetrics and the Special Care Baby Unit (SCBU) at the Horton General Hospital (HGH) (this also affects emergency gynaecology surgery);
- **Changes to Acute Bed Numbers** and increasing care closer to home in Oxfordshire;
- **Planned Care services at the Horton General Hospital (HGH)** - including elective care, diagnostics and outpatients. These proposals have the potential to significantly increase the services available to patients in north Oxfordshire.

2.2 Development of the Proposals

The Oxfordshire Transformation Programme has been clinically-led from the outset with clinicians developing the case for change; identifying best practice; formulating the vision; agreeing the range of options; identifying the requirements and assumptions for enabling functions within possible options (i.e. estates, technology, workforce); considering evaluation criteria; and testing and refining the options.³

² At their meeting on the 30 September 2016, the JHOSC advised that, should OCCG not be in a position to consult on its full plans for service transformation in January 2017, it should hold a 12 week consultation on the changes to bed numbers and maternity services at the Horton starting in January 2017. This led OCCG to revise its consultation plan. As further work was required to work up some of the proposals, and the CCG wished to undertake a longer period of engagement with stakeholders before launching a public consultation on these options, on this basis OCCG proposed to split the consultation into two phases. The JHOSC considered and approved this proposal at their meeting on 17 November 2016 and the Phased approach was formally agreed by the OCCG Board on 29 November 2016.

³ More information on the involvement of clinicians in Phase One is available in Section 7.4.8–7.4.15 of the *Pre-Consultation Business Case for Phase One*. Clinicians have continued to lead the work since the publication of the PCBC including: leading and participating in the public consultation

During development of the proposals, and as part of the NHS England assurance process, we are required to evaluate the financial impact of the proposals and to ensure that they are affordable and sustainable.

2.3 Cross-Boundary Working

The Transformation Programme has maintained close links with health commissioners, providers and GPs in neighbouring areas to ensure that all key organisations and individuals were aware of proposals as they were developed and have been able to highlight any potential implications for the populations they serve. (See section 4.3.1 for more information).

2.4 Formal Assurance

Phase One proposals were scrutinised by the Thames Valley Clinical Senate who held a formal assurance meeting to examine the proposals in Phase One on 7 November 2016.

The Phase One PCBC was approved (subject to receipt of NHSE assurance) in a confidential session of OCCG Board on 29 November 2016 and the proposals formally passed the NHS England assurance process on 5 December 2016.⁴ In approving the PCBC, NHS England recognised that the Oxfordshire Transformation Programme had met the 'Four Tests' for service change proposals. These are:

- Test One: Strong public and patient engagement
- Test Two: Consistency with current and prospective need for patient choice
- Test Three: A clear clinical evidence base; and
- Test Four: Support for proposals from clinical commissioners.

In line with the guidance, this NHS England assurance process also confirmed that the proposals outlined in the PCBC should be affordable in capital and revenue terms.

On the 3 March 2017, the Chief Executive of NHS England, Simon Stevens announced a new 'Patient Care Test for Hospital Bed Closures' for service reconfiguration plans that will apply to all future proposals for NHS reconfiguration that involve NHS bed closures. A retrospective assessment of

events; reviewing the consultation responses and Integrated Impact Assessment (IIA); developing appropriate mitigations in response to the issues raised in the consultation and the IIA; and, in the case of those involved in the maternity workstream, reviewing and evaluating a long list of options for obstetrics.

⁴ Members of the Board should refer to the final *Pre-Consultation Business Case for Phase One*.

the compliance of the Phase One proposals with the new 'Patient Care Test' was undertaken during the summer of 2017.⁵

NHS England received the report from the Thames Valley Clinical Senate setting out their review of Phase One proposals for bed closures against the 5th test.

The Senate recommended that the conditions for the NHS Bed Test had been met subject to the following:

- 1) The delays associated with patients being referred to HART need to be resolved and there needs to be sufficient capacity for HART to discharge once their element of service provision is completed. The Senate was advised that this is currently a problem for HART.
- 2) The Oxfordshire CCG should monitor the system and take action to ensure that delays do not build with regard to the discharge to domiciliary care.
- 3) The Senate retrospective review was based on the current closure of 110 beds. It did not consider any future closures

NHS England, 31 July, 2017, confirmed that it is content to accept the recommendations of the Senate as set out above regarding the review and compliance against the 5th test based on the closure of 110 beds. Any proposal to further reduce beds would need to be reviewed by the Senate.

2.5 The Consultation and Additional Work

A formal twelve week public consultation was held between 16 January and 9 April 2017.

During the first half of 2017, the Oxfordshire Transformation Programme has also undertaken additional work to supplement the analysis described in the PCBC. This will ensure OCCG Board has the maximum amount of information available when considering the way forward. This additional work includes:

- An Integrated Impact Assessment;
- Two pieces of independent travel analysis conducted by Healthwatch and Mott MacDonald;
- A further review of potential obstetric options including those already identified during the consultation in order to provide assurance that all variant options have been considered.

⁵ The NHS England assurance process for Phase One had been completed before this new test was introduced.

3. Recommendations

The OCCG Board is asked to consider five individual recommendations as a result of Phase One to address the need to provide high quality, safe and sustainable services. These are summarised below:

1. Critical Care

Move to a single Level 3 Critical Care Unit (CCU) for patients within Oxfordshire (and its neighbouring areas), located at the Oxford University Hospital (OUH) Oxford sites. The CCU at the HGH would become a Level 2 Centre, working in conjunction with the major centre in Oxford. (Definitions of Level 3 and Level 2 Critical Care can be found on page 23)

2. Acute Stroke Services

Secure an improvement in outcomes for stroke patients through direct conveyance of all patients where stroke is suspected from Oxfordshire (and its neighbouring areas) to the Hyper Acute Stroke Unit (HASU) at the John Radcliffe Hospital (JRH) in Oxford. This will be supported by the roll out of countywide Early Supported Discharge (ESD) (already available in two localities) to improve rehabilitation and outcomes.⁶

3. Changes to Acute Bed Numbers

Agree to make permanent the planned closure of 146 acute beds thereby formalising the temporary changes made as part of the 'Rebalancing the System' delayed transfer project that has been running since November 2015.⁷ The implementation of this will be staged:

- 110 beds are already closed and will remain so and enable the investment in alternative services to be made permanent;⁸
- The additional 36 beds will only be permanently closed when the system has made significant progress in reducing the numbers of delayed transfers of care. Any further planned closures will need to be reviewed by Thames Valley Clinical Senate and assured by NHS England.

The work on 'Rebalancing the System' will continue and this includes ongoing work on clinical pathways which may, in the future, lead to

⁶ Stroke rehabilitation beds will be considered as part of Phase Two.

⁷ This final figure of 146 has been revised from the *Pre-Consultation Business Case for Phase One* when 194 bed closures were planned: more information on this is included in section 9 of this report and in the supplementary paper on the new 'Patient Care Test'.

⁸ A list of these beds and the site is included in the table in section 9.1.1

proposals to change the numbers of beds: These will be subject to NHS England's assurance and public consultation processes.

4. Planned Care Services at the Horton General Hospital

Separate elective from emergency interventions at the HGH and localise care through the development of a new 21st century Diagnostic and Outpatient Facility; an Advanced Pre-operative Assessment Unit; and a reconfiguration of existing theatre space to act as a Co-ordinated Theatre Complex to improve elective services.

The proposed changes and timeline are outlined in more detail in section 10 of this report.

5. Maternity Services

Create a single specialist obstetric unit for Oxfordshire (and its neighbouring areas) at the JRH and establish a permanent Midwife Led Unit (MLU) at the HGH.

More information about each of the five areas is provided in Sections 7-11 of this report including the additional work that has been undertaken since the publication of the PCBC and the issues and concerns raised by stakeholders in the formal 12 week consultation.

Before looking at these specifics it is, however, useful to understand the background and context of this additional work alongside a consideration of any cross-cutting themes that apply across Phase One.

Part Two:

CROSS-CUTTING ISSUES

4. The Public Consultation

4.1 The approach to the public consultation and number of responses

Following a period of pre-engagement during summer/autumn 2016 including the Big Health and Care Conversation Roadshows, OCCG undertook a comprehensive 12 week public consultation between 16 January and 9 April 2017 to gather views from across Oxfordshire and surrounding areas about proposed changes in Phase One of the Transformation programme.

More than 10,000 individual responses were received by OCCG and more than 1,400 people attended the public meetings.⁹ Detailed information on the promotion of the consultation, the methodology used, and the views expressed are available in the *Big Health and Care Consultation Report* published in May 2017.

There was criticism of the survey used as part of the consultation and there was, as a result, some distrust of the survey by members of the public. It should, however, be noted that the survey was not the only way people could respond: OCCG accepted comments in any form people wished to use and all feedback was passed to QA Research who analysed the responses and produced the consultation report.

4.2 Response to the Consultation

The consultation report, and supporting Stakeholder Response Pack, has been considered by all those involved in the Oxfordshire Transformation Programme. Sections 7 to 11 of this DMBC outline the issues raised during the consultation for each individual clinical area along with the response of the relevant workstream.

Travel and concerns about car parking were also raised and the Oxfordshire Transformation Programme responded by commissioning two pieces of independent travel / car parking analysis to provide more information on the extent of the problems in this area. This is summarised in section 6 below.

4.3 Discussions at the OCCG Board on 20 June 2017

The consultation report was formally presented to the OCCG Board at its meeting on 20 June 2017. The Board made a number of requests for additional information and assurance at this meeting. Those which relate to a specific clinical recommendation have been incorporated into the relevant

⁹ 646 surveys were completed (509 online and 137 self-completion); 1,407 people attended the 15 public meetings held; 9,248 letters from the public were received; and 43 submissions were received from stakeholders.

section of this DMBC. There were, however, several issues that relate to the whole of the Phase One and these are covered here.

4.3.1 Cross-boundary working

Throughout the development of the proposals the Oxfordshire Transformation Programme has maintained close links with health commissioners, providers and GPs in neighbouring areas. For example:

- OCCG has taken steps to facilitate cross-boundary meetings (such as a system-wide ambulance workshop¹⁰) and to organise events outside of the formal Oxfordshire boundary (such as visiting GP surgeries in South Warwickshire and Northamptonshire during, and after, the public consultation.¹¹)
- OCCG has used existing formal mechanisms to engage with neighbouring areas such as the Community Partnership Network which considers the needs of patients in North Oxfordshire and the surrounding areas. Membership includes North Oxfordshire Locality GPs (NOLG), OUHFT, Oxfordshire Hospital Foundation Trust (OUHFT), Oxfordshire County Council (OCC), NHS England, Cherwell District Council, South Northamptonshire Council, Stratford on Avon District Council, Banbury Town Council, West Oxfordshire District Council (WODC), North East Oxfordshire Locality GPs (NELG), Nene CCG, Keep the Horton General Campaign, Healthwatch Oxfordshire, Age UK, Oxfordshire Joint Health Overview and Scrutiny Committee (JHOSC)
- Formal letters were sent to all neighbouring organisations both before and during the consultation to ask for their views on the potential implications for their patients. The feedback from this correspondence was included within the Phase One Consultation Report.
- During the consultation, OUHFT engaged with providers in South Warwickshire NHS Foundation Trust (SWFT) and Northamptonshire General Hospital Trust to ensure the implications of the proposals were fully understood and that support for the proposals was secured.
- During the consultation, OCCG also attended a meeting of Stratford-Upon-Avon District Council on 24 March 2017.

¹⁰ On 16 June 2017 OCCG and OUHFT jointly met with the three Ambulance Services – South Central Ambulance Service (SCAS), East Midlands Ambulance Service (EMAS) & West Midlands Ambulance Service (WMAS) – in order to discuss the HGH proposals and the potential implication for each of the ambulance trusts.

¹¹ OCCG met with a range of GPs in Warwickshire and Northamptonshire, in support of the wider public consultation. This has formed an important dialogue which is outside of OCCG's Primary Care locality structures. These discussions have continued since the public consultation and will be used to help shape and test the thinking of Phase Two.

- Additional engagement with CCGs has focused upon South Warwickshire CCG and Nene CCG, reflecting the level of usage by their patients of services at the HGH. Both South Warwickshire CCG and Nene CCG have confirmed to OCCG that they are aware that the proposals will have an impact on some of their population and, if necessary, they will change the way in which they commission these services.

OCCG has also supported the scrutiny function of the local authorities at both District and County Councils. The Oxfordshire JHOSC has scrutinised the Oxfordshire Transformation Programme's plans and proposals in order to ensure the populations surrounding Oxfordshire that would have an interest in the proposed changes have been part of a meaningful dialogue.

4.3.2 Analysis of responses

At their meeting in public on 20 June 2017, OCCG Board noted that all the letters received during the consultation had been read and analysed and that the issues raised were fed into the consultation report. It was, however, agreed that further checks would be made to ensure the analysis was complete with a review to be undertaken of the personalised/individual letters with the support of the OCCG Board Lay Member for PPI.

For the analysis, the 9,248 letters received from members of the public, were organised into those that were template letters (8,036) and those that were either personally written or annotated (1,212). The personal letters were reviewed again to check against the key themes identified by the original analysis.

On 27 July 2017 the Lay Member PPI and a senior member of the Communication and Engagement team reviewed this group of letters. No new, previously unidentified, themes were identified during this review. However, it was noted that the anecdotal references to individual experience were not reflected in the consultation report.

The stories shared can help to illustrate the views shared by members of the public but they are not always easy to analyse. Some are based on personal experience others are stories about someone known to the writer. Usually it is not clear if the experience is recent or took place some time ago.

The experiences shared mostly related to maternity and A&E describing:

- Positive experiences of giving birth at HGH, valuing the staff involved in their care and the ease of access to where they live.
- Instances where the birth had not progressed as expected causing the mother to need emergency obstetric, anaesthetic medical care, or the baby needing neonatal paediatric medical care. The concern expressed by

these respondents was that if the same experience were to happen today, they would fear for their safety and that of their baby as they would need to transfer to Oxford as an emergency.

- Instances where labour started at home and developed into an emergency requiring them to attend the obstetric unit at HGH quickly. The concerns expressed were about the increased distance and travel times between home and Oxford or another hospital meaning they would fear for their safety and that of their baby.
- Experiences of attending the consultant led A&E and it being life saving for them or a family member and fearing future closure or changes to the HGH A&E service.
- Experiences relating to prolonged travel times to Oxford for a wide range of services, the inaccessibility in terms of car parking, and the costs to families that some cannot afford.

The review did not identify any issues of poor care that have not been reported

4.3.3 Impact from any loss of service

OCCG Board agreed that the justification for splitting the consultation into two parts (see section 2.1 above) was based upon concerns over safety and quality but assurance was required that the Phase One recommendations would not prejudice the options in Phase Two.

OCCG maintains an open mind about the services that will be consulted on in the Phase Two and is currently considering all options that may be appropriate to meet the needs of the population of Oxfordshire. This will require OCCG to re-state the Case for Change, which is planned during September and October 2017.

The Board asked for specific reassurance around the reduction in anaesthetic cover at HGH as a result of the maternity proposals. The proposals in Phase One of the consultation in respect of the obstetric unit at HGH will not have a material impact on services that may be subject to consultation in Phase Two (see page 65 for more detail). Health Education England (Thames Valley) has also confirmed that the presence or absence of obstetrics on the HGH site does not affect the training accreditation of junior medical staff in anaesthetics or General Practice.

4.3.4 Capacity

The OCCG Board requested greater assurance that the JRH, NOC and the CH have the capacity to manage the proposed increase in patient numbers.

Maternity Services

The most significant proposed shift of patient activity from the HGH to the JRH is in obstetrics. There is re-assurance for OCCG in the respect that a Contingency Plan was agreed by OUHFT Board in August 2016 and implemented prior to the temporary closure of the HGH obstetric service in October 2016. The Contingency Plan increased the physical capacity in obstetrics at the JRH including creating an additional 11 beds on the maternity ward. The additional beds have been utilised on a minimal number of occasions and were not required at all in two of the months from October 2016 to March 2017. There has not been an occasion when pregnant mothers have been redirected to other units. As a precautionary measure, bookings of secondary level obstetric patients from outside Oxfordshire were suspended in autumn 2016 but booking was re-opened to mothers from surrounding counties in May 2017.

Centralising the obstetric medical team for the county will provide a more resilient service from a staffing perspective. More detail on OUHFT's plans for staffing are included in section 11.5.

There is an anticipated growth in birth numbers across Oxfordshire (700 p.a. increase by 2026) and the surrounding counties and there are discussions taking place across the Thames Valley area to identify the requirement for further physical expansion at JRH.

Both South Warwickshire NHS Foundation Trust and Northampton General Hospital NHS Trusts have confirmed that they have sufficient capacity for the potential increase in obstetric deliveries from the Stratford and Brackley areas respectively. Northampton opened an alongside MLU four years ago and work is currently underway to deliver an alongside MLU at Warwick in early 2018.

Critical Care

In the last full year, 41 patients (using 162 bed days) were admitted to the Level 3 critical care unit at HGH. OUHFT estimates that approximately 50 – 70% of these patients would meet the criteria for admission to a Level 3 critical care bed in Oxford. This represents a 1 - 2 % change in the volume of patients being treated in the JRH and CH. The capacity constraint is mitigated by the maintenance of Level 2 critical care at HGH and the transfer of patients to HGH once they no longer require Level 3 services.

Most of the patients from the catchment population of HGH already receive Level 3 care in Oxford, as many of the associated patient pathways have been centralised for safety reasons. Examples include heart attacks, major trauma and emergency surgery.

Acute Stroke Services

An additional 100 stroke patients will use the HASU at JRH if the proposals are implemented. The flow of patients will be enhanced by the expansion of the ESD across the entire county and by the transfer of stroke patients to the HGH following initial treatment in Oxford for rehabilitation closer to (or at) home.

Planned Care Services at the Horton General Hospital

The substantial proposals for developing Planned Care at HGH will require significant additional capacity on the site. If approved a detailed business case will be developed, part of which will make the argument for a multi-million pound capital investment (see finance section for more detail of capital requirements). Where possible services will be moved in advance of a new build – see Section 10.5 for further detail.

4.3.5 Ambulance Services

The Board requested further assurance that the South Central Ambulance Service (SCAS) could deal with the proposed changes and requested further information on how the relationship between SCAS and the other ambulance services would be affected by the proposals. SCAS has confirmed that the trust does not have any significant clinical concerns with regard to the changes in services in Phase One that have been proposed by OCCG.¹²

The trust has stated that that it will continue to work with OCCG to mitigate the impacts the changes will have on its 999 and Non-Emergency Patient Transport Services (NEPTS).

Critical Care and Acute Stroke Services

SCAS representatives were members of the Urgent and Emergency workstream and are familiar with proposals for the changed pathways for stroke and critical care patients in the North of the County. The trust is supportive of the proposals for all acute stroke patients in the north of the county to go directly to the JRH where the local HASU is situated.

¹² SCAS letter 31.7.2017: Representatives of our Trust have been involved in the consultation process for phase One outside of the workstreams to ensure we provided comprehensive input and responded to the proposals. The Trust is supportive of the proposals within Phase One and whilst these changes will require proper planning and resourcing we recognise that the proposals will improve outcomes for these patients and therefore align with the Trusts strategic vision

Obstetric centralisation

As part of the proposals, obstetric services will be centralised at the JRH and the MLU at the HGH will be made permanent. A dedicated ambulance at the HGH site has been available during the period of the temporary closure of obstetrics at HGH and therefore it has not been necessary to trial transfers using the SCAS Ambulance service.

The transfers to the JRH from the other three freestanding MLUs are undertaken by SCAS clinical staff with an accompanying midwife. This has been shown to be safe and there have not been any adverse events reported using this system. SCAS does not have any clinical concerns with regards to the proposals to centralise obstetric services at the JRH in Oxford and are aware of the potential for additional planned non-emergency patient transports and longer transport times for some patients. SCAS is discussing additional training and support for its clinicians to support longer transport times.

Planned Care at the Horton General Hospital

The proposals for Planned Care and Ambulatory Care will not impact significantly on SCAS and are likely to reduce the demand on its capacity in this regard.

Summary

The proposals in Phase One have been discussed at the Oxfordshire Transformation Board (between 2015- 2017) and through all the relevant clinical workstreams. SCAS does not have any clinical safety concerns with regards to the changes in services that have been proposed by OCCG.

In terms of the capacity of the ambulance service to deliver increased journey distances, it is accepted that the some of the proposals may result in longer travel distances for some ambulance journeys. To that extent, OCCG has asked SCAS to model the impact on their services and identify any reasonable marginal increase in costs associated with the proposals.

5. The Integrated Impact Assessment (IIA)

The aim of the Phase One IIA is explore the positive and negative consequences of the Phase One proposals on health outcomes and health inequalities and provide advice on a set of evidence-based practical recommendations that would mitigate any potential negative impacts that have been identified, particularly for those most vulnerable in our population.

The IIA was undertaken by external consultants Mott MacDonald (Phase One IIA is available on the Oxfordshire Transformation website) and Chapter One

of their report describes the methodology used. The IIA considered the potential impacts in the following areas:

- Health
- Equality
- Sustainability
- Travel and Access

More detail is included in the report itself but the main conclusions for each of these areas is summarised below. The Oxfordshire Transformation Programme's response to these issues varies depending on the clinical area under consideration and are, therefore, described in Part Three of this report.

5.1 Health Impacts

Across the clinical areas considered within Phase One, Mott MacDonald found a number of common impacts for consideration including workforce, safety and healthcare¹³:

- Improved outcomes for patients, as a result of concentrating specific services on certain hospital sites, or creating new specialist centres such as a HASU or an outpatient and diagnostic centre. Whilst this may result in increased journey times for some patients and their visitors and carers, this will allow all patients from across Oxfordshire to benefit from the improved outcomes demonstrated at some hospitals, as well as providing the critical mass of activity that allows the workforce to maintain their skill set and ensure that recognised clinical and workforce standards can be achieved.
- Improved patient experience, as a result of access to joined up care provided through redesigned hospital services where a one stop shop for diagnostic and outpatient services will be available.
- Similarly, the concentration of expertise on certain sites, such as obstetric care at JRH, will allow clinical resources to be pooled, supporting the achievement of workforce standards.
- Staff may experience negative impacts if they are required to change their permanent place of employment. These include some staff having to travel further to their place of work; which is likely to have an impact in terms of the personal costs of travel and the inconvenience associated with additional journey times. Ultimately, this may have an impact on the retention of staff. Counter to this, through the creation of larger, more

¹³ P3 IIA The first phase of the Oxfordshire Transformation Programme focuses on those services for which the Clinical Commissioning Group (CCG) has most pressing concerns about workforce, patient safety and healthcare (for example, where temporary changes have been made) or where proposed changes have already been piloted. These services include: Ambulatory care, Critical care facilities at the Horton General Hospital (HGH), Maternity services including obstetrics, special care baby unit and emergency gynaecology, planned care services at the HGH and Stroke services

coordinated and resilient teams, with stability and job security, staff satisfaction may be positively impacted.

- Capacity at JRH and the ambulance service is likely to be impacted by proposed changes around critical care, stroke and maternity services.
- A reduction in the number of hospitals providing some services could potentially have a negative impact on both patient choice and the resilience of services.
- Potential transitional negative impacts could be experienced during the implementation of planned service changes that will need to be appropriately managed.

5.2 Equality

Mott MacDonald undertook detailed analysis to understand which groups may have a disproportionate need for the services included in Phase One and then assessed the potential impact. They found that:

- Patients identified as having a disproportionate need for certain services are likely to be disproportionately positively impacted by improved health outcomes.
- The potential impacts of increased journey times or the need to make different and/or unfamiliar journeys to access care, is likely to affect some equality groups to a greater extent than the general population.
- Some patients and visitors, (for example those living in north Oxfordshire) who need to access services or visit relatives at the JRH, will experience increased travel costs. This is likely to have a greater impact upon those on traditionally lower incomes such as those from deprived communities, disabled people and older people.
- The variable and high financial cost of certain transport methods, i.e. trains, acts as a barrier to utilising alternative transport modes to cars.
- Increased journey times (and associated costs) for visitors and carers of patients receiving care in a 'non-local' location may limit or prohibit regular visits. This could affect patients' experience in hospital, and could negatively impact those who are more reliant on assistance and support, for example, disabled and older people and especially those with learning difficulties or mental health conditions. Some of those from Black and Minority Ethnic (BAME) backgrounds who do not have English as their first language may also rely on relatives to help translate. Limited access to carer or relative support would mean the patient is less likely to be able to communicate effectively with clinical staff to express their preferences or ask questions about their care.
- Some patients and visitors can become confused or disorientated when they are at an unfamiliar hospital. This can particularly affect older people

and disabled people and may result in a negative impact of patient experience of care.

5.3 Sustainability

Mott MacDonald found the impacts of the Phase One proposals in this area to be negligible.

5.4 Travel and Access

The IIA made the following points about travel and access:

- Should obstetric-led maternity services not be provided at HGH in future, 46% of patients would be able to access obstetric-led maternity services within 30 minutes.
- 38% of patients can access obstetric-led maternity services by public transport within 30 minutes when the HGH is an option and this drops to 24% when it is not.

N.B it should be noted that '30 minute' timeframe has been used by Mott MacDonald as a the measure to assess the impact of the changes on access and has not used to assess the impact of travel distance and time on outcomes for either mother or baby

This work was supplemented by additional car parking and travel analysis (see section 6 below).

5.5 Mitigations

Mott MacDonald outlined a number of potential actions that Oxfordshire Transformation Programme may wish to consider to mitigate or reduce the effect of the potential negative impacts identified in their analysis.¹⁴ These were considered at an OCCG Board workshop on the 11 July 2017 and the results of these deliberations are included in section 6 (in relation to car parking and travel) below and in Part Three of this report which looks at each of the five clinical areas within the scope of Phase One.

¹⁴ See section 7 of the IIA for the full details of these potential mitigations.

6. Car Parking and Travel Analysis

6.1 Many respondents to the consultation raised concerns about car parking and travel to the hospital sites. This included worries from those in the north of the county about the travel times from Banbury and the surrounding areas to the John Radcliffe Hospital (JRH) and about likely difficulties parking when they arrived. Those living in the south of the county also raised issues with travel times and with parking availability.

Both OCCG and OUHFT are aware of these issues and work has been conducted in the past to understand and address congestion. However, in response to these concerns, the Oxfordshire Transformation Programme commissioned two new pieces of travel analysis – from Healthwatch Oxfordshire and Mott MacDonald in order to obtain an independent and up to date understanding of the current issues.

6.2 Healthwatch Oxfordshire

6.2.1 Methodology

Healthwatch Oxfordshire conducted a travel survey of patients, relatives and carers attending the four acute hospital sites in Oxfordshire¹⁵ in order to gain an understanding of patient experience when travelling to and, parking at, hospital sites. They randomly selected and spoke to 295 people over a three-week period between 8 May and 26 May 2017.¹⁶

6.2.2 Findings

Most people chose to travel by car and park on the hospital site. Overall, people's experience of travelling to the four hospital sites was as they had anticipated – early starts to avoid traffic, leaving plenty of time to queue and park, feelings of stress induced by the thought of the queue to get onto the JRH or Churchill sites. However, despite some patients and their representatives having an element of anxiety, others were pleasantly surprised to find that the journey and parking were easier than they had expected.

Travel times to the hospital sites varied depending on the time of day and whether people came from outside of Oxfordshire (taking 1 -2 hours) or within Oxfordshire (taking 30 minutes to 1 hour). On arrival, the longest time taken to park varied depending on the time of day. Based on the responses

¹⁵ The survey included the JRH Hospital in Oxford, the HGH in Banbury, the Churchill Hospital, and the Nuffield Orthopaedic Centre (NOC) in Headington, Oxford

¹⁶ More information on the methodology used is available in the report: Healthwatch Oxfordshire 'Oxford University Hospitals NHS Foundation Trust Travel Survey – People's experiences' May 2017

Healthwatch identified that finding a parking space took longer between 10am and 2pm. Parking at the beginning of the day was easily achieved but gradually took up to 30 minutes longer after 10am at the John Radcliffe, Nuffield Orthopaedic Centre and Churchill sites.

Parking at the HGH was usually achieved in less than 15 minutes throughout the day.

People from Oxfordshire generally had a self-reported total travel and parking time of between 45 and 75 minutes to all the hospital sites. Many people who travel to hospital regularly described much more difficult experiences they had on earlier visits – including missing appointments, dropping the patient off and looking for parking and not getting parked in time to be there for the appointment.

The preference to travel by car was influenced by many factors, including lack of public transport from outside of Oxford or Banbury, travel times and having to take more than one bus, the cost of public transport, and patients unable to use public transport due to illness or disability.

Considering what people said, Healthwatch concluded that it is likely that the preferred choice of most people travelling to hospital will continue to be by **car**.

6.2.3 Healthwatch Recommendations

Given the differences in the parking experience between the Banbury and the Oxfordshire sites, Healthwatch made two sets of recommendations.

At the Horton General Hospital (HGH):

- The planning process for the development of the site should include a consideration of ease of access, especially if plans for additional outpatient visits proceed;
- A proportionate increase in parking spaces on site will be required if the site is expanded; and
- Consideration should be made for dedicated park and ride facilities located on the main routes into Banbury from the expected direction of travel of the 'additional' outpatients.

At the Headington hospitals sites:

- OUHFT should further explore the 'spreading' across the day/week of outpatient appointments. This will relieve the pressure on the access routes and parking facilities, thus improving the patient experience of attending a hospital appointment;

- OUHFT should undertake a review of the number of Blue Badge spaces available at all sites, and their use;
- OUHFT should explore a simple solution, adopted by other hospitals in the country, of a Blue Badge only parking area with separate access.

Healthwatch further recommended that OCCG and OUHFT survey staff to understand the impact that the challenges faced by staff who travel to work, both by public transport and car, have on recruitment and retention of staff.

6.3 Mott MacDonald Car Parking Survey

Mott MacDonald conducted a hospital car parking survey over one week in June 2017 (Wednesday 14 – Friday 16 June, Monday 19 and Tuesday 20 June). They measured the time it took a visitor to the site to access the car park from when they arrived at the hospital site. This was a short snapshot and focused on two carparks most likely to be impacted by Phase One proposals at the JRH (2 and 2a). Over the five survey days, 101 access times were recorded. Of these, 66 were completed in less than five minutes (66%), and 34 lasted more than five minutes. The longest access time lasted 18:19 minutes.¹⁷

Mott MacDonald also measured the queue length at different times of the day. At the JRH the main congestion occurred between 10am and 12pm on 4 of the 5 surveyed days. On the Thursday they also recorded congestion between 1.45pm and 2.45pm. The largest queue recorded 16 cars waiting to enter the car park at 11am. Outside of these times there was little or no congestion.

There were very few or no parking issues on site at the HGH. Only 2 queues were recorded over the 5 survey days that lasted less than 30 seconds.

6.4 The Oxfordshire Transformation Programme's Response

Representatives of OCCG and OUHFT met and considered the findings of the travel analysis undertaken by Healthwatch and Mott MacDonald on 14 July 2017. They acknowledged the issues identified in the two reports, but felt it important to note that the implementation of the proposals around Planned Care at the HGH will transfer significant numbers of appointments to the Banbury site which will decrease existing congestion on the Oxford sites, particularly at the JRH. The potential impact for the HGH site was recognised and will be taken into account in the Planned Care implementation plans.

Small numbers of patients for specialist care (stroke, Level 3 critical care) will have centralised services in Oxford and around 1,000 women will access

¹⁷ For the detailed findings see the Mott MacDonald 'Hospital Car Parking Survey' June 2017

obstetric care in Oxford rather than Banbury. However, up to 90,000 additional patients will be able to access routine care and treatment at the HGH in the future. This translates to a maximum of 3 or 4 additional patients a day treated in Oxford compared to approximately 250 fewer patients a day having to make the journey to the Oxford sites because they will be seen at HGH.

The group also noted that mitigations were already being developed as part of the OUHFT business case on parking. This includes:

The OUHFT developing plans to build multi-storey car parks on all of the Trust's sites. The Trust has started discussions with City planners as a first step in achieving this ambition. Options for delivery will be investigated between July and December 2017, in parallel with initial discussions on outline planning with the City. The Trust estimates it will take 18 months from January 2018 until the preferred parking option is delivered, but this is all subject to final planning permission.

Part Three

CLINICAL RECOMMENDATIONS

7. Critical Care

7.1 Recommendation

To move to a single Level 3 CCU for patients within Oxfordshire (and its neighbouring areas), located at the JRH in Oxford. The CCU at the HGH would become a Level 2 Centre, working in conjunction with the major centre¹⁸.

7.1.1 The New Model of Care

More than 90% of Critical Care patients at the HGH require single organ support or a period of intensive monitoring following emergency admission. These patients can be successfully and safely managed in a Level 2 Unit, with support from the major Level 3 centre in Oxford.

There is already excellent co-ordination between the Units with a single clinical management structure. As part of implementation (see section 7.5 below), a 24 hours a day, 7 days a week retrieval team will be in place to allow the swift and safe transfer of patients from Banbury to Oxford for Level 3 care if needed.

7.2 What we consulted on

The proposal that we consulted on was that the sickest (Level 3) critical care patients from north Oxfordshire and surrounding counties would be treated at the Oxford critical care units and that the HGH would continue to treat Level 2 patients.

This would mean up to an additional 30 Level 3 patients a year being treated at the JRH and the Churchill Hospital in Oxford rather than in Banbury.

Patients living in South Northamptonshire and South Warwickshire might be treated at critical care units in hospitals in Warwick, Northampton or Milton Keynes if these units were closer.

¹⁸ Level 2 are patients requiring more detailed observation or intervention including support for a single failing organ system or postoperative care, and those stepping down from higher levels of care. Level 3 patients requiring advanced respiratory support alone or basic respiratory support together with support of at least two organ systems. This level includes all complex patients requiring support for multi-organ failure.

7.3 The issues raised in Consultation and Additional Work

7.3.1 Views Expressed in the Consultation

The full consultation report provides a detailed analysis of the responses to the consultation. For critical care the following issues were raised:¹⁹

- 60% of respondents were in favour of the proposal to treat all Level 3 critical care patients from Oxfordshire at the JRH in Oxford (unless a critical care unit outside of Oxfordshire would be closer).
- 18% were not in favour of this proposal. This rose to 25% of residents of Banbury and surrounding areas.
- A large number of public responses were received opposing changes to A&E services at the HGH. The key objection in relation to the proposal to cease provision of Level 3 critical care is the perception that this is a precursor to the removal of the entire A&E service at the HGH.
- Although there was some support amongst stakeholders for the lowering of the HGH Level 3 provision to Level 2, concerns were also expressed around the increased pressure on other Oxford hospitals and those further afield e.g. Northampton.

7.3.2 Discussions at the OCCG Board on 20 June 2017

The critical care proposals were discussed by the Board. It is important to note that the overwhelming majority of Level 3 patients already attend the JRH and the proposals are being made on the basis that they will improve quality, safety and outcomes for all patients. The Board requested assurance that appropriate ambulance provision would be available to support the proposals: this is covered in section 4.3.5 above.

7.3.3 Issues raised in the IIA

The Phase One IIA identified both positive and negative impacts of the proposal to transfer Level 3 critical care activity from HGH to the JRH or to neighbouring hospitals outside of Oxfordshire. The report noted the following:

Potential Positive Impacts

- There is a potential for improvement in health outcomes for patients requiring Level 3 Critical Care including reductions in lengths of stay, reductions in mortality rates and greater compliance with national clinical guidelines for intensive care services. The public were concerned about potential risks for patients who might need transferring to the Level 3

¹⁹ This summary is drawn from the survey, letters received, views expressed at public meetings and gathered from other meetings. Where percentages are given, they refer to the survey results.

service at JRH but the report states that this will be safely managed and offset by access to specialist care on arrival.

- Centralising Level 3 services in the JRH will ensure that the workforce will see and treat a critical mass of Level 3 critically ill patients.

Potential Negative Impacts

- Families and carers will experience increased travel time and cost in visiting patients receiving Level 3 Critical Care. Although this will be balanced against the increased quality of care the patient is likely to experience and the numbers of families impacted is low.
- The issues of travel time and cost could potentially impact on the ability of carers to provide appropriate support to the patient affecting the patients' recovery. However this will be offset by moving people back to their local hospital as soon as they are clinically fit.
- The changes could impact on OUHFT capacity at the JRH site and the capacity of SCAS if there were an increased number of transfers from HGH Level 2 CCU to the JRH Level 3 CCU.
- Resilience of the system could be affected by the reduction in the number of Level 3 Critical Care Units in the event of a large scale emergency.²⁰

7.4 The Oxfordshire Transformation Programme's Response to the issues raised

The consultation, IIA and feedback from the Board have been considered by the Transformation Programme. The issues raised have been explored, explained and, where appropriate, mitigations have been put in place to offset the negative impacts.

No	Issues Raised	Programme response
1.	Impact on other HGH services if Level 3 Critical Care is not available on site	<p>The majority of Level 3 Critical Care already takes place in Oxford. Removing the remaining Level 3 Critical Care has no impact on the continued provision of other HGH services.</p> <p>Proposed changes to planned care will increase patient flow to Level 2 critical care where a patient requires high dependency care. Phase One proposals therefore increase the long-term viability of critical care at the HGH</p> <p>We will continue to develop a long term vision</p>

²⁰ The Oxfordshire Transformation Programme's response to this is explained in Section 14.

		for the HGH through the implementation of Phase One plans, following decision making, and in the development of health and social care services in Phase Two of Oxfordshire's Transformation Programme
2.	Repatriation of Level 3 patients to local hospitals when appropriate	Level 2 Critical Care will remain in place at HGH and as Level 3 patients' need reduces, they will be transferred appropriately and safely to local hospitals for their ongoing care. This will make it easier for carers, family and friends to visit.
3.	The JRH and Churchill sites (and over the border) may have insufficient Level 3 capacity	Most patients currently assessed as needing Level 3 Critical Care are already taken directly to the JRH (or to over-the-border hospitals where closer). The likely increase in Level 3 flow to the Oxford hospitals resulting from the proposal is predicted to be low. This is estimated by OUHFT clinicians to be around 30 patients per year (only 1-2% of total activity). The existing capacity in the Oxford hospitals can accommodate this increased flow.
4.	Transport: Car journey times and parking at John Radcliffe; long journey times for public transport	<p>The IIA confirmed that journey times for families and carers would increase in time and cost, but this was balanced by the increase in quality of care for the patient and by the transfer of patients to their local hospital when clinically fit.</p> <p>Most patients currently assessed as needing Level 3 Critical Care are taken directly to the JRH so the number of families affected is predicted to be low. The families affected will experience additional travel to visit their relatives, but this will be offset by better care.</p>
5.	Risk to life in the event of lengthy transfers from HGH	Should Level 2 patients at HGH be deemed to need Level 3 care, a 'Retrieval Team' with clinicians from OUHFT and SCAS would be deployed to ensure they are transferred safely to the JRH. Tele-links between the facilities will be developed further to enhance appropriate clinical advice.

		A 'Retrieval Team' is a standard method of transferring patients between facilities and it used by many critical care networks.
6.	Effect on ambulance service	<p>Most patients currently assessed as needing Level 3 Critical Care are taken directly to the JRH so the increased patient flow to the JRH is predicted to be very low; around 30 per year.</p> <p>SCAS have confirmed their support for the changes and are modelling the impact on their service.</p>
7.	Effect on neighbouring systems	<p>Most patients currently assessed as needing Level 3 Critical Care are taken directly to the JRH or Level 3 Critical Care units at hospitals over-the-border. The increased patient flow to other hospitals is predicted to be very low. The majority of the 30 patients identified would be expected go to the JRH and therefore the effect on neighbouring systems would be negligible.</p> <p>Travel times for families and carers would increase in time and cost, but this would be balanced against the increased in quality of care the patient is likely to receive and by the transfer of patients to their local hospital when clinically fit.</p>
8.	System resilience	<p>OCCG has considered the resilience of the system, and they do not believe that this will be negatively impacted by the proposed changes.</p> <p>Contingencies will be reviewed and incorporated through system wide Emergency Planning to ensure Level 3 Critical Care capacity exists in the event of a large scale emergency.</p>

7.5 Implementation and sustainability

7.5.1 **Implementation: Overview of key changes required**

As outlined above, the majority of critical care patients already attend the JRH.

Due to the proposed changes in critical care provision at HGH, there could be a requirement to transfer approximately 30 intubated and ventilated patients (Level 3) per year from the HGH to adult critical care services in Oxford or surrounding counties.

In order to facilitate this in a time critical and safe manner, an appropriately staffed and trained retrieval service will be established. This retrieval team will be available to receive referrals, and safely transfer intubated and ventilated patients from the HGH 24 hours a day, seven days a week.

The Intensive Care Society has developed detailed and comprehensive guidelines for the transport of the critically ill adult (3rd Edition 2011). These outline best practice in term of organisation and planning for transfer (including the role of dedicated transport teams, training and governance) and clinical guidelines (which includes monitoring, risk assessments and safety).

These national guidelines are used by the OUHFT currently and will continue to be used to support proposed arrangements for the transfer of any Level 3 patients from Banbury to Oxford.

7.5.2 **Workforce considerations and changes**

In order to ensure there is adequate staffing for the retrieval team, a senior nurse (Band 6) and registrar appropriately trained in critical care transfer will be available 24 hours a day, 7 days a week. This team's work will be overseen by a consultant trained in intensive care medicine, in line with Guidelines for the Provision of Intensive Care Services.

The staffing establishment required to ensure 24/7 cover will be five Band 6 nurses trained in critical care transfer and a number (still to be determined) of suitably trained medical registrars. To achieve this level of cover it is likely that a combination of enhanced existing posts and potentially a small increase in new posts will be required. However recognising that these nurses and registrars are only likely to be deployed on approximately 30 transfers per annum, these posts will be shared with other services.

The critical care units in Oxford have a successful recruitment campaign and are confident that any new nursing posts will be attractive and can be filled within the next six months. The recruitment of intensive care medical staff is

likely to be more challenging and mitigations include consideration of a 'transfer' fellowship to attract junior medical staff to Oxford

Adult critical care service has an established in-house training course that has been developed and delivered in conjunction with colleagues from the RAF and Oxford Simulation, Teaching and Research Centre (OxStar). The simulation based course covers all aspects of the transfer of a critically ill adult as set out in the Intensive Care Society guidelines for transfer of critically ill patients. All senior clinical staff in the critical care units in the OUHFT have received this training, and cannot undertake transfer until deemed competent. Staff recruited to the transfer team will probably have undertaken this training already due to their experience and seniority. Checks will be in place to conform this and ensure that members of the team are highly competent in the transfer of critically ill adults. Regular updates will be also provided to ensure they maintain their skills and competencies.

7.5.3 Arrangements with SCAS

Arrangements are already in place with SCAS to bring patients from the HGH to Oxford. However, an additional requirement will be the timely transfer of the retrieval team to HGH. Various options will be explored to ensure arrangements in place. This includes contracting with SCAS or using a responsive private ambulance service. The aim will be to retrieve any patient requiring Level 3 care within a maximum of three hours (as long as the patient is safe and stable to transfer).

7.5.4 Estates changes and major changes to equipment

It is anticipated that no changes to any estates will be required. Transfer equipment is available at the HGH to support the transfer of Level 3 patients and includes monitors, ventilators, syringe drivers and infusion pumps.

7.5.5 Managing the change

The change would be led by the Clinical Director for Critical Care, Pre-operative Assessment, Pain Service and Resuscitation Directorate in conjunction with its medical and nursing workforce. The Clinical Director manages the OUHFT general critical care units and, as such, oversees care at both the HGH and Oxford sites. It is anticipated that, subject to successful recruitment of staff, the service could be fully operational by March 2018.

In this interim period, while recruitment is taking place, the following arrangements would continue (mirroring what OUHFT currently does if a patient requires transfer in Oxford). Following stabilisation, transfer of any intubated patients would occur between 9am-6pm, seven days per week. A standard operating procedure is currently in place. These patients would be

accompanied by a doctor and nurse based at HGH. Should there be any concerns regarding the safe staffing of the transfer to CCU, the on call matron would be contacted. The on call matron has oversight of the nursing teams working across the three adult general critical care areas in OUHFT and would free up staff, or backfill positions to facilitate safe transfer. In the event that the patient's condition requires immediate transfer, the 24/7 on call matron would make arrangements for the patient's safe transfer to Oxford.

8. Acute Stroke Services

8.1 Recommendation

To secure an improvement in outcomes for stroke patients through direct conveyance of all patients where acute stroke is suspected from Oxfordshire (and its neighbouring areas) to a HASU at the JRH in Oxford.²¹ This will be supported by the roll out of countywide Early Supported Discharge (already available in two localities) to improve rehabilitation and outcomes.²²

8.1.1 The New Model of Care

There are three elements to the proposed model of care to improve services for stroke patients:

- **Admission**

All patients where stroke is suspected will be transferred directly to the HASU at the JRH in Oxford for assessment and management.

This will ensure all patients in Oxfordshire and in neighbouring areas have access to the highest quality care including a high nurse to patient ratio (ensuring more one to one care) and access to a CT scan within one hour of arrival if a stroke is suspected.

Patients would be conveyed to their nearest HASU either in Oxfordshire, Northamptonshire or Warwickshire.

- **Discharge**

All patients will be assessed for suitability to receive ongoing care from the Oxfordshire ESD team post discharge. The ESD Service will be expanded from the current two localities to cover all six Oxfordshire GP Localities and all Oxfordshire GP registered patients (subject to rehabilitation criteria).

- **Bed Based Rehabilitation**

Some patients will be too unwell to be discharged and a support pathway will be put in place for those patients whose needs can only be delivered in a hospital bed. Bed based rehabilitation for stroke patients is being considered as part of the Transformation Programme's review of community hospitals in Phase Two.

²¹ 88% of stroke admissions to OUHFT already go via the JRH including all Oxfordshire patients who present within 4 hours of stroke.

²² Stroke rehabilitation beds will be considered as part of Phase Two.

The model of centralised HASUs has been implemented across the country and shown to significantly improve patient outcomes.²³

8.2 What we consulted on

The proposal we consulted on was that all patients where stroke is suspected would be taken immediately by ambulance to the nearest HASU, which for the majority of patients in Oxfordshire would be the JRH in Oxford.

People living in North Oxfordshire, and its borders, who are closer to Northampton General Hospital or Coventry and Warwickshire Hospital, would be taken directly there.

8.3 The issues raised in Consultation and Additional Work

8.3.1 **Views Expressed in the Consultation**

The full consultation report provides a detailed analysis of the responses to the consultation. For stroke services the following issues were raised:²⁴

- Almost four-fifths of respondents agreed that all patients diagnosed with an acute stroke should immediately be taken to their nearest HASU (79%); 10% disagreed with this.
- Residents in Banbury and surrounding areas were somewhat less in favour of this shift in stroke services with 66% agreement and 20% disagreement.
- Over four-fifths of respondents agreed that the ESD should be extended across the county (85%), with little disagreement expressed (4%).
- Some people expressed a concern that the increase in travel times may have an adverse effect on survival and recovery. There were concerns about the ability of the JRH to manage the additional flow of patients.
- It was noted that if, in the future, stroke patients would have to go to the JRH it was important that their carers and family were able to visit them; concerns about parking at JRH were emphasised.
- Some stakeholders felt that the issues around supported discharge/rehabilitation and community inpatient services and primary care would be better considered alongside the plans for acute stroke services.

²³ August 2013; Impact on Clinical and Cost Outcomes of a Centralized Approach to Acute Stroke Care in London: A Comparative Effectiveness Before and After Model; cited by Plos One 2013; 8(8): e70420.

²⁴ This summary is drawn from the survey, letters received, views expressed at public meetings and gathered from other meetings. Where percentages are given, they refer to the survey results.

8.3.2 Discussions at the OCCG Board on 20 June 2017

The stroke proposals were discussed by the Board including the ESD service. It was noted that the majority of patients already attend the JRH and the proposals would improve outcomes for all patients.

8.3.3 Issues raised in the IIA

The Phase One IIA identified both positive and negative impacts of the proposal to convey all acute stroke patients in Oxfordshire directly to the HASU at JRH. The report noted the following:

Potential Positive Impacts

- Conveying all acute stroke patients to a HASU, creating a single point of access to stroke services with access to CT, MRI, thrombolysis, mechanical thrombectomy and the 24-hour presence of a specialist stroke team (doctors and nurses) along with other complementary specialist teams, delivers the best outcomes for patients.
- Compliance with national guidance for treatment of acute stroke patients and best practice.
- Transfer of patients, once the hyper-acute phase is over, to a specialist team who can provide rehabilitation in a stroke rehabilitation ward or when possible to home with ESD as this increases patient satisfaction and delivers better long term outcomes.
- Opportunity for a planned review of staffing numbers for nurses and allied health care professionals (AHPs), review of job plans for some medical staff alongside roll out of the ESD service across the county would ensure that there is sufficient capacity to support patients throughout the hyper-acute and early rehabilitation phase of their illness.

Potential Negative Impacts

- There was public concern about increased travel time for patients with a suspected stroke but national guidance says that ‘people with suspected acute stroke should be admitted directly to a HASU and be assessed for emergency stroke treatments by a specialist physician without delay’ as the benefits of this outweigh any additional Blue Light travel.
- Longer journey times by ambulances could potentially impact on the capacity of SCAS.

8.4 The Oxfordshire Transformation Programme's Response to the issues raised

The consultation, IIA and feedback from the Board have been considered by Oxfordshire Transformation Programme. The issues raised have been explored, explained and, where appropriate, mitigations have been put in place to offset the negative impacts.

No	Issues Raised	Programme response
1.	Impact on other HGH services if acute stroke patients are taken directly to the HASU at the JRH.	<p>Transfer of the remaining Stroke patients from HGH to the JRH, does not impact on other HGH services.</p> <p>Proposed changes to planned care will increase patient flow at HGH; Phase One proposals therefore increase the long-term viability of the HGH</p> <p>We will continue to develop a long term vision for HGH through the implementation of Phase One plans, following decision making, and in the development of health and social care services in Phase Two of Oxfordshire's Transformation Programme</p>
2.	Effect on community hospital provision of stroke rehabilitation	<p>Bed based Stroke rehabilitation is out-of-scope for Phase One of the programme.</p> <p>There is a need to express the long term vision for community hospitals. Phase Two of the programme will review the numbers, capacity and function of all community beds, including the pathway for stroke rehabilitation, across the Oxfordshire health care system. It will develop future options, (including identifying the resources needed) for community bed function and distribution. This will be subject to consultation.</p> <p>As part of Phase Two, a Primary Care Framework, implementation plan and locality plans are being developed with detail of plans for primary care development in specific areas of the county. These are expected to be completed by Autumn 2017.</p>

3.	Capacity to take additional flow of patients at the JRH and over-the-border hospitals	<p>Most patients currently assessed as having had an acute stroke are taken directly to the JRH or to over-the-border hospitals where closer. The likely increase in flow is predicted to be low; around 100 patients per year with acute stroke to the HASU and an additional 100 who have similar symptoms but are not diagnosed with stroke that will follow a different pathway of care.</p> <p>The anticipated flow of patients to a Hospital other than JRH is expected to be negligible.</p>
4.	Additional blue-light travel time for patients	<p>Analysis has found that the majority of patients within Oxfordshire are within 40 minutes “Blue Light” travel time from the HASU at the John Radcliffe. For those assessed with an acute stroke, treatment at a HASU by a specialist physician, with specialist equipment (CT, MRI, thrombolysis, thrombectomy) and with a 24-hour presence of a specialist stroke team (doctors and nurses), outweighs any additional Blue Light travel times.</p>
5.	Effect on ambulance service	<p>Most patients currently assessed as having acute stroke are already taken directly to the JRH so the increased patient flow to the JRH is predicted to be around 200 per year</p> <p>SCAS confirmed in a letter on the 31 July 2017 that they are supportive of the proposals. SCAS has been asked to quantify the resource implication of longer journey distances for up to 200 patients.</p>
6.	Car journey times and parking at JRH for carers, family and friends.	<p>The IIA confirmed that journey times for families and carers would increase and have a cost implication. This was balanced against the increased in quality of care the patient is likely to receive and by the early transfer of patients to their local hospital or home when clinically fit.</p>

7.	Consideration of an alternative models	<p>The model proposed is based on clinical evidence for treating acute stroke patients in a HASU. There is robust evidence on improved patient outcomes and there is clear clinical agreement on this model for Oxfordshire.</p> <p>The expansion of the ESD service will further improve outcomes for the patient and provide adherence to NICE guidelines by reducing length of stay and improvements in rehabilitation outcomes.</p>

8.5 Implementation and sustainability

8.5.1 **Current Position**

The JRH is designated as a provider of hyper acute (immediate assessment of all Oxfordshire patients who presented within 4 hours of stroke onset for eligibility for thrombolysis), acute (assessment and appropriate management of all Oxfordshire patients who presented after 4 hours of stroke onset), and rehabilitation stroke services.

Since 2009, OUHFT (with Oxfordshire PCT and OCCG) has piloted an ESD service to support a corridor of GP practices between the Oxford City and Bicester areas (covering 41% of the Oxfordshire population).

The bed base for acute stroke services is as follows: JRH 18 beds and HGH 10 beds. The ESD, covering the City and Bicester areas, has a maximum capacity for 14 patients at any one time. In addition there are rehabilitation beds in two community hospitals, this is being looked at in Phase Two.

The combined activity of confirmed strokes at both sites was approximately 700 patients in 2014/15: The JRH admitted 88% of stroke patients and the HGH admitted 12%. Under the Phase One proposals all patients with suspected acute stroke, regardless of time of onset, will be conveyed to the JRH which will act as the single point of entry.

8.5.2 **Implementation of the Single Point of Entry, including ambulance transfers and capacity**

In order to improve the quality of care and efficiency of the service, the following has been proposed as part of the Phase One consultation:

- There is a single portal of entry in Oxfordshire for patients with suspected acute stroke at JRH only.
- Expansion of ESD to a county-wide service.

It should be noted that all Face, Arm, Speech, Time (FAST) positive patients within 4 hours of stroke onset have been directly conveyed to the JRH for assessment for eligibility for thrombolysis since 2009.

The implementation plan will aim to ensure that all FAST positive patients regardless of time of onset will be conveyed directly to the JRH by SCAS. All patients in whom a new diagnosis of stroke is made at HGH, either following admission (FAST negative strokes) or while as an inpatient at HGH for another medical condition, would be transferred to JRH.

As part of implementation process, the Medical Directors of West Midlands, East Midlands and South West Ambulance Services would be contacted to ensure that their paramedics are aware that they should convey all potential stroke patients to the nearest HASU for first assessment.

There is adequate capacity in the system to support the changes to the stroke pathway provided the plans to extend the ESD service county-wide are implemented and the patient pathway is managed as a seamless service.

8.5.3 Expanding the current Early Supported Discharge (ESD) provision, including workforce considerations

The present ESD service delivers rehabilitation for patients who live in a corridor between Oxford City and Bicester. The ESD service currently delivers domiciliary rehabilitation to six patients a month with a maximum capacity of 14 patients at any given time. It is a 5-day a week service.

A county-wide service would accommodate an additional 8 patients discharged from the HASU each month. Therapy assessments will be provided 6 days a week (Monday to Saturday).

The expansion of the ESD will take place across all localities simultaneously thereby addressing the existing inequitable access to the service and increasing its current coverage from 41% of the population to countywide.

Work has already begun on the enhancements to this service. It is expected that recruitment of new staff would begin once a decision has been made by OCCG. It is predicted that it will take four to six months to complete recruitment (one to three months for advertising and three months for successful appointees to serve notice). The current ESD service would be expanded as new staff are recruited, implementing the model that has worked well for the last 8 years to the whole of Oxfordshire. As this service develops

over the next 2 years, close interaction with the Home Assessment and Rehabilitation Team (HART) will allow ESD to take on patients with a higher level of dependency enabling further discharges from the HASU.

Composition of the ESD team has been agreed with the Trust.

9. Changes to Acute Bed Numbers

9.1 Recommendation

To agree to make permanent the closure of 146 acute beds thereby formalising the temporary changes made as part of the 'Rebalancing the System' delayed transfer project that has been running since November 2015.²⁵ The implementation of this will be staggered:

- 110 beds are already closed and will remain so and enable the investment in alternative services to be made permanent;
- The additional 36 beds will only be permanently closed when the system has made significant progress in reducing the numbers of delayed transfers care. Permanent closure of these 36 beds will be subject to further Thames Valley Clinical Senate review and NHS England assurance

The work on 'Rebalancing the System' will continue and this includes ongoing work on clinical pathways.

9.1.1 The New Model of Care

In November 2015, Oxfordshire health and social care providers agreed to work together to develop and implement an innovative approach to address delayed transfers of care, improve patient flow and patient experience. The aim of the initiative was to create a sustainable approach that would 'Rebalance the System'.

The approach focused on transferring patients who no longer needed acute medical care from a hospital setting into a nursing home, for a short period of time, while they awaited the next stage of their care (mainly home care packages or the organisation of a long term care home). This approach had been tried the previous winter on a much smaller scale.

²⁵ This is the reduction of 76 beds made in 2015/16, the reduction of 34 made in 2016/2017 and 36 that are proposed for closure during 2017/2018. This final figure of 146 has been revised from the *Pre-Consultation Business Case for Phase One* when 194 bed closures were planned.

The central aims of this initiative were to:

- Ensure that patients, who were medically fit to be discharged from hospital, but awaiting non-acute health and social care support, were cared for in the right environment.
- Reduce avoidable patient deterioration caused by delays in bed-based care.
- Reduce the number of delayed patient transfers.
- Enable the shift to ambulatory (as opposed to bed-based care) thereby supporting the management of the expected increase in hospital admissions due to winter illness affecting the elderly and those with chronic conditions.

In order to coordinate and manage the needs of the patients being transferred to nursing homes, a multi-agency Liaison Hub was established in December 2015 located in OUHFT. This included staff from the three provider organisations; OUHFT, Oxford Health NHS Foundation Trust and Oxfordshire County Council.

This project has enabled patients who no longer need acute medical care to move from a hospital setting into a nursing home. The project has allowed patient needs to be met more appropriately while they wait either to be transferred home with community-based support or to a permanent care home placement.

The table below summarises bed 110 bed closures to date: a further 36 are proposed for closure during 2017/2018 subject to Thames Valley Clinical Senate review and NHS England assurance.

Table: Acute bed closures as a result of the 'rebalancing the system' project

Date	Site	Ward/s	Change	Impact on bed numbers	OUH acute beds
					1,327
1/11/2015	JRH	5C/D	19 beds closed	-19	1,308
1/12/2015	HGH	E Ward	23 beds closed	-23	1,285
	NOC	Ward E	8 beds closed	-8	1,277
	JRH	7F	22 beds closed	-22	1,255
1/8/2016	JRH	5B to 6B	There were 19 beds on 6B and 19 beds on 5B. The stroke beds on 5B were moved 6B. The beds that had been on 6B were not re-provisioned elsewhere.	0	1,255
	JRH	5B	AAU established with 8		

			overnight beds		
	JRH	5A	11 additional beds		
1/10/2016	HGH	Oak, F Ward	There were 18 medical beds on Oak Ward. These were re-provisioned as Trauma beds. The F Ward which was 28 trauma beds closed. There was therefore a reduction in trauma beds of 10, but 28 beds overall were closed.	-28	1,227
	NOC	Ward C	12 beds closed	-12	1,217
	JRH	Gynae	2 beds opened	+2	
				-110	

9.1.2 Alternative Provision

The proposed bed closures under the 'Rebalancing the System' changes have been offset by alternative provision in the community.

This alternative provision includes the following:

- Provision of temporary care for patients in nursing homes across Oxfordshire, supported and coordinated by a Liaison Hub (around 100 beds in nursing homes have been commissioned);
- A significant increase in patients receiving ambulatory care in hospital as a direct alternative to admission; and
- Care for people at home following hospital inpatient care (Acute Hospital at Home - AHAH and the Home Assessment and Rehabilitation Team - HART).

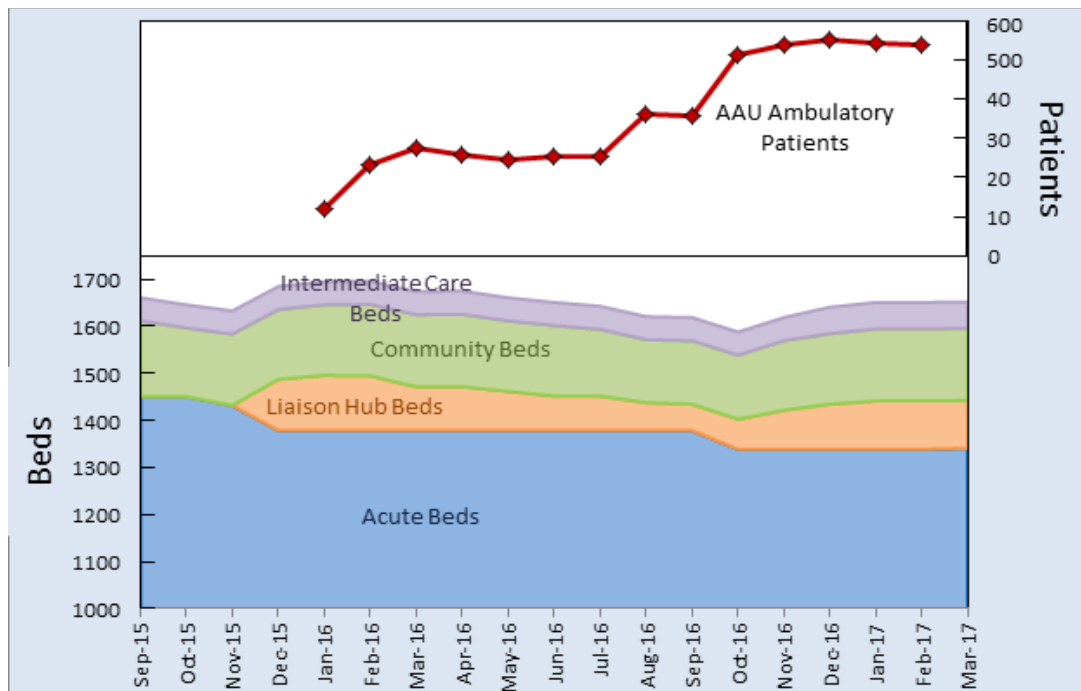
To enable effective pathways for patients, these services are overseen by a Clinical Coordination Centre that is based at the JRH.

The diagram 1 below demonstrates the overall changes to bed capacity in Oxfordshire since September 2015 and the exponential increase in the number of patients seen in the two ambulatory assessment units (since January 2016) at the JRH and HGH.

Overall, the number of beds in the system has not reduced markedly, but these beds are being used in different ways to ensure that when patients are medically fit for discharge (but are still awaiting further care) they are in a more appropriate environment. As can be seen from the diagram below, the

bed changes have been accompanied by a significant increase in the capacity and activity levels in ambulatory assessment. Other non-bed-based services have also been expanded. Further details of these changes and the impact are given in section 9.5 below.

Diagram 1: Changes in bed capacity and ambulatory provision Sept 15 – March 17



9.2 What we consulted on

The proposal we consulted on was to make permanent the closure of the 146 beds that were part of 'Rebalancing the System' delayed transfer project, as they are no longer needed. This would enable resources to be used differently to help patients to be cared for in an environment that is right for them, often closer to home in community settings.

9.3 The issues raised in Consultation and Additional Work

9.3.1 **Views Expressed in the Consultation**

The full consultation report provides a detailed analysis of the responses to the consultation. For the proposed changes to bed numbers and move to care closer at home,²⁶ the following issues were raised:

- Half of survey respondents did not agree with the proposal to permanently close hospital beds and use the money and staff to avoid hospital admissions, support early discharge and care closer to home (50%).

²⁶ This summary is drawn from the survey, letters received, views expressed at public meetings and gathered from other meetings. Where percentages are given, they refer to the survey results.

Those living in Banbury and surrounding areas were most likely to disagree with this proposal (61%).

- 29% of respondents did agree with this proposal. Across all areas, those living in South Oxfordshire were more likely to agree with this proposal than those in some other areas (43%).
- Other public and stakeholder consultation responses show clear concern about the reduction in the number of acute hospital beds. Many people felt that too many acute hospital beds had been lost already and that further closures would mean the JRH and HGH would not be able to meet demand.
- A reasonable number of people did express their interest in and support for the alternative model of care whereby OUHFT were funding beds in the community and providing support for staff in residential and care homes. However it was felt that it was too early to close beds until the success of this approach could be demonstrated.
- Responses from the public frequently referred to an increasing population in Oxfordshire, Warwickshire and Northamptonshire and questioned how proposals to reduce the number of beds would be viable within this context.
- Specific objections were raised concerning the removal of 45 beds in Banbury and there was a view that this should have been a matter for consultation prior to their removal.
- Stakeholders highlighted the need for OCCG to work more closely with Oxfordshire County Council and the voluntary and community sector to fully articulate their roles within the proposed new format of services.

9.3.2 Discussions at the OCCG Board on 20 June 2017

The Board noted that the Oxfordshire Transformation Programme had chosen to ask the Thames Valley Clinical Senate to undertake a retrospective assessment of the compliance with the new 'Patient Care Test'. The Board asked for this to be included in the DMBC (see section 9.5 below).

9.3.3 Issues raised in the IIA`

The Phase One IIA identified both positive and negative impacts of the proposed changes to acute bed numbers. The report noted the following:

Potential Positive Impacts

- Ambulatory care enables emergency patients presenting to hospital for admission to be rapidly assessed, streamed to be diagnosed and treated on the same day, returning home with ongoing care or admitted for short term inpatient care in line with national guidance and best practice.
- Creates opportunities to provide personalised supportive care.

- Delivers improved patient experience and clinical outcomes.
- Delivers reduced costs associated with unnecessary overnight hospital stays and hospital inpatient bed days.
- Facilitates provision of Care Closer to Home with the support of family and friends during recovery

Potential Negative Impacts

- There is a risk that the infrastructure for roll out of the model might not keep pace with developments.
- Patients feeling isolated through decreased face to face contact with nursing, medical and care staff particularly if they do not have a strong family and friends network during recovery.
- Home or community based care not appropriately resourced
- Need for increased recruitment or redeployment of both health and social care staff to support ambulatory pathways and Care Closer to Home.
- Potential for pressure on the wider bed pool when there are high volumes of patients unless bed stock is used flexibly to match demand.

9.4 The Oxfordshire Transformation Programme’s Response to the issues raised

The consultation, IIA and feedback from the Board have been considered by the Transformation Programme. The issues raised have been explored, explained and, where appropriate, mitigations have been put in place to offset the negative impacts.

No.	Issues Raised	Programme response
1.	Capacity of community care (care homes, care at home, carers) to cope with existing and additional demand.	<p>The IIA indicates that the pilot approach has not impacted on the capacity in community beds.</p> <p>As part of the ‘Rebalancing the System’, the funding released from the acute bed closures has been reinvested in community based provision. This includes nursing home beds, coordination centre, ambulatory units and AHAH service.</p> <p>The numbers, capacity and function of all community beds across the Oxfordshire health care system will be reviewed as part of Phase Two. The review will develop future</p>

		<p>options, including identifying the supporting resources needed for community bed function and distribution. This will be subject to public consultation.</p> <p>Home care is a known constraint and we are working to achieve a system wide workforce strategy.</p>
<p>2.</p>	<p>Wider implications of proposals on the 'whole system'. Other agencies include patients, Adult Social Care, community services, GPs and carers.</p>	<p>The impacts of proposals on other agencies have been fully considered and all organisations that have a role in the patient pathway have been involved in the design of the proposals, including social care. Partners have been engaged throughout the programme via the JHOSC, Transformation Board, Clinical Work Streams, meetings with partners outside of the county and through the consultation process.</p> <p>As part of the 'Rebalancing the System', the funding released from the acute bed closures has been reinvested in community based provision. This includes nursing home beds (and their medical cover), coordination centre, ambulatory units and AHAH services.</p> <p>The IIA identified that patients may feel isolated if they do not have a strong family and friends' network during recovery. A dedicated Team with clinical expertise will assess patients for discharge, meaning patients will be discharged with appropriate support. The scheme has received positive feedback from patients.</p> <p>As part of Phase Two plans are being developed that will set out how primary care will organise and develop in specific areas of the county. These plans are expected to be in place by Autumn 2017.</p> <p>All commissioner and provider partners for services in-scope of Phase Two have been formally invited to participate in the</p>

		development of models and options for consultation.
3.	Evidence that the model 'works' and concern over capacity of acute provision (e.g. cancelling of operations and A&E waiting times).	<p>Evidence from ambulatory models of care from elsewhere in Oxfordshire, including the Emergency Medical Units (EMUs), two Ambulatory Assessment Units (AAU) at the JRH and HGH and the Rapid Access Care Unit (RACU) in Townlands Hospital in Henley shows that an ambulatory model of care increases the capacity and capability of acute care to avoid admissions and for patients to receive care in settings beyond hospital wards. This evidence is in-line with anticipated benefits identified by the Royal College of Physicians who state an ambulatory model would have <i>"improved both clinical outcomes and patient experience, while reducing cost"</i>.</p> <p>A realignment of beds in the system to where the demand is at its greatest will prevent delays in the system for patients getting the care they need. This approach ensures the different types of hospital beds are being appropriately used and for their intended purpose. In order to reduce delays in discharging patients, all aspects of the pathway, including domiciliary care provision need to be adequately staffed and resourced.</p>
4.	Concern that patients are likely to be prematurely discharged	<p>Partners across the system agreed to establish a dedicated Team with clinical expertise to assess patients for discharge. This means that the probability of premature discharge is reduced. The scheme has been closely monitored and feedback from patients and their relatives has been positive.</p> <p>Clinicians across the Oxfordshire system are beginning to develop a more robust frailty</p>

		pathway that will focus on care closer to home, including integrated care around the ambulatory model.
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9.5 The new 'Patient Care Test'

On the 3 March 2017, the Chief Executive of NHS England, Simon Stevens announced a new 'Patient Care Test for Hospital Bed Closures' for service reconfiguration plans that will apply to all future proposals for NHS reconfiguration that involve NHS bed closures.

Although the NHS England assurance process for Phase One had been completed when this new test was introduced, the Oxfordshire Transformation Programme prepared a retrospective assurance document outlining how the proposals comply with the new requirement (this is included in supplementary documents listed in Appendix A).²⁷

This was considered by the Thames Valley Clinical Senate on 6 June 2017. The Clinical Senate management team also arranged to meet with the lead clinicians from OUHFT, who have responsibility for leading and developing the alternative provision. This meeting took place on 21 June 2017. The joint OCCG and OUHFT team then attended a follow up Question and Answer session on 11 July 2017 and provided some additional information in writing.

NHS England received the report from the Thames Valley Clinical Senate setting out their review of Phase One proposals for bed closures against the 5th test.

The Senate recommended that the conditions for the NHS Bed Test had been met subject to the following:

- 1) The delays associated with patients being referred to HART need to be resolved and there needs to be sufficient capacity for HART to discharge once their element of service provision is completed. The Senate was advised that this is currently a problem for HART.
- 2) OCCG should monitor the system and take action to ensure that delays do not build with regard to the discharge to domiciliary care.
- 3) The Senate retrospective review was based on the current closure of 110 beds. It did not consider any future closures

NHS England, 31 July, 2017, confirmed that it is content to accept the recommendations of the Senate as set out above regarding the review and

²⁷ This report provides more information on the alternative services in place and an indication of activity and outcomes.

compliance against the 5th test based on the closure of 110 beds. Any proposal to further reduce beds would need to be reviewed by the Senate.

9.6 Implementation and sustainability

The proposals are to make permanent the temporary closure of the 110 beds made as part of the 'Rebalancing the System' project and, as such, will not require a new implementation plan. The next phase of work will continue to consider and develop more integrated and co-ordinated care pathways. When the permanent closure of the additional 36 beds is assured by NHS England, a detailed implementation plan will be agreed with OUHFT.

10. Planned Care at the Horton General Hospital

10.1 Recommendation

Separate elective from emergency interventions at the HGH and localise care through the development of a new 21st century Diagnostic and Outpatient Facility; a Pre-operative Assessment Unit; and a reconfiguration of existing theatre space to act as a Co-ordinated Theatre Complex to improve elective services.

10.1.1 The Model of Care

The proposal is to build a new modern facility on the HGH that will act as a showcase for 21st century healthcare. Under the new arrangements, some current activity from the Oxford sites will be transferred to the HGH site with specialist consultants from the Headington sites in Oxford delivering this care.

Existing theatre infrastructure across all sites will be reconfigured to absorb the projected small increases in elective surgical activity. This reconfiguration will establish an elective surgical service with adjoining day case wards to create an enhanced Elective Care Centre at HGH, where proper scheduling will reduce cancellations, unacceptable delays and breaches.

Where there is a large enough group of patients in a particular speciality and where it would be clinically and financially viable, existing Headington surgical services will be transferred to the elective day case surgical service at HGH for patients in north Oxfordshire and its surrounding geography, removing the need for them and their families to travel to Oxford.

The same will be true for medical interventions. Approximately 3,000 interventions, including chemotherapy and renal dialysis, currently delivered at Headington will be transferred and delivered at HGH.

The proposal is to also build a brand new Diagnostic Facility at the HGH with MRI and CT scanners, ultrasound and other equipment. This would allow the rapid assessment necessary for delivery of high quality ambulatory urgent care and remove the need for patients from the north Oxfordshire and surrounding areas to travel to Headington for routine diagnostic imaging.

A new Outpatient Facility on the HGH site will also be developed with capacity to absorb the tens of thousands of appointments for patients from north Oxfordshire and the surrounding areas currently delivered at Headington. Nearly all the clinical services have committed to transfer, where appropriate, their relevant outpatient activity to HGH, with travel undertaken by OUHFT staff, rather than the patient population.

Sitting alongside the new Diagnostic Facility, this Outpatient Facility will provide the opportunity to rationalise appointments at both facilities and establish 'one-stop clinics', further reducing multiple journeys to hospital sites.

An important component of this integration of outpatient work will be the development of an advanced Preoperative Assessment Unit, which ensures the smooth operation of the elective interventional services. This Unit will address the needs of the patients undergoing elective surgery at the HGH and offer comprehensive preoperative assessment for those local patients undergoing more complex and specialist interventions on the Oxford sites. The new facilities will mean that these patients can truly expect all care apart from the specific intervention to be delivered closer to home by an interventional team that delivers different and appropriate components of care on both the Headington and the HGH sites. The Preoperative Assessment Unit will also be able to offer secondary prevention through fitness regimes before operation that will reduce the perioperative risk of surgical intervention.

10.2 What we consulted on

The proposal we consulted on was to significantly develop the services at the HGH enabling most North Oxfordshire patients to access care locally in buildings using equipment fit for the 21st century. This would include more outpatient and diagnostic appointments for patients and the expansion of some services such as dialysis for kidney patients and chemotherapy for cancer patients.

10.3 The issues raised in Consultation and Additional Work

10.3.1 **Views Expressed in the Consultation**

The full consultation report provides a detailed analysis of the responses to the consultation. For planned care services at the HGH, the following issues were raised:²⁸

- Survey respondents were overwhelmingly in favour of the investment in or expansion of services at the HGH as follows:
 - 85% were in favour of a new diagnostic unit to be introduced at the HGH;
 - 85% agreed with investing in an Assessment Unit for patients before operations, thus avoiding the need to travel to Oxford;
 - 84% agreed that there should be more chemotherapy, renal dialysis and day case surgery at the HGH;

²⁸ This summary is drawn from the survey, letters received, views expressed at public meetings and gathered from other meetings. Where percentages are given, they refer to the survey results.

- 78% agreed with introducing a new Outpatient Unit with a 'one stop shop' clinic for appointments.
- Data suggests that residents of North Oxfordshire, South Northamptonshire and South Warwickshire where such investment and change is designed to benefit, were particularly in favour of these changes.
- Other public and stakeholder responses were generally in favour of an increase in planned care at the HGH, however there was a very strong feeling that this should not be at the expense of other services, including A&E and obstetrics.
- Concerns were also raised around the adequacy of transport links and parking at the HGH.

10.3.2 Discussions at the OCCG Board on 20 June 2017

The Board noted the concerns about transport and parking and also expressed a wish to have as much information as possible on the plans, numbers of specialities and timescales for planned care.

10.3.3 Issues raised in the IIA

The Phase One IIA identified both positive and negative impacts of the Phase One planned care proposals.

Potential Positive Impacts

- The separation of elective and non-elective surgery could result in earlier investigation, treatment and better continuity of care, as well as reducing hospital acquired infections and lengths of stay.
- The potential for reduced cancellations, more predictable workflow, increased senior supervision of complex/emergency cases and excellent training opportunities.
- Reduced risk that provision of emergency treatment will impact on elective throughput and performance, including Referral to Treatment (RTT) and cancer waiting times.
- Consolidation of day case activity at HGH would ensure an appropriate critical mass in complex and low volume cases to achieve excellent outcomes for patients with low complication rates.
- Increased provision of outpatients and creation of a 21st Century Diagnostic facility at HGH, streamlining care for patients at certain parts of their pathway.

- The creation of ‘One stop clinics’ and more co-ordinated appointments leading to a reduction in appointments and fewer multiple journeys to other hospital sites and facilities.
- Significant increase in direct access to diagnostics such as MRI and CT.
- Increase in oncology day cases, including chemotherapy, and renal dialysis.

Potential Negative Impacts

- Changes to the workforce profile who might have to work across sites or from a different site, potential capacity pressures including recruiting to staff groups such as radiographers and other clinical scientists.

10.4 The Oxfordshire Transformation Programme’s Response to the issues raised

The consultation, IIA and feedback from the Board have been considered by the Transformation Programme. The issues raised have been explored, explained and, where appropriate, mitigations have been put in place to offset the negative impacts.

No	Issues Raised	Programme response
1.	Access: car parking, public transport HGH.	The travel and parking surveys commissioned by the programme, indicated that currently there are no significant problems with car parking at HGH. The Healthwatch Oxfordshire survey commissioned suggested that the parking situation at the HGH remain under review and all patient travel options, including new park and ride, are considered as the proposals are rolled out to ensure any mitigating action can be taken early. Healthwatch Oxfordshire recommendations will be taken into consideration in the implementation plans, (section 10.5.5).
2.	Impact on patients from the south of the County	The expansion of planned care at HGH is designed to serve the local catchment population in terms of diagnostics, day cases and out patients.
3.	Evidence of investment and implementation	There will be a new diagnostic facility (MRI, CT scanners and ultrasound etc.), outpatient facility and an Advanced Pre-operative

		<p>Assessment Unit at HGH. The outline cost of this and the source of capital investment required to finance it are supplied in section 13 of this DMBC.</p>
4.	<p>Concern proposals are a 'trade off' for loss of other services</p>	<p>The proposals in Phase One provide the opportunity to address the challenges facing some of the services provided at HGH. There is no pre-condition for the expansion of planned care that requires the transfer out of existing clinical services from the HGH site.</p> <p>The proposals are about ensuring better pathways of care for patients in line with best practice. The proposals seek to be sustainable and provide substantial benefit to the local population.</p>
5.	<p>Impact of planned care changes on A&E and children's services at HGH</p>	<p>A&E and children's services are out of scope for Phase One. Phase Two of the programme will review Urgent and Emergency Services and Children's Services and will develop future options for consultation where appropriate.</p> <p>Increasing planned care activity on the site is likely to require a greater anaesthetic presence and this should make the support for emergency services more resilient.</p> <p>There is a need to express the long term vision for HGH to demonstrate its intended position in the future of health care provision in Oxfordshire. This will be undertaken as part of Phase Two.</p>
6.	<p>Will elective orthopaedic activity be maintained in the north of the county?</p>	<p>Both OCCG and OUHFT are committed to providing the existing range of orthopaedic activity from the HGH site. The provider of this activity is yet to be determined.</p>

10.5 Implementation plans and sustainability

The implementation of the planned care proposals will be undertaken on a phased basis and will build on changes that have already been initiated.

10.5.1 Phase 1: Maximise existing capacity

Although, in general, capacity for expansion at HGH is limited OUHFT will seek to exploit the opportunities to deliver additional workload through the more effective utilisation of its existing physical assets. Examples include:

- Theatres – the Trust is undertaking a major exercise to improve the utilisation of its operating theatres across all four of its sites. The work at HGH will provide additional theatre capacity to support the transfer of relevant theatre procedures from the Oxford sites to Banbury.
- CT scanning – the Trust has recently installed a new 64 slice CT scanner at HGH. This will support the expansion of the volume and range of CT scanning that can be undertaken thereby reducing the need for patients to travel to Oxford.

10.5.2 Phase 2: Utilisation of the Independent Sector Treatment Centre (ISTC)

The OUHFT will become the owner of the ISTC (Ramsay Centre) in April 2018. The building is in excellent condition and accommodates 40 inpatient beds, 3 operating theatres, a MRI scanner and diagnostics facility plus outpatient consulting rooms. This is a modern purpose built facility designed specifically to accommodate low risk, short stay clinical activity e.g. non-complex orthopaedic surgery.

While this facility currently supports the delivery of non-complex orthopaedic surgery primarily, there is the opportunity to utilise spare capacity to support the transfer of appropriate patients attending the Oxford sites for assessment, diagnosis and treatment. Options for achieving this expansion are currently being explored with relevant parties. The initial additional work is likely to focus on growth in orthopaedic activity and potentially some additional activity in another surgical specialty e.g. ophthalmology. It is anticipated that this will begin in 2017/18.

This will be followed by further expansion in the volume and range of services provided from the ISTC from 2018/19 and beyond. It is envisaged that this would encompass the further transfer of other surgery and outpatient activity, including preoperative assessment and diagnostics. This would include both medical and surgical specialities such as orthopaedics, physiotherapy, ophthalmology and dermatology.

10.5.3 Phase 3: Provision of a new Outpatient and Diagnostic Facility

In order to fully realise the vision for HGH and to achieve the full level of patient activity on the site set out in the consultation document, OUHFT intends to invest in a new purpose built facility on the HGH site.

This will provide dedicated outpatient facilities for medical and surgical patients (adults and children), where both assessment and outpatient procedures can be undertaken. This facility will be co-located with a diagnostic suite which will allow access to the following diagnostic imaging:

- X-ray
- Ultrasound
- CT
- MRI
- Mammography
- DEXA (dual energy X-ray absorptiometry)
- Echocardiography

This facility will be designed and located with a view to establishing appropriate clinical adjacencies, optimising efficiency and patient experience, including an extension of the One-stop clinic service.

It will allow the further transfer of specialised clinic activity and the transfer of diagnostic imaging from the Oxford campuses.

The existing theatre infrastructure will be reconfigured to absorb the projected increases in elective day case surgical activity with adjoining day case wards to create an enhanced elective care centre.

10.5.4 Workforce – consideration and changes

Cross-site working is an established medical model for many medical and surgical specialities within the Trust. The transfer of elective and outpatient activity from the south to the north of the county would be supported by cross-site working to provide specialist medical assessment. New medical appointments, where appropriate, mandate working on both the HGH and Oxford sites.

The recruitment and retention of consultant radiologists and radiographers is a recognised problem nationally. There would be a requirement for additional staff to support this proposal. The provision of a new purpose built facility would significantly aid recruitment and retention.

10.5.5 Estates Changes

An initial high level assessment of the options for the location of this facility is in train, focusing on future provision on the north or south part of the current site. This assessment recognises the need to optimise:

- i. The future use of the site
- ii. Take opportunities to change/improve site access for all forms of transport
- iii. Expand and consolidate parking
- iv. Deliver optimal clinical adjacencies

10.5.6 Timescales for Implementation

ACTION	ELEMENTS	INDICATIVE TIMEFRAMES
Phase 1: Use of existing capacity	<ul style="list-style-type: none"> • Theatres/CT 	2017/18
Phase 2: Use of the ISTC	<ul style="list-style-type: none"> • Phase 1 • Phase 2 	2017/18 From 2018/19
Phase 3: Provision of a new Outpatient and Diagnostic Facility		
Development of operational models and development of final detailed design	<ul style="list-style-type: none"> • Confirm volume and range of outpatient at speciality/sub-speciality level that can be transferred • Confirm volume by modality of diagnostic imaging that can be transferred • Development of detailed schedules for operational delivery • Assess staffing implications • Equipment – Schedules of new equipment and transferable equipment to developed 	2019/20
Scheme approvals	Full Business Case approval by : <ul style="list-style-type: none"> • OCCG • OUHFT • NHSI 	By end of 2019/20
Construction/Go Live	Completion of : <ul style="list-style-type: none"> • Enabling works • Construction of new centre • Associated site works 	2020 onwards

11. Maternity Services

11.1 Recommendation

To create a single specialist obstetric unit for Oxfordshire (and its neighbouring areas) at the JRH and establish a permanent MLU at the HGH.

11.1.1 The New Model of Care

The Oxfordshire Transformation Programme has a vision for maternity services in Oxfordshire where every woman receives personalised care from early medical risk assessment through to birth and beyond. The plan is to provide choice and continuity of care throughout the pregnancy, birth and postnatal period. However, given the pressures identified in the 'Case for Change' this will require changes to the current configuration of acute hospital obstetric services.

Under the proposed model there will be a single obstetric unit within Oxfordshire and this will be at the JRH in Oxford. The JRH will also provide tertiary and complex care for the wider Thames Valley region and neonatal intensive care cots for the sickest neonates. This model will provide the safest care and highest quality provision. It will provide a sustainable model for both high risk local women and the highest risk women within the Thames Valley. The specialist fetal medicine service will care for and manage women whose unborn foetuses require specialist monitoring and care.

The model will move Oxfordshire to an increasing number of Consultant hours on the labour ward, in line with the latest Royal College guidance²⁹. By concentrating the Consultant workforce in one large unit, with the added complexity of a tertiary centre, and by employing the same rota system which has proved sustainable in Manchester, it is anticipated that this will attract the desired extra 7 consultants required to achieve 24/7 Consultant presence on the labour ward at the JR. A key finding from the 'Each Baby Counts' report³⁰³¹(looking into neonatal deaths and brain injuries) was the necessity for senior oversight of activity on the delivery suite. A sustainable 24/7 consultant rota will be crucial in providing this oversight and improving the quality of maternity

²⁹ RCOG (2016) 'Providing Quality Care for Women: Obstetrics and Gynaecology Workforce'

³⁰ Marian Knight, Jane Henderson, Jennifer J Kurinczuk. Evidence Review to Support the National Maternity Review 2015; Report 3: Systematic review and case studies to assess models of consultant resident cover and the outcomes of intrapartum care; and two international case studies of the delivery of maternity care. Oxford: National Perinatal Epidemiology Unit, University of Oxford. 2015.

³¹ Royal College of Obstetricians and Gynaecologists. Each Baby Counts: 2015 Summary Report. London: RCOG, 2017

care to achieve the aims of the Department of Health mandate to reduce poor maternal and neonatal outcomes by 20% by 2020 and 50% by 2030.

For women in the HGH catchment population there are two available obstetric units other than the JRH. The obstetric unit at SWFT currently has about 3,000 births per year and has capacity for more women to give birth over the next five years. The same is true in Northamptonshire where the hospital has recently developed an alongside MLU with the obstetric unit currently managing about 3,500 births. In the west of the county women can also choose to book at the Great Western NHS Foundation Trust Hospital and in the south of the county some women can choose to give birth at Royal Berkshire Hospital NHS Foundation Trust.

Women will receive care from one of ten Community Midwifery Teams across Oxfordshire in conjunction with their GP and Obstetrician as required thus receiving personalised care from a small team of midwives. All antenatal care for low risk women will be provided by midwives. GPs will be responsible for the very early pregnancy Maternity Medical Risk Assessment (MMRA). The booking assessment by the midwife at 10 weeks will focus on a health and social care assessment and the development of a bespoke pregnancy plan. Antenatal care requiring obstetrician input will take place at HGH and JHR.

The maternity service will continue to offer all four choices for place of birth; home, freestanding MLU, alongside MLU or obstetric unit. The options will be discussed with the woman and an explanation given about what services are available in each maternity setting. It is important that the woman is aware that she can change her mind about where she wishes to give birth at any time in her pregnancy.

The community midwives will co-ordinate the woman's postnatal care plan. This will include a bespoke feeding plan with information about local services and specialist support postnatally. For women with a previous history of mental health problems there will be a clear plan of support identified and access to the specialist perinatal mental health team.³² Midwives provide screening to identify women at risk of postnatal depression. In the first week women will be reviewed at home or in clinic settings and will be able to access a wide range of other clinics in local settings including breastfeeding support, neonatal examination and neonatal hearing screening. Information on support groups and other local information will be available electronically if preferred.

³² Access to this team is subject to outcome of NHS England bid.

11.2 What we consulted on

The proposal we consulted on was to make permanent the temporary closure of the Obstetric Unit at the HGH and the establishment of a permanent MLU at the HGH. Women would continue to have the option to give birth at an obstetric unit at the JRH in Oxford, in the Spires MLU at the JRH, or at one of the freestanding MLUs.

Women living in the HGH catchment population will also have the choice of travelling to Northampton, Warwick or Milton Keynes for their maternity care.

11.3 The issues raised in Consultation and Additional Work

11.3.1 Views Expressed in the Consultation

The full consultation report provides a detailed analysis of the responses to the consultation. For maternity services, the following issues were raised:³³

- Opinions on the proposal for the JRH to cater for high risk births whilst maintaining a MLU at the HGH were fairly evenly split with 38% of the respondents to the survey agreeing with the proposal and 34% disagreeing with it.
- The level of agreement with this proposal falls further for the areas of Oxfordshire that would be directly affected by such a shift in maternity and obstetric services. The largest proportions of residents in North Oxfordshire, South Northamptonshire and South Warwickshire were opposed to this proposal.
- The proposal to maintain a MLU at the HGH attracted significant levels of opposition in written responses. Respondents considered the permanent removal of a Consultant led unit at the HGH to pose a significant and unreasonable risk to the lives of mothers and babies, particularly in the light of the recommendations of the Independent Reconfiguration Panel in 2008 which deemed the travelling distance between the HGH and the JRH too great.³⁴
- Significant concerns were also raised in relation to the (under) estimated travel times and ambulance response times cited in the consultation documents. The accuracy of the travel times have been questioned along

³³ This summary is drawn from the survey, letters received, views expressed at public meetings and gathered from other meetings. Where percentages are given, they refer to the survey results.

³⁴ This quote from the Consultation Report, reflects the comments made by respondents. This is reflected slightly differently in the IRP Report (2008) which states in Recommendation Two (p.40) *'The IRP does not support the Trust's proposals to reconfigure services in paediatrics, obstetrics, gynaecology and the SCBU at Horton Hospital. The IRP does not consider that they will provide an accessible or improved service to the people of north Oxfordshire and surrounding areas.'*

with a perceived lack of information/evidence on ambulance service capacity/provision.

- The point was repeatedly made that although some women present with low risk pregnancies, problems in childbirth can quickly escalate to the point where urgent consultant intervention is required.
- Objections were also made on the basis that the proposals would have the knock-on effect of reducing the choice available to pregnant women across the wider area. Proposals overlook the issue of pain relief options and it is not made sufficiently clear that women requiring an epidural would not be able to access this at the HGH.
- There was significant concern that the permanent removal of the Consultant led unit would mean that 24 hour anaesthetic provision for epidurals etc. would no longer be available and this would have a 'domino effect', eventually rendering the A&E unviable along with the special care baby unit and paediatric services.
- There was widespread disappointment expressed about the withdrawal of the HGH training status by the Deanery, so preventing it from providing obstetric training for doctors not yet fully qualified as consultants. Questions were asked if additional steps could be taken for the HGH to be able to have its training status re-instated.
- Another area of concern expressed by respondents was the issue of recruitment/availability of suitable staff for the Consultant led unit. Many respondents felt strongly that more could have been done to attract and recruit suitable staff. A number of suggestions were provided including whether a shared rota could be run with trained consultants at the JRH.

11.3.2 Discussions at the OCCG Board on 20 June 2017

A number of issues around the obstetric proposals were discussed at the meeting on the 20 June and clarification was provided at the meeting confirming that:

- When considering the maternity proposals, the Board needs to make the best decision for the total population of patients served within OCCG;
- The model in which all high risk pregnant women attend the JRH has been in place for many years and is a safe one;
- In 2016, a national strategy, *Better Births*, endorsed the provision of freestanding MLUs as one of the choices available to women. Since the temporary closure of the obstetric unit at the HGH, OCCG has monitored

the freestanding MLU closely and there are no clinical concerns about the service offered;

- Phase Two will look at the provision of MLUs in the county but it will not reconsider the provision of obstetric services or the HGH MLU.

It was agreed that further testing of the obstetric options would be undertaken to provide assurance a rigorous review had been undertaken to determine whether suggestions made as part of the consultation affected the option selected (see section 11.4.1 below).

The Board also requested additional information about the proposals for ambulance provision for both obstetric and special care baby unit patients if the maternity recommendation is accepted. This is covered earlier in section 4.3.5 of this report.

11.3.3 Issues raised in the IIA

The Phase One IIA identified both positive and negative impacts of the maternity proposals.

Potential Positive Impacts

- Compliance with Royal College of Obstetricians and Gynaecologists (RCOG) recommendations for obstetric services to be concentrated to more effectively deal with the increasing numbers of complex pregnancies and with women being transferred from other birth locations.
- Provision of continuous senior obstetric medical staff presence on the labour ward.
- Increased quality of maternal care and a reduction in the likelihood of complications as a result of access to specialist staff that have experience in dealing with a critical mass of births.
- Creation of a larger workforce that could create opportunities for increased training and development opportunities particularly if midwives are enabled to rotate across obstetric and midwifery led services to maintain and develop their skill set.
- Provision of midwife-led care that is as safe as hospital care for women having a straightforward, low risk, pregnancy that results in fewer interventions and equitable outcomes for the baby.

Potential Negative Impacts

- Continued problems with recruitment of consultants to meet medical staffing levels for obstetric care recommended by RCOG
- Increased travel times to an obstetric unit for women and their families. It should be noted however that many 'high risk' women already travel to the JRH.
- Increased number of ambulance transfers if a mother requires transfer from an MLU to an obstetric unit with concurrent risk to mother and baby.
- Limitation of patient 'choice' within the county.
- Increased risk for women and their babies as a result of longer journeys to the JRH.

11.4 The Oxfordshire Transformation Programme's Response to the issues raised

The consultation, IIA and feedback from the Board have been considered by the Transformation Programme. The issues raised have been explored, explained and, where appropriate, mitigations have been put in place to offset the negative impacts.

No	Issues Raised	Programme response
1.	Travel times for emergency maternity transfers from HGH to JRH are too long	<p>The midwives at the MLU incorporate a process of individual risk assessment and transfer. This has operated successfully in the last 6 months, and transfers have taken place without adverse consequence.</p> <p>The average ambulance transfer travel time for 'time-critical' transfers from Banbury to JRH is 38 minutes, 7 minutes longer than the time from Wantage and 5 minutes longer than Wallingford. 50% of these journeys take 36 minutes or less (median time)source OUH</p> <p>There is no national comparative data for travel times (time-critical or otherwise) and there is no generally accepted standard for travel times. The 2011 National Birthplace Study found that the average transfer time for all types of journey was 60 minutes, and this value included the time from decision to</p>

		<p>transfer to the start of the ambulance journey.</p> <p>The Public Health Wales Observatory Research Evidence Review (2015)³⁵ “did not find conclusive evidence to support a causal link between increasing distance, or the time, required to travel from mother’s residence to maternity services and adverse birth outcomes”.</p>
2.	The proposal represents a reduction in Choice for mothers requiring obstetric care.	Choice in the context of Maternity services requires OCCG to offer freestanding MLUs, alongside MLUs, home or Obstetric Unit care options. These choices will all still be available albeit with a proposed reduction in access to low risk obstetric services at the HGH site.
3.	The provision of epidural pain relief at HGH MLU was unclear in the consultation	<p>It is recognised that the provision of an epidural service at HGH in an MLU was not made explicit in the consultation document. This was clarified during the consultation period. As a significant interventional procedure, an epidural service requires the provision of medical anaesthetic and obstetric rotas and is, therefore, only available at obstetric units not MLUs.</p> <p>Midwives discuss pain relief options throughout pregnancy and will ensure women who choose an MLU birth are aware that an epidural service is not available.</p> <p>The number of women transferred in labour from all Oxfordshire freestanding MLUs to JRH for an epidural birth is very low at 3 (out of 241 births).</p>
4.	Travelling distance for visitors	<p>The average length of stay across maternity services and including both high and low risk births is still less than 2 days.</p> <p>Babies admitted to the Level 1 SCBU will have shorter lengths of stay than Level 2 and</p>

³⁵ p.23; Research Evidence Review: Impact of Distance/Travel Time to Maternity Services on Birth Outcomes; 1 October 2015; Public Health Wales Observatory

		3 babies so the Trust is looking at improving the Parental accommodation offer for babies who will need to stay in hospital for the longest periods.
5.	Transport for pregnant women: car journey times and parking at JRH; long journey times for public transport	<p>Most midwifery care will be provided, as at present, by community midwifery teams in the North Oxfordshire locality.</p> <p>For those women who choose to give birth at South Warwickshire NHS Foundation Trust Hospital, the option of receiving antenatal care at HGH with Warwickshire staff is being explored.</p> <p>Higher-risk women will continue to receive obstetric care at JRH as has been the case for many years. In future, ante-natal clinics for women requiring higher risk obstetric care will be provided at the HGH site in addition to JRH which will reduce some journeys for residents of North Oxfordshire and surrounding counties.</p>
6.	The absence of obstetrics may have a knock-on effect for a continued A&E service at HGH (anaesthetic training accreditation and emergency gynaecology surgery)	<p>The anaesthetist for the epidural service was dedicated to the obstetric rota and not available for general emergency services. In the absence of the epidural service, the main (non-obstetric) anaesthetic rota will be retained at HGH to support general services.</p> <p>Health Education England (Thames Valley) does not envisage a direct link between the absence of obstetric services at HGH and the loss of training accreditation for the anaesthetic and general practice trainees.</p> <p>It is accepted that the absence of emergency gynaecology surgery on site will lead to fewer emergency patients overall being treated at HGH.</p>
7.	The absence of obstetrics may have a knock-on effect for a continued	There is no clinical dependency for Paediatric services to have Obstetrics on the same site. The proposal makes the HGH Paediatric

	Paediatric service at HGH	<p>services less economically favourable but it remains clinically viable.</p> <p>There will not be a training accreditation effect as Paediatrics is a consultant-provided service.</p>
8.	Creation of a freestanding MLU in Banbury may render nearby freestanding MLUs unviable	<p>Since the temporary provision of the HGH MLU, the births at the Chipping Norton MLU are projected to reduce by 17% in a full year. It is anticipated that this trend would continue if the decision is made to provide a permanent MLU service in Banbury.</p> <p>The staffing model for the freestanding MLUs is flexible, with community midwives attending Chipping Norton as required to support a woman giving birth. This means that the staffing costs for the MLUs can vary directly in line with the number of births</p>
9.	Insufficient capacity at the JRH to accommodate additional births	<p>Physical capacity has been created at JRH (35 beds rising to 46 beds) to accommodate additional births through the re-configuration of non-clinical space in the Maternity unit. The plan was to accommodate up to 1,000 additional births. Between October 2016 and March 2017, this additional capacity was not required in two of the six months, and there were no transfers out of Oxfordshire in this period.</p>
10.	Proposal does not take account of substantial expected population growth in Banbury/ Brackley/South Warwickshire	<p>Based on ONS forecasts, there is a projected rise in births of 700 p.a. by 2026 across Oxfordshire, with around third coming from the Cherwell area. Forecasting in this area incorporates a number of variables and assumptions. Assuming that the HGH attracts all 230 women, this will take the total HGH volume to around 1,700 p.a.</p> <p>Whilst more complicated than this, OCCG residents have approximately 1 birth, per 1,000 people, per annum. Assuming an average occupancy of 2.4 people per</p>

		<p>dwelling, then every additional 1,000 houses built would generate an additional 24 births per year.</p> <p>Health Education England (Thames Valley) has confirmed that an increase to 2,500 births p.a. will not enable training accreditation to be restored at HGH. There are insufficient training posts available and nationally there will not be an expansion of training numbers as there is expected to be an oversupply in the future (Centre for Workforce Intelligence, 2016).</p>
11.	Ambulance service unable to accommodate increase in journeys	<p>SCAS has confirmed ³⁶that it does not have any clinical concerns regards the proposals for a centralised obstetric service within Oxfordshire. They confirm that they are aware of the potential for some patients in the SCAS catchment area to require longer transport times to hospital and potential transfers which will pose a challenge for their current resourcing plans within the 999 service. The additional pressures will be modelled and discussed with OCCG</p> <p>There is extensive experience of running freestanding MLUs in Oxfordshire and the transport arrangements are monitored. A risk assessment for women is made at the time of booking and antenatal review and this will minimise the need for emergency transfer.</p> <p>There is an existing protocol in place for transfers from MLUs to an obstetric unit</p>
12.	Insufficient capacity in neighbouring systems to accommodate additional births e.g. Northamptonshire / Warwickshire	<p>Northampton General Hospital NHS Trust opened an alongside MLU (AMLU) in 2013 and has sufficient capacity to deal with additional births.</p> <p>Additional capacity is being developed at Warwick General Hospital for an AMLU, and</p>

³⁶ SCAS letter 31.7.2017

		<p>South Warwickshire NHS Foundation Trust has confirmed that it is able to manage additional births from the South Stratford area. Additional capacity has been created at JRH.</p>
13.	<p>Insufficient effort made to recruit junior and consultant obstetric medical staff to HGH</p>	<p>Despite significant efforts, OUHFT has not been able to fill all its current obstetric consultant or middle grade vacancies for both the HGH and JRH and is therefore unable to provide a dedicated resident consultant rota at HGH. A rolling programme of recruitment continues and medical staff are supporting the service at JRH while the temporary closure at HGH is in place.</p>
14.	<p>Increase viability of HGH obstetric unit by encouraging wider catchment of women to give birth there.</p>	<p>Health Education England (Thames Valley) has confirmed that an increase to 2,500 births p.a. will not enable training accreditation to be restored at HGH. There are insufficient training posts available nationally.</p> <p>The Maternity Clinical Workstream considered all obstetric options including some that has not previously been explored including a variant proposed by Cherwell District Council (see Ob2 in table Page 71)</p>
15.	<p>Other small units have maintained obstetric services.</p> <p>There has been insufficient consideration of alternative staffing structures including HGH – JRH rotation</p>	<p>The examples quoted during consultation were investigated and all those responding in either England or Wales had not retained training accreditation in obstetrics. Three hospitals had continued to provide obstetric services through consultant and middle grade staffing, and the future of two of the services was under review. One service would be considered remote.</p> <p>There are two hospitals in Scotland with small obstetric volumes, which have retained training accreditation, as these are considered remote.</p> <p>Alternative staffing structures were assessed</p>

		by the Maternity workstream in the long list of options, but not considered feasible. See 11.4.1 for further detail of the alternative staffing structures considered.
16.	Regain accreditation for obstetric medical staff in training	Regaining training accreditation in obstetrics would require at least additional 1000 births per year to affect accreditation decisions. Furthermore, the Health Education England (Thames Valley) has confirmed that an increase to 2500 births p.a. will not enable training accreditation to be restored at HGH. There are insufficient training posts available nationally.
17.	Accuracy of statement that additional 22 whole time equivalent (WTE) staff would be required to run a 24/7 rota for consultant-provided service	<p>The accuracy of the statement has been confirmed by OUHFT.</p> <p>Seven additional consultant posts would be required to provide 24/7 labour ward cover at the JRH. 22 additional posts would be required to provide 24/7 medical cover for two obstetric units.</p>
18.	Usage of HGH MLU is lower than predicted in temporary closure plan	<p>The usage is lower than predicted in the OUHFT Contingency Plan (August 2016), and is more accurately described in the Consultation document (January 2017).</p> <p>A clinical viewpoint is that the current temporary status of the MLU at HGH may deter women from booking at the unit but on current projections OUHFT is expecting around 200 births per year.</p>

11.4.1 The Obstetrics Option Analysis

There was a widely-held view that insufficient consideration had been given to the expected growth in population in the catchment area of the HGH or of alternative options for maternity services in Banbury. In order to address this concern, the maternity workstream members reviewed the options for obstetric services, taking into account all the options which were considered in 2016 and any alternative options put forward during the consultation and in written consultation responses.³⁷

The maternity workstream’s members revised the long list of options and then assessed this list using the evaluation criteria set out in the OUHFT Horton Strategic Review in May 2016, see table below³⁸:

Additional Obstetric Options Table			
Ob1	Status quo	2 obstetric services at JRH and HGH with current volumes of births and staffing arrangements including consultant and junior doctor rotas at both sites	Rejected. Unable to maintain medical rotas to continue obstetric service at HGH as described in PCBC
Ob2	50 / 50 births	2 obstetric services at JRH and HGH, with women from the north half of the County being booked at HGH. A variant is the Cherwell DC proposal for 2500/6500 split of deliveries	Rejected. 3000 women required to travel to Banbury from Oxford City and South. Variant is based on premise of re-accreditation of medical training posts. There is evidence to the contrary
Ob3a	2 obstetrics units – fixed consultant	2 obstetric services at JRH and HGH, staffed by fixed 24/7 consultant rotas. Separate pools of medical staff for two sites	Rejected. Very high cost, risk in relation to recruitment. In terms of equity, full consultant labour ward cover required at JRH. Risk of loss of skills with this volume of births
Ob3b	2 obstetrics units – rotating consultant	2 obstetric services at JRH and HGH, staffed by 24/7 consultant rotas with staff rotating between sites	Rejected. Very high cost, risk in relation to recruitment. In terms of equity, full consultant labour ward cover required at JRH.

³⁷ Stratford Upon Avon District Council, South Northamptonshire and Cherwell District Council offered a variant base on rotation of staffing. Victoria Prentis also referred to a similar model. This was considered by the Maternity Clinical Working Group see Obs 2 Option

³⁸ These were: Quality of Care; Access to Care; Affordability and Value for Money; Workforce; Deliverability

Ob3c	2 obstetrics units – fixed combined consultant and middle grade	2 obstetric services at JRH and HGH, staffed by fixed 24/7 combined consultant and middle grade. Separate pools of medical staff for two sites	Rejected. Increased medical costs and risk in relation to recruitment. Higher risk deliveries at JRH could not be covered by middle grade alone. Risk of loss of skills the difficulty retaining middle-grade staff, because so little clinical experience can be gained in a unit with so few deliveries, would persist. Hence, we would still be running the risk of having to close the obstetric unit on a regular basis because of lack of staff.
Ob3d	2 obstetrics units – rotating combined consultant and middle grade	2 obstetric services at JRH and HGH, staffed by 24/7 combined consultant and middle grade rotas, with staff rotating between sites	Rejected. Increased medical costs and risk in relation to recruitment. Higher risk deliveries at JRH could not be covered by middle grade alone. Risk of loss of skills the difficulty retaining middle-grade staff, because so little clinical experience can be gained in a unit with so few deliveries, would persist. Hence, we would still be running the risk of having to close the obstetric unit on a regular basis because of lack of staff. In addition 6-10 additional consultants would need to be employed in a hybrid model depending upon the number of middle-grade staff available.
Ob4	2 obstetrics units – external host for HGH	2 obstetric services at JRH and HGH, with service provided on HGH site by another NHS Trust	Rejected. OUHFT has consulted SWFT on this model, and is considered unviable.
Ob5	2 obstetrics units – elective CS at HGH	2 obstetric services at JRH and HGH, with all Oxfordshire elective CS taking place at HGH	Rejected. Evaluated during the pre-consultation period. Support for high risk women

No	Title	Identified Option	Evaluation
			may need to transfer to JRH. Significant clinical interdependencies would also require relocation
Ob6	Single obstetric service at JRH	1 obstetric service for Oxfordshire at JRH	Proposed. Rationale described in PCBC
Ob7	Single obstetric service at HGH	1 obstetric service for Oxfordshire at HGH	Rejected. Requires tertiary obstetric service to relocate to HGH. Significant clinical interdependencies would also require relocation

A new option with a mixed rota of consultant level and middle grade obstetric staff at HGH was investigated further. This was included following the publication of additional professional guidance in December 2016 from the RCOG, which recommended that a mixed rota should be considered in some circumstances. Previously, such a mixed rota had not been recommended.

OUHFT have discussed the proposal, based on the description of a hybrid model in the RCOG (2016) document 'Providing Quality Care For Women: Obstetrics & Gynaecology Workforce' and strongly believe that the hybrid model is not a viable option for HGH.

A hybrid model would require the employment of an additional 6-10 consultants depending on the number of middle-grade staff available and does not eliminate the essential problem, which is the difficulty of recruiting and retaining a stable number of appropriately qualified medical staff at middle-grade level recognised by RCOG as a national problem: OUH have tried many times to recruit staff grades/trust doctors but have had very little success' (Peterborough) and 'It was difficult to get long-term locums and we advertised many times without success' (York).

OUH also believe they would continue to have difficulty in retaining middle-grade staff, because so little clinical experience can be gained in an obstetric unit such as that at HGH that was experiencing so few deliveries. This then would continue to create a risk of having to close the obstetric unit on a regular basis because of lack of staff.

Other options on the long list were excluded on the grounds that they were not feasible or would significantly reduce access to services for a substantially greater number of women than the original proposal.

After consideration, the original proposal of centralising obstetric services at the JRH was supported.

11.5 Implementation and sustainability

The proposals are to make permanent the temporary changes made as part of the contingency plans, put in place in October 2016, and as such this will not require a new implementation plan.

Since the temporary closure of the obstetric unit at the HGH, OCCG has monitored the freestanding MLU closely and there are no clinical concerns about the service offered. A quality assurance process has been in place since the temporary closure of obstetrics and the establishment of an MLU at the Horton General Hospital in October 2016. OCCG has held monthly meetings with OUHFT to provide assurance on the implementation of the Contingency Plan and to monitor the key performance indicators (KPIs) that were agreed prior to the temporary closure. Regular reports have been received by the OCCG Quality Committee. During this period of transition incidents have been reported and have been investigated in line with OUHFT processes. Maternal and neonatal outcomes for the reconfigured obstetric service and the midwifery led units will continue to be monitored during the transition to the new model of care.

As part of the temporary change a permanent dedicated ambulance was sited at the HGH MLU. This is not consistent with the other MLUs provided in Oxfordshire. Over a period of nine months, SCAS has confirmed that the dedicated ambulance has been utilised to support 73 journeys booked as transfers from HGH to JRH. Maintaining the dedicated ambulance at the HGH costs £730,000 per year. SCAS and OCCG are aware that this model may not be clinically or financially justified over time, because of its low rate of utilisation.

The staffing model at the temporary HGH MLU was established based on projected usage. As previously indicated the OUHFT have confirmed that the difficulties in recruiting middle grade and consultant obstetric staff is a national problem. The training posts at the JRH have been popular and over time though possible to recruit to all the posts there is no waiting list for training posts. OUHFT's view is that centralising the obstetric service will make the jobs more attractive and enable the Trust to build consultant numbers (by 7) to provide 24/7 presence on the labour ward; this is a developing position and has moved from 54 hours of consultant presence 5 years ago to 108 hours at

the end of July 2017; this is planned to increase to 114 at the end of September 2017.

Again there is a national shortage of midwives and OUHFT has a systematic approach to recruitment. The main source of midwives is recruitment of the newly qualified students. There is one intake of students who qualify each year and the OUHFT would normally recruit the majority of the new graduates and are confident this will continue. The Midwife Support Workers are important members of the team.

Further review and advice will be required from the Clinical Senate, in terms of any proposal put forward prior to any change in both ambulance provision or staffing arrangements at HGH MLU. The evidence for change will be presented to the Clinical Senate, once a full year of data is available. In the interim, no change will be made to the provision of MLU services at HGH.

The provision of obstetric services incurred a premium of approximately £700,000 p.a. OCCG has agreed that the premium previously paid to OUHFT for obstetric services at HGH will remain in the OUHFT contract value until December 2017 with a view to securing quality benefits. The range of benefits under consideration are outlined in the table below:

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Quality improvements in new model of obstetric care

Improvement	Impact	Cost	Over and above what is already delivered?
a) All women will be offered a very early medical risk assessment by their GP.	All women are consistently and effectively screened and medically risk-assessed by their GP as early as possible in pregnancy	Cost neutral to primary care but dependent on b)	Yes. Some GPs already do a risk assessment but this is not consistent across Oxfordshire.
b) Community midwives to deliver all routine antenatal appointments in line with NICE standard.	Continuity of care and consistency of clinical practice with GP time released to focus on a)	A <u>maximum</u> of 3.85 WTE additional midwifery time ³⁹	Yes. See below for workings.
Local provision of community midwifery care	Each of the 10 community midwifery teams will have a local base to provide community clinics	Four of the 10 teams can use existing MLUs as a base. The Oxford City Team could use EOHC or Rose Hill Family Centre and the remaining teams could use Community Hospitals (dependent on space available) apart from the Blenheim team where no suitable alternative NHS accommodation can currently be identified. It is likely that costs would be incurred for all of the above apart from the MLUs.	Clinics currently held in GP practices and OUH have historically not been charged for this clinical space.

³⁹ Calculation used:

7,500 Oxfordshire births per year

20 minute midwife appointments x 3 additional appointments per woman = 7,500 additional hours ~ 3.85 WTE midwives.

This would be the maximum impact of the changes as not all women will require all appointments (at least one of the appointments is for nulliparous women only and some women will give birth prior to their 38 week appointment)

Improvement	Impact	Cost	Over and above what is already delivered?
<p>d) Increase dedicated Consultant hours of presence on the obstetric labour ward to facilitate the recommendations of Each Baby Counts report</p>	<p>A sustainable consultant workforce, leading the number and complexity of births. Adequate clinical exposure to enable them to maintain and develop their specialist knowledge.</p>	<p><u>Would need additional 7 WTE Consultant Obstetrician</u></p> <p>This would provide 168 hours cover in a sustainable manner as per the model introduced at St Mary's Hospital in Manchester (9 consultants covering daytime on call including weekends and 16 consultants covering night time on call)⁴⁰. OUHFT has recently re-advertised for consultants using this model and has received a better response.</p>	<p>Yes. Consultant hours on JR labour ward was at 92 hours in June 2017 but increased to 108 hours for July and August and is anticipated to go up further to 114 hours by the end of September when the final new consultant is in post.</p>
<p>OUH Consultants will provide more clinics for high risk women at the Horton</p>	<p>Reduced travel times and easier access for approximately 400 women⁴¹ who would have previously received their antenatal care at the JRH because of assessed risk.</p>	<p>Cost neutral</p>	<p>Antenatal Clinics held twice a week at HGH and a Day Assessment Unit is operational throughout the week (according to OUH Contingency Plan).</p> <p>If the number of consultants have increased to cover Ob labour ward (see d) above) there would be staff to increase the general Antenatal clinic x1 and could introduce some specialist services At HGH. 1.Diabetic ANC 2.High risk Fetal /maternal med clinic 3.Perinatal mental health ANC.</p>

⁴⁰ See NPEU report

⁴¹ Figure taken from Horton Strategic Review (OUH, 2016)

Improvement	Impact	Cost	Over and above what is already delivered?
f) Space for Warwickshire Consultants to provide clinics for high risk women at the Horton Page 87	Reduced travel times for women who chose to book at Warwick Hospital who require antenatal obstetric care.	Cost neutral or small cost. During the 2016/17 year (but likely to be from October 2016 when the Horton became a temporary MLU) OCCG has paid South Warwickshire NHSFT 29 Maternity Pathway Payments for antenatal care and 49 payments for the intrapartum and postnatal care. Assuming these payments largely occurred in the latter 6 months of the 2016/17 year then it can be projected that an estimated 156 Oxfordshire women (13 women per month) will chose to give birth at Warwick Hospital. It is not clear how many of these women would require consultant-led antenatal care but it is likely that the numbers would be relatively small.	Yes. Was not implemented as part of Contingency Plan.
g) to achieve aims of DOH mandate to reduce poor maternal and neonatal outcomes by 20% by 2020 and 50% by 2030 to implement recommendations from MBRRACE	A senior obstetrician maintaining oversight of the activity on the delivery suite allowing problems to be anticipated earlier and improving outcomes. Ensure that the right women seen in right place with expansion of Perinatal mental health care and improved access to high risk maternity clinics Expansion of diabetic services	Would be covered with consultant expansion to provide 168 hours dedicated labour ward presence costs as above.	yes

Part Four:

ACTIVITY AND FINANCE

12. Activity

12.1 Activity Assumptions

There is no change in the activity assumptions and resultant activity levels shown between PCBC and this DMBC.

The activity growth assumptions are based on population growth and demographic changes, plus an additional non-demographic growth element of 1.5% per annum.

The model underlying the projected growth in demand for health and social care services⁴² is described in the PCBC and is based upon the following key assumptions:

- The model was, wherever possible, based on actual underlying activity data for the period 2014/15 and 2015/16 (including at Health Resource Group - HRG level for Acute activity);
- In order to understand the projected impact of the ageing population (demographic change) within Oxfordshire, where possible activity was divided by:
 - Locality;
 - Age bands – 0-19, 20-64, 65-84 and 85 and above;
 - Point of delivery (acute only): elective day cases, elective inpatients, non-elective zero day admissions, non-elective inpatients, maternity, first outpatients, follow-up outpatients and A&E;
 - The top-3 providers plus 'others';
 - The number of long-term conditions (0, 1, 2-4, 5 or more).
- By applying these growth elements to the actual underlying activity data, the projected activity for the period 2016/17 to 2020/21 was determined.
- The activity modelling in this model excluded the potential impact of any additional new housing because any population growth due to new housing developments that bring additional population into Oxfordshire (from other CCGs) will be reflected in annual adjustments to the CCG's allocation. However all clinical plans in part three take account of projected housing growth.

⁴² This includes all CCG and NHS England commissioned health services provided to people registered with OCCG GP practices, and Oxfordshire County Council services (adult social care and public health).

- The PCBC Chapter 10 details the activity relevant to the recommendations in this DMBC.

13. Finance

13.1 Purpose and Approach

This section describes the financial implications of each recommended option for change. The detailed financial analysis set out in the PCBC has been reviewed: where there has been no underlying change to the financial impact of the recommended decision the position is summarised again and where there have been changes the impact of these is described.

13.2 Summary PCBC Financials

This 'Phase One' of transformation work will have its main impact on the Oxford University Hospitals NHS Foundation Trust (OUHFT). The Trust financial position was modelled using two scenarios with a common set of activity assumptions:

1. A "do nothing" scenario. In this scenario there was no reconfiguration of services other than minor changes to the model of care in outpatients. The basis of the scenario was the projected deficit for OUHFT up to 2020/21 if the demand, activity and cost assumptions were left to unfold without any response. This was described as Option 1.

In this scenario:

- a. The projected deficit for the Trust was £27.3m by 2020/21
- b. The projected capital expenditure requirement was £106m, being the increase inpatient bed and diagnostic capacity required to meet expected increases in demand.

2. A "do something" scenario. In this scenario the impact of the Oxfordshire Phase One reconfiguration was modelled, and the projected deficit position presented. This was described as Option 2.

Under this scenario:

- a. The projected deficit for the Trust reduced to £16.2m in 2020/21; an improvement of £11.1m.
- b. Projected capital expenditure was £127m, to reflect further reconfiguration of bed capacity across the Trust together with additional diagnostic capacity and reconfiguration of outpatient facilities, mainly at the HGH site.

While the scenario modelling presented a total capital requirement linked to un-mitigated demand growth, the majority of this requirement is outside the scope of this reconfiguration.

Incremental capital development to achieve the required changes is £20.8m, to reflect additional diagnostic capacity and reconfiguration of outpatient facilities, mainly at the HGH site. £6.3m of the £20.8m is sourced by transferring equipment from other sites or via internal Trust funding sources. This identified £14.5m as the incremental capital ask to implement the changes described collectively as Option 2.

In comparative terms the £11.1m improvement in the income and expenditure (I&E) position between Options 1 and 2 is derived from the changes to models of care and location of clinical activities that are implemented under Option 2. In terms of impact, £3.3m of this difference relates to changes in models of care with the remaining £7.8m being from the ability to more effectively and efficiently use estate due to the movement of clinical services between sites.

The additional costs of purchasing nursing home beds was included in the Trust 2016/17 financial position and were therefore extrapolated from this position in the baseline to the 20/21 “do nothing” gap. The same is true of the financial implications of all changes relating to the DTOC and bed realignment programmes. There was not expected to be any further incremental investment above this going forward.

The Trust had assumed for financial modelling purposes that it would have access to external finance for capital expenditure at rates comparable with Public Dividend Capital (PDC) (3.5% pa). The Trust acknowledged that of the £127m capital expenditure required to support the proposed Phase One changes to models of care in Oxfordshire, £21m related to the incremental change specific to enabling new models of care and that the remaining amount relates to additional capacity to support activity growth and site moves.

The PCBC assumed that as a minimum there would be access to PDC to cover the £14.5m of incremental capital not funded by the Trust. If PDC funding were not available alternative options might include internal, alternative-NHS or commercial sources of finance. The Trust has an expected capital programme of c£150m over 5 years, with further expected funding through payment of Sustainability and Transformation Funding of up to £60m over 3 years to 2018/19.

The Trust believes that flexibility could be created in the outer years of its five year programme to support investment in these changes, in-part through internally generated means. Financing of capital investment in new facilities

could also be in the form of strategic land disposal, or through a more effective use of existing estate on the same site.

13.3 Impact of DMBC Recommendations

13.3.1 Critical Care

There is no change in the financial impact of the recommended changes to Critical Care between PCBC and this DMBC. The costs of providing Level 3 critical care support will transfer along with the activity.

13.3.2 Acute Stroke Services

There is no change in the financial impact of the recommended changes to the HASU between PCBC and this DMBC. The costs of providing this will transfer along with the activity.

The DMBC recommendation does require additional investment to implement a county-wide Early Support Discharge (ESD) . The required OCCG investment is £505,299 on a full year effect basis with a part year effect in 2017/18 from the point of implementation post decision making.

The existing ESD service for North East and City has treated on average 140 patients per annum for a registered population of 298,795 (at 1 April 2017).

An expansion based on per registered population of Oxfordshire 730,558 would mean the service would treat 342 patients per annum, an increase of 202, full year effect.

To grow this service, it is planned to increase the number of patients treated on a phased basis. An initial target of 250 patients treated is being set for 2018/19.

The expansion of the ESD service is anticipated to have a benefit in terms of reductions in inpatient lengths of stay and outcomes for patients and thereby system long term costs. These benefits will be evaluated as part of the Phase Two evaluation of the full stroke rehabilitation pathway.

13.3.3 Changes to Acute Bed Numbers

The recommendation in this DMBC reflects a change to proposed option and financial modelling in the PCBC.

Summary position of the PCBC

The summary position presented in the PCBC is as follows:

There was a modelled reduction of an additional 118 beds, which together with the 76 beds temporarily closed in 2015/16, brought the original planned reduction to 194 beds, with reinvestment and re-provision in the following new model of care:

- Ambulatory care units in JRH and HGH
- AHAH
- A liaison hub managing patients who are complex delayed discharges by transferring the patients to Nursing homes beds managed by the hub;
- A trust wide Discharge Liaison Team, co-ordinating delayed discharges across the four sites to reduce avoidable delays in the discharge process'

The financial consequences for OUHFT of these changes at PCBC stage are summarised in the tables below.

Ward	Saving 2016/17 £'000	Saving 2017/18 £'000
F ward HGH	644	1,288
John Warin Ward	332	663
5B converting to ambulatory	252	336
Combine 7C and 7D into one ward	718	1,231
Combine 7A and 7B	0	0
C Ward	147	195
6A/5C to West Wing JRH	698	1,197
Total	2,791	4,910

The costs associated with the alternative services are set out below.

Service	Pay £'000	Non Pay £'000	Total cost £'000	2016/17 Cost £'000
Liaison Hub	1,103	24.9	1,127.9	1,127.9
Ambulatory Unit	1,650	0	1,650	825

Service	Pay £'000	Non Pay £'000	Total cost £'000	2016/17 Cost £'000
Supported Hospital Discharge (non acute Hospital at Home)	1,250	0	1,250	830
Trust Discharge Team Expansion	100	0	100	100
Totals	4,103	24.9	4,127.9	2,882.9

The impact on OUHFT's overall financial position is summarised below.

	2016/17 £'000	2017/18 £'000
Bed reconfigurations	2,791	4,910
Service Investments	(2,882.9)	(4,127.9)
Commissioner Investment - Hub	900	900
Non Direct Savings	Tbc	tbc
Maternity Saving	25	50
Total saving	833.1	1,732.1

The PCBC expected OUHFT to generate savings of £4.9m in 2017/18 as a result of bed reductions. £4.1m was to be invested in service developments, £0.9m funded by OCCG and £3.2m funded by the OUHFT from bed reduction savings. This resulted in a net financial benefit of £1.7m to OUHFT.

OCCG committed to invest £0.9m in the Liaison Hub (see above) and £1.6m to purchase 36 intermediate care beds from the private sector.

The bed realignment programme was anticipated to result in savings of £1.7m per year to OUHFT, but at a cost of £2.5m to OCCG.

New financial modelling based on current bed closures

As outlined in the HOSC paper of September 2016 the Trust initially planned to realign 194 beds. There were two tranches or bed realignment. Plans for the additional 118 beds closures in the second tranche were operationally revised. Of these, a number of beds have been closed (bringing the total

number of beds closed since December 2015 to 110). A further 36 bed closures are planned in 2017/18 but are subject to Senate approval and NHSE assurance. Permanent closure of the remaining 48 beds is not being taken forward as part of this DMBC. However investment in the new services has been made in full

The impact of this on the financial modelling is detailed below.

Savings from ward bed changes:

Ward	Site	Saving 2016/17 £'000	Saving 2017/18 £'000
5 C/D	JRH	381	381
E Ward	Horton	550	550
Ward E	NOC	274	274
7F	JRH	0	0
5 A/B	JRH	158	237
Oak & F Ward	Horton	1,004	2,008
Ward C	NOC	0	48
Gynae	JRH	0	-60
Total		2,367	3,438

OUHFT Service investments have been:

Service Investments	Cost 2016/17 £'000	Cost 2017/18 £'000
Liaison Hub	900	900
Acute Hospital at Home	465	1,600
Trust Discharge Team Expansion	74	100
Nursing Home Beds	2,666	2,884
Transport	394	394
Total	4,498	5,878

Commissioner Investment has been:

Commissioner Investment	Spend 2016/17 £'000	Spend 2017/18 £'000
Liaison Hub	900	900
Nursing Home Beds (Note 1)	1,600	1,600
Total	2,500	2,500

Summary financial impact for OUHFT:

Summary:	PCBC	Revised
	2017/18	2017/18
	£'000	£'000
Bed reconfigurations	4,910	3,438
Service Investments (Note 1)	(5,728)	(5,878)
Commissioner Investment - Hub	900	900
Commissioner Investment - Nursing Home Beds	1,600	1,600
Maternity Saving	50	0
Total OUH Saving / (Cost)	1,732	60
Less Commissioner Investment - Hub	(900)	(900)
Less Commissioner Investment - Nursing Home Beds	(1,600)	(1,600)
Total System Saving / (Cost)	(768)	(2,440)

The inability to release the planned number of acute beds alongside the investment in non-acute capacity, as well as the added costs of transporting patients to non-acute locations, has created an additional cost to the system of £1,672k.⁴³

Sustainability of the Alternative Provision:

Although the full financial impact has not been evaluated, the programme has demonstrated a range of benefits that would support the return on investment:

1. `Patient experience – feedback from patients and their families showed that “on the whole, patients, their families and carers felt the care was good and their experience of care within nursing homes has been positive”

⁴³ During 2017/18 OUHFT successfully tendered for a new service with Oxfordshire County Council (OCC) integrating the old Supporting Hospital Discharge Scheme (SHDs) (an OUHFT service) and ORS (an OHFT service) and a new service, HART, was established (See Section 9.1.2). It is not possible to determine the specific costs within the HART service that related to the enhanced SHDs as planned to support the programme as set out in the PCBC. These costs are related to a procurement and not the Rebalancing the System initiative.

2. Since the commencement of the programme:
 - a. the average length of stay for patients over the age of 65 has fallen from 3 days to 2.5 days
 - b. the % of non-elective admissions with Same Day Discharge, has increased from 30% to 37%
3. The number of patients treated in the AAU has risen to 540 per month
4. At the same time there has been a growth in the number of non-elective admissions, and a significant growth in emergency department attendances of 18% over the past 30 months. ⁴⁴

The underlying DTOC position initially improved under the programme, but since 2015/16 has been affected by a number of impacts including; the loss of several domiciliary providers and pressures on the HART reablement service due to workforce pressures and high levels of vacancies.

Given the increase in demand for services across the Oxfordshire system, the redesign of the services has however ensured that the quality of care provided has been maintained, particularly during the peak winter period, a position endorsed by the Clinical Senate Bed Test review. ⁴⁵

It is notable that if the Board does not support this bed position the system would need to decommission the co-ordination hub and AHAH. Also OCCG would have to review the ambulatory model. This would be a significant backward step.

⁴⁴ Source: Clinical Senate Report, Oxfordshire Transformation Programme – Patient Care Test for Hospital Bed Closures 2017

⁴⁵ Source: Clinical Senate Report 2017, Oxfordshire Transformation Programme – Patient Care Test for Hospital Bed Closures “The changes that have been implemented since November 2015 across the Oxfordshire health system have been aimed at creating more sustainable services that provide prompt, effective and high quality care for patients. These changes are a core part of the overarching strategy to provide care closer to patient’s homes. There is clear evidence that ‘doing nothing’ (i.e. maintaining the status quo) is not financially sustainable and does not provide the best possible patient experience or quality of care. The substantial increase in patients (of all ages) receiving diagnostics, treatment and care on an ambulatory model has enabled beds to be reduced and the resource to be used to provide care closer to and in people’s home. The next phase of work will continue to consider and develop more integrated and coordinated care pathways.”-

13.3.4 Planned Care Services at the Horton General Hospital

There is no change in the financial impact of the recommended changes to Planned Care Services between PCBC and this DMBC.

It is these changes that require the incremental capital investment identified in the PCBC. To summarise this requirement:

Comparison of Capital Requirements for Oxfordshire Phase 1 PCBC

	Option 1		Option 2		Option 2*		Option 1 to Option 2*	
	JR	Horton	JR	Horton	JR	Horton	JR	Horton
Beds	70.8	22.5	75.4	21.2	75.4	21.2	4.6	-1.4
Theatres	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Outpatients	0.0	0.0	0.0	9.5	0.0	9.5	0.0	9.5
Diagnostics	0.0	7.9	0.0	18.9	0.0	12.6	0.0	4.8
Other	0.0	5.0	2.0	0.0	2.0	0.0	2.0	-5.0
Total	70.8	35.4	77.4	49.6	77.4	43.3	6.6	7.9
	106.2		127.0		120.7		14.5	

2* Diagnostic equipment at the Horton could be provided through transferring existing equipment from other sites or internally through growth.

It should be noted that more detailed work is required to confirm the capital investment requirement as part of the capital business case process used by the NHS. If the DMBC recommendation is approved by the OCCG Board then the Trust should be instructed to commence this process to gain approval for and to source the identified external capital investment required to implement the changes.

13.3.5 Maternity Services

There is no change in the financial impact of the recommended changes to maternity services between PCBC and this DMBC. The premium previously paid by OCCG to maintain the obstetric service at HGH will remain in the contract value with the Trust until December 2017 with a view to securing the described quality benefits based on consideration of a case to National Health Service Improvement (NHSI) for the retention and reuse of this funding to support trust-wide maternity services. Such a case would need to be approved under the mandated process for local modifications to the national payment framework.

13.4 Summary

The PCBC identified that against the “Do Nothing” scenario the implementation of the recommendations for Planned Care at OUHFT should reduce the projected deficit for OUHFT by £11.1 million (to £16.2 million) in 2020/21. The planned DTOC programme required an investment in excess of savings of £0.8m. This delivered a commensurate net benefit to the Oxfordshire Health System:

Financial Benefit to System:	2020/21- £'m
OUHFT Financial Position	11.1m
DTOC programme*	(0.8m)
Impact on Oxfordshire STP	10.3m

The review for this DMBC has identified that with the changes to the levels of net investment in both the DTOC programme and the extended Stroke ESD service, the impact on the Oxfordshire STP ⁴⁶ is as follows:

Financial Benefit to System:	2020/21 - £'m
OUH Financial Position	11.1m
DTOC programme*	(2.4m)
Enhanced investment in Stroke ESD	(0.5m)
Impact on Oxfordshire STP	8.2m

In addition to the financial benefit set out above, the recommendations has retained services for patients and improved the ambulatory model as well as providing some of the new capacity needed to meet increasing demand and deliver a significantly improved environment for a large number of patients and deliver the beneficial reconfiguration of clinical services.

The recommendations will, however, require significant capital investment of £20.8 million (for the most part to reflect additional diagnostic capacity and reconfiguration of outpatient facilities at HGH) £6.3 million of this £20.8 million can be sourced by transferring equipment from other sites or growth funding.

⁴⁶ For the purposes of the Oxfordshire STP “Do Nothing” scenario, a significant element of the DTOC programme was included within the baseline costs for 2016/17 and therefore was extrapolated forwards in the “Do nothing” STP Oxfordshire deficit.

This leaves £14.5 million of additional capital investment. OUHFT have made an application to NHS England for external funding support for this capital investment. If successful this is likely to be provided through additional PDC. Alternatively OUHFT will look to fund the programme through its own internal capital investment programme or via other NHS or commercially based sources.

Part Five:

THE 'BEST PRACTICE' CHECKS AND CONCLUSION

14. Legal Advice and Other ‘Best Practice’ Checks

OCCG has taken legal advice throughout the public consultation process and in the preparation of this report. This has included advice on OCCG’s compliance with its legal duties, including amongst other things, its duties to:

- make arrangements to secure public involvement in the planning, development and consideration of proposals for changes and decisions affecting the operation of commissioning arrangements;
- have regard to the need to reduce inequalities; and
- to comply with its requirements in respect of choice, competition and procurement under The Public Contracts Regulations 2015; The NHS (Procurement, Patient Choice and Competition) Regulations 2013 and relevant EU law and directives.

An initial review of Emergency Planning has been undertaken that conclude that there is no significant impact on emergency plans in Oxfordshire. As part of the regular cycle of reviewing Emergency Planning we will look again at the potential impact of any changes that are made at the HGH.

15. Conclusion

The information in this business case should give a clear picture of the programme’s responses to both the public consultation and the formal impact assessments, including any proposed mitigations.

The final clinical recommendations are clearly laid out for the OCCG Board to consider.

Read in conjunction with the PCBC and other supporting documents listed in Appendix A, this business case demonstrates that the proposals are based on a strong clinical evidence base and that OCCG has a plan for how the changes can be implemented within existing resources.

Appendix A: Supporting Documents

This report should be read in conjunction with a series of supporting documents that the OCCG Board has previously considered as well as a small number of additional documents that have been produced, and are published on the Oxfordshire Transformation website, to ensure the Board is fully informed. These are listed below along with information of when the Board received these documents.

1. The Oxfordshire Transformation Programme's **Pre-Consultation Business Case (Acute Hospital Services: Phase One)**

The report was approved by OCCG Board on 29 November 2016 for submission for formal assurance by NHS England. A few minor changes were made as part of this NHS England assurance process and all references in this DMBC are to the final version dated 10 January 2017.

2. The Oxfordshire Transformation Programme's **Big Health & Care Consultation Report** (Oxfordshire Healthcare Transformation Programme – phase one), May 2017

This is the report on the formal 12 week consultation held on the proposals in Phase One. It was considered by the OCCG Board on 20 June 2017.

3. The Oxfordshire Transformation Programme's **'Patient Care Test' for Hospital Bed Closures**

- *The minutes of the Thames Valley Clinical Senate for their meeting on 6 June 2017*
- *The recommendations from the Thames Valley Clinical Senate meeting 26 July 2017*

<http://tvsenate.nhs.uk/work-plan/senate-recommendations/>

4. Mott MacDonald, **The Integrated Impact Assessment**, July 2017-

This report explores the potential positive and negative consequences of Oxfordshire Transformation Programmes proposals to transform healthcare in Oxfordshire and to make recommendations for the mitigation of any potential negative impacts. This report was considered by the OCCG Board on 11 July 2017

5. Healthwatch Oxfordshire **'Oxford University Hospitals NHS Foundation Trust Travel Survey – People's experiences'** May 2017

This report summarises the methodology and findings of Healthwatch Oxfordshire's travel survey conducted in May 2017.

6. Mott MacDonald **'Hospital Car Parking Survey'** June 2017

This short report summarises the finding of the hospital car parking survey conducted by Mott MacDonald over one week in June 2017 (Wednesday 14 – Friday 16 June and Monday 10 and Tuesday 20 June).

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MINUTES:

OXFORDSHIRE CLINICAL COMMISSIONING GROUP EXTRAORDINARY BOARD MEETING

20 June 2017, 09.30 – 11.30 Jubilee House, 5510 John Smith Drive, Oxford, OX4 2LH

	Dr Joe McManners, Clinical Chair
	David Smith, Chief Executive
	Dr Stephen Attwood, North East Locality Clinical Director (voting)
	Dr Ed Capo-Bianco, South East Locality Clinical Director (voting)
	Dr Miles Carter, West Locality Clinical Director (voting)
	Dr David Chapman, Oxford City Locality Clinical Director (voting)
	Dr Jonathan Crawshaw, South West Locality Clinical Director (voting)
	Mike Delaney, Lay Member (non-voting)
	Roger Dickinson, Lay Vice Chair (voting)
	Dr Shelley Hayles, North Deputy Locality Clinical Director (voting) [for Paul Park]
	Gareth Kenworthy, Director of Finance (voting)
	Catherine Mountford, Director of Governance and Business Process (non-voting)
	Duncan Smith, Lay Member (voting)
	Kate Terroni, OCC Director for Adult Services (non-voting)
	Dr Louise Wallace, Lay Member Public and Patient Involvement (PPI) (voting)
	Sula Wiltshire, Director of Quality and Lead Nurse (voting)
In attendance:	Lesley Corfield - Minutes
Apologies:	Diane Hedges, Chief Operating Officer (non-voting)
	Stuart MacFarlane, Practice Manager Representative (non-voting)
	Dr Jonathan McWilliam, Director of Public Health Oxfordshire (non-voting)
	Dr Paul Park, North Locality Clinical Director (voting)
	Dr Guy Rooney, Medical Specialist Adviser (voting)

Item No	Item	Action
1	<p>Chair's Welcome and Announcements</p> <p>The Chair welcomed everyone to the meeting and reminded those present the OCCG Extraordinary Board was a meeting in public and not a public meeting. He advised this was an Extraordinary Board meeting to receive the reports of the consultation. For this meeting there would not be an opportunity to ask questions from the floor. Members of the public had been invited to submit written questions ahead of the meeting and Board members would endeavour to answer those relating to the consultation process during the meeting. Written responses to process questions would, as usual, be posted on the website within 20 working days of the meeting.</p>	
2	Apologies for absence	

	Apologies were received from the Chief Operating Officer, the Practice Manager Representative, the Director of Public Health, the North Locality Clinical Director and the Medical Specialist Adviser.	
4	Declarations of Interest There were no declarations of interest pertaining to the paper or over and above those already recorded.	
5	Minutes of OCCG Board Meeting held on 25 May 2017 The minutes of the meeting held on 25 May 2017 were approved as an accurate record.	
6	Matters arising from the Minutes of 25 May 2017 The actions from the 25 May 2017 minutes were reviewed and updates provided where these were not covered under items later on the agenda.	
7	<p>Report on Phase 1 of the Oxfordshire Transformation Programme Public Consultation</p> <p>Chair introduced Paper 17/43 containing a detailed consultation report describing the process of the consultation and providing an analysis of the responses. The introductory paper set out the status of the detailed consultation report and the other work being undertaken to support the Board in preparing for the decision-making meeting on 10 August 2017. The Chair explained the main focus for the Board was to consider the paper and the report and to be assured on the consultation process; to note the work commissioned to ensure sufficient information which would be available to enable decision-making at the meeting on 10 August 2017; and to identify any areas where it was felt further additional information was required prior to decision-making. The Chair stressed the Board was not making any decisions during this meeting.</p> <p>The Director of Governance reiterated the focus of the meeting and reminded the Board of the reasons for the consultation being in in two phases; detailed the areas covered in Phase 1 of the consultation; advised the Report was published on the OCCG website. In addition the Board had received copies of all the responses received from MPs, Local Authorities, other organisations and a selection of individual letters. Board Members had also attended the consultation events. The Report contained details of the other engagement which had been undertaken. The Director of Governance summarised the key themes identified from the consultation, the make-up of the more than 10,000 individual responses received and advised 1,400 people had attended the public meetings.</p> <p>The Director of Governance advised during the consultation the Chief Executive of NHS England (NHSE) had announced a new test to be undertaken to ensure processes and services were in place prior to any bed closures. OCCG was confident of the evidence for the services and processes but was undertaking some retrospective assurance from the Thames Valley Clinical Senate and NHSE against the test. Other work being undertaken: an Integrated Impact Assessment (IIA) for Phase 1 and Phase 2 had been commissioned and this was expected to be published in early to mid-July; Healthwatch was conducting a travel survey and asking people about their experience on busy days at the Oxford Hospitals and the Horton General Hospital; a study of actual parking times measuring the time a car arrived on site and the time taken to park; a review of the obstetric options including additional options proposed during the consultation to ensure each of the options had been reviewed thoroughly</p> <p>The Director of Governance advised the Extraordinary meeting had been called to review the Report and to ensure sufficient work had been commissioned to cover any outstanding work. The Extraordinary Board on 10 August 2017 would be a decision making meeting. All the reports and additional information would be published ahead of the meeting on 10 August 2017.</p>	

The Board discussed the paper and the report with points raised grouped under similar themes below.

Cross Boundary Working

- At the Thame and Brackley events concerns had been raised around cross boundary working and difficulties in terms of joint commissioning between CCGs and the provision of integrated coordinated care groups. It was felt this had not been picked up sufficiently in the Report and further work was required especially for the Phase 2 work
- It would be helpful to understand the efforts undertaken on cross border engagement and how this had been captured
- The extent to which the IIA would look at the population outside of Oxfordshire was questioned
- North Oxfordshire residents used maternity services across the borders. An issue had been raised around maintaining continuity both of services and with GPs. There was a need to ensure services outside of the county were fit for purpose
- It would be reasonable to include the Stroke services and patients' further care or repatriation as this would be affected by issues raised in the consultation.

The Director of Governance commented on the need to ensure questions were asked around the work being undertaken to support decision making and the on-going work of the Quality Committee, which would also be reported back to the Board. The Director of Quality observed access and borders were very important but many aspects were on-going work and there was a question around how to interface with people and residents in Oxfordshire which would be a slightly different process.

The Chief Executive observed borders were shared all around Oxfordshire and specialist services from the John Radcliffe covered a very wide footprint. A Commissioning Executive had been formed with Buckinghamshire and Berkshire to help manage the situation but there was a need to consider how best to commission services across the other borders. He remarked boundaries did create difficulties when commissioning services and this needed to be addressed. OCCG had written to both Warwickshire and Nene CCGs to ensure their views were taken into account in decision making.

The Director of Governance advised some patients in South Northamptonshire and Warwickshire might be registered with Oxfordshire GPs and thus be OCCG patients. OCCG had spoken with both South Warwickshire and Nene CCGs as part of the consultation and further follow up work was taking place. OCCG had recognised the need to make contact and had made efforts to ensure they were aware of and engaged in the consultation. As part of the work for the consultation advertising had taken place in those areas; two events had been held in Brackley; and information had been placed in GP settings for patients. The IIA would look at all those affected whether or not they were registered as Oxfordshire patients. This had given rise to an added complication around obtaining data to inform the report as OCCG did not have access to the data and had written to the other CCGs requesting data for their residents.

Analysis of Responses

- Of the 9,248 letters received 8,036 were a template letter meaning well over a 1,000 letters appeared to be individual. A breakdown of analysis of those letters was requested as OCCG owed it to the public if they had made an effort to write to ensure these were fully scrutinised and comments brought out. There was a need to ensure the information was

fully digested and reported to the Board. The Lay Member PPI offered to support this piece of work.

The Director of Governance advised this work would build on work already undertaken advising the letters had all been read. Most were a template but some of the templates had additional comments. The letters had already been read and fed in to the report, but further analysis would be undertaken and the offer of support from the Lay Member PPI was welcomed. The further analysis of the letters would be available for the August meeting.

Survey

- The criticism of the survey should be acknowledged and the Board should be cognisant of that criticism. The survey could have been seen as leading people in a certain direction and as a result there had been some distrust of the survey by members of the public.

The Director of Governance accepted the point but pointed out the survey had not been the only way people could respond. As an example, at the first Banbury meeting a report undertaken by a local campaign group was received and that had been fed into the review undertaken on behalf of OCCG by Qa Research who had been commissioned to analyse the responses and write the consultation report. OCCG had been prepared to take comments in any form people had wished to supply them.

The Chair advised the breakdown indicated there had been a wide spread of comments from many areas. The Director of Quality added the consultation had been well-advertised and there had been good opportunities for people to make comments. More than one way to provide comments had been available and she believed there had been sufficient opportunities including for those who required more support as engagement had taken place with specific groups.

Impact from any loss of service

- The justification for splitting the consultation into two parts was still sound but there was one or two implications from Phase 1 where assurance was required that it would not prejudice the options in Phase 2. For instance the recent reduction in anaesthetist cover at the Horton where OCCG needed information from the Oxford University Hospitals NHS Foundation Trust (OUHFT) on the implications and any effect on other services which would be considered in Phase 2 of the consultation.

The Deputy North Locality Clinical Director stated the need to note and be aware of the possible loss of anaesthetists but advised there was a drive to maintain the facility particularly in regard to A&E. She added that other areas within planned care at the Horton could sustain an anaesthetic service going forward.

The Chair observed part of the consultation was to flush out issues and concerns if it was decided to proceed with changes to services. The loss of anaesthetists was part of this and as yet an answer was not available. He felt there was a need to create a list of items on which further assurance was required and the work to obtain this assurance.

Capacity

- Greater assurance was required around the capacity within the John Radcliffe and the Oxford hospitals to manage the increase in patient numbers
- There was a need to be sure when considering aspects further around services and training that there were no unintended consequences and

there would be staff capacity if changes were made

- A lot of discussion had taken place around staffing and there had been discussion with the Trust. There was a need to be able to present this discussion as there had been some concern about level of staffing and to be clear around assurance
- A concern centred on sufficient work force in primary and community care to cope with bed closures. Would this be covered by the IIA?

The Chair stated midwife and obstetric capacity had previously been discussed but observed there were other areas of concern. The point had also been raised by members of the public and assurance was required.

The Director of Governance advised the IIA would only consider the impact on population groups, travel and access. In terms of the evidence being presented to the Board to help with decision making, this would include information around investments in primary and community services to enable changes to be made. Monies released from bed closures were being reinvested in alternative services. The OCC Director for Adult Services advised the Oxfordshire Joint Health and Overview Committee (HOSC) had considered this aspect closely. HOSC had noted there had been investment, they were keen to ensure patients were not disadvantaged by the decision to close beds and had been closely focussed on the outcomes from the alternative forms of care.

The Director of Quality observed workforce was a constraining factor on all services. Brexit and the removal of bursaries had impacted on the availability of workforce. Retaining staff, encouraging staff to remain and attracting new staff would be a big challenge and constraining factor going forward across all areas.

Ambulance Services

- Assurance was required that ambulance services would be able to cope with changes going forward particularly around maternity where at present there was a dedicated ambulance based at the Horton and there was a question of whether this could continue should the change in obstetric services become permanent
- Some assurance around ambulance services relating to the Special Care Baby Unit (SCBU) and critical care was also required
- There was a need to know the South Central Ambulance Service (SCAS) could deal with the changes on-going but it was also necessary to know the relationship between SCAS and the other ambulance services that would be affected.

The Chief Executive stressed the need to follow up all the issues and to write formally to the OUHFT Board to seek assurances. These assurances would be required for the August meeting. The Chief Executive reminded the Board that representatives from OUHFT had been present at most of the consultation events and had had the opportunity to take part in the discussion. In seeking these assurances OCCG was not starting from scratch as there had been a series of discussions which had been on-going with the Trust and there was a need to build on these discussions to obtain formal assurance from OUHFT. There had been engagement with senior clinical members of the Trust. The Chair stated questions had been raised and answered in public and private meetings but assurance for the OCCG Board was required.

Obstetrics/Maternity

- If it was decided to re-open the obstetric unit as consultant led, there might be a need for staffing to move from the John Radcliffe to cover vacancies. This would result in difficulties in servicing the rest of Oxfordshire. Were

the Board considering the question for all patients in Oxfordshire or a theoretical question around services to Banbury and the surrounding area?

- There was a need to be clear of the impact on Phase 2 of any decision made at the 10 August meeting. Whichever way the decision on obstetric services was taken, it was necessary to be clear the debate would not re-open as part of Phase 2
- Traditionally as a centre of obstetric medicine, the highest risk pregnancies were always delivered at the John Radcliffe. Was there any evidence to show that this group of patients had ever been at risk because of the geographical location of the delivery unit for this group of patients? Had this been considered as part of the consultation? The model for high risk patients had been in place for many years and unless any evidence to the contrary had arisen, the Board should be assured it was a safe model.

The Chair stated the Board needed to consider services for patients for all Oxfordshire but in order to do this, the facts to make an informed decision were required. The Director of Governance confirmed that the focus of the decision was on the provision of safe, effective obstetric services to all patients of Oxfordshire. The Chief Executive acknowledged how difficult for some areas a decision might be when it was made but stressed OCCG must consider the needs for the total population of patients registered with the CCG and for all of Oxfordshire. The decision making would be difficult but part of the need for the consultation was around clinical risk and safety for the whole population and that was the theme through the whole process. The Board needed to remember this was the case.

The Chair advised there had been some options for the obstetrics service and some suggestions had arisen during the consultation. The options and suggestions would be further tested to establish whether or not they were viable. The Chief Executive clarified options had been set down in the original document along with the reasons as to why it was believed none, other than the one consulted on, were viable. This had been challenged. The further testing was not reopening the debate but as part of the assurance process the options would be reassessed and the suggestions considered to provide assurance a rigorous review had been undertaken to determine whether suggestions made as part of the consultation effected the option selected.

The Chief Executive stressed when decisions were made they needed to be based on the consultation undertaken and the responses received. OCCG must take account of the clinical advice on services particularly from the clinicians who were running those services. Any decisions in Phase 1 could not be used to force a decision in Phase 2. However the Board needed to remain aware of change and that the health care service was not static. As yet the midwife led units (MLUs) across the county had not been considered and this needed to be borne in mind. If there were changes before the start of the Phase 2 consultation, these would need to be taken into account. When any decision was made the Board needed to be as assured as it could be around the thoroughness of the process and have all the evidence required to make a decision at that point in time. The Chair commented the Board also needed to be clear what it was making a decision on.

The Deputy North Locality Clinical Director advised prior to and during the consultation there had been focus in the north around safety issues of MLUs. A report last year had shown the MLU was as safe as any other MLU provided the selection process was followed. If patients were screened correctly high risk patients would be referred to the obstetric service as that would be the correct and

safest place for that patient.

Population Analysis

- This was not necessarily an additional piece of work but from an assurance point of view it would be useful for the Board to understand the data used in the population analysis and the methodology and assumptions mapped into the analysis.

The Director of Governance advised the projected housing and population growth had been taken into account and advised this would be presented to the Board.

Judicial Review

- What would be the effect of the Judicial Review?

The Director of Quality advised the Judicial Review was referred to in both the cover report and the letter received from Victoria Prentis MP. OCCG had responded. OCCG had not been informed it should cease any actions and it was important to continue due to the concerns around patient safety. No date had as yet been set for the Judicial Review. Also outstanding was the referral by HOSC of OUHFT to the Secretary of State for the temporary closure of the obstetric unit at the Horton. Stratford-on-Avon District Council had also put forward a Judicial Review request to the Secretary of State but it was unclear whether or not this would proceed as District Councils were not one of the formal bodies able to refer.

Planned Care

The Chair advised there had been support for the planned care changes but some concern around delivery. The North East Locality Director advised these concerns were being picked up in the further work. Repatriation to the Horton was supported but it was necessary for further assurance that plans were in place and transport and parking were available. The Trust was very aware of the concerns around parking and had been in discussion with Oxfordshire County Council (OCC) but it was felt it would be useful if this was picked up further.

The Chair expressed a wish for sight of plans, numbers of specialities and timescales for planned care adding it would be useful to have as much information as possible. The Chief Executive advised it would be possible to be very clear on plans for planned care and the areas committed. He explained that OCCG was the statutory body required to consult on planned care but the work was being jointly undertaken with OUHFT. When decisions were made they would be based on plans and timescales which would be as clear as it was possible to be at that point in time.

The Chair reiterated where new services were developed following temporary bed closures, the need to know numbers and outcomes. He felt there was also a question around long term sustainability of the funding for the services and the need for some guarantee of continuation for the services. The Chair suggested this should form part of the assurance for the Secretary of State test. The Director of Governance stated if there was an alternative model then it would be necessary to be clear on the funding and that the service would continue to be provided. The Chief Executive advised on the involvement of the Clinical Senate. As the Clinical Senate had signed off the original case before it went out to consultation they had been asked to review the evidence against the bed test. The Chief Executive observed the beds had not been in the system for 18 months and consequently outcome data was available. He acknowledged there were major workforce issues but explained when decisions were made it would be necessary to make them based on the best workforce predictions available. There would also be a need to address any issues in staffing a particular service. This would

include newly commissioned beds in care homes.

The Chief Executive stated work undertaken at present on Phase 2 was insufficient to enable questions to be answered but Phase 2 proposals would have an impact somewhere in the system. In the NHS most of the money was spent in large institutions and any reduction would have an impact on bed numbers. The overall strategy was to provide care closer to home which would require more resources closer to people's homes. This would have implications in terms of staffing and beds for the hospitals. There was a need to work through these implications and further work was required.

The OCC Director for Adult Services advised the community had responded to the increased complexity of patients in the community but the challenge faced by the community from increased complexity especially if there was more need in phase 2 should be noted. There would be a further ask if there was another shift in that direction.

Stroke and Critical Care

- Questioned whether further work was required around stroke and critical care as although the consultation showed there was a lot of support for the hyper-acute unit there were concerns around the rehabilitation locations
- Questions had been received expressing concern around how quickly people were discharged home from the John Radcliffe and to what location. The proposed models were not very clear.

The Director of Quality advised on the Early Supported Discharge service which would work to get people home as soon as possible and support them to function as per pre-stroke. This would be the model for the majority of patients but there would always be some patients who would need further care.

The South West Locality Clinical Director explained this area was driven by new technology and further new technology was coming on stream over the next few years. The Early Supported Discharge service had been piloted in the north and north east of the county and there were plans to expand the service. The rehabilitation of stroke patients would form part of Phase 2. There was a requirement to deliver the service in a joined up way but it would be a change over the whole system during the next few years meaning a break between the two phases of the consultations would not have any real effect on this service. A proportion of patients would need the high technology intervention immediately whilst others would decline over a few days and would then require the hyper-acute service.

The Chief Executive observed the majority of patients in the north who suffered a stroke already went to the John Radcliffe. OCCG was now consulting on all people immediately going to the hyper-acute stroke unit (HASU) and the question being raised was around where patients received rehabilitation. The outcome for patients was better through this service. It was the extra not the totality of the service which was raising some concerns. This was the same argument around the critical care service. The majority of people already attend the John Radcliffe and this would improve the outcome for all patients.

The Chair reiterated the actions required of the Board and the further work already commissioned:

- Retrospective assurance from the Thames Valley Clinical Senate and NHS England around the new 'Patient Care Test'
- The Integrated Impact Assessment for Phase 1 and Phase 2
- The travel survey being conducted by Healthwatch

	<ul style="list-style-type: none"> • The study of actual parking times to measure the time from a car arriving on site to being parked • The review of the obstetric options including the additional options proposed during the consultation. <p>The Director of Governance summarised the additional pieces of work identified:</p> <ul style="list-style-type: none"> • Clarity on implications and impact on sites for all service changes • Capacity to deliver and cope with extra services that are moved to Oxford hospitals and/or Horton • Clarity that the context for the decisions on service models is the whole of the population of Oxfordshire and • Capacity and workforce in community services to support changed model of care and proposed bed closures • Ambulance services capacity – including obstetric, SCBU and critical care • A further level of detail to be provided to the Board on the modelling of housing and population growth • Clarity of the evidence informing decision making • Planned care implementation plans • Links (if any) to Phase 2 on service areas • Cross boundary issues including impact on population over the county boundary and also impact on other CCG’s commissioning plans. • Bed closures – alternative services in place and an indication of activity and outcomes • Workforce plans • Anaesthetics at the Horton • Stroke rehabilitation model • Analysis of individual letters to show themes had been pulled through. <p>The OCCG Board:</p> <ul style="list-style-type: none"> • Agreed it was assured on the process for the consultation • Received the report on the consultation and noted the findings • Noted the work being commissioned to ensure sufficient information would be available for the decision-making meeting on 10 August 2017 • Identified areas where additional information was required prior to decision-making. 	
	<p>Any Other Business There being no other business the meeting was closed.</p>	
	<p>Date of Next Meeting:</p> <p>27 July 2017, OCCG Board meeting to receive normal business of the Board, 09.00 – 12.45, Sudbury House Hotel, London Street, Faringdon, SN7 7AA</p> <p>10 August 2017, Extraordinary Board meeting to make decisions on the transformation consultation, 09.30 – 11.30, Oxford Examination Schools, 75 – 81 The High Street, Oxford, OX1 4BG</p>	

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Oxfordshire Transformation Programme

Integrated Impact Assessment: Post-Consultation
report

July 2017

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Oxfordshire Transformation Programme

**Integrated Impact Assessment: Post-Consultation
report**

July 2017

Issue and Revision Record

Revision	Date	Originator	Checker	Approver	Description
A	5 July 2017	Joe Hitchcock Sarah Reeves April Smith	Frances Parrott Neil Hurst	Kerry Scott Brian Niven	Final post consultation report-for client comment
B	21 July 2017	Joe Hitchcock Neil Hurst Frances Parrott Sarah Reeves April Smith	Sophie Elliott	Kerry Scott	Final post consultation report

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Executive summary

Introduction to the integrated impact assessment

The aim of an integrated impact assessment (IIA) is to explore the potential positive and negative consequences of Oxfordshire Transformation Programme's proposals to transform healthcare in Oxfordshire. The purpose of impact assessments is not to determine the decision; rather it is to assist decision-makers by giving them better information on how best they can promote and protect the well-being of the local communities that they serve.

The scope of the Oxfordshire Transformation Programme service review and study area for the IIA is the whole of the county of Oxfordshire. A health impact assessment, a travel and access impact assessment, an equality impact assessment (in which the impacts of the proposals on protected characteristic groups¹ and deprived communities are assessed) and a sustainability impact assessment have been conducted as part of this IIA.

An outline of service changes proposed by the Oxfordshire Transformation Programme

The Oxfordshire Transformation Programme is designed to develop plans for integrated GP, community, and hospital services. Its aims are to:

- provide innovative ways of delivering outcomes for a society that lives longer and expects more;
- maximise the value of Oxfordshire's health and social care spend;
- find ways to become better at preventing and managing demand; and
- help people to take greater responsibility for their own health and prevent avoidable disease

Phase One

The first phase of the Oxfordshire Transformation Programme focuses on those services for which the Clinical Commissioning Group (CCG) has the most pressing concerns about workforce, patient safety and healthcare (for example, where temporary changes have been made) or where the proposed changes have already been piloted. The services include:

- Ambulatory care
- Critical care facilities at the Horton General Hospital (HGH)
- Maternity services: including obstetrics, special care baby unit (SCBU) and emergency gynaecology.
- Planned care services at the HGH
- Stroke services

¹ These are set out as age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation in the Equality Act 2010.

Phase Two

The second phase of the Oxfordshire Transformation Programme will focus on proposed options for the reconfiguration of the following services:

- Urgent and emergency services:
 - Current accident and emergency (A&E) centres
 - Minor injuries units and first aid units
 - Urgent treatment centres
 - Non-elective inpatient services
- Rehabilitation beds for stroke patients
- Paediatric services
 - Paediatric inpatient services
 - Current processes for assessment, including a short stay paediatric assessment unit or clinical decision unit
 - Paediatric elective day case care
 - Provision of paediatric outpatient clinics
- Planned care services across the county
- Community hospital services
- Maternity services
 - Configuration of maternity led units (MLU) across Oxfordshire
 - Increase in maternity clinics (antenatal, postnatal and breastfeeding)
 - Establishing a comprehensive perinatal mental health pathway
- Primary Care

The work of the Oxfordshire Transformation Programme will feed into the over-arching five-year Sustainability and Transformation Plan (STP) across Buckinghamshire, Oxfordshire and Berkshire West. For more information on the detail of the programme please see [chapter two](#).

This IIA report focuses on the services changes in Phase One of the programme only. A separate IIA report will be prepared to for Phase Two of the programme.

Impact assessment of proposed changes

The following sections summarise the likely positive and negative impacts identified through this IIA, under the four impact topic headings.

Health impacts

Positive impacts

- **Improved outcomes for patients** will be achieved as a result of concentrating specific services on certain hospital sites, or creating new specialist centres such as a HASU or a diagnostic centre.
- **Patient experience will be improved** through access to joined up care provided through redesigned hospital services where a one stop shop for diagnostic and outpatient services will be available.
- The concentration of expertise on certain sites, such as obstetric care at JRH, will allow **clinical resources to be pooled, supporting the achievement of workforce standards.**

- Through the creation of larger, more coordinated and resilient teams, with stability and job security, **staff satisfaction may be positively impacted.**

Negative impacts

- **Staff may experience negative impacts if they are required to change their permanent place of employment.** Associated impacts may include some staff having to travel further to their place of work, which is likely to have an impact in terms of personal costs of travel and the inconvenience associated with additional journey times. Ultimately, this may have an impact on the **retention of staff.**
- **Capacity at JRH and the ambulance service** is likely to be impacted by proposed changes around critical care, stroke and maternity services.
- A reduction in the number of hospitals providing some services could potentially have a **negative impact the resilience of services.**
- **Potential transitional negative impacts** could be experienced **during the implementation of planned service changes.** Historical experience has shown that this can impact capacity, operational effectiveness, and patient experience, unless this can be appropriately managed.

Travel and access impacts

Negative impacts

- Should obstetric-led maternity services not be provided at the HGH in future, 52 per cent of patients would be able to access obstetric-led maternity services within 30 minutes by blue light, in comparison to 73 per cent of maternity patients currently.²
- Should stroke services not be provided at the HGH in future, 55 per cent of patients would be able to access stroke services within 30 minutes by blue light, in comparison to 71 per cent of stroke patients currently.
- There are concerns about the capacity of car parking, particularly at the JRH currently but at the HGH in the future. Both hospitals will see a change or rise in patient activity as Phase One plans are implemented.

Equality impacts

For the services proposed for reconfiguration, evidence was reviewed to identify those equality groups with protected characteristics who may have a disproportionate need³ for these services. The output from this is presented below; the ticks indicate where people from the identified group are more likely to need access to each, as compared to the general population.⁴

² It should be noted that not all maternity patients will require obstetric-led maternity care; some patients will be able to continue to give birth at the HGH at the MLU. Impacts associated with MLU proposals will be analysed further in the IIA of phase two of the Oxfordshire Transformation Programme.

³ Disproportionate need for services = having a greater than average need for a service i.e. a which is over and above the level of need that is typical of the general population.

⁴ Where there is not a tick in a particular cell, this is not to say that other groups will not need these services; rather it suggests that there does not presently exist a body of strong clinical evidence indicating this group's need is disproportionate.

Table 1: Summary of scoped in groups

Group	Ambulatory care	Maternity	Planned care services	Stroke
Age (children under 16)			✓	
Age (older people aged 65 and over)	✓		✓	✓
Deprived communities		✓	✓	✓
Disability			✓	✓
Gender reassignment	✓		✓	
Marriage and civil partnership				
Pregnancy and maternity	✓	✓		
Race and ethnicity: BAME communities		✓	✓	✓
Religion and belief ⁵				
Sex: Female		✓		
Sex: Male				
Sexual orientation				

Source: Mott MacDonald scoping report

Positive impacts

- **Improved health outcomes:** patients identified as having a disproportionate need for the services under the phase one review are likely to use these services more and, therefore, experience the benefits of improved health outcomes to a greater extent.

Negative impacts

- **Increased stress and anxiety:** increased journey times or the need to make different and/or unfamiliar journeys to access care, is likely to affect some equality groups more than the general population.
- **Increased costs associated with travel:** some patients and visitors will experience increased travel costs, which are likely to disproportionately impact upon those on lower incomes.
- **Lack of viable alternative transport methods:** the high financial cost of certain transport methods could act as a barrier to utilising alternative transport modes to cars.
- **Access difficulties for visitors and carers:** increased journey times for visitors and carers may limit or prohibit regular visits. This could affect patient experience in hospital, and could disproportionately impact those who are more reliant on assistance and support.
- **Unfamiliarity of hospital:** some patients and visitors can become confused or disorientated when they are at an unfamiliar hospital. This can particularly affect older people and disabled people.

Sustainability impacts

Total emissions from patient travel in the 'do -something' scenario are predicted to be 4,313tCO₂e per annum, and emissions associated with patient travel without the changes are estimated to be 4,293tCO₂e. Within the context of the total travel emissions from the NHS,

⁵ Please note that for religion and belief a differential need was identified for planned care. This is due to a differential need for diabetes services by certain religious groups that adhere to fasting practices. This evidence is further explained and captured in appendix D.

which are 3.2MtCO₂e, **the increase in emissions due to the changes to services is considered to be negligible.**

Enhancements and mitigations

The following table provides a summary of the key enhancement and mitigation measures that have been identified through this IIA.

Table 2: Enhancements and mitigations summary table

Impact assessment area	Summary of mitigations and enhancements
Health	<ul style="list-style-type: none"> ● Programme level to effectively manage implementation concerns through active change management and engagement with stakeholders ● Service level to ensure that clinical interdependencies are monitored and reviewed ● Workforce plan and engagement to understand further the consequences of the potential impacts and recruitment
Travel	<ul style="list-style-type: none"> ● Promotion of public transport so that the level of traffic accessing the sites does not increase beyond necessity ● Car park review and management strategy to mitigate the parking issues that have been identified ● Encouraging greater use of active travel modes so that the level of traffic accessing the sites does not increase beyond necessity and to promote overall health benefits ● Communication and marketing to ensure effective adoption of any travel plan
Equality	<ul style="list-style-type: none"> ● Collaboration with others to mitigate increased journey times for patients and their families ● Communication and information to ensure that local communities understand how to access and use services if the proposed changes are made.
Sustainability	<ul style="list-style-type: none"> ● N/A: impacts are negligible

Source: Mott MacDonald

1 Scope and approach

1.1 The Oxfordshire Transformation Programme

The Oxfordshire Transformation Programme is designed to develop plans for integrated GP, community, and hospital services. Its aims are to:

- provide innovative ways of delivering outcomes for a society that lives longer and expects more;
- maximise the value of Oxfordshire's health and social care spend;
- find ways to become better at preventing and managing demand; and
- help people to take greater responsibility for their own health and prevent avoidable disease.

1.1.1 The study area

The impact assessment considers the impacts on patients that use hospitals within Oxfordshire. Primarily the patients that use hospitals within Oxfordshire are residents of the county and this is where most impacts are experienced. It is acknowledged that some patients will come from outside Oxfordshire to use the services provided in Oxfordshire hospitals, for example patients resident in south Northamptonshire or Stratford upon Avon. Where possible analysis has been undertaken to consider the impacts on these patients and particularly the journey time impacts which may be experienced. For further information please see section 1.5.

The Oxfordshire Transformation Programme is split into two phases as describe below.

1.1.2 Phase One

Phase One of the programme focusses on those services for which the Oxfordshire CCG has the most pressing concerns about patient safety, workforce and healthcare. For example, these may be areas where temporary changes have been made or where the proposed changes have already been piloted. The services include:

- Ambulatory care
- Critical care facilities at the HGH
- Maternity services: including obstetrics, SCBU and emergency gynaecology
- Planned care services at the HGH
- Stroke services

1.1.3 Phase Two

The second phase will focus on proposed options for the reconfiguration of the following services:

- Urgent and emergency services:
 - Current A&E centres
 - Minor injuries units and first aid units
 - Urgent treatment centres
 - Non-elective inpatient services
- Rehabilitation beds for stroke patients
- Paediatric services

- Paediatric inpatient services
- Current processes for assessment, including a short stay paediatric assessment unit or clinical decision unit
- Paediatric elective day case care
- Provision of paediatric outpatient clinics
- Planned care services across the county
- Community hospital services
- Maternity services
 - Configuration of MLU across Oxfordshire
 - Increase in maternity clinics (antenatal, postnatal and breastfeeding)
 - Establishing a comprehensive perinatal mental health pathway
- Primary Care

The work of the Oxfordshire Transformation Programme will feed into the over-arching five-year STP plan across Buckinghamshire, Oxfordshire and Berkshire West. For more information on the detail of the programme please see [chapter two](#).

This IIA report focuses on the proposed services changes in Phase One of the programme only. A separate IIA report will be prepared for Phase Two of the programme.

1.2 The integrated impact assessment

In February 2017, the Oxfordshire Transformation Programme team commissioned Mott MacDonald to undertake an IIA of its proposals. The purpose of the IIA is help those involved in making decisions on future services configuration understand the impacts that could be experienced by the local population and, in particular, identify those groups and communities who may be most sensitive to changes.

Impact assessments are a key component of policy-making and act to guide and evaluate investment.

They have long been identified as a mechanism by which potential effects on health outcomes and health inequalities can be identified and redressed prior to implementation. They provide:

“...a combination of procedures, methods and tools by which a policy, programme or project may be judged as to its potential effects on the health of a population, and the distribution of those effects within the population”.⁶

The aim is to explore the positive and negative consequences of different options and produce a set of evidence-based, practical recommendations, which can then be used by decision-makers to maximise the positive impacts and minimise any negative impacts of proposed policies or projects.⁷

It is best practice within impact assessments to undertake analysis for the whole population, but also to highlight if, and where, certain sections of the population will experience greater effects (either positive or negative). Assessment of impacts and recommendations for opportunities and mitigations are based on the participation of relevant and informed stakeholders, thereby giving the impact assessments independence and democratic legitimacy.

⁶ European Centre for Health Policy (1999): 'Health Impact Assessment: main concepts and suggested approach' (Gothenburg Consensus Paper), Brussels. Available at: www.who.dk/document/PAEGothenburgpaper.pdf,

⁷ Taylor, L. and Quigley, R. (2002): 'Health Impact Assessment: A review of reviews'

1.3 The objectives of the IIA

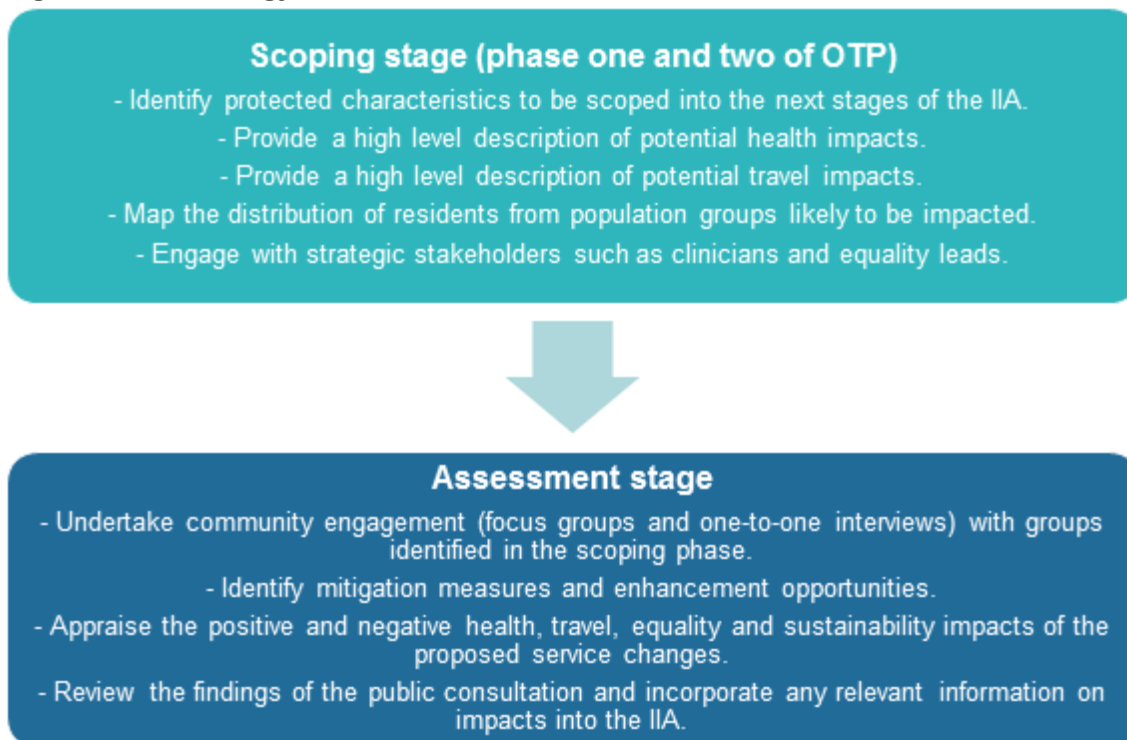
The objectives of this IIA are to:

- Identify the health impacts for the population of Oxfordshire as a result of the proposed Oxfordshire Transformation Programme, Phase One service proposals.
- Identify travel and access impacts.
- Identify which (if any) of the protected characteristics groups⁸ are more likely to be affected by the proposals. This is critical in order to support the Oxfordshire Transformation Programme in meeting its obligations under the Equality Act 2010.⁹
- Provide recommendations on ways in which positive impacts can be maximised and adverse effects can be mitigated or minimised.

1.4 Methodology

The diagram below sets out the methodology of the IIA.

Figure 1: Methodology of the IIA



Source: Mott MacDonald

⁸ Protected characteristic groups are defined in the Equality Act (2010). They are: age; disability; gender reassignment; marriage and civil partnership; pregnancy and maternity; race; religion or belief; sex; sexual orientation. In line with industry good practice, we also consider the impact of changes on those from deprived communities.

⁹ Equality Act 2010 (Commencement No.3) Order 2010.

1.4.1 Scoping

A scoping report was issued at the end of the first stage of this IIA. This was based on analysis of available secondary data pertaining to the population and health conditions, as well as the service needs of the Oxfordshire population.

The scoping report presented preliminary observations on which groups with protected characteristics were considered to have disproportionate need for the hospital services under review. It also mapped the density and distribution of these groups across Oxfordshire, in order to illustrate where there are high numbers of these groups locally. The purpose of this was to ensure that the assessment focusses on those groups that are most likely to be affected by the Oxfordshire Transformation Programme proposals. Please review appendix A for a comprehensive bibliography of the sources used to inform this IIA.

1.4.2 Assessment of health and equality impacts

In undertaking this assessment of the health and equality impacts, the study has:

- Sought the views of the representatives from patients and protected characteristic groups in Oxfordshire through one-to-one telephone interviews and focus groups, with a focus on the north of the county and on those patient groups which were considered most likely to be affected by service changes.
 - 21 representatives from patient and protected characteristic groups were invited to take part in one-to-one telephone interviews
 - Oxfordshire CCG supplied nine representatives, Mott MacDonald identified a further 12 representatives via a stakeholder mapping exercise
 - Nine interviews were completed
 - Two focus groups were conducted with residents in Banbury
 - Group one comprised 10 members of the public from in or around Banbury aged 65 years or more
 - Group two comprised seven members of the public from the most deprived postcodes in Banbury¹⁰
- Sought the views of clinicians in Oxfordshire through one-to-one interviews
 - Four clinicians were invited to take part in one-to-one telephone interviews. Access to clinicians was facilitated by Oxfordshire CCG. Four interviews were completed
- Refreshed and updated evidence presented in the scoping report which used clinical and other published evidence to identify those equality groups most likely to experience certain health conditions and, therefore, most likely to be affected by the proposed service changes.

1.4.3 Assessment of the travel and access impacts

In undertaking an assessment of the potential travel impacts, transport isochrones (areas of equal travel time) and patient data provided from the Commissioning Support Unit (CSU) were analysed. Where the travel and access assessment aligns with the proposals, analysis has been carried out linking patient's home locations, characteristics and travel times in order to determine the impacts on journey times to services should the Oxfordshire Transformation Programme changes be introduced. Analysis provides an estimation of the number of patients impacted. Lower Super Output Areas (LSOAs) with less than six patients were suppressed to ensure patient confidentiality.

¹⁰ Please note that 10 participants were invited to the group, but only seven attended on the day

Impacts for blue light ambulance journey time have been presented in the assessment of travel and access as the journeys by patients for the services assessed would typically be made by this mode of transport, impacts for private car and public transport are included in appendix F.

The blue light ambulance journeys have been measured on the basis of 'pick up to destination' both at non-peak and peak times.

1.4.4 Assessment of the sustainability impacts

In undertaking an assessment of the sustainability impacts, this assessment only considered greenhouse gas emissions (GHG)¹¹. In doing so, it considered:

- Patient travel data available between October 2015 and October 2016 (1 year). The data is broken down into service areas (e.g. maternity, planned care etc.), and details the numbers of patients visiting all local hospitals by journey time. Travel with and without the proposed changes has been compared.

For more detailed information on the methodology for the sustainability impacts, please refer to appendix E.

1.5 Methodological assumptions and limitations

It is important to set out the following principles on which this IIA is based:

- It is not the purpose of the IIA to justify, defend or challenge the rationale or principles behind proposed reforms put forward by Oxfordshire CCG.
- The purpose of the IIA is to inform rather than decide. The objective is not to determine the decision, but to assist decision makers by providing better information.
- Socio-demographic analysis (see appendix D) has been undertaken to provide an insight into the geographical distribution of certain key populations. This profiling concentrates on the population groups most sensitive to the proposed changes i.e. those who have been identified as having a 'disproportionate need' for the services under review.
- Socio-demographic analysis has been conducted on the basis of the clinical service domains in Phase One of the programme.
- With respect to the engagement that has been undertaken to support this IIA:
 - Four interviews were undertaken with clinicians. Access to additional clinicians involved in the programme was requested but further contacts were not made available by the CCG.
 - Community groups were invited via email to participate in this report through one-to-one interviews. They were sent two reminder emails to take part in an interview.
 - Two focus groups were undertaken in Banbury (with older people and those from deprived communities).¹²
- All hospitals in the transport analysis provided to Mott MacDonald by the CSU are aligned against the service provision.
- The travel modelling parameters are set to provide an indication of typical journeys. They will not exactly match each individual patient experience.
- The transport and access impact analysis has been conducted at two levels:
 - all Oxfordshire CCG registered patients irrespective of residence who were accessing hospitals provided in the analysis from the CSU; and

¹¹ Please see chapter six for further information as to the rationale behind this assessment.

¹² Please note that Mott MacDonald suggested that two additional focus groups should take place to enable a wider selection of participants. However, the CCG did not agree to this.

- all Oxfordshire CCG registered patients, who are resident in Oxfordshire and only accessing hospitals located in Oxfordshire.
- To obtain an understanding of the car parking at the HGH and JRH sites, video surveys were conducted in June 2017 with cameras set up across each of the car parks at two hospital sites – the HGH and the JRH. The cameras captured the area around entry barriers and observed any queues forming on surrounding roads leading into the sites. For further information, please refer to the hospital car parking survey, which was submitted to the CCG in addition to this IIA.
- The proposed changes to NHS services have the potential to change the level of GHG (green-house gas) emissions in three principle areas: travel, building energy use, and procurement. At this stage, it is unclear how the changes will alter the energy consumption of NHS buildings, and how consumption of consumables (procurement) will be affected.
- The new planned care services to be located at the HGH could result in higher levels of energy use and consumption, and therefore emissions. However, it is not possible to quantify these emissions at present. As such, the assessment presented here only examines the GHG emissions from travel. Travel includes journeys undertaken by NHS staff, visitors, patients, and contractors. The travel data made available for this assessment was patient data. As such, a quantitative analysis has only been undertaken on patient travel. However, it is likely that the changes will affect the travel of NHS staff, visitors, and contractors in a similar manner.
- The impact on patients living outside Oxfordshire has been quantitatively considered in chapter four (travel and access) and section 5.2.2 (travel and access equality impacts). The remaining health, equality and sustainability impacts will be realised regardless of a patient's address.
- Level 3 critical care has not been included in the travel and access analysis due to the low volumes of patients accessing the service.
- Level 3 critical care has not been included in the analysis of the equality impacts. This is because of the dependency of other clinical services currently being delivered at the HGH which will require access to Level 3 critical care. These clinical specialities (such as complex theatre) are not included in Phase One of the Oxfordshire Transformation Programme and will be considered in the IIA of Phase Two.

- The GHG has used the following parameters:
 - To estimate journey distances for the GHG assessment, the medium journey time has been used alongside the average speed of local A roads. To estimate GHG emissions from distances, the mode of transport has been assumed to be in line with the national breakdown of distance travelled by each mode, excluding air, motorcycle and peddle cycle.

1.6 Structure of the report

The remainder of the report is structured as follows:

- Chapter two: detail on the Oxfordshire Transformation Programme
- Chapter three: assessment of health impacts
- Chapter four: assessment of travel and access impacts
- Chapter five: assessment of equality impacts
- Chapter six: assessment of sustainability impacts
- Chapter seven: conclusions including opportunities for enhancement and mitigation measures

2 Oxfordshire Transformation Programme

Since early 2015, the Oxfordshire Transformation Programme Board has been looking at how healthcare across acute hospital services and in the community can be improved. The Programme was established to bring partners together to address the challenges that the health and social system faces, including the rising demand for services and budgetary pressures. The agreed vision statement for Oxfordshire is: 'Best care, best outcomes, best value for all the people of Oxfordshire'.¹³

2.1 The need for review

A number of lifestyle factors impact on current and future health care needs in Oxfordshire. In general, the county's residents are healthier and live longer than elsewhere in England. However, there is a concern that health outcomes are inconsistent across the county. People living in deprived areas are not living as long as those in more affluent areas and those who are more deprived also experience more years of disability. The life expectancy gap within Oxfordshire is as much as nine years, and the disability-free life expectancy gap can rise as high as 12 years¹⁴.

In addition, there is increasing demand for services:

- The number of people aged over 85 in Oxfordshire is anticipated to rise from around 15,000 to around 24,000 between 2011 and 2026.
- In 2014/15 there were around 28,100 GP-registered patients aged 17 and over in the OCCG area with a diagnosis of diabetes, an increase of 1,000 (or 3.7%) since 2013/14.
- There are increasing numbers of people who have several long term conditions, which increases the complexity of their care. In 2014/15 there were around 5,000 Oxfordshire GP-registered patients who had a diagnosis of dementia, an increase of 1,000 (or 25.3%) since 2013/14.
- Demand for both children's and adult social care is growing, adding pressure to a health and care system that historically has a poor performance in relation to delayed transfers of care (DTOC).

There is going to be growth across all service areas included in Phase One. The forecasted growth for 2016-2021 can be summarised as:

- Increase in need for level three critical care of approximately 5%
- Increase in need for obstetric services of approximately 5%
- Increase in need for diagnostics services of approximately 16%
- Increase in non-elective admissions (including stroke) of approximately 10%¹⁵

Overall, the health and social care system in Oxfordshire, as in other localities around England, is increasingly struggling to deliver good access to services for the whole population when they require them. The situation is further intensified by financial constraints and workforce shortages across the public sector.

¹³ <http://www.oxonhealthcaretransformation.nhs.uk/what-is-the-vision/consultation-documents/160-pcbc-appendix-3-8-draft-oxfordshire-storyboard-v3-6-wip/file>

¹⁴ ONS 2011 Mid-Year Population Estimates, ONS death data, and ONS mortality assumptions for future years (taken from 2011 SNPPs)

¹⁵ Mott MacDonald (derived from Oxfordshire Transformation OTP PCBC for Acute Hospital Services: Phase One)

2.2 The future of hospital services in Oxfordshire: the options for Phase One

Over 50 clinicians from the Oxford University Hospitals Foundation Trust (OUHFT) were involved in generating a range of options for clinical models, these were then assessed against criteria. This process resulted in the emergence of options relating to clinical services specifically located at the HGH.

2.3 Strategic context and the case for change

The overarching ‘case for change’ developed by the Oxfordshire Transformation Programme demonstrates that ‘doing nothing’ is not an option if the county’s population is to continue to enjoy good health. It is also critical that accessibility and quality issues are addressed to ensure that everyone has access to high quality care when required. The Programme has recognised the ‘whole system’ linkages between general practice, community, and hospital services, with changes to models of care in one service area likely to impact on models of care delivered by others¹⁶. The table below details the options for Phase One.

Table 3: Options for Phase One

Clinical area	Current provision	Option 1 – “Do nothing”	Option 2 – “Do something”
Ambulatory care	<p>Currently the ‘Rebalancing the System’ is in place and features:</p> <ul style="list-style-type: none"> • Single point of access to medical review, specialist opinion and diagnostics. • Reducing long waits for medical and ‘frailty’ patients in A&E departments. • Access to senior, expert decision makers seven days a week between 08:00 - 22:00. • Ambulatory care pathway managed by a single MDT and supported by psychological medicine. • Patient and carer involvement in decision making. • Prompt discharge planning within 24hrs unless hospital treatment is necessary. • Post discharge support. • Effective and appropriate rehabilitation and re-ablement after acute illness. 	<p>Reopening acute hospital beds, and removing the Liaison Hub, Hospital at Home service, and ambulatory assessment units</p>	<p>Make permanent the current pilot arrangements</p>
Critical care	<p>Level 2 and level 3 critical care is currently delivered at HGH and the John Radcliffe Hospital (JRH) through its adult intensive care unit and the Churchill intensive care unit.</p>	<p>Maintain 6-bedded Level 3 critical care unit (CCU) at HGH.¹⁷</p>	<p>Create a single Level 3 CCU within Oxfordshire, located at the JRH in Oxford.</p> <p>CCU at the HGH would function at Level 2, working in conjunction with the major centre.¹⁸</p>

¹⁶ Oxfordshire Transformation Programme: Pre-Consultation Business Case (Acute Hospital Services: Phase One)

¹⁷ Level 3 CCU is defined as patients requiring two or more organ support (or needing mechanical ventilation alone). This level of care is staffed with one nurse per patient and usually with a doctor present in the unit 24 hours per day.

¹⁸ Level 2 CCU is defined as patients needing single organ support (excluding mechanical ventilation) such as renal haemofiltration or inotropes and invasive BP monitoring. It is staffed with one nurse to two patients

Clinical area	Current provision	Option 1 – “Do nothing”	Option 2 – “Do something”
Stroke	There is a Hyper Acute Stroke Unit (HASU) at the JRH. An acute/Rehabilitation Stroke Unit at the HGH and a transient ischaemic attack (TIA / 'mini stroke') outpatient clinics at the JRH and HGH	Maintain acute/rehabilitation stroke unit at HGH	Centralise stroke services by enabling direct conveyance of all appropriate Oxfordshire patients to a HASU at the JRH in Oxford - supported by the roll out of countywide Early Supported Discharge to improve rehabilitation and outcomes.
Planned care services	Planned care services are offered at both the HGH and at the Oxford Hospitals (incorporating JRH, the Churchill and the Nuffield Orthopaedic Centre).	Maintain current level of planned care activity at HGH	<p>Separation of elective from emergency interventions.</p> <p>Develop a new modern diagnostic facility at HGH to deliver diagnostic procedures (MRI, CT scanners and ultrasound etc.), rapid assessment and reduced travel to Oxford for routine diagnostic imaging.</p> <p>Develop a new outpatient facility at HGH with capacity for significant transfer of outpatient activity from Oxford in order to make local services more accessible to north Oxfordshire's population. This includes 'one stop clinics' which should also reduce multiple journeys.</p> <p>Introduce an advanced pre-operative assessment unit at HGH to enable smooth running of elective interventional services</p> <p>Develop a coordinated theatre complex at HGH to improve surgical throughput and complement an enhanced elective care centre.</p>
Maternity	OUHFT provides maternity services for women in Oxfordshire and for up to 1,000 women from surrounding counties. Services are delivered in two separate obstetric units (at JRH and HGH), one alongside MLU and three freestanding MLUs. The MLUs are in Wallingford, Wantage, Cotswold and Spires.	Maintain an obstetric unit, SCBU and emergency gynaecology service	<p>Create a single specialist obstetric unit for Oxfordshire at the JRH, supported by midwife led units in both the north and the south of the county:</p> <p>Necessary consequential changes arising from the consolidation of obstetric services at the JRH:</p> <ul style="list-style-type: none"> • Transfer of SCBU services from HGH to JRH • Centralisation of emergency gynaecology services at JRH. <p>Make permanent the midwife led unit at HGH</p>

Source: Oxfordshire Transformation Programme, Pre-Consultation Business Case

Appendix B sets out the baseline for each service area, detailing the current providers and the future proposed provision.

3 Health impacts

The following chapter sets out the likely positive and negative health impacts of the proposed phase one service changes.

3.1 Ambulatory care services and acute bed closures

Proposals to develop ambulatory care services are being considered in both phases of the transformation programme. Within this phase, proposals are focused on making permanent the current pilot on 'rebalancing the system' delayed transfer project and ambulatory care developments which have delivered:

- A multi-agency Liaison Hub to manage complex delayed discharge patients by transfer to nursing home beds managed by the hub. This includes 134 intermediate care beds commissioned by the system in local nursing homes. This is further supported by an extended Supported Hospital Discharge Service (SHDS) and Discharge Liaison Team, to co-ordinate delayed discharges across the four OUHFT sites to streamline the discharge process.
- An ambulatory care pathway for medical patients which incorporates acute ambulatory units (AAUs) at both JRH and HGH. These are able to assess, diagnose and treat patients who are referred by the GP or A&E, discharging them home with a follow up if required, or transferring them to an inpatient ward. The ambulatory pathway also includes providing care in-reach to people's homes (to deliver acute care for a set period of time).

Proposals seek to make permanent the decommissioning of 110 acute hospital beds and the remaining 36 subject to NHSE assurance, should these developments be adopted. This reduction in beds is associated to the reduction in hospital activity resulting from the movement of activity into the ambulatory care model and the avoided delayed discharges and transfers.

3.1.1 Potential positive impacts

The negative effects of delayed transfers of care are well established. They include:

- The effects on the patient as longer stays in hospital are associated with increased risk of infection, low mood and reduced motivation, which can affect a patient's health after they've been discharged and increase their odds of re-admission. The National Audit of Intermediate Care shows that, for older patients, 'a wait of more than two days negates the additional benefit of intermediate care, and seven days is associated with a 10 per cent decline in muscle strength'.¹⁹
- Preventing staff from treating other patients with greater urgent needs.
- A financial consequence as delayed patients incur the cost the hospital staff time and space, when this could be more effectively used.
- Indirect effects in the flow of patients through a hospital and the wider impact on the pool of hospital beds is used.²⁰

¹⁹ NHS Benchmarking Network (2014) National Audit of Intermediate Care 2014 summary report⁴

²⁰ The Kings Fund (2015) Delayed transfers of care

This is also supported by a national Healthwatch enquiry which highlighted the negative experiences of patients as a result of delayed or untimely discharge.²¹ **Reducing these delayed transfers of care and their associated negative effects, therefore has the potential to improve the quality care for patients and enhance their experience of care.**

The multi-agency Liaison Hub was established in December 2015, designed to enable patients who no longer needed acute medical care to move from the hospital setting into a nursing home; thereby removing a delayed transfer in care. Local evaluation of the Liaison Hub (from December 2015 to August 2016) has demonstrated the potential scope of this improvement, identifying that:

- During this period, 483 patients were transferred from a hospital bed to a nursing home, with support.
- In June 2016, the lowest number of patients (68) delayed in OUHFT beds in the previous five years was recorded. The number of patients delayed in community hospital beds did not show a rise.
- A survey was undertaken of patients (and their relatives) discharged through the Liaison Hub. Of those who responded:
 - 77.5% strongly agreed or agreed that they were involved in the decision to be moved to a nursing home, and that they had sufficient information about their transfer and the support they would receive once in the nursing home;
 - 77.5% agreed that the nursing home was a better environment for them while they awaited further care; and
 - 92.5% of respondents agreed they had been treated with dignity and respect in the move to the nursing home.

This local evidence is also supported by national best practice. This highlights that integrated hubs, a single point of contact and Discharge Liaison Teams which include all relevant professionals are practical solutions to resolving these delayed transfers and discharges.²²

Making permanent the Liaison Hub and supporting discharge services therefore provides an opportunity to reduce these delayed transfers of care further and on a permanent basis.

This will in turn reduce the negative effects these create on patients and health system, and instead providing supportive and personalised care for patients.²³ Should these developments be withdrawn, it is likely that delayed transfers of care and delayed discharges would increase.

There is also an established evidence base which makes the case for ambulatory emergency care (AEC) and the positive impacts associated with this model of care. The Royal College of Physicians reports that “implementing AEC ensures that, where appropriate, emergency patients presenting to hospital for admission are rapidly assessed and streamed to AEC, to be diagnosed and treated on the same day with ongoing clinical care. Processes are streamlined, including review by a consultant, timely access to diagnostics and treatments all being delivered within one working day. **This has improved both clinical outcomes and patient experience, while reducing costs**”.²⁴ More specifically, in terms of positive impacts they highlight that “a wide range of acute hospitals have now developed AEC processes and pathways, although there is a wide variation in models and the stages of implementation.

²¹ Healthwatch England (2015) Safely home: What happens when people leave hospital and care settings?

²² NHS England (n.d) Quick guide: Improving hospital discharge into the care sector

²³ Healthwatch England (2015) Special Inquiry: Safely Home, Findings

²⁴ Royal College of Physicians (2014) Acute care toolkit 10: Ambulatory Emergency Care

Several sites have demonstrated considerable progress in a variety of process and system metrics, for example:

- Over 30% of emergency referrals managed through AEC in some units.
- Reductions in medical outliers.
- Improvement in the 4-hour standard.
- Closure of escalation beds.
- Improved patient experience.²⁵

The Royal College of Physicians advocates rapid access to an ambulatory emergency care unit, as well as ongoing ambulatory care may be provided either directly through the AEC unit or by community services, primary care or hospital-at-home, and this is supported by other national bodies. For example, NHS England recommends that each acute site should consider establishing an AEC facility that is resourced to offer emergency care to patients in a non-bedded setting, although the precise model may vary. They note that **ambulatory emergency care is clinically safe, reduces unnecessary overnight hospital stays and hospital inpatient bed days.**²⁶

The model being set out in Oxfordshire is in line with this guidance, through the implementation of the ambulatory pathway which comprises both AAUs and in-reach into people's homes. Under the proposed service changes the new ambulatory care model will result in 2,596 inpatient medical non-elective admissions being replaced with a zero-day attendance at HGH, as these patients would receive ambulatory care.

It is apparent that **a reduction in bed days is an anticipated benefit** of both implementing AEC²⁷ as well as delayed transfers of care on a permanent basis. Providing that a sufficient level of bed capacity is already available within the local system, this will enable a shift in resources to be made from hospital based care to this new model of care. One stakeholder²⁸ commented on the positive impact that the ambulatory service model and hospital at home has already had in terms of delivering **same day care for patients**, facilitating a management plan to be developed, as well as supporting increased care to be provided in a patient's home. They consider that this has had a **positive impact in reducing hospital admissions** (which can result in a DTOC), as well as on primary care capacity. Another stakeholder commented that by receiving **care closer to home, family and friends will be better able to visit patients and support their recovery**. It has been highlighted however that for those who may be isolated in their homes, it is essential that the care provided is comprehensive. This reflects views expressed within the public consultation; there is support for efforts to prevent people being admitted to an acute hospital unnecessarily and for discharged patients to be supported more effectively, provided that appropriate home or community based care is available.²⁹

Through increased collaboration between all parties involved in discharge planning and the Liaison Hub, as well as delivery of the ambulatory care model, a further positive impact is that **care has the potential to become better coordinated, reducing unnecessary duplication and enabling resources being used more effectively.**

²⁵ Royal College of Physicians (2014) Acute care toolkit 10: Ambulatory Emergency Care

²⁶ NHS England (2015) Transforming urgent and emergency care services in England

²⁷ Royal College of Physicians (2014) Acute care toolkit 10: Ambulatory Emergency Care

²⁸ Engaged with as part of this IIA

²⁹ QA Research (May 2017) Big Health and Care Consultation

3.1.2 Potential negative impacts

One stakeholder³⁰ commented that extending these services to a county wide basis can **stretch current workforce resources, resulting in increased travel time for staff and decreased patient facing time**. In terms of resources more widely, stakeholders through the public consultation expressed concern that **the social care infrastructure is not currently sufficiently developed to support the roll out of this model of care**, and this could constrain the potential impact of the initiative.

This reduction in acute beds, does have the **potential to create pressures on the wider bed pool, particularly at times of the year when there is a high volume of patients**. Through the public consultation, stakeholders expressed a concern regarding the **feasibility of removing hospital capacity** (despite the implementation of the ambulatory model of care), highlighting the potential negative impact this would have on hospital services if a corresponding shift in activity does not become evident.

3.2 Critical care services

It is proposed that level 3 critical care activity will be transferred from HGH to the JRH or to neighbouring sites outside of Oxfordshire. High dependency services (level 2 critical care) will continue to be provided from the HGH.

3.2.1 Potential positive impacts

These proposals are built on a definitive case for change. The HGH strategic review has highlighted that the current activity levels at the CCU have reduced over time, as a result of changes to other services such as major trauma and emergency general surgery. This activity is now at a level at which it is having an impact on the ability of clinicians to be able to maintain their skill set for level 3 critical care patients.

As highlighted within the Pre-Consultation Business Case (PCBC), data provided by the Intensive Care National Audit and Research Centre (ICNARC) for 2013/14 demonstrates that patients remain on the HGH CCU relatively longer in relation to peer units in the Thames Valley and Wessex. ICNARC data also demonstrates that the unit has the lowest number of ventilated patients in this region, but that its mortality for ventilated patients is the highest amongst peers.³¹ In addition, the Horton CCU is consistently failing to meet the Guidelines for Provision of Intensive Care Services (GPICS).

Therefore, under the proposals, **there is the potential for an improvement in health outcomes for those patients requiring level 3 critical care as they will be able to benefit from the improved outcomes demonstrated at the JRH. These benefits may include reductions in length of stay, reductions in mortality rates and greater compliance with the GPICS**. The achievement of better outcomes for level 3 critical care at JRH has also been reflected by stakeholders, including reduced mortality and serious complications. During the public consultation, some stakeholders expressed concerns around the potential increased risks arising from transferring patients requiring level 3 critical care to at the JRH. However, it is considered that these risks will be offset by the receipt of specialist care on arrival.

³⁰ Engaged with as part of this IIA

³¹ ICNARC data, 2013/14

This proposal will also ensure that **the workforce providing care to level 3 patients will see a sufficient critical mass of patients to be able to maintain their skill set**, thereby delivering a higher quality service. One stakeholder highlighted that the rotation of staff across sites may also be important in ensuring that critical care staff providing level 2 support at HGH are also able to maintain their levels of competency.

3.2.2 Potential negative impacts

Critical care nursing and support **staff may experience negative impacts if they are required to change their permanent place of employment**; this could have an impact in terms of the personal costs of travel and the inconvenience associated with additional journey times. Ultimately, this may have a negative impact on the retention of staff. This is also relevant to other services areas described below.

Two stakeholders³² have highlighted that proposals will mean that **some families will experience increased travel time to visit patients receiving level 3 critical care**, although it is acknowledged that this impact must be balanced against the increased quality of care the patient is likely to experience and the numbers of families impacted by this is likely to be low. Through the public consultation, stakeholders have highlighted that where services are being consolidated on one site, this **may also negatively impact on the ability of carers to provide appropriate support to patients**. These potential impacts regarding the accessibility of visitors and carers can arguably have an **impact on patient recovery and wellbeing** and are also relevant to sections Stakeholders have suggested that moving patients back to their local hospital as soon as patients are clinically fit will reduce these potential negative impacts.

Capacity at JRH and the ambulance service is likely to be impacted by the proposed change, with one stakeholder³³ expressing concern about the capacity of JRH to accommodate these additional patients. There is also the potential that a reduction in the number of hospitals providing level 3 critical care could **potentially have a negative impact on the resilience of services**, if for example, there were to be an unanticipated large number of patients requiring emergency general surgery or acute medical care which requires level 3 critical care support. However, it is recognised that given the small number of beds at the HGH, and the low probability of a spike in patients requiring level 3 critical care beds, this scenario is relatively unlikely.

3.3 Maternity

The proposed service changes under the 'do something' option necessitate that most births move away from the HGH to JRH, or alternative acute hospitals such as Northampton or Warwick (depending upon travel times). Presently, HGH delivers 18% of all OUHFT's births (1,508) and under the proposed reconfiguration this may fall to 6% (496 low risk births) which would take place at the Horton midwifery led unit (MLU).³⁴ Given the interdependencies between services and shared workforce, the SCBU will also transfer to the JRH and emergency gynaecology services will also be centralised there. Evidence regarding the impact of the MLU at HGH will be considered as part of Phase 2.

3.3.1 Potential positive impacts

The Royal College of Obstetricians & Gynaecologists (RCOG) recognises that for maternity services to improve, obstetric care must be concentrated to deal with the increasing numbers of

³² Engaged with as part of this IIA

³³ Engaged with as part of this IIA

³⁴ The proposals for MLUs are to be considered in more detail in phase two of the Transformation Programme.

complex pregnancies and women being transferred from other birth locations. Such obstetric units should provide continuous senior medical staff presence on the labour ward.³⁵ This is also in the context of an increase in the complexity of cases nationally, caused by changing demographic factors including women giving birth later in life, obesity, multiple pregnancies and existing co-morbidities.

Currently, both sites do not meet the minimum medical staffing levels for obstetric care and it is reported in the Pre-Consultation Business Case that the low numbers of births at HGH makes it challenging for the general obstetricians to maintain their clinical skill set. The number of deliveries at JRH means there should be 168 hours of consultant cover for the obstetric unit but, as of August 2016, there was 106 hours of cover. **Through the consolidation of obstetric services into one unit, it is understood that the service could be staffed at RCOG standards of 24/7 consultant cover by 2020/21.**³⁶

Stakeholders have commented that this consolidation of obstetric services will enable an **increased quality of care as patients will be able to access specialist staff that have experience of dealing with a critical mass of births**. Another commented that this higher quality maternal care will **reduce the likelihood of complications**. One stakeholder highlighted the positive patient stories that have been anecdotally shared since obstetric services were temporarily consolidated at JRH.

3.3.2 Potential negative impacts

Four stakeholders³⁷ stated that proposals **may mean increased travel time to an obstetric unit for patients and their families**, although it has been noted that many 'high risk' women already travel to JRH. Through the public consultation, stakeholders raised significant concerns that the proposals would negatively affect the safety of women and babies, as a result of the longer journey for some to JRH.

As with other service proposals, **there will be some staff who will be required to change their place of employment and this is likely to present some negative implications**. However many of the impacts for staff have been worked through as part of the implementation of the temporary transfer of obstetrics from HGH to JRH in October 2016. The creation of a larger and therefore more resilient workforce, may create opportunities for increased training and development opportunities. One stakeholder has also commented on the need to ensure that midwives have the opportunity to rotate across obstetric and midwifery led services to ensure that they have the opportunity to maintain their skill set.

There is likely to be an **impact on the capacity of neighbouring providers, which if not sufficiently resourced, has the potential to negatively impact on the quality of care**. It is understood that Oxfordshire CCG is in discussions with Northampton General Hospital NHS Trust and South Warwickshire NHS Foundation Trust to ensure that the obstetric activity moved to these providers can safely be absorbed into their current capacity. There **may also be some impact on the ambulance service in terms of longer journeys to JRH or increased number of transfers** the ambulance service may be required to support.

There is also the potential that **a reduction in the number of hospitals providing obstetric maternity care could potentially have a negative impact on the resilience of services**, if for example, there were to be an unanticipated event which meant that the obstetric service at JRH

³⁵ Royal College of Obstetricians and Gynaecologists, Royal College of Midwives (2007) Towards Safer Childbirth: Minimum Standards for the Organisation of Labour Wards.2007 London: RCOG

³⁶ Oxfordshire Transformation Programme (2017) PCBC for Acute Hospital Services: Phase One

³⁷ Engaged with as part of this IIA

was not able to provide services or was at full capacity. For example, an outbreak of infection may reduce the ward space available for maternity cases, however the likelihood of this significantly impacting on the substantial closure of the ward is relatively low.

3.4 Planned care at the HGH

The centralisation of specialist services for urgent, emergency and critical care at the JRH offers an opportunity for the HGH to deliver more elective work and more care closer to residents in the north of the county.

Under the proposed service changes, HGH will provide an increased proportion of OUHFT's day case activity, across both medical and surgical specialties.³⁸ In parallel, all elective inpatient surgery would move from the HGH and Ramsay treatment centre (at HGH) to the JRH. There is an anticipated investment under option 2 to improve diagnostic capacity and reconfiguration of outpatient facilities at the Horton site of between £12.6m and £18.9m.

3.4.1 Potential positive impacts

The consolidation of day case activity at HGH and elective inpatient medicine and surgery at JRH, is in line with national guidance which outlines that providers should work to make sure that robust networks are set up to ensure appropriate critical mass in complex and low volume cases to achieve excellent outcomes for patients, with low complication rates.³⁹

Evidence supports the drive to separate elective and non-elective surgery pathways, with guidance from the Royal College of Surgeons, National Institute for Care and Health Excellence (NICE), the British Orthopaedics Association (BOA) and other advisory bodies recommending this direction of travel, and outlining the link between volume and outcomes. It is suggested that this separation can result in positive outcomes for patients including **earlier investigation, definitive treatment and better continuity of care, as well as reducing hospital-acquired infections and length of stay.**^{40 41} Other linked outcomes have included: reduced cancellations; **a more predictable workflow; increased senior supervision of complex/ emergency cases; and provision of training opportunities.**⁴²

The PCBC identifies that a potential benefit of increased elective throughput and improved planning of these services will be for **the trust to improve its performance with Referral to Treatment (RTT) and cancer waiting times targets.** A Monitor study on elective orthopaedic and ophthalmic surgery explored opportunities for improving operational performance, which resulted in improved care and the release of resources for the delivery of further healthcare, where needed.⁴³ One centre which participated in this study, South West London Elective Orthopaedic Centre, reported not only improved operational performance but also a reduction in cancellations, consistent delivery of 18 week targets and 95% theatre utilisation, reductions in length of stay (LOS) and a reduction in infections.⁴⁴

Under the proposed service changes, HGH will also look to provide an increased proportion of OUHFT's outpatient activity, across both medical and surgical specialties and diagnostic activity

³⁸ At the time of this report, a breakdown of specialities impacted was not available.

³⁹ Briggs T (2013) A national review of adult elective orthopaedic service in England, Getting it Right First Time, British Orthopaedic Association

⁴⁰ The Kings Fund (2014). The reconfiguration of clinical services

⁴¹ Imison, C., Sonola, L., Honeyman, M., & Ross, S. (2014). The reconfiguration of clinical services. What is the evidence.

⁴² The Royal College of Surgeons of England (2003): 'Separating emergency and elective surgical care: Recommendations for practice'

⁴³ Monitor (2015) Helping NHS providers improve productivity in elective care

⁴⁴ NHS Providers (n.d) South West London Elective Orthopaedic Centre: A Centre Of Excellence In Patient-Focused Elective Orthopaedic Care <https://www.nhsproviders.org/media/1823/swleoc-final-m.pdf>

is assumed to increase in line with outpatients. There is also an assumed significant increase in oncology day case care such as chemotherapy and renal dialysis spells will be consolidated at the HGH. It is also important to note that under the ‘do something’ option, activity across the full range of diagnostic assessments increases substantially, as a result of the creation of a 21st century diagnostic facility at HGH. These activity assumptions are highlighted in Table 4.

Table 4: Change in outpatient, diagnostic and other care at HGH

		2016/17 baseline	Impact of new models of care (regardless)	“Do nothing” option	“Do something” option	Change
Outpatient appointments	Medicine	50,752	1,522	49,320	81,229	+31,999
	Surgery	35,529	1,066	34,483	97,875	+63,412
Outpatient and direct access diagnostics	X-ray	12,378	0	12,378	12,378	0
	Ultrasound	11,254	0	11,254	12,942	+1,688
	CT	3,928	0	3,928	5,892	+1,964
	MRI	953	0	953	6,195	+5,242
	Other	1,850	0	1,850	6,104	+4,254
Other, spells	Oncology – day case chemotherapy	3,550	0	3,550	9,103	+5,553
	Renal dialysis	2,838	0	2,838	4,057	1,159

Source: Mott MacDonald (derived from Oxfordshire Transformation Programme PCBC for Acute Hospital Services: Phase One)

Through the creation of planned care facilities, **there is the potential to streamline care for patients at certain parts of their pathway of care; through the creation of one stop clinics and more coordinated appointments. This is likely to have a positive impact on patients** as it will reduce the number of appointments they are required to attend, reducing multiple journeys to hospital sites and the associated use of their time. This potential impact was highlighted by four stakeholders⁴⁵, who commented that patients in the north of the county will benefit by having these services available more locally. For outpatients, it is understood that, where appropriate, nearly all clinical services have committed to transfer their relevant outpatient activity to HGH. As existing staff will deliver these services, it is anticipated that patients should not experience any disruption in their care as they will continue to be seen by the same set of professionals.

One stakeholder has also commented on the ‘bottleneck’ that diagnostic services currently present. The **development of the diagnostic centre provides an opportunity to organise services and integrate diagnostic services into care pathways**, in such a way as to address this current system constraint and support the achievement of waiting time targets.

3.4.2 Potential negative impacts

These proposals are likely to result in some changes in the workforce profile of services. **If appropriate staffing levels at HGH for outpatient activity and at JRH for inpatient activity are not achieved, then there is a potential for patients to experience a negative impact in their quality of their care.** For example, the significant increase in direct access diagnostics such as MRI and CT will have an impact on workforce required on site at the new Diagnostic Facility at HGH, particularly to ensure that key standards such as reporting times can still be achieved. Staffing implications should be assessed as plans develop in greater detail, and the

⁴⁵ Engaged with as part of this IIA

potential implications for staff should also be explored, including the impact of them being prepared to work across sites or from a different site. Existing challenges in recruiting some staff groups, such as radiographers and other clinical scientists to operate an expanded diagnostic facility may impact on the ability to provide this increased workforce needed to deliver these services safely. One stakeholder has also commented on the need to ensure that IT can enable these services to access specialist second opinion (at JRH).

One stakeholder has also highlighted that **by changing the location of care, some patients may experience some 'discontinuity' to their care.**

3.5 Stroke services and non-elective medical inpatients

Under proposals, all appropriate stroke patients in Oxfordshire should be conveyed directly to the HASU at JRH. The HGH presently sees roughly 10% of the stroke patients in the county at its acute stroke unit⁴⁶. Phase Two of the Oxfordshire Transformation Programme will consider the configuration of stroke rehabilitation services.

3.5.1 Potential positive impacts

Stroke patients require specialist multidisciplinary care and rehabilitation. Clinical evidence⁴⁷ and stakeholders have highlighted that the best outcomes for patients are delivered within specialist units like HASUs that have adopted measures such as:

- rapid access to advanced tests such as CT and MRI scanning;
 - treatments such as thrombolysis and thrombectomy; and
 - the 24-hour presence of specialist stroke doctors and nurses along with other complementary specialist teams.
- It can therefore be concluded that a centralised model of acute stroke care can improve patient outcomes in terms of reduced mortality and length of stay.⁴⁸

It can therefore be concluded that a centralised model of acute stroke care can improve patient outcomes in terms of reduced mortality and length of stay.⁴⁹

Once the hyper-acute phase is over, care will be subsequently transferred to a specialist team providing rehabilitation in a stroke rehabilitation ward, or when possible at home (Early Supported Discharge), where patient satisfaction and outcomes are better than for rehabilitation in hospital.^{50 51} The Transformation Programme aims to roll out a consistent model for early supported discharge across the county, which will create **equity of stroke rehabilitation provision.**

3.5.2 Potential negative impacts

Through the public consultation, some stakeholders expressed **concern about the estimated travel time to JRH for patients with a suspected stroke and the negative impact that this could have on their outcomes.** National guidance states that people with suspected acute stroke should be admitted directly to a HASU and be assessed for emergency stroke treatments

⁴⁶ Oxfordshire Transformation Programme (2017) PCBC for Acute Hospital Services: Phase One

⁴⁷ The King's Fund (2014) The reconfiguration of clinical services

⁴⁸ Imison, C., Sonola, L., Honeyman, M., & Ross, S. (2014). The reconfiguration of clinical services. What is the evidence.

⁴⁹ Imison, C., Sonola, L., Honeyman, M., & Ross, S. (2014). The reconfiguration of clinical services. What is the evidence.

⁵⁰ Ramsay AI, Morris S, Hoffman A, et al. (2015) Effects of centralizing acute stroke services on stroke care provision in two large metropolitan areas in England. *Stroke* 46: 2244–2251

⁵¹ Fearon P, Langhorne P (2012) Early Supported Discharge Services for reducing duration of hospital care for acute stroke patients. *Cochrane Database of Systematic Reviews Issue 9*

by a specialist physician without delay.⁵² It recognises the balance between location and critical mass: “*stroke services should be organised to treat a sufficient number of patients to ensure that the specialist skills of the workforce are maintained. At the same time, the closer a rehabilitation service is to the person’s home the more that family/carers can be engaged and the more targeted the rehabilitation can be.*”

In the public consultation, stakeholders raised concerns about the ability of the JRH to manage the additional flow of stroke patients; meaning that **without sufficient capacity and resources, there could be negative impacts on the quality of patient care**. It is noted by the Horton Strategic Review that there is a consideration to review staffing numbers for nurses and allied health care professionals (AHPs), and also for the review of job plans for some medical staff in order to ensure full cover at the HASU unit. In response to this, it has been stated by Oxfordshire CCG that, provided the early supported discharge service (outlined in the ambulatory care proposals) is available across Oxfordshire, there is adequate capacity to care for the additional patients received at the JRH⁵³.

With the ambulance service diverting patients to the HASU at JRH, this may result in longer journeys, creating a **potential negative impact on the capacity of the ambulance service**. The impact on ambulance service resources and logistics, due to the modified transfers of patients, has previously been a key factor in decision-making around configuring stroke services in the UK⁵⁴. These changes might implicate additional capital and revenue costs associated with increased ambulance provision. However many potential acute stroke patients are currently being conveyed directly to JRH and SCAS have confirmed that they support the change to this pathway.

The Transformation Programme, in Phase Two, is undertaking a review of community hospitals to further consider options for bed-based rehabilitation for stroke patients. These service changes across the whole stroke pathway may involve the movement of some workforce resources to the JRH or community sites. As the programme progresses, it will be important to understand the number of potential staff who may be required to change their permanent place of employment and the impacts arising from this. This may include some **staff having to travel further to their place of work, which is likely to have an impact in terms of the personal costs of travel and the inconvenience associated with additional journey times**.

In the implementation of any planned changes, one stakeholder has highlighted the potential **transitional negative impacts** that this can present. From their experience of being involved in service change, this had the potential to result in short-medium term capacity, operational effectiveness, and patient experience issues, unless this can be appropriately managed. This is relevant to the other services areas discussed within this report.

3.6 Impacts summary

Across the clinical areas considered within this phase one report, there are a number of potential health impacts which need to be considered:

3.6.1 Positive impacts

- **Improved outcomes for patients** will be achieved as a result of concentrating specific services on certain hospital sites, or creating new specialist centres such as a HASU or a

⁵² RCP (2016) National clinical guideline for stroke

⁵³ Oxfordshire Transformation Programme (2017) PCBC for Acute Hospital Services: Phase One S01.3 Achieving the Single Portal of Entry to OUHFT

⁵⁴ NHS England (2015) Stroke Services: Configurations Decision Support Guide

diagnostic centre. Whilst this may result in increased journey times for some patients and their visitors and carers, this will allow all patients from across Oxfordshire to benefit from the improved outcomes demonstrated at some hospitals. It will also provide the critical mass of activity that allows the workforce to maintain their skill set and ensure that recognised clinical and workforce standards can be achieved. Travel and access implications are explored in more detail in chapters 4 and 5.

- **Patient experience will be improved** through access to joined up care provided through redesigned hospital services where a one stop shop for diagnostic and outpatient services will be available.
- The concentration of expertise on certain sites, such as obstetric care at JRH, will allow **clinical resources to be pooled, supporting the achievement of workforce standards.**
- Through the creation of larger, more coordinated and resilient teams, with stability and job security, **staff satisfaction may be positively impacted.**

3.6.2 Negative impacts

- **Staff may experience negative impacts** if they are required to change their permanent place of employment. Associated impacts may include some staff having to travel further to their place of work, which is likely to have an impact in terms of personal costs of travel and the inconvenience associated with additional journey times. Ultimately, this may have an impact on the **retention** of staff.
- **Capacity at JRH and the ambulance service** is likely to be impacted by proposed changes around critical care, stroke and maternity services.
- A reduction in the number of hospitals providing some services could potentially have a **negative impact on the resilience of services.**
- **Potential transitional negative impacts** could be experienced **during the implementation of planned service changes.** Historical experience has shown that this can impact capacity, operational effectiveness, and patient experience, unless this can be appropriately managed.

As further detail on each of these service changes becomes available, and move into implementation planning, it is essential that these impacts, along with the suggested mitigating actions at the end of this report are reviewed on an ongoing basis.

4 Travel and access impacts

This chapter identifies travel and access impacts, which could potentially be experienced as a consequence of implementing the proposals. The chapter presents impacts for blue light ambulance as the journeys by patients for the services assessed would typically be made by this mode of transport; impacts for private car and public transport are included in appendix F. Impacts have been identified through quantitative journey time analysis, as well as a desk review. Detailed analysis by an equality group is included within the equality chapter (chapter 5). Appendix C provides heat maps for changes in travel times and appendix F provides a further breakdown of the changes in travel times.

Travel and access analysis has been undertaken on the basis of available current patient activity for the phase one services. Activity data, rather than population data, has been used so as to provide as accurate picture as possible about the potential impacts for patient journey times and to understand the potential volume of patients which would require longer trips. Data have been analysed at two levels, defined as:

- Overall patient activity: this refers to the number of patients who have accessed services within Oxfordshire CCG, regardless of whether they are resident in Oxfordshire or have come from outside Oxfordshire to access services.
- Oxfordshire patient activity only: this refers to the number of patients who have accessed services within Oxfordshire CCG and are resident in Oxfordshire.

This report has utilised thresholds of 30 and 60 minutes to report on the travel impacts. This allows for a consistent baseline upon which to record the differences between option configurations. Further details of the travel impact for additional travel time bands can be seen in appendix F.

4.1 Ambulatory care

Travel and access impacts have not been assessed for ambulatory care. This is because patients will continue to receive care at an AAU at their local hospital site, or because ongoing ambulatory care will be delivered in or closer to patients homes.

4.2 Critical care services

Analysis for the change to critical care services has not been assessed for travel and access impacts. This is due to the low volumes of patients receiving level 3 critical care.

4.3 Maternity

The tables below highlight the difference in travel times for maternity patients accessing hospitals for the baseline position and under a future scenario with obstetric-led maternity care removed from HGH. Residents living in the north of the county, namely Banbury and Chipping Norton and the surrounding areas, will need to travel further for their care.

The change to maternity services will not affect all patients. The HGH would move from providing 18 per cent of OUHFT's births to 6 per cent under the proposals in Phase One. The remaining 6 per cent (496) of births would be delivered at HGH at the on-site MLU.

4.3.1.1 Quantitative analysis of journey time impacts: overall patient activity

Based on current maternity patient activity data, 73 per cent of maternity patients can access obstetric-led maternity services by blue light within 30 minutes and 93 per cent within 60 minutes. Should obstetric-led maternity services not be provided at the HGH in future, 52 per cent of patients would be able to access obstetric-led maternity services within 30 minutes and 93 per cent within 60 minutes.

Table 5: Blue light ambulance journey time to obstetric-led maternity services: baseline - including services at the HGH (all patients)

	Travel time – blue light (baseline - including HGH)						
Journey time (number of minutes)	0-10	11-20	21-30	31-40	41-50	51-60	>60
Number of patients reaching maternity services in journey time range	3,515	2,205	2,692	1,786	543	20	772
Percentage of patients reaching maternity services in journey time range	30%	19%	23%	15%	5%	0%	7%
Cumulative percentage	30%	50%	73%	88%	93%	93%	100%

Source: SUS SEM

Table 6: Blue light ambulance journey time to obstetric-led maternity services: without services at the HGH (all patients)

	Travel time - blue light (excluding HGH)						
Journey time (number of minutes)	0-10	11-20	21-30	31-40	41-50	51-60	>60
Number of patients reaching maternity services in journey time range	1,798	1,540	2,676	3,809	910	19	781
Percentage of patients reaching maternity services in journey time range	16%	13%	23%	33%	8%	0%	7%
Cumulative percentage	16%	29%	52%	85%	93%	93%	100%

Source: SUS SEM

4.3.1.2 Quantitative analysis of journey time impacts: Oxfordshire patient activity only

Based on current maternity patient activity data, 79 per cent of patients resident in Oxfordshire can access obstetric-led maternity services by blue light within 30 minutes and 100 per cent within 60 minutes. Should obstetric-led maternity services not be provided at the HGH in future, 57 per cent of patient's resident in Oxfordshire would be able to access obstetric-led maternity services within 30 minutes and 100 per cent within 60 minutes.

Table 7: Blue light ambulance journey time to obstetric-led maternity services: baseline – including services at the HGH (Oxfordshire resident patients only)

	Travel time – blue light (baseline - including HGH)						
Journey time (number of minutes)	0-10	11-20	21-30	31-40	41-50	51-60	>60
Number of patient's resident in Oxfordshire reaching maternity services in journey time range	3,515	2,073	2,636	1,742	469	0	0
Percentage of patient's resident in Oxfordshire reaching maternity services in journey time range	34%	20%	25%	17%	4%	0%	0%
Cumulative percentage	34%	54%	79%	96%	100%	100%	100%

Source: SUS SEM

Table 8: Blue light ambulance journey time to obstetric-led maternity services: without services at the HGH (Oxfordshire resident patients only)

	Travel time - blue light (excluding HGH)						
Journey time (number of minutes)	0-10	11-20	21-30	31-40	41-50	51-60	>60
Number of patients reaching maternity services in journey time range	1,798	1,532	2,641	3,679	785	0	0
Percentage of patients reaching maternity services in journey time range	17%	15%	25%	35%	8%	0%	0%
Cumulative percentage	17%	32%	57%	92%	100%	100%	100%

Source: SUS SEM

4.4 Planned care services

Travel analysis on the impact of the changes to planned care services has not been possible for this IIA. To robustly assess the impacts on planned care services at the HGH, requires a greater level of disaggregation of the patient data than has been available. However, it is likely that travel times will be reduced for patients using these services, given the additional capacity being proposed at the HGH.

4.5 Stroke services

Stroke services for Oxfordshire will be centralised in the JRH. Direct conveyance of all appropriate Oxfordshire patients to the HASU at the JRH will be supported by the roll out of countywide early supported discharge to improve rehabilitation and outcomes. Residents living in the north of the county, namely Banbury and Chipping Norton and the surrounding areas, will have longer journeys to access care.

4.5.1.1 Quantitative analysis of journey time impacts: overall patient activity

Based on current stroke patient activity data, 71 per cent of patients can access stroke services by blue light ambulance within 30 minutes and 98 per cent within 60 minutes. Should stroke services not be provided at the HGH in future, 55 per cent of patients would be able to access stroke services within 30 minutes and 98 per cent within 60 minutes.

Table 9: Blue light ambulance journey time to stroke services: baseline - with series at the HGH (all patients)

	Travel time – blue light (baseline: including HGH)						
Journey time (number of minutes)	0-10	11-20	21-30	31-40	41-50	51-60	>60
Number of patients reaching stroke services in journey time range	128	136	174	117	50	0	12
Percentage of patients reaching stroke services in journey time range	21%	22%	28%	19%	8%	0%	2%
Cumulative percentage	21%	43%	71%	90%	98%	98%	100%

Source: SUS SEM

Table 10: Blue light ambulance journey time to stroke services: without services at the HGH (all patients)

	Travel time - blue light (excluding HGH)						
Journey time (number of minutes)	0-10	11-20	21-30	31-40	41-50	51-60	>60
Number of patients reaching stroke services in journey time range	68	101	170	200	66	0	12
Percentage of patients reaching stroke services in journey time range	11%	16%	28%	32%	11%	0%	2%
Cumulative percentage	11%	27%	55%	87%	98%	98%	100%

Source: SUS SEM

4.5.1.2 Quantitative analysis of journey time impacts: Oxfordshire patient activity only

Based on current stroke patient activity data, 72 per cent of patients resident in Oxfordshire can access stroke services by blue light within 30 minutes and 100 per cent within 60 minutes. Should stroke services not be provided at the HGH in future, 58 per cent of patients resident in Oxfordshire would be able to access stroke services within 30 minutes and 100 per cent within 60 minutes.

Table 11: Blue light ambulance journey time to stroke services: baseline - with the services at the HGH (Oxfordshire resident patients)

	Travel time – blue light (baseline: including HGH)						
Journey time (number of minutes)	0-10	11-20	21-30	31-40	41-50	51-60	>60
Number of patient's resident in Oxfordshire reaching stroke services in journey time range	128	121	171	114	48	0	0
Percentage of patient's resident in Oxfordshire reaching stroke services in journey time range	22%	21%	29%	20%	8%	0%	0%
Cumulative percentage	22%	43%	72%	92%	100%	100%	100%

Source: SUS SEM

Table 12: Blue light ambulance journey time to stroke services: without services at the HGH (Oxfordshire resident patients)

Journey time (number of minutes)	Travel time - blue light (excluding HGH)						
	0-10	11-20	21-30	31-40	41-50	51-60	>60
Number of patient's resident in Oxfordshire reaching stroke services in journey time range	68	100	170	190	54	0	0
Percentage of patient's resident in Oxfordshire reaching stroke services in journey time range	12%	17%	29%	33%	9%	0%	0%
Cumulative percentage	12%	29%	58%	91%	100%	100%	100%

Source: SUS SEM

4.6 Car parking

The separate parking study identified that there were few car parking issues at the HGH, but the findings from the JRH site highlighted some congestion issues when accessing the car park on particular days and times. For example, over the five survey days the JRH car parks sometimes saw queues form outside the car park barriers. It was suggested that further traffic planning take place in order review the access to the JRH and HGH sites given that patient activity at both sites is set to increase if Phase One proposals get implemented.

5 Equality impacts

5.1 Overview

In order to assess the impact of the service changes on protected characteristic and deprived groups, the scoping phase involved detailed analysis to understand which groups may have a disproportionate need for the services included in phase one of the Oxfordshire Transformation Programme.

This section, and Table 13 below, provides a summary of the groups scoped in for each of the services, and also provides an indication of the demographic representation of each group (where relevant and where the demographics of Oxfordshire differ from the national averages.) The full scoping analysis can be found in appendix D.

5.1.1 Ambulatory care: summary

The following groups have been identified as having a disproportionate need for ambulatory care:⁵⁵

- Age (older people aged 65 and over)
- Gender reassignment
- Pregnancy and maternity

Certain lifestyle factors, such as higher rates of inactivity or taking certain medications, are risk factors for requiring access to this type of care. For example, treatment for simple pulmonary embolism is likely to be disproportionately needed by certain equality groups (*older people aged 65 and over, pregnancy and maternity*) or deep vein thrombosis (*older people aged 65 and over, pregnancy and maternity*).

5.1.2 Critical care: summary

We have not provided analysis on the equality impacts of the proposed changes to the delivery of level three critical care. This is because of the dependency of other clinical services currently being delivered at the HGH which will require access to level three critical care. These clinical specialities (such as complex theatre) are not included in phase one of the Oxfordshire Transformation Programme and will be considered in the IIA of phase two.

5.1.3 Maternity: summary

The following equality groups have been identified as having a disproportionate need for maternity services:

- Deprived communities
- Pregnancy and maternity
- BAME communities
- Sex: Female

⁵⁵ Please note that for sex, there is not a disproportionate need for ambulatory care by men or women; however, there is a differential need for planned care services i.e. females and males are likely to require the services equally, but the reasons why they require services are different). This evidence is further explained and captured in appendix D.

This is due to the nature of the service, which deals with women during pregnancy and lifestyle risk factors, such as having more children (*BAME communities*) and greater risk of complication (*BAME communities, deprived communities*).

5.1.4 Planned care services: summary

The following equality groups have been identified as having a disproportionate need for planned care services:⁵⁶

- Age (children under 16)
- Age (older people aged 65 and over)
- Deprived communities
- Disability
- Gender reassignment
- BAME communities

Certain lifestyle factors, such as higher rates of smoking, obesity, diabetes or needing to take specific long-term medications, are risk factors for needing to access services. For example, musculoskeletal services are likely to be disproportionately needed by certain equality groups (*age (older people aged 65 and over), deprived communities, disability, gender reassignment, BAME communities*) or plastic surgery services (*children under 16, older people aged 65 and over*).

5.1.5 Stroke services: summary

The following equality groups have been identified as having a disproportionate or differential need for stroke services:⁵⁷

- Age (older people aged 65 and over)
- Deprived communities
- Disability
- BAME communities

Lifestyle and cultural factors that are associated with a disproportionate or differential risk of stroke, such as obesity (*deprived communities*), diabetes (*BAME communities, deprived communities*) or heart problems (*disability*).

⁵⁶ Please note that for sex, there is not a disproportionate need for planned care services by men or women; however, there is a differential need for planned care services i.e. females and males are likely to require the services equally, but the reasons why they require services are different). This evidence is further explained and captured in appendix D.

⁵⁷ Please note that for sex, there is not a disproportionate need for stroke services by men or women; however, there is a differential need for stroke services (i.e. females and males are likely to require the services equally, but the reasons why they require services are different). This evidence is further explained and captured in appendix D.

Table 13: Summary of scoped in groups

Group	Ambulatory care	Maternity	Planned care services	Stroke	Demographic analysis
Age (children under 16)			✓		This is in line with national average.
Age (older people aged 65 and over)	✓		✓	✓	This is in line with national average.
Deprived communities		✓	✓	✓	In Oxfordshire, four per cent of the population is classified as living in the most deprived quintile. This is compared to 20 per cent of the population of England.
Disability			✓	✓	In Oxfordshire, 14 per cent of the population is classified as living in with a long-term disability or illness. This is in comparison to 18 per cent of the population of England.
Gender reassignment	✓		✓		No demographic analysis is available.
Marriage and civil partnership					N/A
Pregnancy and maternity	✓	✓			This is in line with national average.
Race and ethnicity: BAME communities		✓	✓	✓	In Oxfordshire, 17 per cent of the population is classified as being from a BAME background. This is in comparison to 20 per cent of the population of England.
Religion and belief ⁵⁸					N/A
Sex: Female		✓			N/A
Sex: Male					N/A
Sexual orientation					N/A

Source: Mott MacDonald scoping report, see Appendix D

5.2 Impacts on those groups identified as having a greater need for phase one services

5.2.1 Health impacts

The proposals under the Oxfordshire Transformation Programme are likely to provide positive health impacts, including improved patient outcomes, as well as improved patient experience and care which is better co-ordinated. The groups, which have a greater need for the services for which these health benefits are forecast (as summarised in table 13 above), are therefore likely to experience these positive health impacts to a disproportionate extent.

⁵⁸ Please note that for religion and belief a differential need was identified for planned care. This is due to a differential need for diabetes services by certain religious groups that adhere to fasting practices. This evidence is further explained and captured in appendix D.

The health component of this IIA has also identified that there could be some short-medium term transitional impacts of moving towards a new service configuration; these impacts are also likely to be experienced to a greater extent by those patient groups which have a higher need for the services under review. The transitional issues related to service and geographical familiarity are particularly likely to affect some protected characteristic groups (older people, disabled people and some people from BAME backgrounds, particularly those who do not have English as a first language) which traditionally find it more difficult to navigate the healthcare system.

5.2.2 Blue light ambulance travel and access impacts

As with the travel and access analysis presented in chapter four, this analysis has been undertaken on the basis of available current patient activity for the phase one services. Activity data, rather than population data, has been used so as to provide as accurate picture as possible about the potential impacts for patient journey times and to understand the potential volume of patients which would require longer trips.

Travel times for patients with particular characteristics (for example age, ethnicity, gender, level of deprivation) are compared to the travel times of all patients to ascertain whether there is a greater impact on a particular group.⁵⁹

In reviewing the commentary and analysis below, please note that:

- Where differences in travel times have been identified, that is not to say that other groups are not also experiencing impacts, rather it is saying that an impact is likely to be felt to a greater or lesser extent.
- Deprivation is calculated using the lower layer super output area (LSOA) in which a patient is resident⁶⁰. It is recognised that not every patient in a deprived LSOA will be deprived themselves, but that this is the best available data.

⁵⁹ Please note that analysis for disabled people is not provided as disability is not a characteristic that is linked to the patient data provided by the CSU for this IIA; as such, it is not possible to cross tabulate the impacts on patients by disability.

⁶⁰ An LSOA is an administrative boundary with a minimum population of 1,000 and a maximum population of 3000.

5.2.2.1 Maternity

The tables below highlight the travel times to obstetric-led maternity services for maternity patients within one of the scoped-in equality groups; baseline journey times are compared with the future proposal.

Table 14: Percentages able to reach obstetric-led maternity services in 30 minutes or less by blue light ambulance

Group	Baseline percentage able to reach obstetric-led maternity services by blue light ambulance in 30 minutes or less (including services at HGH)	Future percentage able to reach obstetric-led maternity services by blue light ambulance in 30 minutes or less (without services at HGH)	Difference
Overall – all patient activity	73%	52%	-20pp change
Oxfordshire patients only	79%	57%	-22pp change
Women aged 15-44 (all patients)	74%	52%	-22pp change
Women aged 15-44 (Oxfordshire patients only)	79%	57%	-22pp change
BAME (all patients)	86%	64%	-22pp change
BAME (Oxfordshire patients only)	92%	68%	-24pp change
Most deprived quintile (all patients)	99%	59%	-40pp change
Most deprived quintile (Oxfordshire patients only)	100%	59%	-41pp change

Source: SUS SEM

Table 15: Percentage able to reach obstetric-led maternity services in 60 minutes or less with by blue light ambulance

Group	Baseline percentage able to reach obstetric-led maternity services by blue light ambulance in 60 minutes or less (including services at HGH)	Future percentage able to reach obstetric-led maternity services by blue light ambulance in 60 minutes or less (without services at HGH)	Difference
Overall – all patient activity	93%	93%	No change
Oxfordshire patients only	100%	100%	No change
Women aged 15-44 (all patients)	93%	93%	No change
Women aged 15-44 (Oxfordshire patients only)	100%	100%	No change
BAME (all patients)	94%	94%	No change
BAME (Oxfordshire patients only)	100%	100%	No change
Most deprived quintile (all patients)	99%	99%	No change
Most deprived quintile (Oxfordshire patients only)	100%	100%	No change

Source: SUS SEM

- There is a 40 percentage point reduction in patients from deprived communities being able to reach these services within 30 minutes (by blue light ambulance), compared to a 20 percentage point reduction for the population overall. The change is due to the removal of the HGH as an option, the higher concentration of deprived communities (compared to other protected characteristic groups) in the Banbury area and the longer distances that could be involved in transporting a patient to the JRH.
- Women aged 15-44 will have the lowest percentage of patients who can access maternity services within 30 minutes by blue light (52 per cent - using activity data from all patients); these percentages are in line with access for the overall population.

5.2.2.2 Stroke

The tables below highlight the travel times for stroke patients by scoped in equality group, comparing the baseline scenario with the future proposal.

Table 16: Percentage able to reach stroke services within 30 minutes or less by blue light ambulance

Group	Baseline percentage able to reach stroke services by blue light ambulance in 30 minutes or less (including services at HGH)	Future percentage able to reach stroke services by blue light ambulance in 30 minutes or less (without services at HGH)	Difference
Population overall – all patient activity	72%	55%	-17pp change
Population overall - Oxfordshire patients only	72%	58%	-14pp change
Aged 65 years (all patients)	75%	56%	-19pp change
Aged 65 years (Oxfordshire patients only)	75%	57%	-18pp change
Most deprived quintile (all patients)	100%	57%	-43pp change
Most deprived quintile (Oxfordshire patients only)	100%	57%	-43pp change

Source: SUS SEM

Table 17: Percentage able to reach stroke services in 60 minutes or less with by blue light ambulance

Group	Baseline percentage able to reach stroke services by blue light ambulance in 60 minutes or less (including services at HGH)	Future percentage able to reach stroke services by blue light ambulance in 60 minutes or less (without services at HGH)	Difference
Population overall – all patient activity	100%	98%	-2pp change
Population overall - Oxfordshire patients only	100%	100%	No change
Aged 65 years (all patients)	100%	100%	No change
Aged 65 years (Oxfordshire patients only)	100%	100%	No change
Most deprived quintile (all patients)	100%	100%	No change
Most deprived quintile (Oxfordshire patients only)	100%	100%	No change

Source: SUS SEM

- There will be a 43 percentage point reduction in patients from the most deprived quintile being able to reach stroke services within 30 minutes compared to only a 14-17 percentage point drop for the general population.
- Those aged 65 years or more will have the lowest percentage of patients able to access stroke services within 30 minutes by blue light (56 per cent based on all patient activity data). However, this is in line with the overall patient average.

5.2.3 Other travel and access impacts for equality groups

There are several other **negative** impacts associated with increased journey times for equality groups:

- **Increased stress and anxiety:** increased journey times or the need to make different and/or unfamiliar journeys to access care, is likely to affect some equality groups to a greater extent than the general population, these issues and the associated impacts were highlighted in the focus groups, and interviews with community and patient representatives. These groups include:
 - Those who find navigating new journeys, particularly using public transport, more challenging and problematic, for example older people and those with mobility of vision impairments.
 - Those who are less confident in making unfamiliar journeys, which may result in anxiety or panic attacks.
 - Those who also no longer frequently drive in busy areas, such as older people or disabled people especially those with mental health issues, are also likely to be affected.
 - Those who may not be confident in making journeys at night, for example older people or those with impaired vision
 - Those who do not have access to a private mode of transport and are reliant on assistance or public transport, such as older people who cannot afford to run a car or are unable to drive anymore, as well as those from deprived communities.
- **Increased costs associated with travel:** some patients and visitors, for example those living in north Oxfordshire who need to access services or visit relatives at the JRH, will experience increased travel costs. This is likely to disproportionately impact upon those traditionally on lower incomes, such as those from deprived communities, disabled people and older people.
- **Lack of acceptable alternative transport methods:** the variable and high financial cost of certain transport methods, i.e. trains, acts as a barrier to utilising alternative transport modes of transport (other than cars). This impact is particularly relevant to those living in deprived communities, disabled and older people. This is particularly likely to affect patient relatives.

5.2.4 Experience and quality of care for equality groups

Issues of accessibility are likely to disproportionality impact certain protected characteristic groups including those with communication challenges, those who are not confident/nor speak English as a first language, the elderly and those with physical and learning disabilities. These negative impacts include:

- **Access difficulties for visitors and carers:** increased journey times (and associated costs) for visitors and carers of patients receiving care in a 'non-local' location may limit or prohibit regular visits. This could affect patients' experience in hospital, and could disproportionately impact those who are more reliant on assistance and support, for example, disabled and older people – especially those with learning difficulties or mental health conditions. Some of those from BAME backgrounds who do not have English as their first language may also rely on relatives to help translate. Limited access to carer or relative support would mean the patient is less likely to be able to communicate effectively with clinical staff to express their preferences or ask questions about their care.
- **Unfamiliarity of hospital:** some patients and visitors can become confused or disorientated when they are at an unfamiliar hospital. This can particularly affect older people and disabled people and may result in a negative impact of patient experience of care.

6 Sustainability impacts

Changes to how NHS services are delivered across Oxfordshire have the potential to change emissions of GHG, which contribute to climate change.

6.1 Impact analysis

Total emissions from patient travel in the 'do -something' scenario are predicted to be 4,313tCO₂e per annum, and emissions associated with patient travel without the changes are estimated to be 4,293tCO₂e. This means that with the proposed changes, GHG emissions would increase by approximately 20tCO₂e per annum, an increase of around 0.5 per cent, due to patient travel. It should be noted that the assessment has been based on 2015/16 data, and in line with NHS patient number forecasts, which are expected to increase in the future. The increase in emissions is likely due to the centralisation of services within the JRH resulting, on balance, in an increased average journey distance.

Across the whole of the NHS patient travel accounts for 1.4MtCO₂e⁶¹, which is 44 per cent of all travel emissions (including NHS staff, visitors, patients, and contractors). If the proportion of travel emissions from patients within Oxfordshire are in line with national data, and if the changes to patient travel affected all travel equally, the changes would be expected to increase emissions by approximately 45 tCO₂e per annum due to all travel. Within the context of the total travel emissions from the NHS, which are 3.2MtCO₂e, the increase in emissions due to the changes to services is considered to be negligible.

⁶¹ NHS Sustainable Development Unit (2012), Carbon Footprint update for NHS in England 2012, <http://www.sduhealth.org.uk/policy-strategy/reporting/nhs-carbon-footprint.aspx> - (2012 is that most recent year where the travel data is broken down into travel types)

7 Conclusions

This chapter brings together the impacts from across the service areas and impact assessment topics and outlines potential ways to enhance opportunities and to mitigate or reduce the effect of the negative impacts.

7.1 Summary of impacts

Table 18: Impact summary table

Impact Assessment area	Summary of positive impacts	Summary of negative impacts
<p>Health</p>	<ul style="list-style-type: none"> ● Improved outcomes for patients, as a result of concentrating specific services such as a HASU or a diagnostic centre. ● Improved patient experience, as a result of access to joined-up care. ● Through the creation of larger, more coordinated and resilient teams, with stability and job security, staff satisfaction may be positively impacted and the achievement of workforce standards. 	<ul style="list-style-type: none"> ● Staff may experience negative impacts if they are required to change their permanent place of employment - this may impact the retention of staff. ● A reduction in the number of some hospital services could negatively impact the resilience of services. ● Potential transitional negative impacts could be experienced during the implementation of planned service changes. ● Capacity at the JRH and the ambulance service is likely to be impacted by proposed changes around critical care, stroke and maternity services.
<p>Travel</p>		<ul style="list-style-type: none"> ● Should obstetric-led maternity services not be provided at the HGH in future, 52 per cent of patients would be able to access obstetric-led maternity services within 30 minutes by blue light, in comparison to 73 per cent of maternity patients currently. ● Should stroke services not be provided at the HGH in future, 55 per cent of patients would be able to access stroke services within 30 minutes by blue light, in comparison to 71 per cent of stroke patients currently.

Equality

- **Improved health outcomes:** patients identified as having a disproportionate need for certain services are likely to be disproportionately positively impacted by improved health outcomes.
- **Increased stress and anxiety:** increased journey times or the need to make different and/or unfamiliar journeys to access care, is likely to affect some equality groups to a greater extent than the general population.
- **Increased costs associated with travel:** some patients and visitors will experience increased travel costs, which are likely to disproportionately impact upon those on lower incomes.
- **Lack of viable alternative transport methods:** the high financial cost of certain transport methods acts as a barrier to utilising alternative transport modes to cars.
- **Access difficulties for visitors and carers:** increased journey times for visitors and carers may limit or prohibit regular visits. This could affect patient experience in hospital, and could disproportionately impact those who are more reliant on assistance and support.
- **Unfamiliarity of hospital:** some patients and visitors can become confused or disorientated when they are at an unfamiliar hospital. This can particularly affect older people and disabled people.

Sustainability	● N/A: impacts are negligible	● N/A: impacts are negligible
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Source: Mott MacDonald

7.2 Enhancements and mitigations

Arising from this assessment, are a set of actions which focus on potential ways to enhance opportunities and to mitigate or reduce the effect of the potential negative impacts. It is suggested that these are considered by the Oxfordshire Transformation Programme as part of the implementation of proposals.

7.2.1 Health impacts

7.2.1.1 Programme level

- To overcome transitional implementation concerns, a clear change process is required. This should involve all key programme management and clinical group stakeholders in the development of implementation plans.
- The proposed changes will have an impact on the capacity of the ambulance service and it is essential that they are engaged on an ongoing basis in the development and refinement of the Oxfordshire Transformation Programme

7.2.1.2 Service level

- Clinical Groups to consider 2008 IRP recommendations where they continue to be relevant.
- Ensuring that the whole pathways of care for the services subject to change is considered. For example this includes considering both early stroke care and longer term support, as well as prevention initiatives which may support the modification of lifestyle behaviours known to be associated with this condition.
- Where clinically appropriate, consider the ability to move patients back to their local hospital as soon as patients are clinically fit. This will offset additional travel requirements for visitors and carers.
- Ensure that identified clinical interdependencies, monitored and reviewed as proposals develop. For example, this includes the ongoing link between level 2 critical care at HGH,

A&E and the proposed increase in inpatient elective surgery at HGH. It also includes ensuring that ambulatory care initiatives are fully implemented, so that patients can move through the stroke pathway and community rehabilitation beds do not become oversubscribed. Alignment with other clinical pathways should also be considered, including for example, any inter-dependency between the childhood and adult stroke pathway.

- Where relevant, communication between clinicians on different sites will continue to be essential, for example, allowing specialist opinion to be sought and expertise shared. IT and infrastructure must be able to facilitate this.
- Ensure that all providers of care (including those in surrounding areas) are aware of the changes and the appropriate pathways they should take with patients.
- Ensure that activity moving to neighbouring providers can be safely be absorbed into their capacity plans.

7.2.1.3 Workforce

- Offer and promote an engagement programme with staff to understand further the consequences of the potential impacts incurred when being required to work across sites, or from a different place of employment.
- Development of a workforce plan which quantifies and considers: recruitment requirements and potential lead times, skills gaps and considers mechanisms to ensure that the skills of staff can be maintained such as rotation. This includes recruiting sufficient medical physicians to ensure that AAUs can be resourced on a permanent basis, as well as securing 50 WTE⁶² staff for the SHDS.

7.2.2 Travel impacts

A travel plan is a package of measures designed to manage the access to an establishment (e.g. a hospital site). Though hospitals already have a travel plan in place this should be reviewed in light of the proposals. A travel plan can address a range of travel issues such as staff commuting, business trips, journeys made by patients and visitors to the site, how an organisation's fleet is managed and how travel is made by suppliers. Research has found that the most successful way of managing an organisation's transport impacts is through improving the quality and choice of non-car modes and providing disincentives for the use of the car.

The following overarching objectives are recommended for a travel plan to support the Oxfordshire Transformation Programme:

7.2.2.1 Promotion of public transport

The travel plan needs to consider how staff, visitors and patients that currently use the services in the HGH can access the JRH by sustainable transport modes so that the level of traffic accessing the sites does not increase especially in the light of car parking issues at the JRH.

Consideration needs to be given to the potential impact of the increased volume of traffic to the HGH site if the Planned Care proposals are implemented. New park and ride options around Banbury might have to be considered in collaboration with the local authorities and transport providers.

Some of the major barriers to public transport use are related to a lack of knowledge regarding bus services, times and the areas that they serve; this is likely to see increased significance for

⁶² Whole Time Equivalent

users required to access a less familiar location. It is therefore important that high quality information is provided to ensure that the lack of knowledge is not a barrier to public transport use. Public transport and travel planning information could be issued with appointment letters and correspondence. Provision of detailed public transport and travel planning information should also be made available on the HGH and JRH website and regularly kept up to date.

The Programme could also consider working closely with the Council and/or local bus operators in order to improve access to the sites by public transport and try and secure discounts for the cost of weekly, monthly and annual bus tickets for their staff.

7.2.2.2 Car park review and management strategy

A car park management strategy would need to be implemented for parking at the JRH taking full account of the current situation and the proposals. This strategy should apply to all users at the hospital, including staff, patients and visitors. It is suggested that a full-scale parking review is implemented as significant parking issues have been identified at the JRH for users under the current situations. Both on-site and off-site parking options need to be investigated, as well as related alternatives e.g. park and ride.

While reducing the availability of car parking is potentially an opportunity to encourage employees, visitors and patients to consider alternative modes of transport, each site should have a level of car park availability which does not put undue pressure on the surrounding area, prevent access to services or add additional stress to user experience.

The NHS organisations should therefore recognise the importance of allowing sufficient parking provision whilst not encouraging unnecessary use of the car. As an opportunity to reduce car trips car sharing or lift-sharing can be an effective way to reduce congestion, especially at peak times. The main user benefits associated with car sharing are financial due to the shared petrol cost and reduced parking charges; there are also environmental and social benefits. This could be explored particularly for staff and be linked to rotas and home locations to help define potential opportunities.

The introduction and promotion of smarter working practices for example, flexi time, working from home, compressed working and teleconferencing wherever possible and the potential to reduce the need to travel for selected staff.

The whole site at the JRH should be signed to allow for easy navigation for all users to their respective car parks.

7.2.2.3 Encouraging greater use of active travel modes

This can be done by:

- Promoting the health benefits of walking and cycling to patients with appointment letters and correspondence.
- Promoting the health benefits of walking and cycling to staff through information posted in common areas, staff intranet, site website, distributed with pay slips, newsletters, etc.
- Establishing a Bicycle User Group (BUG) for all staff in order to promote cycling and gain feedback.
- Providing sufficient cycle parking for use by staff and visitors

- Reviewing lighting and signage for pedestrians and cyclists on site and ensuring pedestrian and cyclist signage to the site and within the site is clear.
- Working in partnership with the Council to improve pedestrian and cyclist access and signage to the site

7.2.2.4 Communication and marketing strategy

The full travel plan related to the proposals should be carefully marketed to staff, patients and visitors in order to ensure it is effective. Lack of information about the alternatives to single occupancy car use such as walking, cycling and public transport is often the most significant barriers to their use. It is important that this information is available to employees, patients and visitors in a variety of 'user friendly' formats.

Signposting staff, patients and visitors to information about Community Transport schemes on the Oxfordshire County Council website would be useful.

7.2.3 Equality impacts

7.2.3.1 Collaborate with others to improve access to the JRH

To mitigate the impact of increased and long journey times on patients and their families due to the poor connectivity and congestion between the north of Oxfordshire and Oxford, the CCG can seek to engage with local transport operators to investigate options to improve access to the JRH from the north of the county.

7.2.3.2 Communication and information

An important consideration in implementing proposals and in promoting accessibility is to ensure that the future model of care is well communicated to the local population, so they understand how to access and use services. Whilst there has been a formal consultation process undertaken to outline and seek views on the proposed changes, it is important and necessary for the communication of the changes to be a sustained activity that goes beyond this into the implementation of changes.

Reconfiguration is unlikely to be instantly understood, so educational activities would develop awareness gradually, with clear message reinforced by all health and social care professionals across Oxfordshire. Communication also needs to further demonstrate the rationale behind the changes and the potential for benefits to people's health, wellbeing and clinical outcomes as a result of the changes.

It is suggested that communication should take a variety of forms, for example Council and other advice centres, online, leaflets, press articles, through local community groups and voluntary associations, and directly by the NHS to its staff, primary care and to local authority staff. There is also an opportunity to target particular equality groups and groups who are known to face issues of accessibility such as traveller communities, or those who do not have English as their first language and those living in deprived communities.

7.2.4 Sustainability impacts

Although sustainability impacts have been assessed as negligible, any negative impacts can be further minimised by encouraging the use of public transport and active travel. Please see section 7.2.2 of the travel mitigations and enhancements section for more information on this.

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A. Bibliography

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B. Current and future provision

B.1 Ambulatory care

Ambulatory care is currently being delivered by the pilot 'rebalancing the system' delayed transfer project

This has delivered:

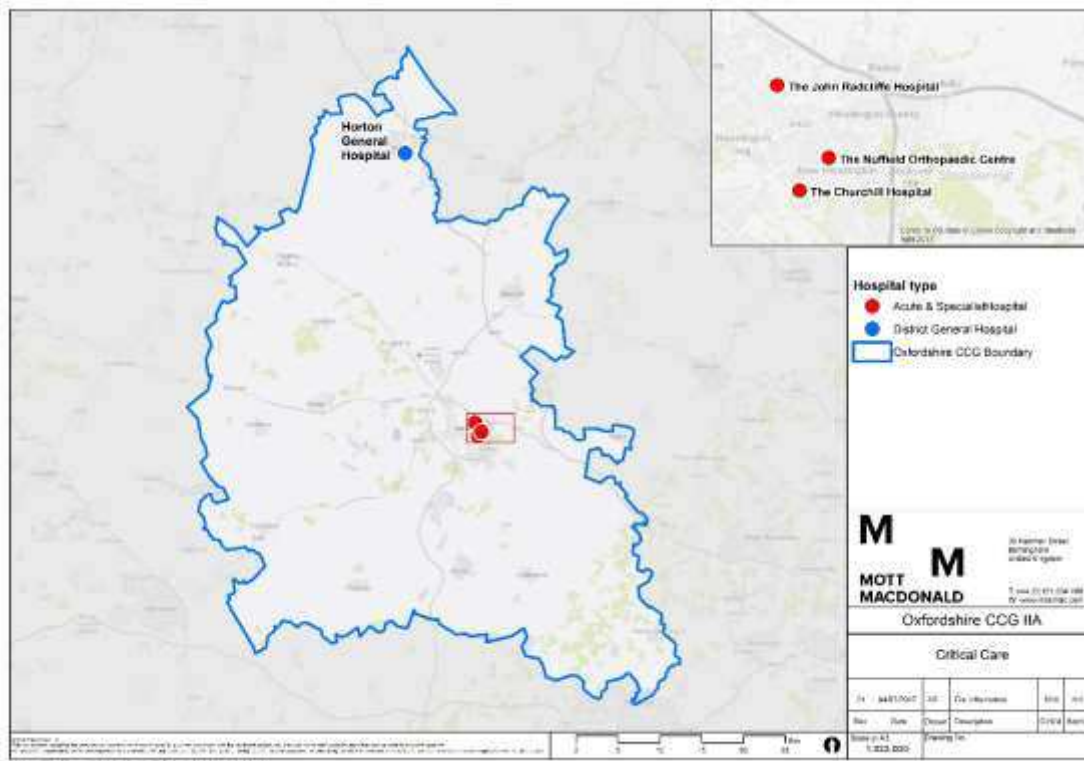
- A multi-agency Liaison Hub to manage complex delayed discharge patients by transfer to nursing home beds managed by the hub. This includes 134 intermediate care beds commissioned by the system in local nursing homes. This is further supported by an extended Supported Hospital Discharge Service (SHDS) and Discharge Liaison Team, to co-ordinate delayed discharges across the four OUHFT sites to streamline the discharge process.
- An ambulatory care pathway for medical patients which incorporates acute ambulatory units (AAUs) at both JRH and HGH. These are able to assess, diagnose and treat patients who are referred by the GP or Emergency Department, discharging them home with a follow up if required, or transferring them to an inpatient ward. The ambulatory pathway also includes providing care in-reach to people's homes (to deliver acute care for a set period of time).

Proposals seek to make permanent the decommissioning of 110 acute hospital beds that have already been closed and the 36 beds that are planned for closure subject to NHSE assurance, should these developments be adopted. This reduction in beds is associated to the reduction in hospital activity resulting from the movement of activity into the ambulatory care model and the avoided delayed discharges and transfers.

B.2 Critical care

Critical care is currently predominantly delivered at the HGH, the JRH through its adult intensive care unit and the Churchill intensive care unit.

Figure 2: Current critical care hospitals



The table below sets out current patient activity by hospital. Please note this refers to all levels of critical care, not just level three. Additional breakdown of critical care activity data has been requested by Mott MacDonald.

Table 19: Patient activity by hospital

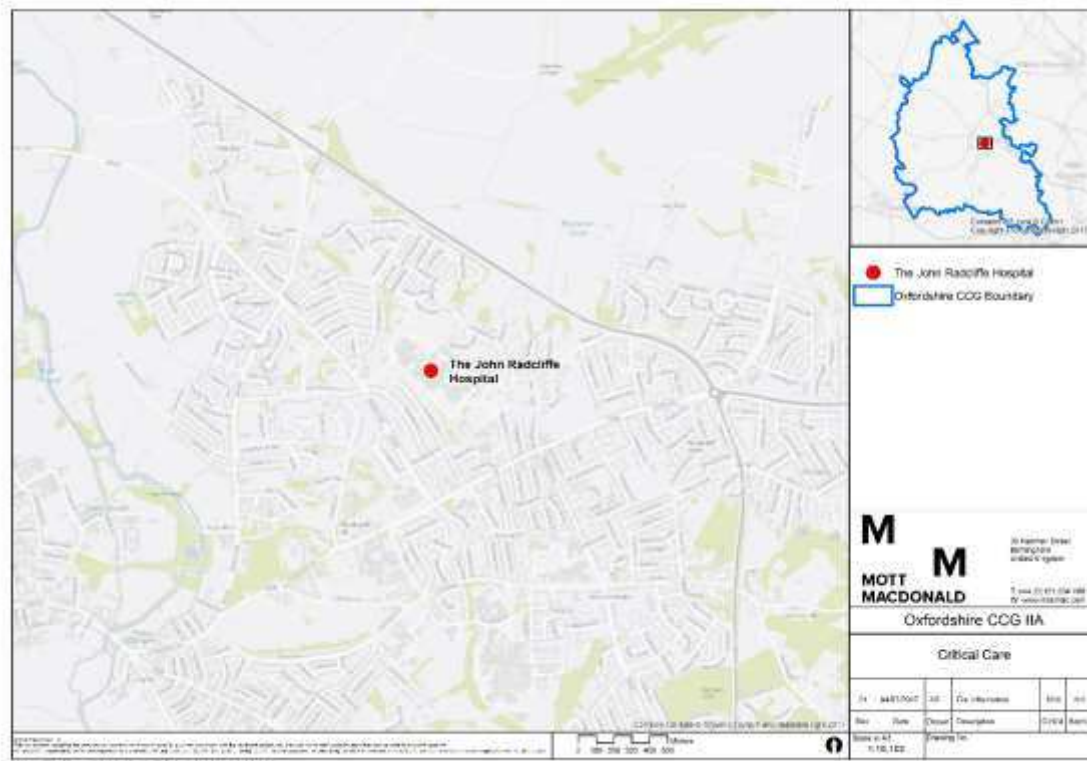
Hospital	Churchill	Horton General	Nuffield Orthopaedic Centre	John Radcliffe	Other Oxfordshire	Other Non-Oxfordshire
Total number of patients	91	141	36	526	0	161

Source: Data relates to the time period October 2015-September 2016. Data provided by Oxfordshire CCG

Under the proposals, critical care will continue to be delivered the HGH and the JRH through its adult intensive care unit and the Churchill intensive care unit, however Level 3 critical care beds will be delivered solely at the JRH, rather than at the HGH (as shown below in Figure 4). It is projected that there will be a 5.23 per cent growth in demand for Level 3 critical care from 2016/17-2020/21.⁶³

⁶³ PCBC

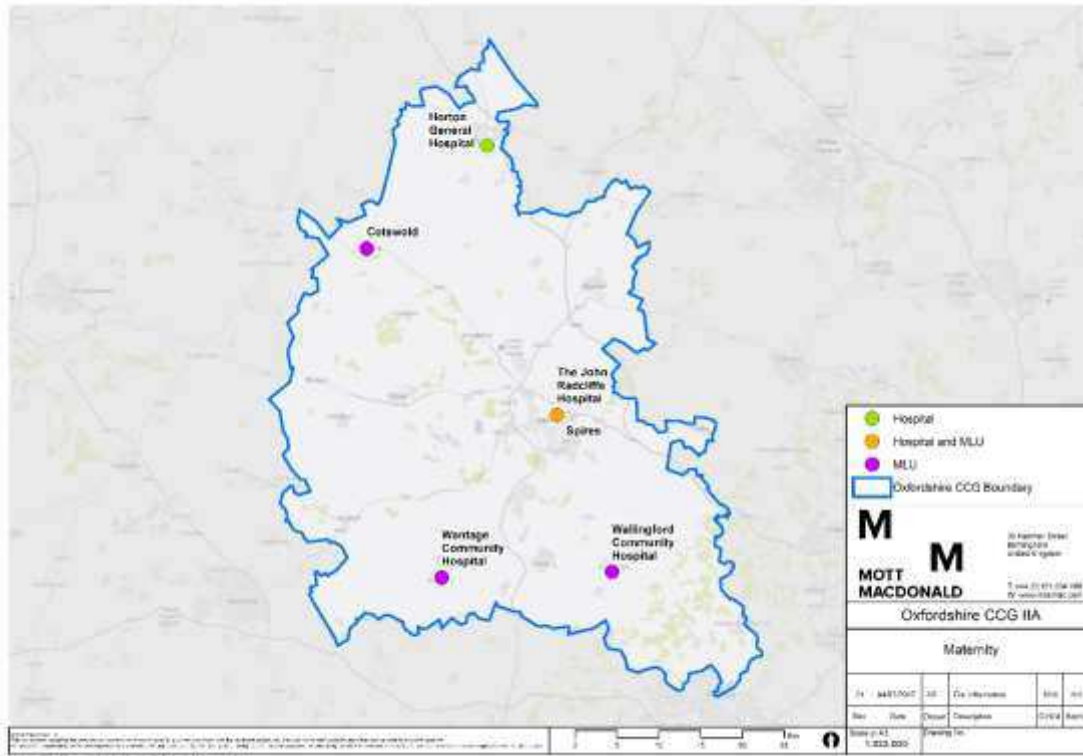
Figure 3: Proposed Level 3 critical care hospitals



B.3 Maternity

OUHFT provides maternity services for women in Oxfordshire and for up to 1,000 women from surrounding counties. Services are delivered in two separate obstetric units (at the JRH and the HGH), one alongside MLUs and three freestanding MLUs. The MLUs are in Wallingford, Wantage, Cotswold and Spires (as shown below in Figure 5).

Figure 4: Maternity hospitals and MLUs



Source: 2015 IMD

The table below sets out current activity by hospital. Please note this includes all maternity activity data.

Table 20: Patient activity by hospital

Hospital	John Radcliffe	Churchill	Horton General	Nuffield Orthopaedic Centre	Other Oxfordshire	Other Non-Oxfordshire
Total number of patients	7,970	-	2,556	-	325	685

Source: Data relates to the time period October 2015-September 2016. Data provided by Oxfordshire CCG

Under the proposals, a single specialist obstetric unit for Oxfordshire at the JRH will be created, supported by MLUs in both the North and the South of the county. Necessary consequential changes arising from the consolidation of obstetric services at the JRH are:

- SCBU services will be moved from the HGH to the JRH.
- Emergency gynaecology services will be centralised at the JRH.

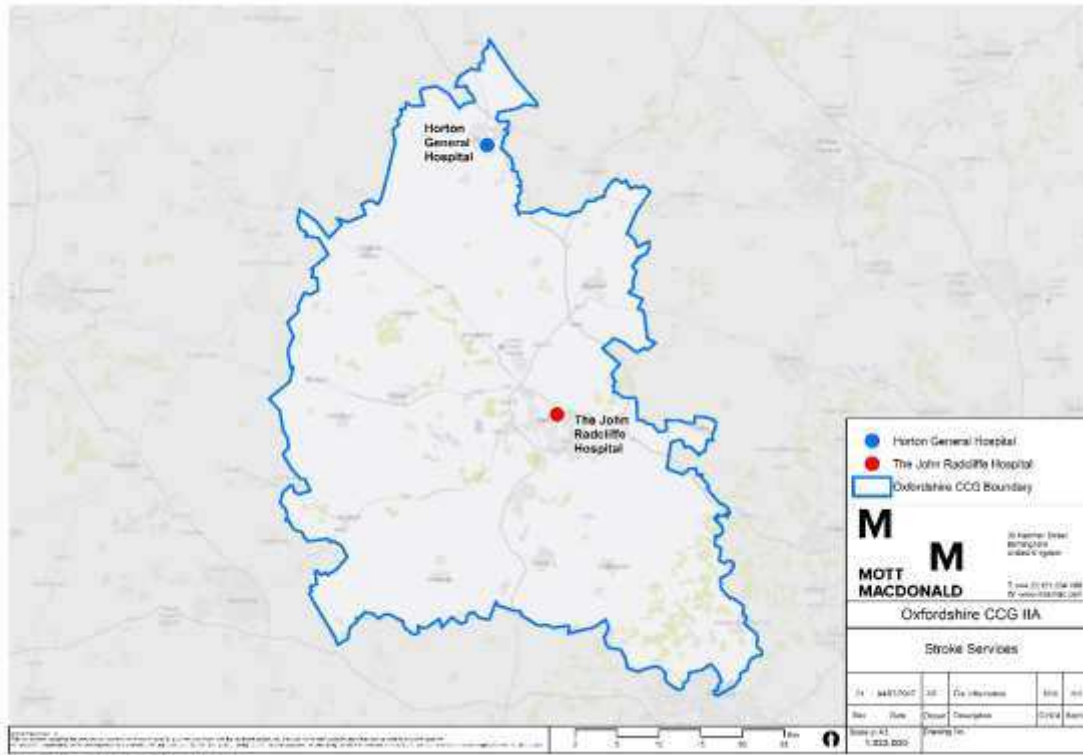
It is predicted that there will be a 5.23 per cent growth in the period 2016/2017 to 2020/21.⁶⁴

⁶⁴ PCBC

B.4 Stroke services

There is a Hyper Acute Stroke Unit (HASU) at the JRH. An acute/Rehabilitation Stroke Unit at the HGH and a transient ischaemic attack (TIA / 'mini stroke') outpatient clinics at the JRH and the HGH (as shown below in Figure 6).

Figure 5: Current stroke services



Source: 2015 IMD

The table below sets out current stroke activity data.

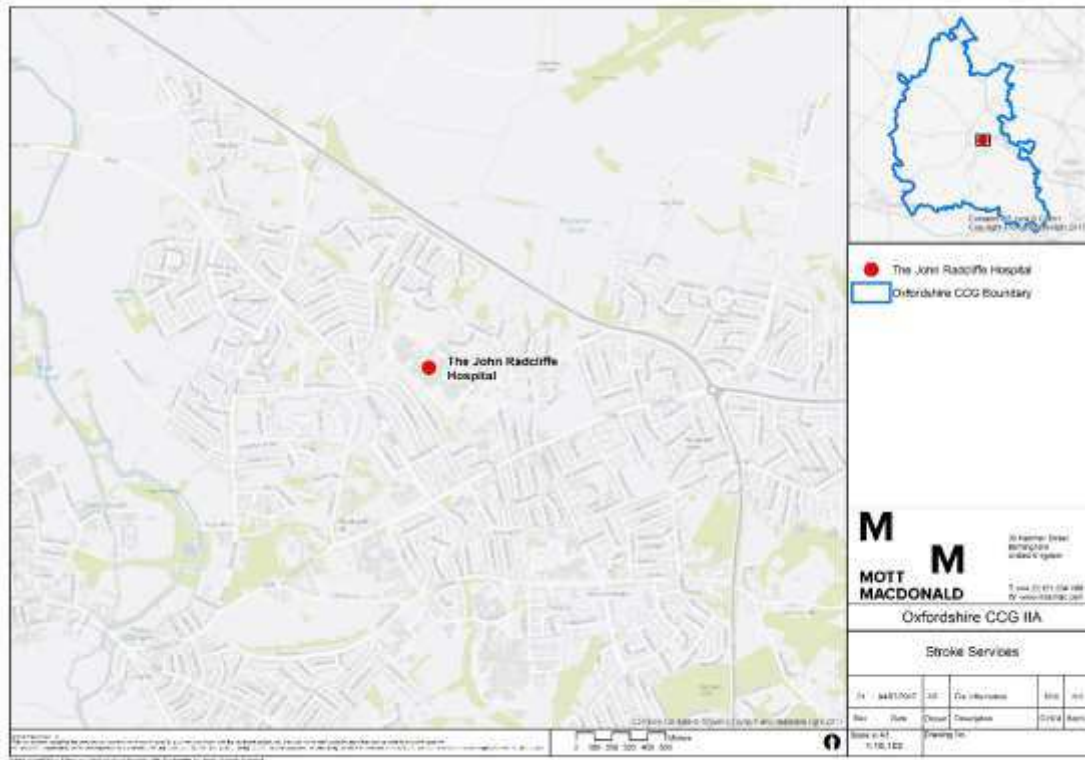
Table 21: Patient activity by hospital

Hospital	Churchill	HGH	Nuffield Orthopaedic Centre	JRH	Other Oxfordshire	Other non-Oxfordshire
Total number of patients	0	93	37	404	46	77

Source: Oxfordshire CCG

Under the proposals, stroke services will be centralised by enabling direct conveyance of all appropriate Oxfordshire patients to a HASU at the JRH in Oxford. This will be supported by the roll out of countywide Early Supported Discharge to improve rehabilitation and outcomes.

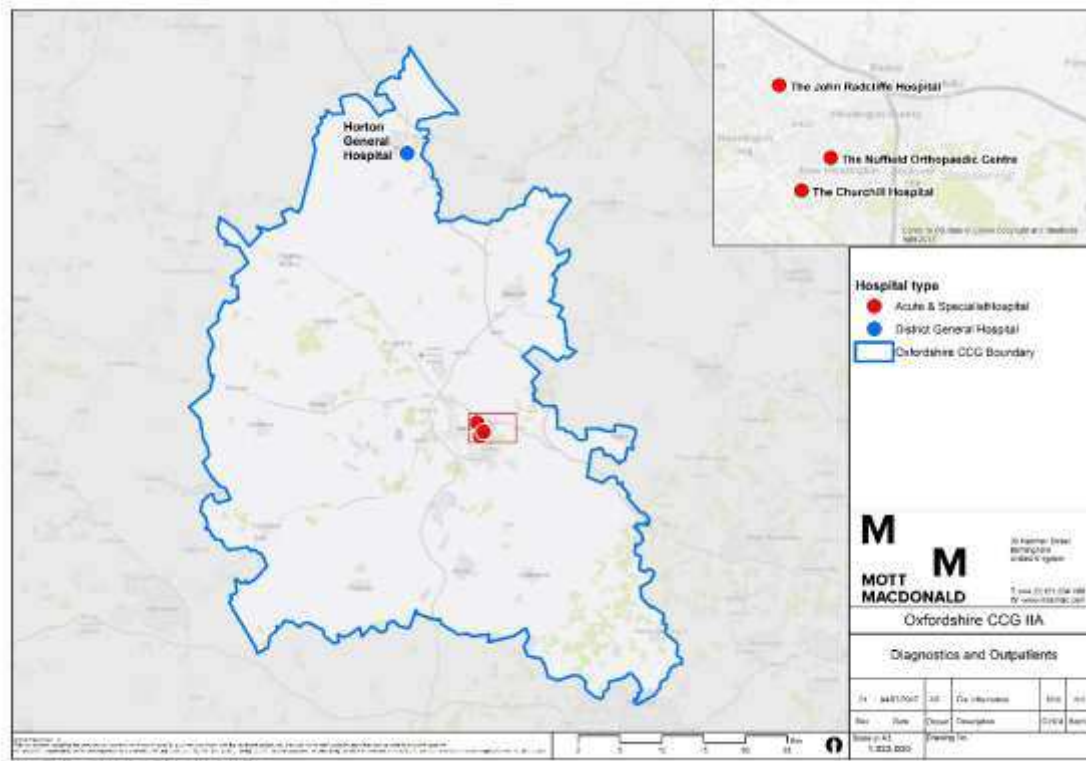
Figure 6: Future stroke services



B.5 Planned Care services

Planned Care services are offered at both the JRH, the Oxford Hospitals and Churchill Nuffield Orthopaedic Centre. However, the majority of Planned Care appointments are delivered at the Oxford Hospitals, and residents in the north of the country travel to the JRH for their treatment. This is shown below in Figure 8.

Figure 7: Diagnostics and outpatients hospitals



The table below details current activity

Table 22: Patient activity by hospital

Hospital	John Radcliffe	Churchill	Horton General	Nuffield Orthopaedic Centre	Other Oxfordshire	Other Non-Oxfordshire
Total number of patients	250,594	141,948	65,343	87,053	66,598	67,171

Source: Data relates to the time period October 2015-September 2016. Data provided by Oxfordshire CCG

Under the proposals, the following services will be delivered at the HGH:

- A new diagnostic facility will be developed at the HGH to provide high quality diagnostic procedures (MRI, CT scanners and ultrasound etc.), rapid assessment and reduced travel to Oxford for routine diagnostic imaging.
- A new outpatient facility will be developed with capacity for significant transfer of outpatient activity from Oxford in order to make local services more accessible to North Oxfordshire's population. This includes 'one stop clinics' which should also reduce multiple journeys.
- An Advanced Pre-Operative Assessment Unit will be introduced to enable smooth running of elective interventional services
- A Coordinated Theatre Complex will be developed at the HGH to improve surgical throughput and complement an enhanced Elective Care Centre.

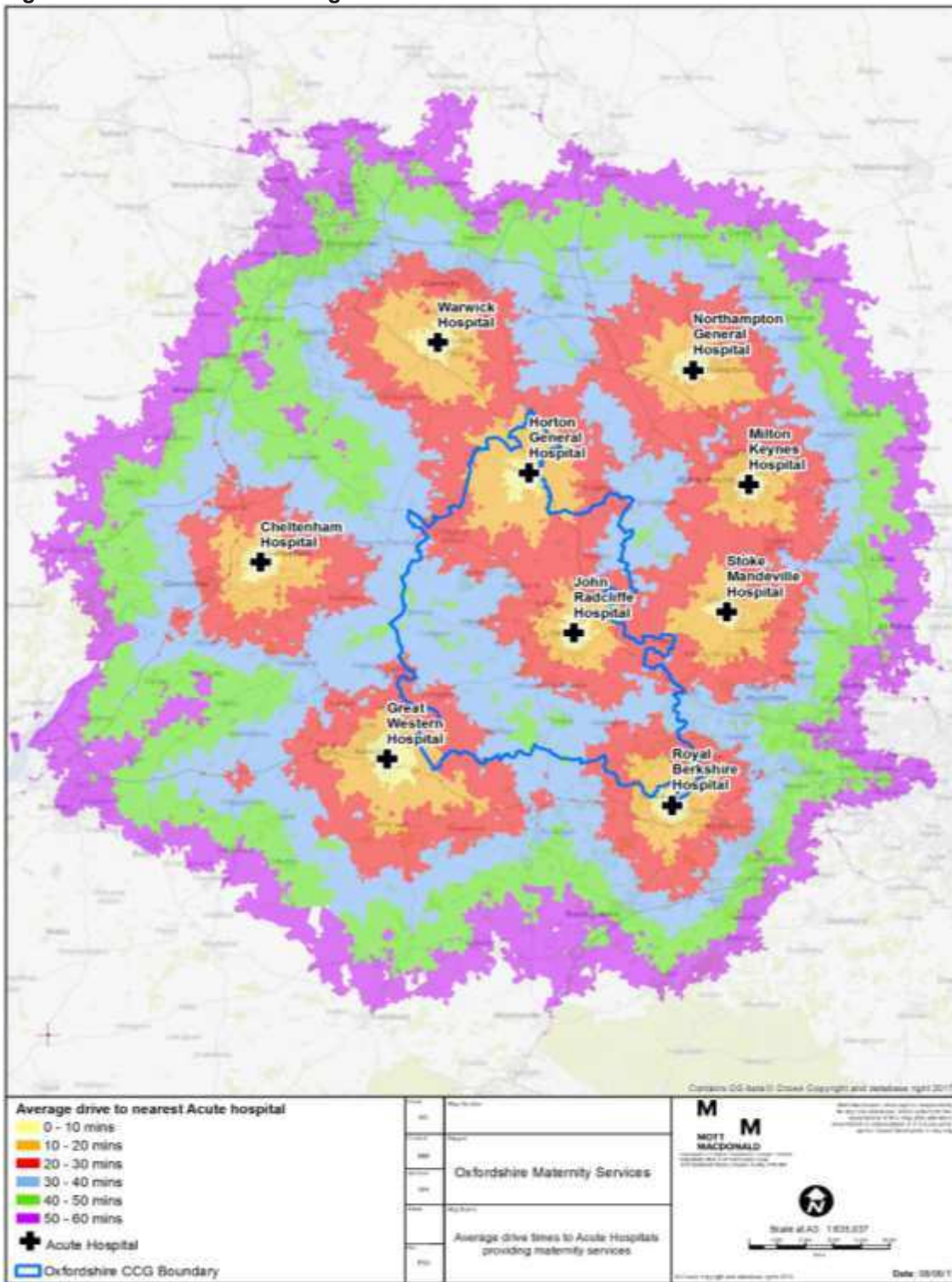
It has been estimated that there will be a 16.25 per cent increase from 2016/17-2020/21 in diagnostics.⁶⁵

⁶⁵ PCBC

C. Travel analysis heat maps

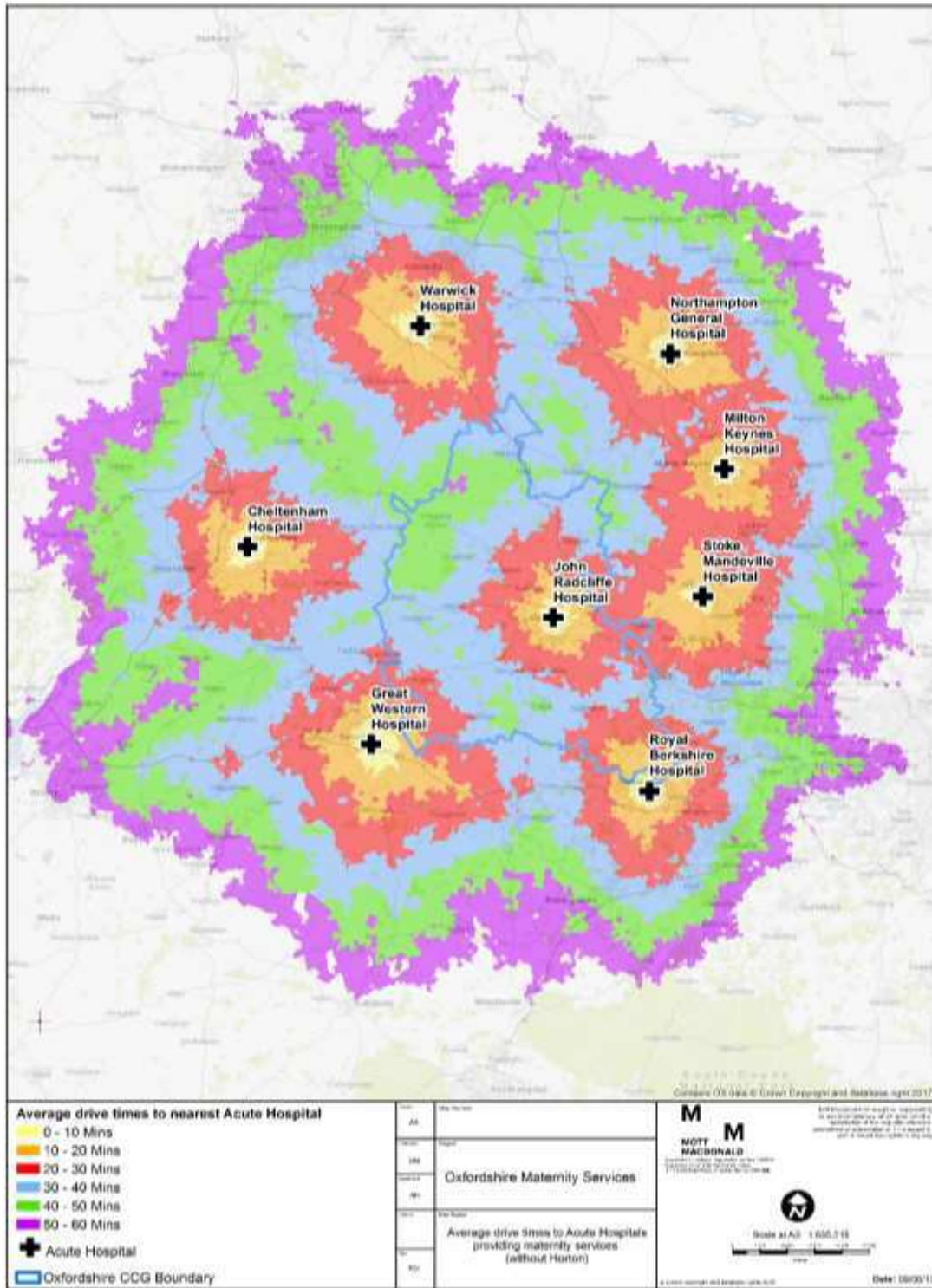
Transport accessibility plots are provided in the form of heat maps. These are produced from accessibility planning software which takes account of observed road speeds, public transport networks and the service locations (hospital sites) to create isochrones (areas of equal travel time). Once added to base mapping these highlight the travel time to access the service based on the site configuration in each assessed option for each transport mode. It is important to note that the model uses historic observed speed data and public transport timetables and therefore it is to be used as a snapshot for each travel mode and does not represent all potential journey's. Individuals may experience different travel durations.

Figure 8: Private vehicle average times with Horton



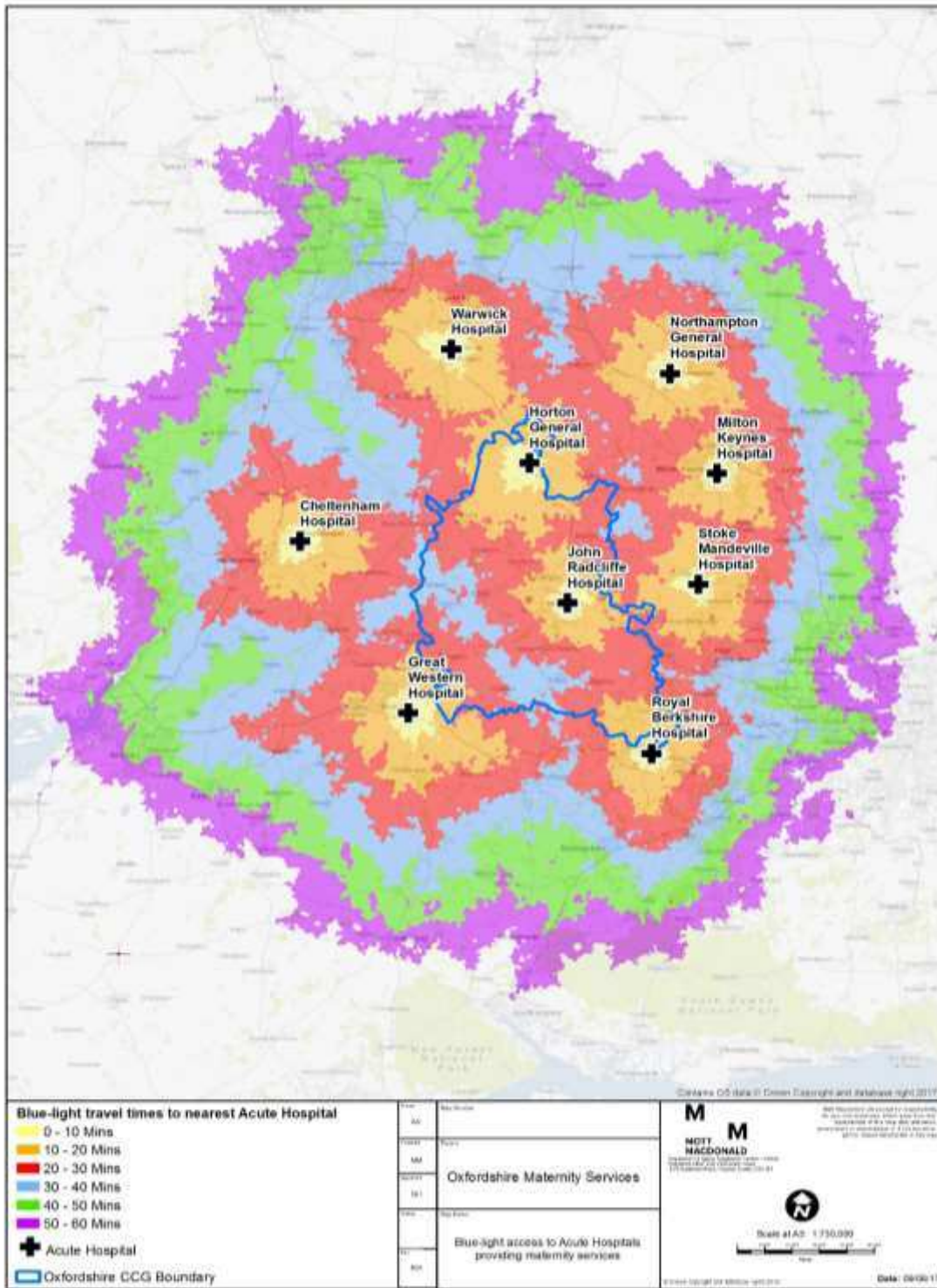
Source: Data provided by the CSU

Figure 9: Private vehicle average times without Horton



Source: Data provided by the CSU

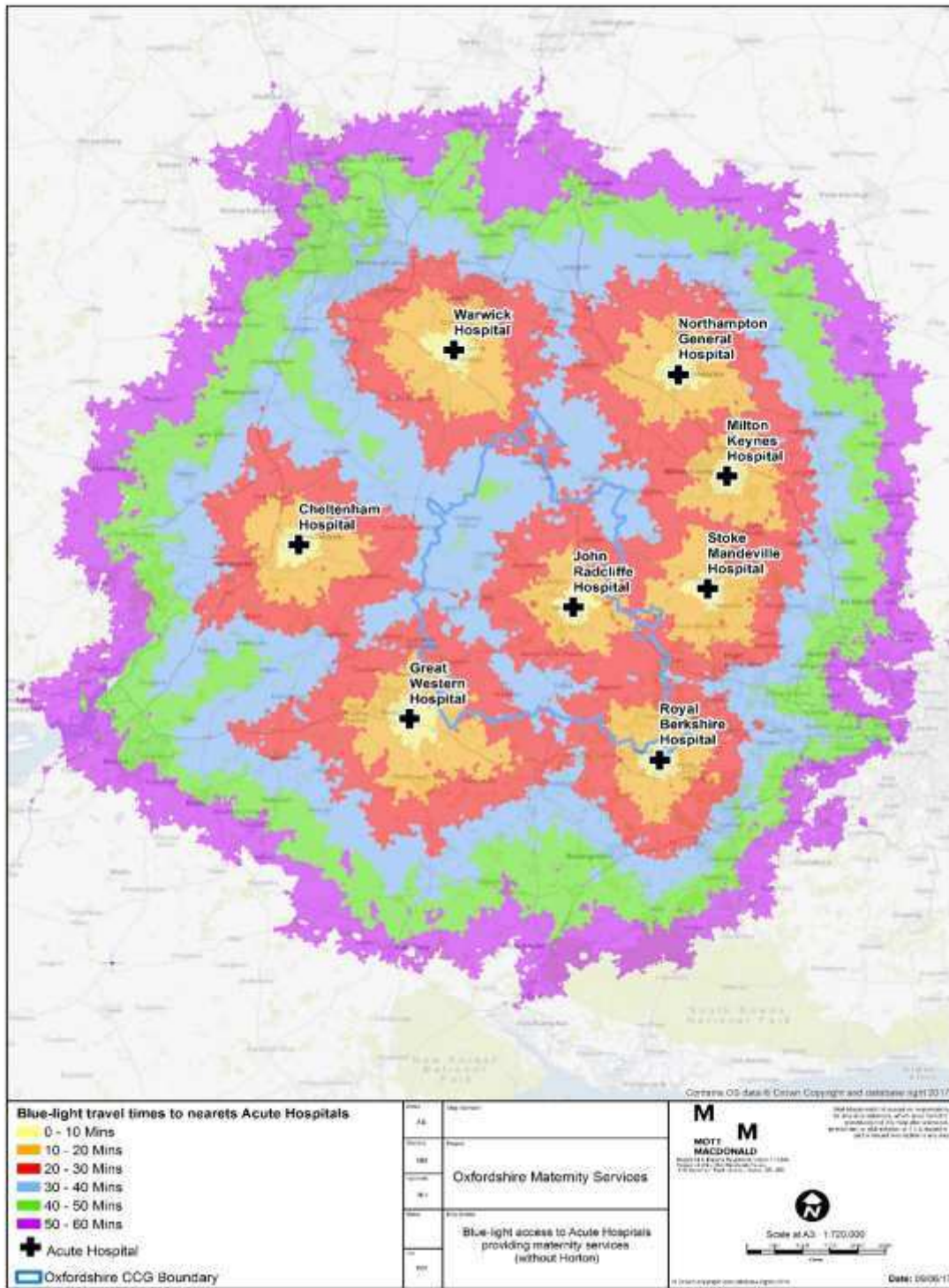
Figure 10: Blue light access with Horton⁶⁶



Source: Data provided by the CSU

⁶⁶ Modelling has been done on the basis of pick up to destination both at non peak and peak times.

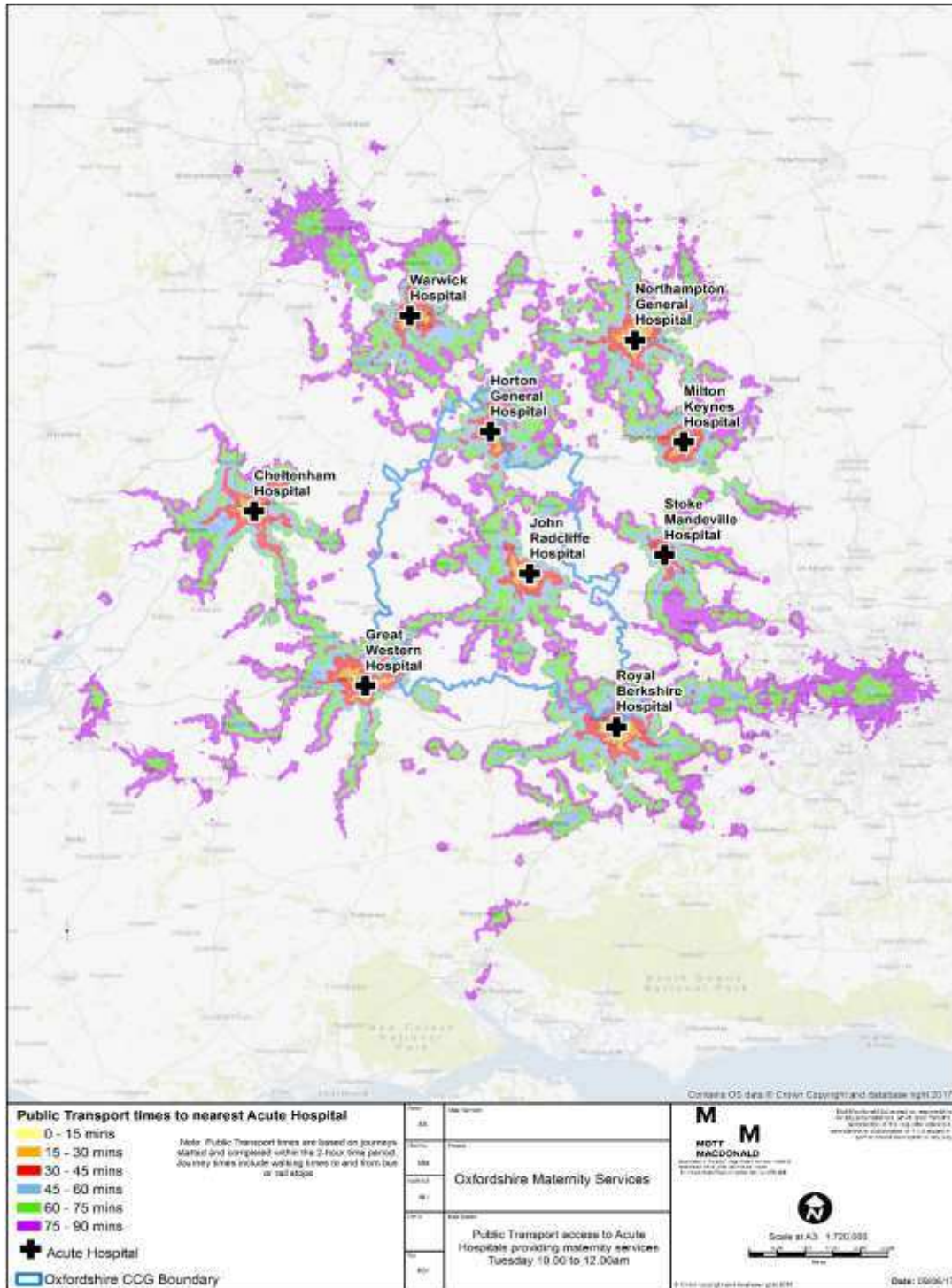
Figure 11: Blue light access without Horton⁶⁷



Source: Data provided by the CSU

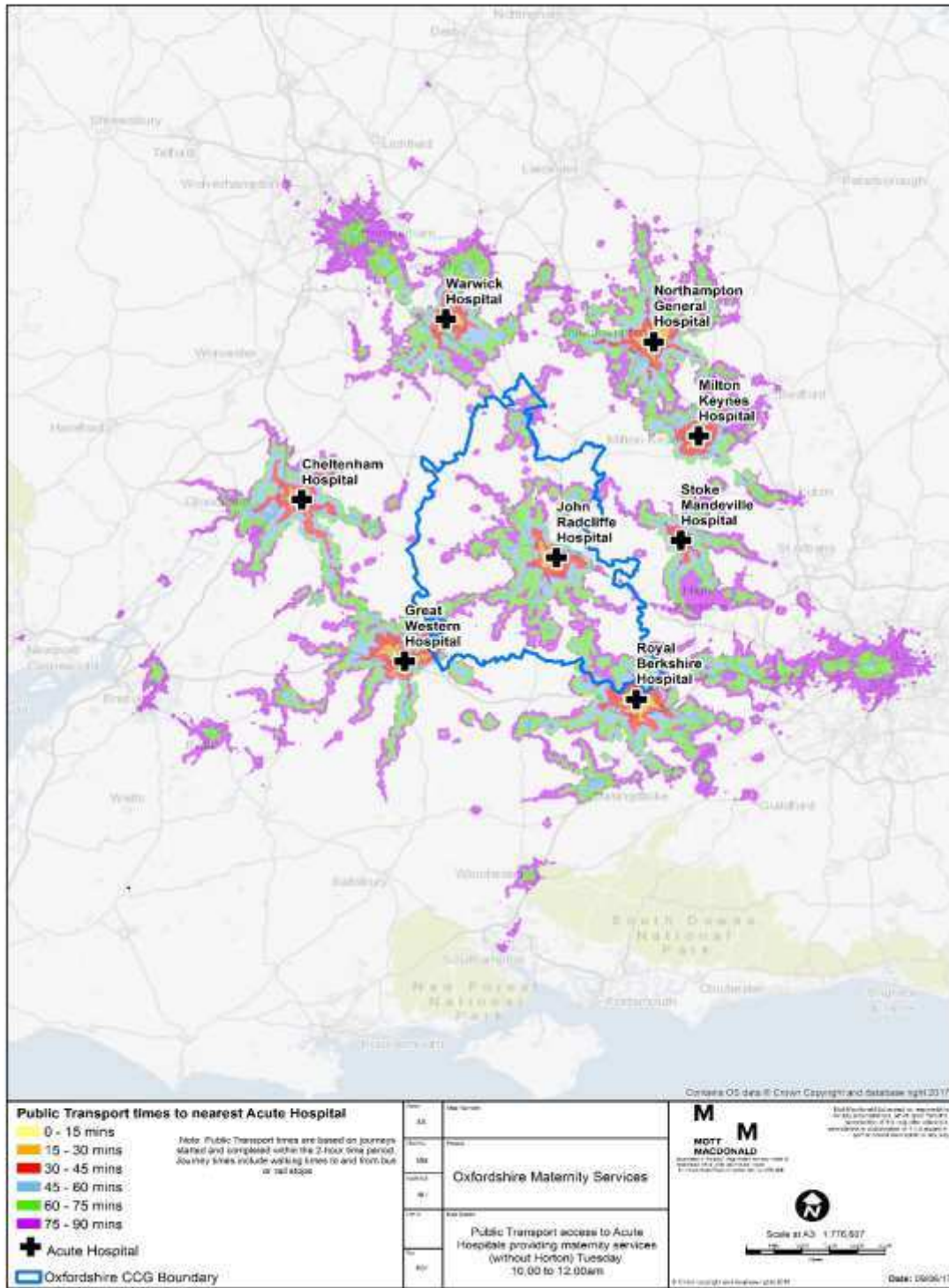
⁶⁷ Modelling has been done on the basis of pick up to destination both at non peak and peak times.

Figure 12: Public transport Tuesday 10am-12am with Horton – (e.g. access to antenatal services)



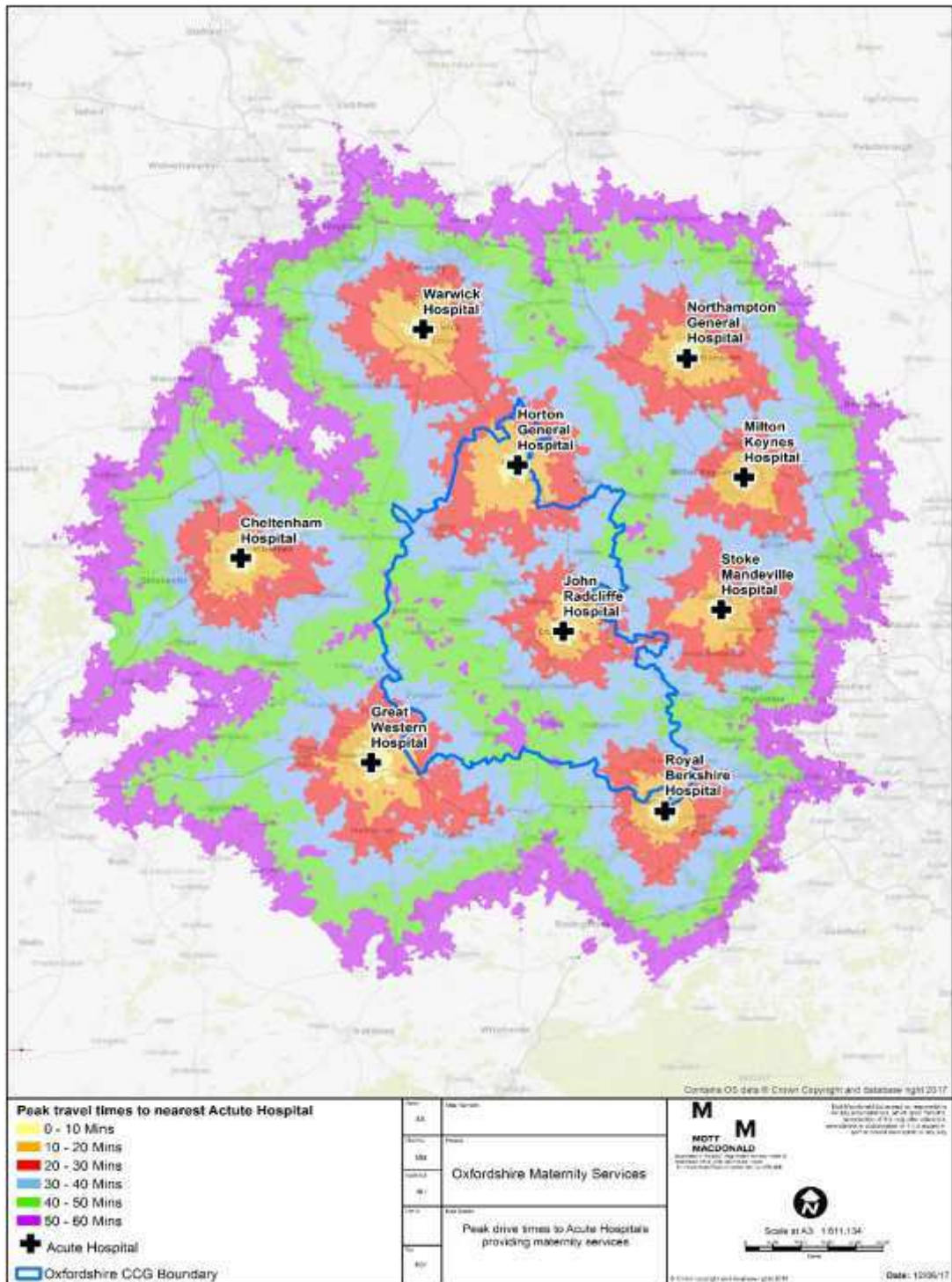
Source: Data provided by the CSU

Figure 13: Public transport Tuesday 10am-12am without Horton – (e.g. access to antenatal services)



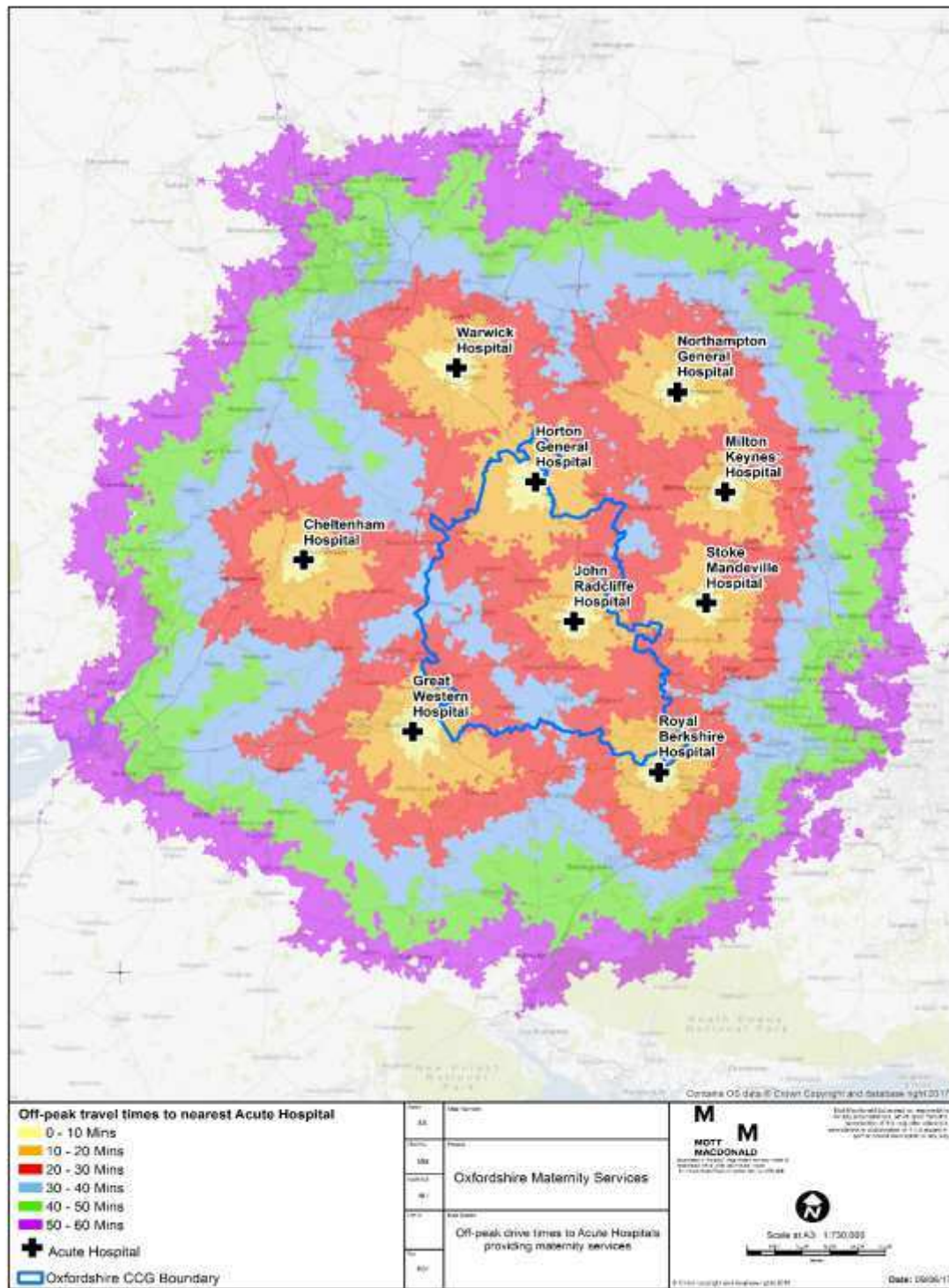
Source: Data provided by the CSU

Figure 14: Private vehicle peak times with Horton



Source: <Insert Notes or Source>

Figure 15: Private vehicle off-peak times with Horton



Source: Data provided by the CSU

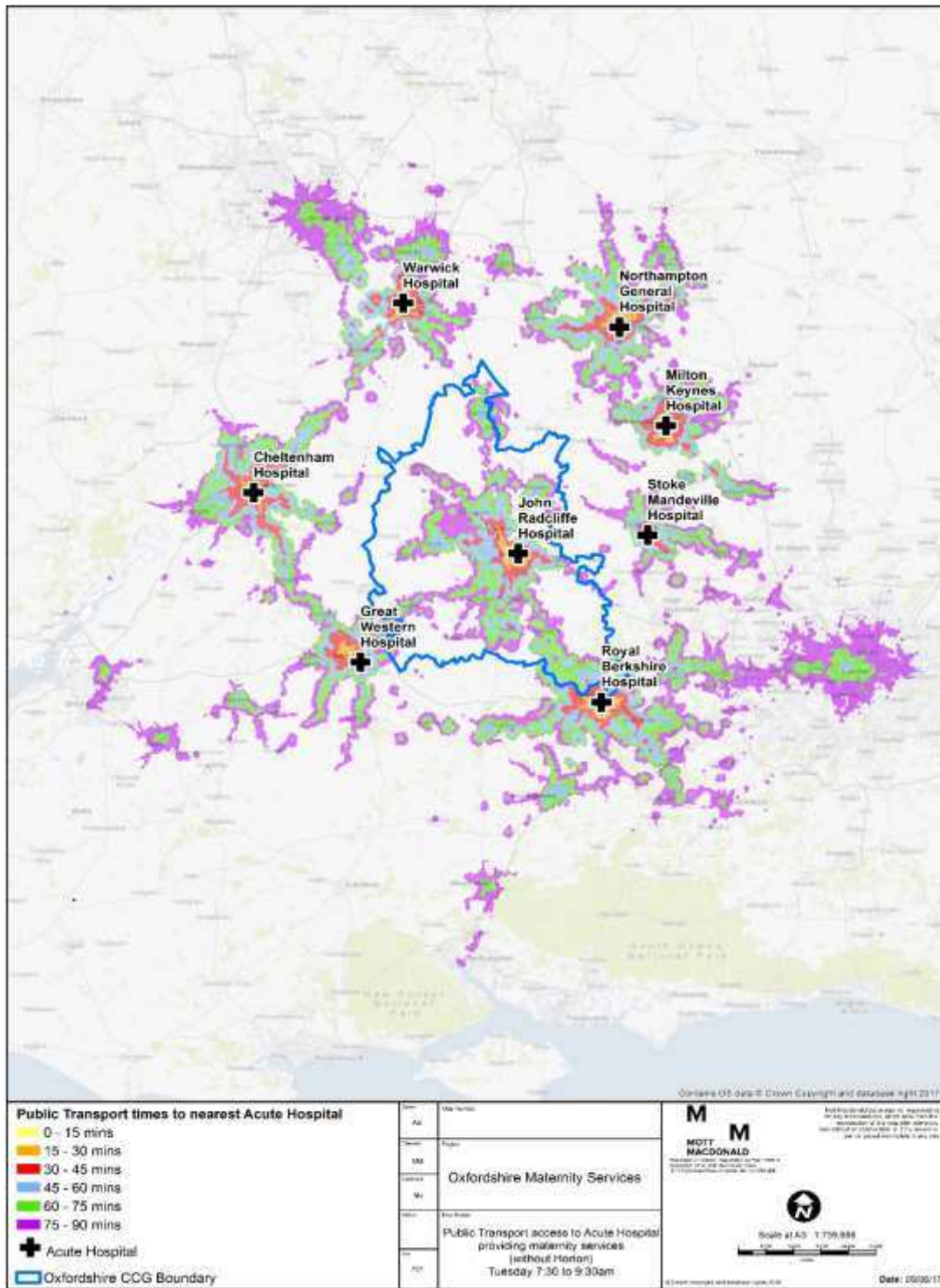
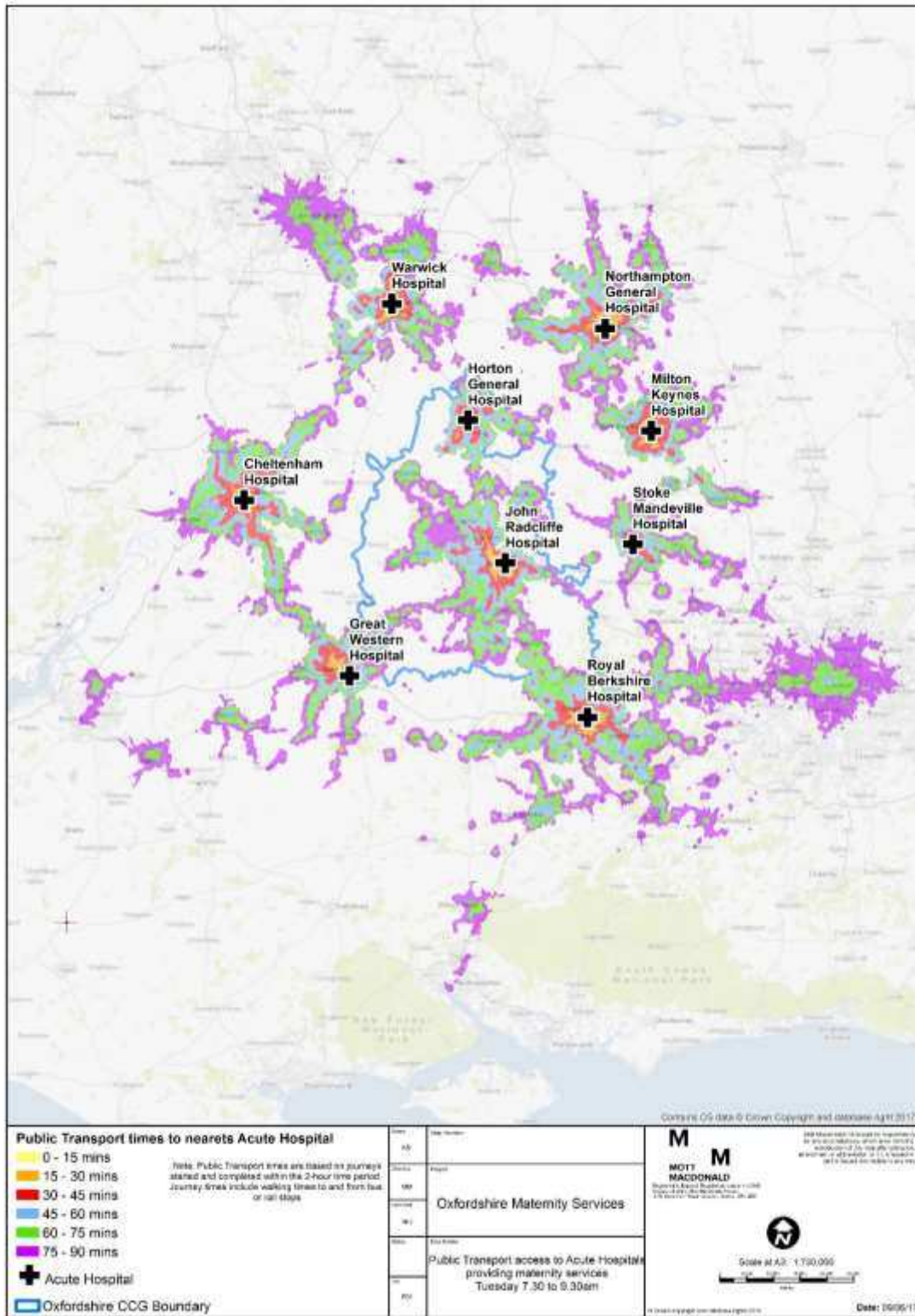
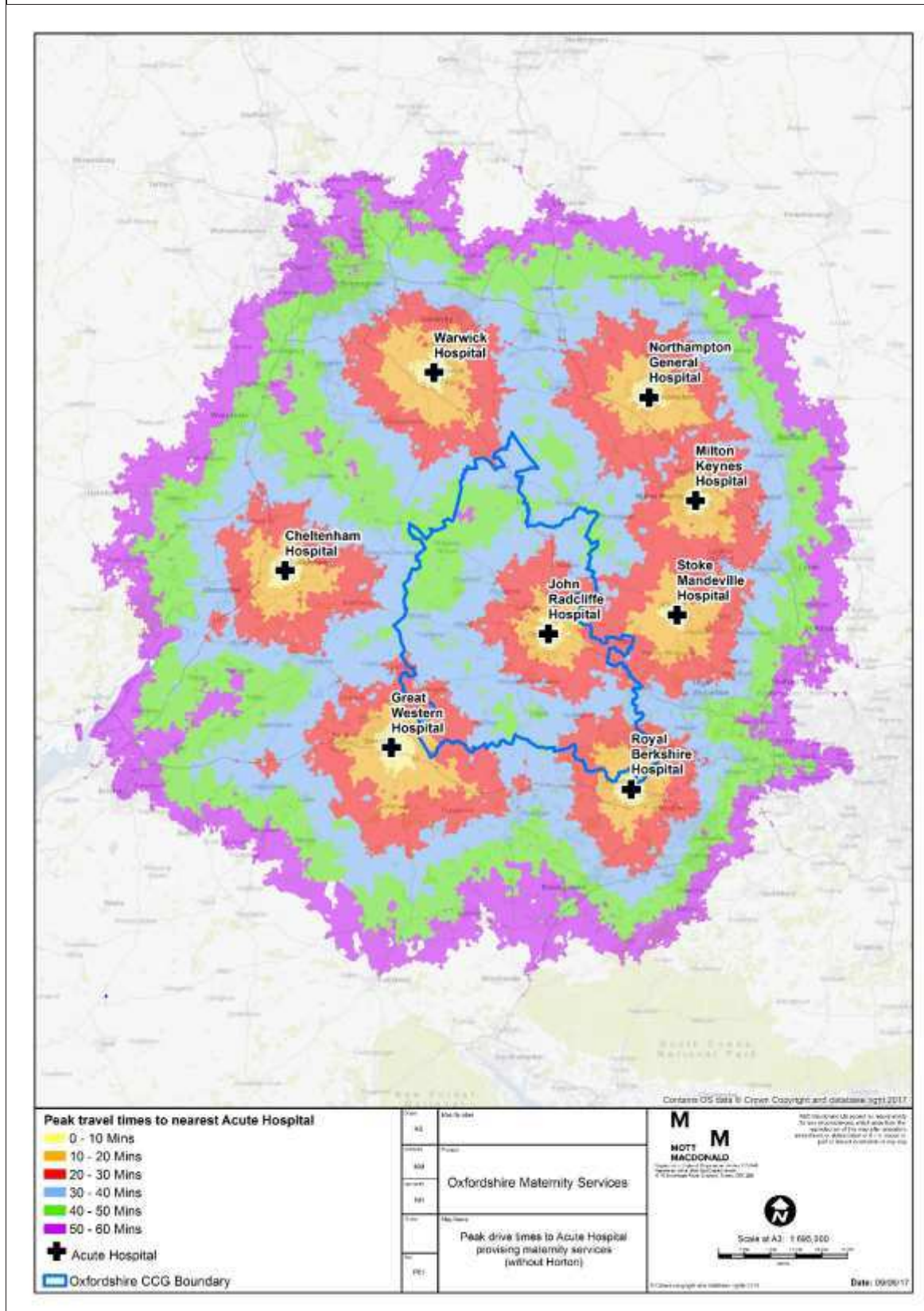


Figure 17: Public transport Tuesday 7.30-9.30 without Horton
Figure 16: Public transport Tuesday 7.30-9.30 with Horton



Data provided by the CSU

Figure 18: Private vehicle peak times without Horton



D. Equality chapter of the scoping report

This section of the report considers each of the nine 'protected characteristic' groups as defined by the Equality Act 2010, as well as considering deprived communities.⁶⁸ These groups are:

- Age (specifically children and older people)
- Deprived communities
- Disability
- Gender reassignment
- Marriage and civil partnership
- Pregnancy and maternity
- Race and ethnicity
- Religion and belief
- Sex
- Sexual orientation

For each group, a summary table is presented identifying whether and which services the group has is considered to have a disproportionate need (that is a need which is above the general population) or a differential need (that is a need which differs from the general population). Please note that we have not provided analysis on the equality impacts of the proposed changes to the delivery of Level 3 critical care. This is because of the dependency of other clinical services currently being delivered at the HGH which will require access to Level 3 critical care. These clinical specialities (such as complex theatre) are not included in Phase One of the Oxfordshire Transformation Programme and will be considered in the IIA of Phase Two. Services have been categorised into following:

- Ambulatory care
- Stroke services
- Maternity
- Planned Care services. *(Please note that we have included a number of clinical specialities in the evidence base below on the assumption that elective surgery will also require the use of Planned Care services prior to surgery).*

For each group, where possible, density maps and population tables are provided. The population for the whole study area and national figures are also provided to act as a comparator.

⁶⁸ Although not included as a protected characteristic under equality legislation, it is accepted best practice to review potential impacts on deprived communities in health service IIAs due to the well-established links between deprivation and poorer health outcomes.

D.1 Age: Children (16 and under)

Evidence of disproportionate need has been identified for the following service areas.

Table 23: Scoped in services –children (16 and under)

Service area	Evidence of disproportionate need	Evidence of differential need
Ambulatory care		
Maternity		
Planned Care services	✓	
Stroke services		

Source: Mott MacDonald

D.1.1 Planned Care services

D.1.1.1 Ear nose and throat (ENT) services

ENT services are commonly required by children. For example, tonsillitis is a condition most common in children aged three to seven, as children have larger tonsils than adults and older children.⁶⁹

Adenoids are small lumps of tissue at the back of the nose, above the roof of the mouth. They are part of the immune system, which helps fight infection and protects the body from bacteria and viruses. Adenoidectomy is sometimes required for children who experience breathing or sleeping problems or recurrent problems with the ears occur.⁷⁰

D.1.1.2 Plastic surgery

There are certain conditions experienced predominantly by children which require plastic surgery treatment. This is likely to take place in childhood. Examples of these conditions include cleft lips (and other craniofacial birth defects), hand defects, blood vessel malformations, and skin / tissue defects.^{71 72 73 74}

D.1.1.3 Respiratory services

Asthma is a common long term condition that often starts in childhood.⁷⁵ Around one in 11 children are currently receiving treatment for asthma, compared to around one in 12 adults.⁷⁶ Respiratory conditions account for 50% of long term illnesses in children⁷⁷, suggesting that long term management care for these types of illnesses is likely to be higher for children.

⁶⁹ NHS (2015): 'Tonsillitis'.

⁷⁰ NHS (2016): 'Adenoids and adenoidectomy'.

⁷¹ NHS (2016): 'Cleft lip'.

⁷² NHS (2014): 'Craniosynostosis'.

⁷³ The British Society for Surgery of the Hand (date unknown): 'Congenital hand conditions'. See: http://www.bssh.ac.uk/patients/congenital_hand_conditions.aspx

⁷⁴ GOSH (2016): 'Haemangiomas'.

⁷⁵ NHS Choices (2016) 'Asthma'

⁷⁶ Asthma UK (date unknown) 'Asthma facts and statistics' and 'Diagnosing asthma in adults'

⁷⁷ NHS England (2014) 'NHS standard contract for paediatric medicine: respiratory'

D.1.1.4 Urology services

There are some urological conditions that are more common to children, with many requiring surgical intervention. These include hypospadias, bladder reconstruction, sex differentiation disorders, and childhood genitourinary tract cancers.⁷⁸

D.1.2 Demographic profile

The table below shows that within Oxfordshire CCG, the number of 16 year olds is broadly in line with the national average

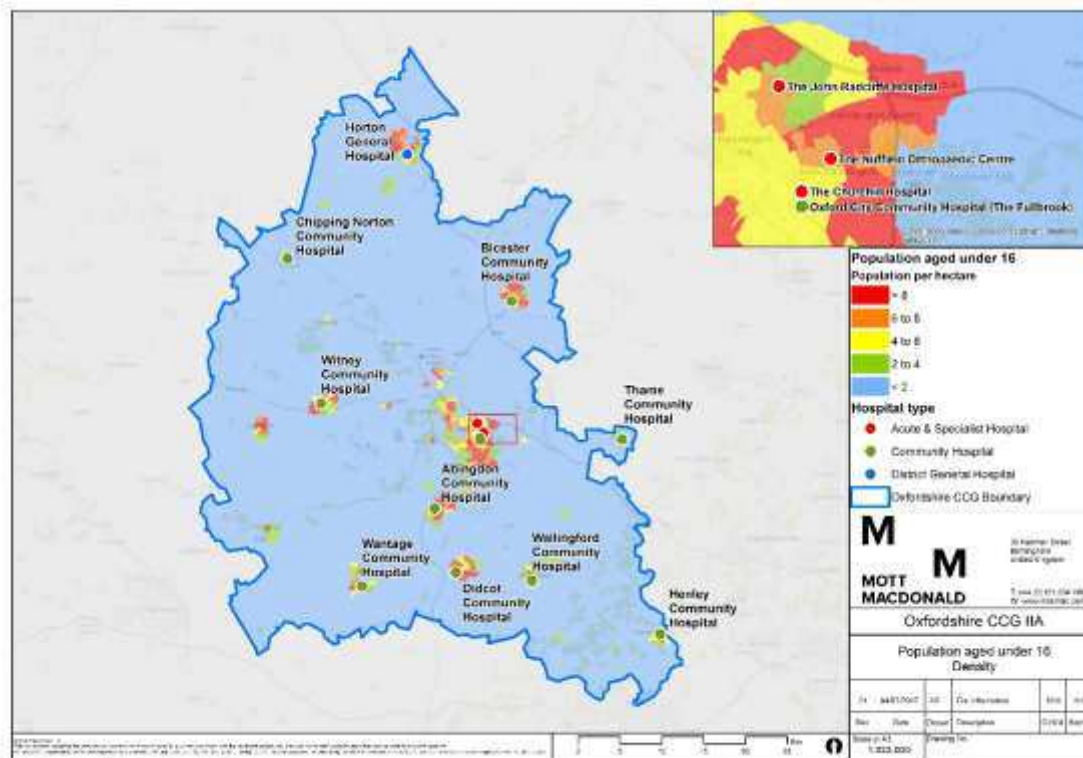
Table 24: Age (Children under the age of 16)

Study area	Total population	Under 16	Under 16 (%)
Oxfordshire CCG	663,556	138,648	21%
England	54,786,327	11,677,856	21%

Source: 2015 mid-year estimates

Figure 21 below shows that the highest densities of those aged under 16 match with urban centres, with a particular concentration around Oxford.

Figure 20: Population under 16



Source: 2015 mid- year estimates

⁷⁸ The British Association of Urological Surgeons (date unknown): 'Patients: gender information. Paediatrics'. See: <http://www.baus.org.uk/patients/information/paediatrics.aspx>

D.2 Age: Older people (65 and over)

Evidence of disproportionate and differential need has been identified for the following service areas:

Table 25: Scoped in services – age: older people (65 and over)

Service area	Evidence of disproportionate need	Evidence of differential need
Ambulatory care	✓	
Maternity		
Planned Care services	✓	
Stroke services	✓	

Source: Mott MacDonald

D.2.1 Ambulatory care

D.2.1.1 Abdominal pain

Inguinal hernias, a common reason for admission for abdominal pain, occur when fatty tissue or a part of the bowel, such as the intestine, pushes through the groin at the top of the inner thigh.⁷⁹ Older people disproportionately suffer from inguinal hernias as the muscles surrounding their abdomen weaken over time.⁸⁰

Gastric ulcers, also known as stomach ulcers, are open sores that develop on the lining of the stomach.⁸¹ Stomach ulcers mostly occur in people aged 60 or over.⁸²

D.2.1.2 Deep Vein Thrombosis (DVT)

DVT is a blood clot that develops within a deep vein in the body, typically in the leg.⁸³ DVT is usually caused by being inactive for long periods.⁸⁴ A study by Sport England showed that those who are over 65 are more likely to be inactive than those who are under 65.⁸⁵ The NHS states that DVT becomes more common as you age.⁸⁶

D.2.1.3 Simple pulmonary embolism

A pulmonary embolism (PE) occurs when the artery that carries blood to the lungs becomes blocked.⁸⁷ Pulmonary embolisms can be prevented by avoiding long periods of inactivity.⁸⁸ A study by Sport England showed that those who are over 65 are more likely to be inactive than those who are under 65.⁸⁹ Moreover, the NHS states that 'for every 10 years after the age of 60,

⁷⁹ NHS Choices (2015) 'Inguinal hernia repair'

⁸⁰ NHS Choices (2015) 'Inguinal hernia repair'

⁸¹ NHS Choices (2015) 'Stomach Ulcer'

⁸² NHS Choices (2015) 'Stomach Ulcer'

⁸³ NHS Choices (2016) 'Deep Vein Thrombosis'

⁸⁴ NHS Choices (2016) 'Deep Vein Thrombosis'

⁸⁵ Sport England (2016) 'Active Lives Survey'

⁸⁶ NHS Choices (2016) 'Deep Vein Thrombosis'

⁸⁷ NHS Choices (2015) 'Pulmonary embolism – causes'

⁸⁸ NHS Choices (2015) 'Pulmonary embolism'

⁸⁹ Sport England (2016) 'Active Lives Survey'

the risk of having PE doubles'.⁹⁰ Therefore, older people have an increased risk of pulmonary embolism.⁹¹

D.2.2 Planned Care services

D.2.2.1 Cardiovascular services

Older people are likely to have a disproportionate need for cardiovascular long term care and management services. Most serious arrhythmias (heart rhythm problems)⁹² are likely to affect people older than 60, as older adults are more likely to have heart disease and other health problems.⁹³

D.2.2.2 Dermatology services

People with venous leg ulcers can develop rashes with scaly and itchy skin, often due to varicose eczema. The prevalence of venous leg ulcers increases markedly with age; people aged over 85 are sixteen times more likely to have venous leg ulcers compared to the general population and may require the treatment of a dermatologist for example where the ulcer fails to progress after three months, there is suspected malignant change or there is suspected contact allergic dermatitis.^{94 95}

D.2.2.3 Diabetes services

Older people are likely to have a disproportionate need for long term care and management services in relation to diabetes. Evidence from Public Health England shows that 14.3% of people aged 55-74 years and 16.5% of those aged over 75 years are estimated to have diabetes.⁹⁶ In comparison, it is estimated that less than 2% of people aged 16-34 years have diabetes.⁹⁷

D.2.2.4 ENT services

Over one quarter of people over 65 have a hearing impairment, which raises to one third in people over 75. There are also some conditions which are more common in older people for example vestibular imbalance and tinnitus requiring treatment within ENT services.⁹⁸

D.2.2.5 Musculoskeletal services

Conditions which require musculoskeletal services are more likely to occur in older people. For example, osteoporosis affects around 50% of people over the age of 75.⁹⁹ Another rheumatic condition which commonly affects older people is osteoarthritis; this affects joints within the knee, hip, foot, ankle, hand and wrist. In addition to this, cases of rheumatoid arthritis (the most common inflammatory joint disorder) in the UK are more frequent among those who are 75 years and over, followed by those who are aged between 64-74 years¹⁰⁰.

⁹⁰ National Heart, Lung and Blood Institute (2011) 'Who Is at Risk for Pulmonary Embolism'

⁹¹ NHS Choices (2015) 'Pulmonary embolism – causes'

⁹² British Heart Foundation (date unknown) 'Abnormal heart rhythms'

⁹³ National, Heart, Lung and Blood Institute (2011) 'Who Is at Risk for an Arrhythmia?'

⁹⁴ Primary care dermatology society, (2012). Clinical guidance leg ulcers

⁹⁵ Nursing times (2015) The burden of chronic wounds in the UK

⁹⁶ Public Health England (2014) 'Adult obesity and type 2 diabetes'

⁹⁷ Public Health England (2014) 'Adult obesity and type 2 diabetes'

⁹⁸ Tucci, D et al., (date unknown): 'Effects of aging on the Ears, Nose and Throat'.

⁹⁹ Age UK (2017) 'Osteoporosis>Could you be at risk?'

¹⁰⁰ Arthritis Research UK (date unknown) 'Rheumatoid Arthritis'

D.2.2.6 Ophthalmology services

Age-related macular degeneration is an eye condition that causes the loss of central vision, usually in both eyes. Age related macular degeneration is by far the leading cause of blindness in adults. One in five people aged 75 and over live with sight loss, which raises to half of people aged 90 and over.¹⁰¹

Glaucoma is an eye condition where the optic nerve, which connects the eye to the brain, becomes damaged. It can lead to loss of vision if not detected and treated early on. Glaucoma becomes more likely as people's age increases and the most common type affects around 1 in 10 people over 75.¹⁰²

D.2.2.7 Plastic surgery

As rates of cancer and infections are higher among older people, there is likely to be a higher need for plastic surgery procedures to deal with the impacts of these illnesses. For example, as 65% of people with cancer are over 65 it is likely that procedures such as the removal of malignant tumours and benign lesions of the skins, and the rate of reconstruction surgery is going to be higher among older people.¹⁰³

D.2.2.8 Urology services

Benign prostatic hyperplasia is an enlarged prostate gland. Benign prostatic hyperplasia is very common in older men and requires urological treatment.¹⁰⁴ Over 50% of men in their 60s and nearly all men in their 70s are believed to suffer some symptoms of an enlarged prostate.¹⁰⁵

Older adults are more prone to develop urinary tract infections (UTIs) than younger individuals. This is due to a number of reasons: incomplete bladder emptying (e.g. due to prostate enlargement), increased susceptibility to infection due to frailty and higher risk of catheter use.¹⁰⁶

D.2.3 Stroke services

There is a high demand for stroke services within this age group. Three quarters of strokes in the UK occur in people aged 65 or older, in comparison to 18% of the population who are 65 or over.¹⁰⁷ Further evidence states that more than half of all people over the age of 75 have high blood pressure, which contributes towards 54% of strokes.¹⁰⁸ The regularity with which strokes occur in this age bracket show that they are likely to experience a disproportionate impact of any change in this service.

¹⁰¹ RNIB (date unknown): 'Key information and statistics'. See: <http://www.rnib.org.uk/knowledge-and-research-hub/key-information-and-statistics>

¹⁰² NHS Choices (2016). 'Glaucoma'

¹⁰³ Royal College of Surgeons (date unknown): 'Plastic and reconstructive'. See: <https://www.rcseng.ac.uk/news-and-events/media-centre/media-background-briefings-and-statistics/plastic-and-reconstructive/>

¹⁰⁴ NHS (date unknown): 'Benign prostate enlargement'. See: <http://www.nhs.uk/conditions/Prostate-enlargement/Pages/Introduction.aspx>

¹⁰⁵ ProstateHealth UK (date unknown): 'Facts about enlarged prostate'. See: <https://www.prostatehealthuk.com/prostate-cancer-information/enlarged-prostate-bph>

¹⁰⁶ Woodford H J, George J, (2011). Diagnosis and management of urinary infections in older people

¹⁰⁷ Stroke Association (2015) 'Stroke Statistics'

¹⁰⁸ Stroke Association (date unknown)

D.2.4 Demographic profile

The table below shows that within the study area the population aged 65 and over is broadly in line with the national average (17% compared to 18%).

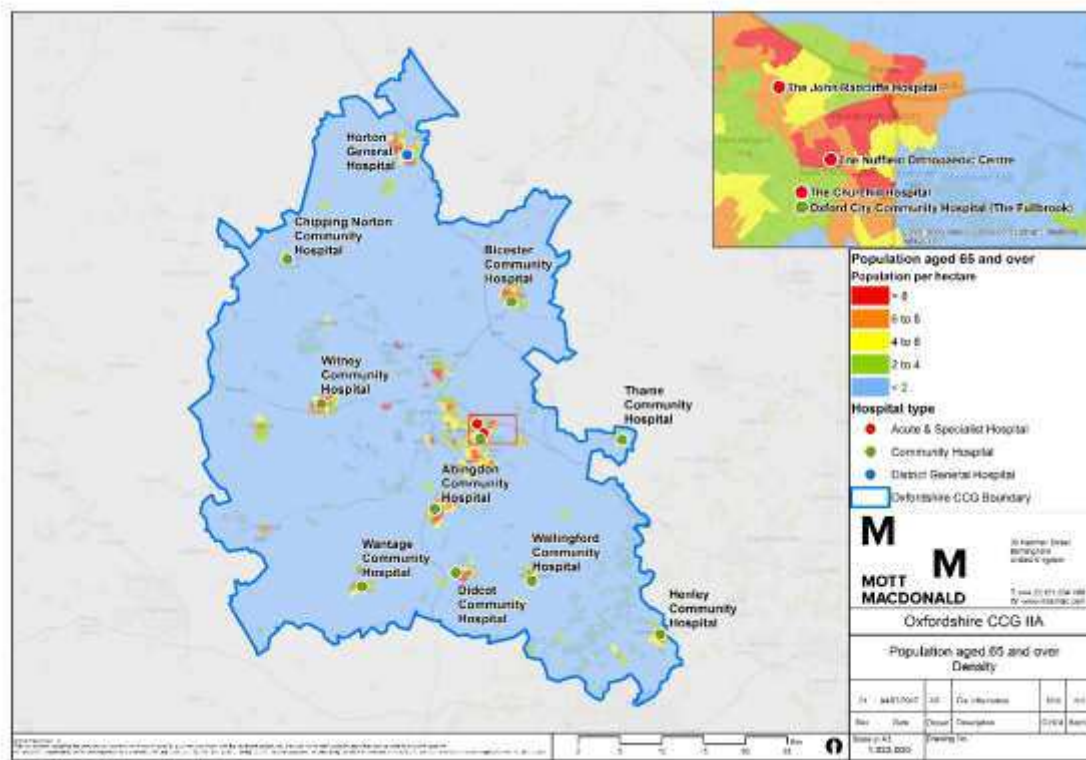
Table 26: Age (older people, 65 and over)

Study area	Total population	Aged 65 and over	Aged 65 and over (%)
Oxfordshire CCG	663,566	115,613	17%
England	54,786,327	9,711,572	18%

Source: 2015 mid-year estimates

Figure 22 shows that the highest densities of population aged 65 and over are found in urban centres, with a particular concentration around Oxford and Banbury. Small areas of high density can be found around Witney, Didcot and Wallingford.

Figure 21: Population aged 65 and over



Source: 2015 mid year estimates

D.3 Disabled people

Evidence of disproportionate need has been identified for the following service areas.

Table 27: Scoped in services – disabled people

Service area	Evidence of disproportionate need	Evidence of differential need
Ambulatory care		
Maternity		
Planned Care services	✓	
Stroke services	✓	

Source: Mott MacDonald

D.3.1 Planned Care services

D.3.1.1 Dermatology services

Psoriasis is a skin condition which is particularly common in people who have HIV. Psoriasis is also more complicated for those with HIV as the treatment for it tends to include immunosuppressive drugs; which are likely to put someone with HIV at even greater risk of an infection.¹⁰⁹

People with certain disabilities and long term conditions can also have skin problems due to their treatments. This is especially common when treatment includes drugs that suppress a persons immune system such as anti-epileptics, cancer therapies and radiotherapy, or transplants - due to the drugs given to prevent transplant rejection.^{110 111}

D.3.1.2 Diabetes services

People with mental health disorders are at increased risk of developing diabetes; this has been observed in depression, schizophrenia.¹¹² Rates of depression in people with type 1 and type 2 diabetes are three times and twice higher than those in the general population, respectively.¹¹³ Those who have bipolar illness, depression or are receiving treatment with antipsychotic medication are more at risk of developing type 2 diabetes.¹¹⁴

D.3.1.3 ENT services

People who are deaf are disproportionate users of ENT services in comparison to those without hearing impairments, for both management and treatment of their conditions. ENT services also provide cochlear implants, which enable the profoundly deaf people to gain a sense of hearing for the first time.¹¹⁵

D.3.1.4 Musculoskeletal services

People with learning disabilities have increased risk factors associated with osteoporosis and are likely to have a disproportionate need for MSK services. People with learning disabilities

¹⁰⁹ Roland J and Kim S (2016), 'What You Should Know About Psoriasis and HIV'

¹¹⁰ Barts Health NHS, (2013). Patient information: Skin care after an organ transplant Also for those who have a suppressed immune system

¹¹¹ Parliament (2013) 'Written evidence from the British Association of Dermatologists (LTC 89)'

¹¹² Kenneth M. Shaw, Michael H. Cummings, (2012). Diabetes Chronic Complications

¹¹³ Chris Garrett and Anne Doherty, (2014). Diabetes and mental health

¹¹⁴ Diabetes UK (2017) 'Diabetes risk factors'

¹¹⁵ Royal College of Surgeons (date unknown): 'Ear, nose and throat'. See: <https://www.rcseng.ac.uk/news-and-events/media-centre/media-background-briefings-and-statistics/ear-nose-and-throat/>

have an increased prevalence of low bone mineral density.¹¹⁶ Contributory factors for this include possible lack of weight-bearing exercise and immobility, delayed puberty, entering menopause at an earlier than average age for women, poor nutrition, being underweight, use of anti-epilepsy medication and diagnosis of down's syndrome.¹¹⁷

D.3.1.5 Neurology services

More than 40% of patients with HIV develop neurological complications. Some of these are caused directly by HIV, but a number of conditions are a side effect of treatment or other conditions caused by HIV.¹¹⁸

D.3.1.6 Ophthalmology services

Adults with learning disabilities are 10 times more likely to go blind or partially sighted than the general population, and therefore are more likely to be higher users of ophthalmology services.¹¹⁹

D.3.2 Stroke services

The need for stroke services among disabled people is likely to be high. Disabled people are more likely to have atrial fibrillation (which causes irregular heartbeat) which can increase the risk of having a stroke by five times.¹²⁰

D.3.3 Demographic profile

To approximate the number of disabled people within the study area, data on population with a life-limiting long term illness (LLTI) has been used as a proxy. The table below shows that within the study area there is a lower proportion of the population who have a LLTI (14%) compared to the national average (18%).

Table 28: Disability (LLTI)

Study area	Total population	Aged 65 and over	Aged 65 and over (%)
Oxfordshire CCG	663,566	88,095	14%
England	54,786,327	9,352,586	18%

Source: 2011 Census

Figure 23 shows that the highest densities of population with a LLTI are in urban centres, with a particular concentration around Oxford.

¹¹⁶ Srikanth, R., Cassidy, G., Joiner, C. and Teeluckdharry, S. (2010). Osteoporosis in people with intellectual disabilities: a review and a brief study of risk factors for osteoporosis in a community sample of people with intellectual disabilities.

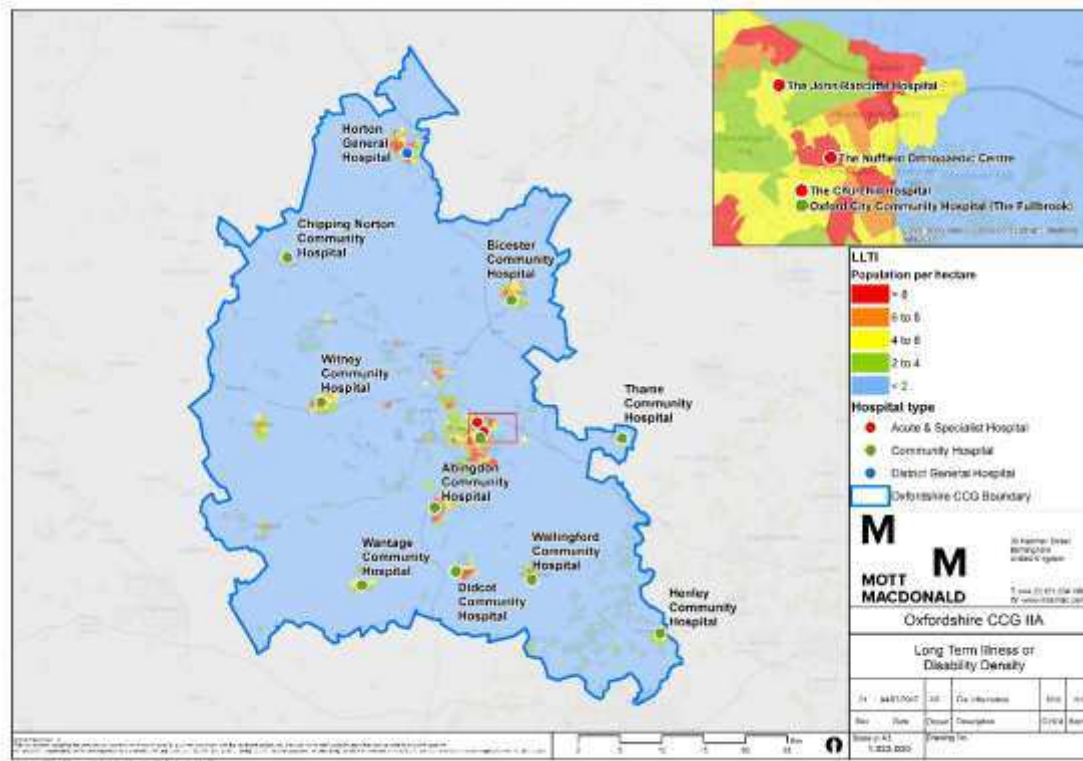
¹¹⁷ Emerson et. Al (2012) 'Health inequalities and People with Learning Disabilities in the UK'

¹¹⁸ Singh, R., Kaur, M., & Arora, D. (2011). Neurological complications in late-stage hospitalized patients with HIV disease.

¹¹⁹ RNIB (date unknown): 'Key information and statistics'. See: <http://www.rnib.org.uk/knowledge-and-research-hub/key-information-and-statistics>

¹²⁰ Stroke Association (2012) 'Stroke statistics'

Figure 22: Population with an LLTI



Source: 2011 census

D.4 Sex

Evidence of disproportionate and differential need has been identified for the following service areas.

Table 29: Scoped in services – Gender

Service area	Evidence of disproportionate need	Evidence of differential need
Ambulatory care	✓	
Maternity	✓	
Planned Care services		✓
Stroke services		✓

Source: Mott MacDonald

D.4.1 Ambulatory care

D.4.1.1 Abdominal pain

Inguinal hernias, a common reason for admission for abdominal pain, are more common in men than in women .¹²¹ This is due to the higher potential for a weakened inguinal canal.¹²²

¹²¹ NHS Choices (2015) 'Hernia'

¹²² Healthline (2017) 'Hernia'

D.4.1.2 Deep Vein Thrombosis

Women who take hormone therapy pills or birth control pills are at increased risk of DVT.¹²³

D.4.2 Maternity

By the very nature of these service areas, women of childbearing age (16-44 years old) will experience a disproportionate need. Evidence has shown that in recent years, more women in Oxfordshire are having children at an older age: in 2015, 406 women gave birth over the age of 40, this follows the national trend.¹²⁴

D.4.3 Planned Care services

Men and women have a disproportionate need for the different Planned Care services under review.

D.4.3.1 Dermatology services

Melasma, also called 'chloasma' and 'pregnancy mask', in which light to dark brown or greyish patches of pigmentation develop mainly on facial skin. 90% of the cases of melasma are in women.¹²⁵ Treatments for the condition include chemical peels, dermabrasion, and laser treatment, meaning a potential differential need for dermatology services.¹²⁶

D.4.3.2 Diabetes services

The National Diabetes Audit, in 2012 found that 56% of all adults with diabetes in the UK are men in comparison to 44% of women.¹²⁷ This highlights a potential disproportionate need amongst men for diabetes services. Research has highlighted that men are more biologically susceptible than women to develop the condition.¹²⁸

D.4.3.3 ENT services

Men are twice as likely to require treatment for certain conditions, such as obstructive sleep apnoea (OSA), that are treated by ENT services.¹²⁹ This is likely to be related to different patterns of body fat distribution and having a larger neck size. Treatment options for OSA include lifestyle changes, using a continuous positive airway pressure device, or wearing a mandibular advancement device.¹³⁰ These treatments mean that men are more likely to need ENT services.

There are also some conditions that women are more likely to require ENT services for than men, such as Meniere's disease, otitis externa and thyroid disorders.¹³¹ This indicates a potential differential need for ENT services.

¹²³ National Heart, Lung and Blood Institute (2011) 'Who Is at Risk for Pulmonary Embolism'

¹²⁴ JSNA Annual Report (2016): 'Oxfordshire'

¹²⁵ British Association of Dermatologists (2015): 'Melasma'. See: <http://www.bad.org.uk/for-the-public/patient-information-leaflets/melasma/?showmore=1&returnlink=http%3A%2F%2Fwww.bad.org.uk%2Ffor-the-public%2Fpatient-information-leaflets#.WNOnvtJviUk>

¹²⁶ British Association of Dermatologists (2015): 'Melasma'. See: <http://www.bad.org.uk/for-the-public/patient-information-leaflets/melasma/?showmore=1&returnlink=http%3A%2F%2Fwww.bad.org.uk%2Ffor-the-public%2Fpatient-information-leaflets#.WNOnvtJviUk>

¹²⁷ Diabetes UK (2016) 'Facts and Stats'

¹²⁸ NHS (2011): 'Men develop diabetes more easily'. See: <http://www.nhs.uk/news/2011/10October/Pages/males-more-likely-to-get-diabetes.aspx>

¹²⁹ NHS (2015): 'Obstructive sleep apnoea'.

¹³⁰ NHS (2015): 'Obstructive sleep apnoea'.

¹³¹ NHS (2015): 'Meniere's disease, otitis externa, thyroid disorders'.

D.4.3.4 Gynaecology

A key service within outpatient gynaecology is screening for cervical cancer. As identified by Cancer Research UK, cervical cancer is the twelfth most common cancer among women females in the UK, accounting for around two per cent of all new cases of cancer in females. Over three-quarters (78 per cent) of cervical cancer cases occur in women aged between 25 and 64 years, however, women aged between 30-34 and 80- 84 are within the peak age specific incidence rates.¹³²

Both endometriosis and heavy menstrual bleeding (HMB) are conditions solely experienced by women. Endometriosis, a condition where tissue similar to the lining of the womb (endometrium) is found outside the womb affects about 1 in 10 women of childbearing age.¹³³ HMB is the excessive menstrual blood loss which interferes with the woman's physical, emotional, social and material quality of life, and which can occur alone or in combination with other symptoms.

For endometrial polyps, a mass in the inner lining of the uterus, increasing age also appears to be the best-documented risk indicator with prevalence increasing by age during the reproductive years. It is not clear however whether it continues to rise or decreases after menopause.¹³⁵ Cervical polyps are also common in women over 20 years who have had children.¹³⁶

Treatments and services relating to fertility are provided under the gynaecology remit of the NHS. As women age, the quality and number of their reproductive eggs deplete, the decline is more rapid over the age of 35¹³⁷ indicating that older women who still want to become pregnant are more likely to require gynaecological services relating to subfertility.

D.4.3.5 Musculoskeletal services

There is evidence to suggest that men, particularly between the ages of 40 and 50, are more likely to develop gout than women.¹³⁸ Gout impacts the joints by causing inflammatory arthritis, intermittent swelling, redness, heat, pain, and stiffness in the joints.¹³⁹

As women tend to have smaller bones than men, and around the time of menopause, the amount of oestrogen (the hormone that protects bones) decreases sharply, women are more likely to develop osteoporosis than men.¹⁴⁰ In addition to this, Rheumatoid Arthritis is the most common inflammatory arthritis, with prevalence being two to four times greater in women (1.16%) than men (0.44%).¹⁴¹

D.4.3.6 Neurology services

There are a number of neurological conditions that are more common among men that require neurological services. There are more boys born with cerebral palsy than girls. For every 100 girls with cerebral palsy, there are 135 boys with cerebral palsy.¹⁴² Motor neurone disease

¹³² Cancer Research UK website: <http://www.cancerresearchuk.org/cancer-info/cancerstats/types/cervix/incidence/>

¹³³ Liverpool Women's NHS Foundation Trust (2008): http://www.liverpoolwomens.nhs.uk/Library/our_services/gynaecology/General_Gynaecology/Endometriosis.pdf

¹³⁴ Endometriosis; NICE CKS, June 2009

¹³⁵ AAGL Practice Report: Practice Guidelines for the Diagnosis and Management of Endometrial Polyps (2012) Journal of Minimally Invasive Gynecology 19, 3–10

¹³⁶ <http://www.nlm.nih.gov/medlineplus/ency/article/001494.htm>

¹³⁷ NHS Choices (2014) 'Protect your fertility'

¹³⁸ National Institute of Arthritis and Musculoskeletal and Skin Diseases (2016) 'Gout'

¹³⁹ National Institute of Arthritis and Musculoskeletal and Skin Diseases (2016) 'Gout'

¹⁴⁰ National Osteoporosis Foundation (2017) 'What Women Need to Know'

¹⁴¹ College of Occupational Therapists (2015) 'Hand and wrist orthoses for adults with rheumatological conditions'

¹⁴² PACE (date unknown): 'Disability statistics'. See: <https://thepacecentre.org/information-centre/stats-facts/>

affects slightly more men than women.¹⁴³ Such conditions in the long term will require support of neurological services.

Some neurological conditions are more prevalent in women. For example, 65% of people living with dementia are women.¹⁴⁴ Research also suggests the proportion of women with Multiple Sclerosis (MS) is increasing and that roughly between two and three women have MS for every man with the condition.¹⁴⁵ These are both complex conditions that require neurological services, indicating that women are likely to have a differential need for these services.

D.4.3.7 Ophthalmology services

Nearly two thirds of people living with sight loss are women.¹⁴⁶ A number of factors put women at a greater risk of suffering eye conditions, including longer life expectancy, hormonal changes, and an increase prevalence of obesity. Eye problems among women often occur at an earlier stage than in men.¹⁴⁷ Thyroid eye disease is a condition that is mainly associated with an over-active thyroid / Graves disease, which is up to 10 times more likely to affect women than men.¹⁴⁸

D.4.3.8 Plastic surgery

Women who have suffered from breast cancer are high users of reconstructive plastic surgery. As one in eight women (compared with one in 870 men) will be diagnosed with breast cancer during their lifetime, the use of plastic surgery services for this purpose it likely to be higher among women.¹⁴⁹

D.4.3.9 Respiratory services

Asthma is a common long term condition that requires the need for respiratory services. In adulthood, asthma affects more females than males.¹⁵⁰ Research has shown that just over one-third of women find their asthma symptoms get worse just before or during their period.¹⁵¹ This is due to a change in the level of hormones oestrogen and progesterone.¹⁵²

D.4.3.10 Urology services

There are many conditions that women are more likely to be affected by such as problems with the pelvic floor, urinary infections, bladder prolapse, and incontinence.¹⁵³ The Urology Foundation notes that women are much more likely to get a unitary tract infection, with about

¹⁴³ NHS (2015): 'Motor neurone disease'. See: <http://www.nhs.uk/conditions/Motor-neurone-disease/Pages/Introduction.aspx>

¹⁴⁴ Alzheimer's Research UK (date unknown): 'Women and Dementia'

¹⁴⁵ MS Trust (date unknown): 'Prevalence and incidence of multiple sclerosis'. See: <https://www.mstrust.org.uk/a-z/prevalence-and-incidence-multiple-sclerosis>

¹⁴⁶ RNIB (date unknown): 'Key information and statistics'. See: <http://www.rnib.org.uk/knowledge-and-research-hub/key-information-and-statistics>

¹⁴⁷ RNIB (date unknown): 'Key information and statistics'. See: <http://www.rnib.org.uk/knowledge-and-research-hub/key-information-and-statistics>

¹⁴⁸ British Thyroid Eye Disease (2015): 'Thyroid Eye Disease'. See: <http://www.btf-thyroid.org/information/leaflets/36-thyroid-eye-disease-guide>.

¹⁴⁹ Cancer Research UK (date unknown): 'Breast cancer'. See: <http://www.cancerresearchuk.org/about-cancer/breast-cancer/treatment/surgery/breast-reconstruction/about>

¹⁵⁰ Asthma UK (2016): 'Women and Asthma'

¹⁵¹ Asthma UK (2016): 'Women and Asthma'

¹⁵² Asthma UK (2016): 'Women and Asthma'

¹⁵³ Cancer Research UK (date unknown): 'Urinary problems in women'. See: <http://www.cancerresearchuk.org/about-cancer/coping/physically/sex-hormone-symptoms/women-coping-with-hormone-symptoms/urinary-problems>.

50% of women having one during their lifetime.¹⁵⁴ This indicates that women are likely to have a differential need for urological services.

D.4.4 Stroke services

The cause of using stroke services is different for men than women. Men are at a 25% higher risk of having a stroke and at a younger age compared to women.¹⁵⁵¹⁵⁶ Men are 1.5 times more likely to have atrial fibrillation, which increases the risk of having a stroke by five times,¹⁵⁷ whilst a recent research study in England found that the risk of ischaemic stroke is more likely to be inherited by women than men.¹⁵⁸

D.4.5 Demographic profile for males and females

The table below shows that Oxfordshire is broadly in line with the national average with regard to the population proportions of males and females.

Table 30: Population of males and females

	Total population	Males	Males (%)	Females	Females (%)
Oxfordshire CCG	663,566	329,974	50%	333,592	50%
England	54,786,327	27,029,286	49%	27,757,041	51%

Source: 2015 mid-year estimates

D.5 Gender reassignment

Evidence of disproportionate need has been identified for the following service areas.

Table 31: Scoped in services – Gender re-assignment

Service area	Evidence of disproportionate need	Evidence of differential need
Ambulatory care	✓	
Maternity		
Planned Care services	✓	
Stroke services		

Source: Mott MacDonald

D.5.1 Ambulatory care

D.5.1.1 Deep Vein Thrombosis

Many transwomen are treated with oestrogen. Oestrogen therapy can cause an increased risk of thrombosis including DVT.

¹⁵⁴ The Urology Foundation (date unknown): 'Urinary tract infection'.

¹⁵⁵ Royal College of Physicians Sentinel Stroke National Audit Programme (SSNAP) (2014). How good is stroke services? First SSNAP Annual Report prepared on behalf of the Intercollegiate Stroke Working Party

¹⁵⁶ Townsend, N., Wickramasinghe, K., Bhatnagar, P., Smolina, K., Nichols, M., Leal, J., Luengo Fernandez, R., Rayner, M. (2012). Coronary heart disease statistics 2012 edition. British Heart Foundation: London

¹⁵⁷ Stroke Association (2015) 'Stroke Statistics'

¹⁵⁸ Stroke Association (2012) 'Women and Stroke'

D.5.1.2 Simple pulmonary embolism

Oestrogen therapy can cause an increased risk of thrombosis including pulmonary embolism.¹⁵⁹

D.5.2 Planned Care services

D.5.2.1 Musculoskeletal services

Trans men (female-to-male) and trans women (male-to-female) are at risk of developing osteoporosis because of the need to take hormones that change the balance of oestrogen and testosterone in the body.¹⁶⁰ After gender reassignment surgery, the level of hormones may decrease and this may also affect bone density increasing the risk of osteoporosis.¹⁶¹

D.5.2.2 Neurology services

A study by British researchers in 2016 found that men who have undergone gender re-assignment surgery (male to female conversion) had a nearly seven fold higher risk of developing MS in comparison to the general public.¹⁶² A study discovered a link between low testosterone and MS risk.¹⁶³ The link represents evidence for the potential disproportionate need for neurology services among this protected characteristic.

D.5.3 Demographic profile for gender reassignment

There is no population data on gender reassignment

D.6 Marriage and civil partnership

The evidence review does not indicate a disproportionate or differential need for this protected characteristic group for services which are part of the Oxfordshire Transformation Programme Phase 1 review.

D.7 Pregnancy and maternity

Evidence of disproportionate need for the services under review has been identified for the following service areas.

Table 32: Scoped in services – Pregnancy and maternity

Service area	Evidence of disproportionate need	Evidence of differential need
Ambulatory care	✓	
Maternity	✓	
Planned Care services	✓	
Stroke services	✓	

Source: Mott MacDonald

¹⁵⁹ The Chartered Society of Physiotherapy (2016) 'Physiotherapy treatment of transgender patients'

¹⁶⁰ National Osteoporosis Society (2014) 'Transsexual people and osteoporosis'

¹⁶¹ National Osteoporosis Society (2014) 'Transsexual people and osteoporosis'

¹⁶² Neurology Advisor (2016) "Sex Change from Male to Female May Increase Risk"

¹⁶³ Neurology Advisor (2016) "Sex Change from Male to Female May Increase Risk"

D.7.1 Ambulatory care

D.7.1.1 Deep Vein Thrombosis

During pregnancy, blood clots more easily. This is the body's way of preventing too much blood being lost during childbirth. Pregnant women are up to 10 times more likely to develop thrombosis than non-pregnant women of the same age. A clot can form at any stage of pregnancy and up to six weeks after the birth.¹⁶⁴

D.7.1.2 Simple pulmonary embolism

The NHS states that the risk of single pulmonary embolism is increased for up to six weeks after giving birth.¹⁶⁵ This is due to the hypercoagulable state of pregnancy that begins with conception, baseline levels of coagulation factors that do not return to normal until beyond 8 weeks postpartum.¹⁶⁶ There is increased venous stasis in the pelvic and lower limb veins due to the vasodilatory effects of pregnancy hormones.¹⁶⁷

D.7.2 Maternity

By the very nature of these service areas, women who are pregnant, new mothers, or breastfeeding will experience disproportionate need for this type of care - in 2016 85% of births in England were in an obstetric unit.¹⁶⁸

D.7.3 Planned Care services

D.7.3.1 Diabetes services

Gestational diabetes affects up to 5% of all pregnancies, and any pregnant women can develop gestational diabetes.¹⁶⁹ Gestational diabetes requires close monitoring, including blood sugar tests, throughout the pregnancy and therefore any changes to diabetes services may have an impact on those with gestational diabetes.

D.7.3.2 Musculoskeletal services

Women who are pregnant, new mothers (with babies under six months old), or breastfeeding may experience a disproportionate need for musculoskeletal services. Weight gain and hormonal changes in pregnancy have a huge impact on a woman's body. Pregnancy causes biomechanical and physiologic changes that may be responsible for a wide spectrum of musculoskeletal disorders in the mother.¹⁷⁰

D.7.3.3 Respiratory services

Approximately one third of asthmatic women are likely to experience a worsening of their symptoms when pregnant. This is most likely to peak at six months.¹⁷¹ Therefore asthmatic pregnant women are likely to have a disproportionate need for respiratory services.

¹⁶⁴ NHS Choices (2016) 'Deep vein thrombosis'

¹⁶⁵ NHS Choices (2015) 'Pulmonary embolism – causes'

¹⁶⁶ Simcox L, Ormesher L, Tower C and Greer I (2015) 'Pulmonary thrombo-embolism in pregnancy: diagnosis and management'

¹⁶⁷ Simcox L, Ormesher L, Tower C and Greer I (2015) 'Pulmonary thrombo-embolism in pregnancy: diagnosis and management'

¹⁶⁸ National Maternity Review (date unknown): 'Better births: Improving outcomes of maternity services in England'. See: <https://www.england.nhs.uk/wp-content/uploads/2016/02/national-maternity-review-report.pdf>

¹⁶⁹ Diabetes UK, (2016). 'FACTS AND STATS'

¹⁷⁰ Proisy, M., Rouil, A., Raoult, H., Rozel, C., Guggenbuhl, P., Jacob, D. and Guillin, R. (2014). 'Imaging of Musculoskeletal Disorders Related to Pregnancy'

¹⁷¹ NHS Choices (2015) 'Asthma and pregnancy'

D.7.3.4 Gynaecology

Urinary incontinence (UI) is a common condition for women; pregnant women are more likely to be affected by UI due to associated changes in pelvic muscle structure. UI requires both gynaecology services and musculoskeletal services (under physiotherapy exercises) to prevent the repeat occurrence of the condition. This is also a condition that can also be treated under urological services.

D.7.4 Stroke services

Pregnancy, causes the levels of female hormones to rise, this causes changes in the blood vessels and the make-up of the blood. Also, pregnancy can cause increased blood pressure. These changes increase the risk of stroke. Pregnant women are 13 times more likely to have a stroke than non-pregnant women of the same age.¹⁷²

Several causes of stroke are unique to pregnancy and the postpartum period, such as preeclampsia and eclampsia, amniotic fluid embolus, postpartum angiopathy and postpartum cardiomyopathy.¹⁷³

D.7.5 Demographic profile

Data on the number of women aged 16-44 has been used to approximate the levels of pregnancy and maternity in the study area. The table below shows that the study area has the same percentage of females aged 16-44 when compared to the national average (both 19%).

Table 33: Population of females aged 16-44

Study area	Total population	Females 16-44	Females 16-44 (%)
Oxfordshire CCG	663,566	126,267	19%
England	54,786,327	10,336,501	19%

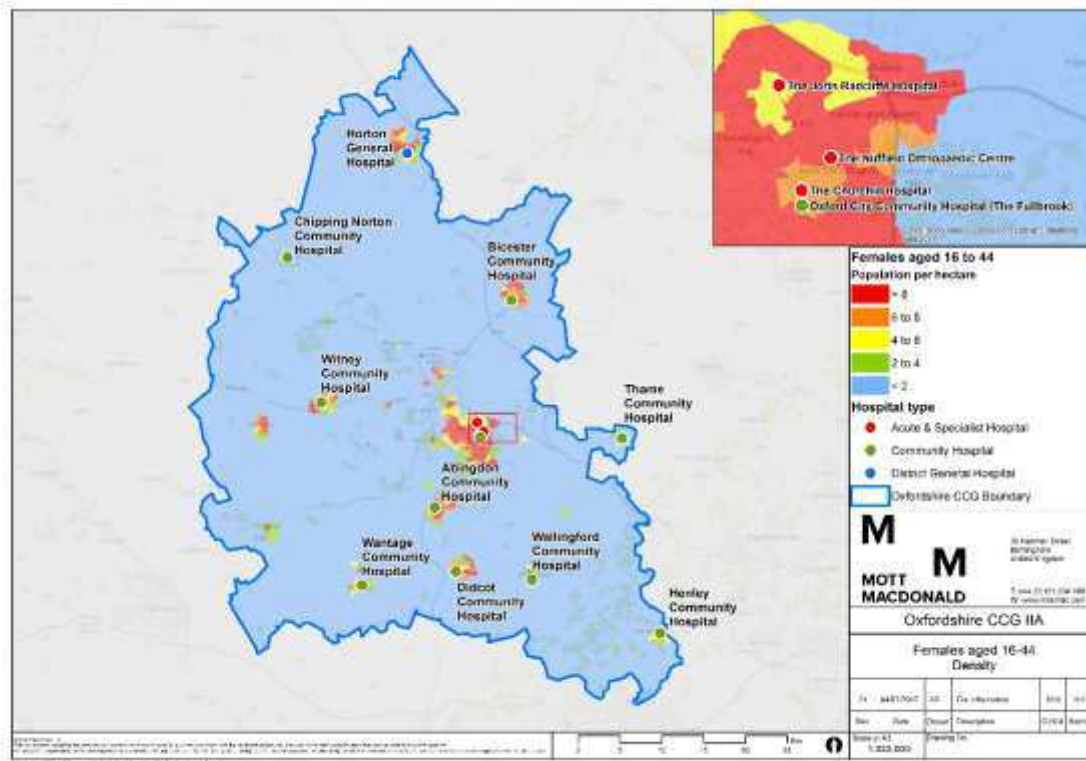
Source: 2015 mid-year estimates

Figure 24 shows that the highest densities of females aged 16-44 are in urban centres, particularly around Oxford. High densities are also in Abingdon, Horton and Witney.

¹⁷² Stroke Association, (2012). Women and stroke

¹⁷³ Tate, J. and Bushnell, C. (2011). 'Pregnancy and stroke risk in women'

Figure 23: Population of females aged 16-44



Source: 2015 mid-year estimates

D.8 Race and ethnicity

Evidence of disproportionate need has been identified for the following service areas.

Table 34: Scoped in services – Race and ethnicity

Service area	Evidence of disproportionate need	Evidence of differential need
Ambulatory care		
Maternity	✓	
Planned Care services	✓	
Stroke services	✓	

Source: Mott MacDonald

D.8.1 Maternity

Pakistani and Bangladeshi communities among others are likely to have a greater demand for maternity services as they tend to have a higher number of children.¹⁷⁴

¹⁷⁴ Coleman, D. A and Dubuc S (2010): 'The fertility of ethnic minorities in the UK, 1960s-2006' in Population Studies

The risk of maternal death in 2012-14 was found to be significantly higher among women from a minority ethnic background compared to White women. The need of minority ethnic women for maternity and obstetric services therefore is likely to be higher.¹⁷⁵

D.8.2 Planned Care services

D.8.2.1 Dermatology services

Many forms of hyperpigmentation or dyschromia can disproportionately affect people from BAME communities including Lichen planus pigmentosus and Naevus of Ota.¹⁷⁶ The treatment of dyschromia is influenced by skin type, and thus people of Black and ethnic minorities will have a differential treatment need.¹⁷⁷

Vitiligo, which results in the loss of normal skin colour, can have a significant effect on self-esteem for people from Black and ethnic minorities. People of Black and ethnic minorities will have a differential need in the treatment of Vitiligo.¹⁷⁸

D.8.2.2 Diabetes services

Those from a minority ethnic background are likely to be disproportionate users of diabetes services as they are more than twice as likely to have diabetes than the UK general population.¹⁷⁹ A large-scale study undertaken in London revealed that by age 80 years, 40-50% of British South Asian, African, and African-Caribbean men and women had developed diabetes, at least twice the proportion of White Europeans of the same age.¹⁸⁰

People from a minority ethnic background are likely to need the services earlier than White people. Type 2 diabetes affects people of South Asian, African-Caribbean, Chinese, or Black African descent up to a decade earlier than White Europeans.¹⁸¹

Women of minority ethnic backgrounds are likely to demonstrate a disproportionate and differential need for diabetes services. Women are at an increased risk of gestational diabetes if their family origins are South Asian, Chinese, African-Caribbean or Middle Eastern.¹⁸²

D.8.2.3 Musculoskeletal services

A number of rheumatic conditions, such as Systemic Lupus Erythematosus (SLE) and osteomalacia, show particular prevalence and/or disease expression according to ethnic factors. Ethnic minorities may disproportionately use rheumatology services as a result. For example clinical variations in the epidemiology of SLE have been described in British South Asians. These patients with SLE have been noted to have much more aggressive disease and higher mortality rates than their White counterparts.¹⁸³

Those from South Asian and Black/Afro-Caribbean background are at a higher risk and have a higher incidence of diabetes. Complications from diabetes can affect the feet and diabetics are advised to visit their podiatrist regularly for risk assessments. This is because diabetes causes

¹⁷⁵ Maternity, Newborn and Infant Clinical Outcome Review Programme (2016): 'Savings Lives, Improving Mothers' Care'

¹⁷⁶ Primary Care Dermatology Service (2016) 'Hyperpigmentation – of the face and neck'

¹⁷⁷ Kang SJ et al. (2014) 'Dyschromia in skin colour'

¹⁷⁸ Parliament (2013) 'Written evidence from the British Association of Dermatologists (LTC 89)'

¹⁷⁹ Stroke association, (2016). 'State of the Nation Stroke statistics'

¹⁸⁰ Public Health England (2014) 'Adult obesity and type 2 diabetes'

¹⁸¹ Public Health England, (2014). 'Adult obesity and type 2 diabetes'.

¹⁸² Nhs.uk. (2017). 'Gestational diabetes'

¹⁸³ Samanta, Ash, and Shireen Shaffu, (2012). 'Ethnicity and musculoskeletal health: census and consensus'.

nerve damage known as peripheral neuropathy, affects the circulation and are more prone to infection.¹⁸⁴

D.8.2.4 Ophthalmology services

People from BAME backgrounds are at a greater risk of some of the leading causes of sight loss. The Black population aged under 60 has a greater risk of developing age-related macular degeneration compared to the White population of the same age.¹⁸⁵

Asian people have a greater risk of developing cataracts compared to both the Black and White population. The risk and severity of glaucoma is much higher for Black people compared to White people. Glaucoma can also develop at an earlier stage for Black people in comparison to White people.¹⁸⁶

D.8.3 Stroke services

Black people are twice as likely to have a stroke than White people.¹⁸⁷ In addition, Black or Afro-Caribbean people are more likely than White people to have high blood pressure or diabetes both of which increase the risk of having a stroke.¹⁸⁸

People from a South Asian background are more likely to have a stroke at a younger age than White people. They also have an increased prevalence of factors that increase their risk of stroke, including high blood pressure, cholesterol and diabetes.¹⁸⁹

D.8.4 Demographic profile

To understand the race and ethnic composition of the study area, figures for those from BAME communities have been analysed. The table below shows the proportion of those from a BAME background in the study area (17%) is slightly lower than the national average (20%).

Table 35: Population of people from BAME backgrounds

Study area	BAME	BAME (%)
Oxfordshire CCG	106,173	17%
England	10,733,220	20%

Source: 2011 census

Figure 25 shows the highest densities of people from BAME backgrounds are in urban centres, with a particular concentration around Oxford. There are higher densities in Abingdon.

¹⁸⁴ Diabetes.co.uk. Diabetes Podiatry. <http://www.diabetes.co.uk/features/diabetes-podiatry.html>

¹⁸⁵ RNIB (date unknown): 'Key information and statistics'. See: <http://www.rnib.org.uk/knowledge-and-research-hub/key-information-and-statistics>.

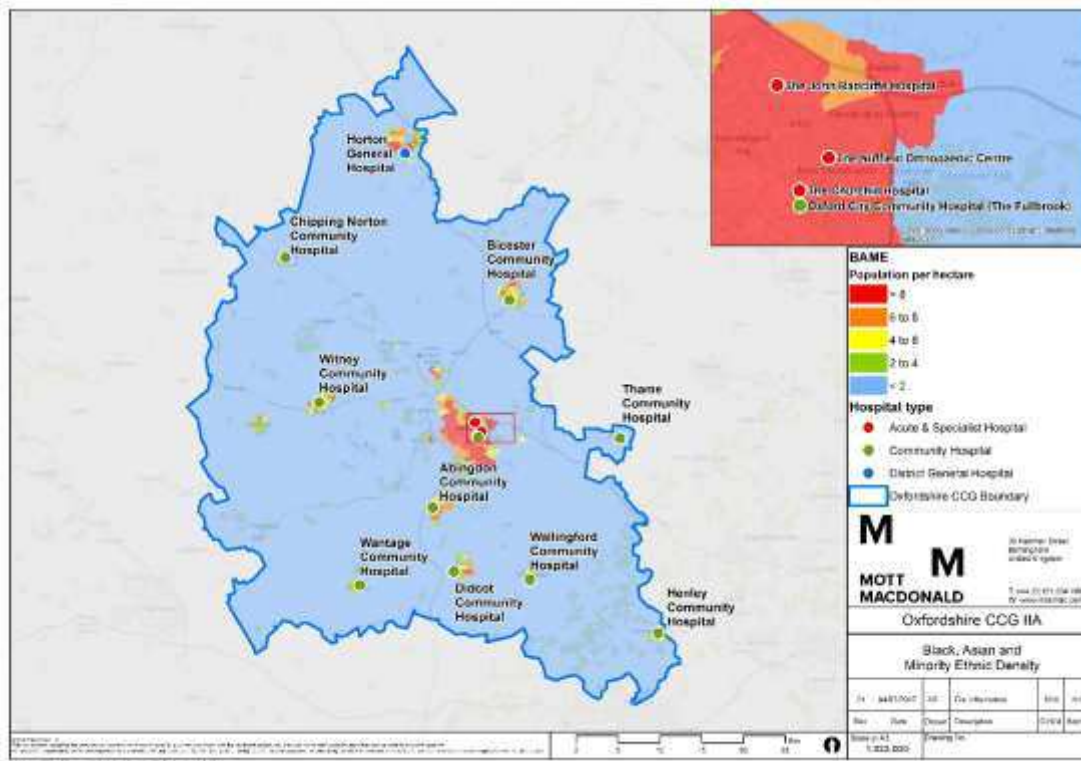
¹⁸⁶ Action for the blind (date unknown): 'Key statistics'. See: <https://actionforblindpeople.org.uk/about-us/media-centre/key-statistics/>.

¹⁸⁷ Stroke association, (2016). 'State of the Nation Stroke statistics'

¹⁸⁸ Stroke association, (2016). 'State of the Nation Stroke statistics'

¹⁸⁹ Stroke association, (2016). 'State of the Nation Stroke statistics'

Figure 24: BAME population



Source: 2011 census

D.9 Religion and belief

Evidence of disproportionate need has been identified for the following service areas.

Table 36: Scoped in services – Religion and belief

Service area	Evidence of disproportionate need	Evidence of differential need
Ambulatory care		
Maternity		
Planned Care services		✓
Stroke services		

Source: Mott MacDonald

D.9.1 Planned Care services

D.9.1.1 Diabetes services

Adherence to certain religions or beliefs may cause people to have a differential need for diabetes services. Some religions or beliefs (i.e. fundamental Christian sects, Sikhism, Hinduism, Islam, and Judaism) require a form of food avoidance/fast as part of their observances. This may have potential adverse effects on diabetes control. Diabetes medication doses may need to be altered during a fast, this would need to be done in consultation with a

person's clinician. This is as during fasting periods, low blood sugar (hypoglycaemia) is a potential issue and can be dangerous.

D.10 Sexual orientation

There is no evidence of disproportionate need for services included in Phase One of the Oxfordshire Transformation Programme on the basis of this protected characteristic.

D.11 Deprivation

Evidence of disproportionate need has been identified for the following service areas.

Table 37: Scoped in services – Deprivation

Service area	Evidence of disproportionate need	Evidence of differential need
Ambulatory care		
Maternity	✓	
Planned Care services	✓	
Stroke services	✓	

Source: Mott MacDonald

D.11.1 Maternity

Mothers from poorer backgrounds have a higher risk of perinatal mortality (foetal deaths after 24 weeks of gestation and death before seven completed days), maternal death, cardiac disease, miscarriage or premature births, preeclampsia, gestational diabetes, and infections among other conditions. ^{190 191}

D.11.2 Planned Care services

D.11.2.1 Diabetes services

In England, type 2 diabetes is 40% more common among people in the most deprived quintile compared with those in least deprived quintile. Short term mortality risk from type 2 diabetes is also higher among those living in more deprived areas in England. ¹⁹²

People in social class V (unskilled manual) are three and a half times more likely to be ill as a result of diabetic complications than those in social class I (professional). ¹⁹³

D.11.2.2 Gynaecology

Cancer Research UK has identified that the rates of cervical cancer for women living in the most deprived areas are more than three times as high as those in the least deprived areas. ¹⁹⁴

¹⁹⁰ NHS England (2016): 'Saving Babies; Lives: A care bundle for reducing stillbirth'

¹⁹¹ Heslehurst N et al (2010): 'A nationally representative study of maternal obesity in England'

¹⁹² Public Health England, (2014). 'Adult obesity and type 2 diabetes'

¹⁹³ Ibid.

¹⁹⁴ Cancer Research UK: Cervical cancer statistics <http://www.cancerresearchuk.org/cancer-info/cancerstats/types/cervix/>

D.11.2.3 Musculoskeletal services

Complications from diabetes can affect the feet and diabetics are advised to visit their podiatrist at least once per year for a risk assessment. This is because diabetes causes nerve damage known as peripheral neuropathy, affects the circulation and are more prone to infection.¹⁹⁵

Ankylosing Spondylitis (AS) is a long-term rheumatological condition where the spine and other areas of the body become inflamed. The need for healthcare is greatest for patients with AS who are living in more socially deprived areas. Those living in more deprived areas demonstrated significantly greater disease severity and poorer psychological health.¹⁹⁶

D.11.2.4 Neurology services

Certain lifestyle factors that are strongly associated with people from deprived communities, such as high levels of smoking and diabetes, are factors that are strongly linked to having a stroke. ONS data shows that there is a link between smoking and deprivation in England; rates of smoking are highest in the most deprived areas of England. People who smoke are around twice as likely to develop MS compared to those who do not smoke.¹⁹⁷ Furthermore, as noted above levels of diabetes are high amongst people from deprived communities and people with this condition may require treatment and support from neurological services. About 60 to 70% of people with diabetes have some form of neuropathy. Diabetic neuropathy can be classified as peripheral, autonomic, proximal, or focal – each affects different parts of the body in various ways.¹⁹⁸

D.11.2.5 Ophthalmology services

There are a number of lifestyle factors (obesity and smoking) which are highly prevalent among people from poor socioeconomic backgrounds, meaning that such people are likely to have a disproportionate need for ophthalmology services.

People who are obese are likely to develop certain eye conditions such as glaucoma.¹⁹⁹ Smoking also increases the risk of developing some eye conditions, such as thyroid eye disease (TED). A heavy smoker is eight times more likely to develop TED than non-smokers.²⁰⁰

Children and young people from deprived backgrounds are also more likely to have a visual impairment than those from less disadvantaged families.²⁰¹

D.11.2.6 Oral surgery

Smoking and poor diet are both lifestyle factors which are most prevalent among deprived communities. An estimated 91% of oral cancer cases are linked to lifestyle factors, including smoking, alcohol, and infections. Smoking is the main avoidable risk factor for oral cancer,

¹⁹⁵ Diabetes.co.uk. Diabetes Podiatry. <http://www.diabetes.co.uk/features/diabetes-podiatry.html>

¹⁹⁶ Healey, E. L., Haywood, Kirstie L., Jordan, Kelvin, Garratt, Andrew M. and Packham, J. C. (2010) 'Disease severity in ankylosing spondylitis: variation by region and local area deprivation'

¹⁹⁷ <http://www.nhs.uk/Conditions/Multiple-sclerosis/Pages/Causes.aspx>

<http://www.ons.gov.uk/ons/rel/disability-and-health-measurement/do-smoking-rates-vary-between-more-and-less-advantaged-areas-2012/sty-smoking-rates.html>

¹⁹⁸ Public Health England, (2014). Adult obesity and type 2 diabetes. [online] Public Health England, p.17. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/338934/Adult_obesity_and_type_2_diabetes_.pdf [Accessed 2 Mar. 2017].

<http://www.diabetes.co.uk/diabetes-complications/diabetic-foot-ulcers.html>

¹⁹⁹ Spaeth G., (date unknown): 'How does lifestyle affect glaucoma'.

²⁰⁰ British Thyroid Eye Disease (2015): 'Thyroid Eye Disease'. See: <http://www.btf-thyroid.org/information/leaflets/36-thyroid-eye-disease-guide>.

²⁰¹ Vision 2020 (2016): 'Key facts about vision impairment in children and young people'.

linked to an estimated 65% of oral cancer cases in the UK.²⁰² Furthermore, a diet that consists of insufficient fruit and vegetable intake is linked to an estimated 56% of oral cancer cases in the UK. Mouth cancer requires a range of treatments, including oral surgery to remove tumours and affected tissue.²⁰³ Therefore, people from deprived communities are likely to be high users of oral surgery services.

D.11.3 Stroke services

People from the most economically deprived areas of the UK are around twice as likely to have a stroke and are three times more likely to die from a stroke than those from the least deprived.²⁰⁴ This is linked to the strong association between deprivation and stroke risk factors such as higher levels of obesity, physical inactivity, an unhealthy diet, smoking and poor blood pressure control.²⁰⁵

D.11.4 Demographic profile

The table below shows that the proportions of the population of Oxfordshire living in the most deprived quintile (4%) and second most deprived quintile (8%) are significantly lower than the national averages (20% for each quintile). Conversely, the populations living in the fourth most deprived quintile (27%) and least deprived quintile (46%) are significantly higher than the national average. Overall, this indicates that deprivation is low across the county.

Table 38: Overall deprivation quintiles

	Most deprived quintile	Second most deprived quintile	Third most deprived quintile	Fourth most deprived quintile	Least deprived quintile
Oxfordshire CCG	4%	8%	15%	27%	46%
England	20%	20%	20%	20%	20%

Source: 2015 IMD

Figure 26 below shows the distribution of the deprivation quintiles across the study area. The areas in which there is highest deprivation are around urban centres i.e. Oxford and Banbury.

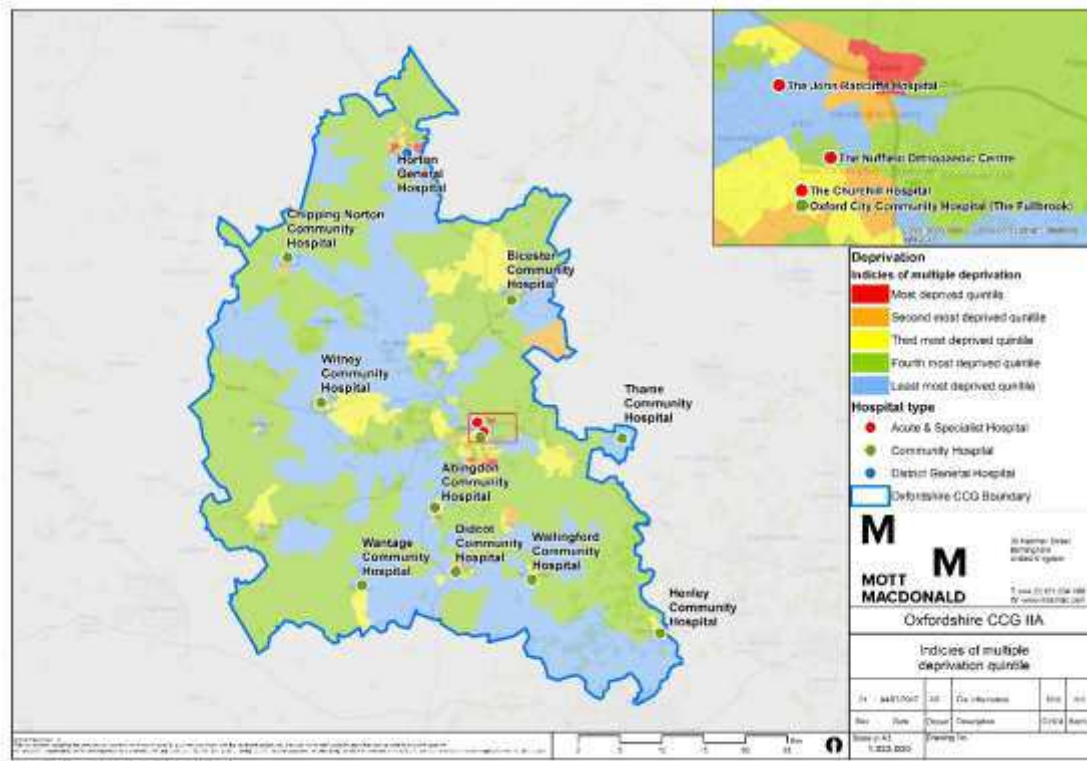
²⁰² Cancer research UK (2014): 'Oral cancer'. See: <http://www.cancerresearchuk.org/health-professional/cancer-statistics/statistics-by-cancer-type/oral-cancer#heading-Three>

²⁰³ NHS (2016): 'Treating mouth cancer'. See: <http://www.nhs.uk/Conditions/Cancer-of-the-mouth/Pages/Treatment.aspx>

²⁰⁴ Stroke association, (2016). 'State of the Nation Stroke statistics'

²⁰⁵ Public Health England, (2014). 'Adult obesity and type 2 diabetes'.

Figure 25: Indices of Multiple Deprivation (IMD) – overall deprivation quantiles



Source: 2015 IMD

D.12 Summary

D.12.1 Scoped in equality groups according to service area

The matrix below identifies which groups, based on the initial literature review, have a disproportionate need for the services under review. The headline findings are:

- Those from deprived communities, females 16-44 and those from a BAME background have a disproportionate need for all the services under the scope of the review.
- Disabled people, older people have a disproportionate need for more than one service under the scope of the review.

Table 39: Summary of scoped in groups

Group	Ambulatory care	Maternity	Planned Care services	Stroke care
Age (children under 16)			✓	
Age (older people aged 65 and over)	✓		✓	✓
Deprived communities		✓	✓	✓
Disability			✓	✓
Gender reassignment	✓		✓	
Marriage and civil partnership				
Pregnancy and maternity	✓	✓	✓	✓
Race and ethnicity: BAME communities		✓	✓	✓
Religion and belief			✓	
Sex: Female	✓	✓		
Sex: Male	✓		✓	✓
Sexual orientation				

Source: Mott MacDonald scoping report

E. Sustainability impact assessment methodology

Patient travel data available between October 2015 to October 2016 (1 year) has been used. The data is broken down into service areas (e.g. maternity, Planned Care etc.), and details the numbers of patients visiting all local hospitals by journey time. The data is also split up into two scenarios; the first represents actual traffic during the assessment period therefore with services delivered without any changes, and the second is a prediction of what the traffic would have been during the assessment period if the HGH was not available to deliver services.

To assess the impact of the proposed changes to NHS services on GHG emissions, the travel with and without the changes has been compared. The proposed changes to both maternity and stroke services are to move services from the HGH to the JRH. As such these changes have been assessed by comparing the scenario with the Horton and the scenario without the Horton from non-emergency stroke patients and maternity patients. The proposed changes to planned care, diagnostics and outpatients are to provide new services at the Horton. These changes were not presented in the data and were therefore not assessed. The proposed changes to critical care are to centralise level 3 critical care services in the JRH, whilst maintain level 2 critical care services in the HGH. The data available does not breakdown critical care into levels, and as such it is not clear how many of the critical care patients would be moved from the HGH to the JRH. Therefore, these changes were not assessed.

To calculate emissions with and without the changes, first the distance of each journey was assumed based on its duration. The data provided numbers of patients per service area by journey time bands if they were traveling by private vehicle. The medium of the journey times bands, was multiplied by the average speed on local A roads in Oxfordshire in 2016²⁰⁶. This produced an assumed distance. This was then multiplied by the number of patients, which resulted in the total distance travelled by all patients.

The total distance was then apportioned to transport mode using national 2015 data²⁰⁷. It was assumed patients would not travel by motorcycle, peddle bicycle, or air. Once the distances had been apportioned to transport mode, Defra's 2016 GHG emissions factors²⁰⁸ were applied to the distances to estimate emissions, assuming one patient per car. The emissions were estimated with and without the changes, and doubled to account for return journeys, which were assumed to be the same in both directions for all patients. The difference between with and without the changes was then calculated.

²⁰⁶ Department for transport (2017), Road congestion statistics Table CGN0501b.

²⁰⁷ Department for transport (2017), Passenger transport, by mode: annual from 1952 Table TSGB0101

²⁰⁸ <https://www.gov.uk/government/publications/greenhouse-gas-reporting-conversion-factors-2016>

F. Travel and access additional breakdown

F.1 Maternity services

F.1.1 Population overall

Table 40: Baseline travel time by blue light to maternity services

	Travel Time - Blue light (including HGH)						
Journey time (number of minutes)	0-10	11-20	21-30	31-40	41-50	51-60	>60
Number of patients reaching maternity services in journey time range	3,515	2,205	2,692	1,786	543	20	772
Percentage of patients reaching maternity services in journey time range	30%	19%	23%	15%	5%	0%	7%
Cumulative Percentage	30%	50%	73%	88%	93%	93%	100%

Source: SUS SEM

Table 41: Future travel time to maternity services by blue light excluding the HGH

	Travel Time – Blue light (excluding HGH)						
Journey time (number of minutes)	0-10	11-20	21-30	31-40	41-50	51-60	>60
Number of patients reaching maternity services in journey time range	1,798	1,540	2,676	3,809	910	19	781
Percentage of patients reaching maternity services in journey time range	16%	13%	23%	33%	8%	0%	7%
Cumulative Percentage	16%	29%	52%	85%	93%	93%	100%

Source: SUS SEM

Table 42: Baseline travel time by car to maternity services

	Travel Time - Car (including HGH)						
Journey time (number of minutes)	0-10	11-20	21-30	31-40	41-50	51-60	>60
Number of patients reaching maternity services in journey time range	2,974	2,154	2,533	2,693	411	6	762
Percentage of patients reaching maternity services in journey time range	26%	19%	22%	23%	4%	0%	7%
Cumulative Percentage	26%	44%	66%	90%	93%	93%	100%

Source: SUS SEM

Table 43: Future travel time to maternity services by car excluding the HGH

	Travel Time - Car (excluding HGH)						
Journey time (number of minutes)	0-10	11-20	21-30	31-40	41-50	51-60	>60
Number of patients reaching maternity services in journey time range	1,332	1,757	2,227	4,435	996	24	762
Percentage of patients reaching maternity services in journey time range	12%	15%	19%	38%	9%	0%	7%
Cumulative Percentage	12%	27%	46%	85%	93%	93%	100%

Source: SUS SEM

Table 44: Baseline travel time by public transport to maternity services

	Travel Time - Public transport (including HGH)						
Journey time (number of minutes)	0-15	16-30	31-45	46-60	61-75	76-90	>90
Number of patients reaching maternity services in journey time range	363	2,240	1,789	1,913	2,053	1,258	1,917
Percentage of patients reaching maternity services in journey time range	3%	19%	16%	17%	18%	11%	17%
Cumulative Percentage	3%	23%	38%	55%	72%	83%	100%

Source: SUS SEM

Table 45: Future travel time to maternity services by public transport excluding the HGH

	Travel Time - Public transport (excluding Horton)						
Journey time (number of minutes)	0-15	16-30	31-45	46-60	61-75	76-90	>90
Number of patients reaching maternity services in journey time range	148	1,179	1,475	2,521	2,732	1,355	2,123
Percentage of patients reaching maternity services in journey time range	1%	10%	13%	22%	24%	12%	18%
Cumulative Percentage	1%	12%	24%	46%	70%	82%	100%

Source: SUS SEM

F.1.2 Population overall in Oxfordshire only

Table 46: Baseline travel time by blue light to maternity services

Journey time (number of minutes)	Travel Time - Blue light (including HGH)						
	0-10	11-20	21-30	31-40	41-50	51-60	>60
Number of patients reaching maternity services in journey time range	3,515	2,073	2,636	1,742	469	0	0
Percentage of patients reaching maternity services in journey time range	34%	20%	25%	17%	4%	0%	0%
Cumulative Percentage	34%	54%	79%	96%	100%	100%	100%

Source: SUS SEM

Table 47: Future travel time to maternity services by blue light excluding the HGH

Journey time (number of minutes)	Travel Time – Blue light (excluding HGH)						
	0-10	11-20	21-30	31-40	41-50	51-60	>60
Number of patients reaching maternity services in journey time range	1,798	1,532	2,641	3,679	785	0	0
Percentage of patients reaching maternity services in journey time range	17%	15%	25%	35%	8%	0%	0%
Cumulative Percentage	17%	32%	57%	92%	100%	100%	100%

Source: SUS SEM

Table 48: Baseline travel time by car to maternity services by car including the HGH

Journey time (number of minutes)	Travel Time - Car (including Horton)						
	0-10	11-20	21-30	31-40	41-50	51-60	>60
Number of patients reaching maternity services in journey time range	2,955	1,802	1,930	2,097	1,365	286	0
Percentage of patients reaching maternity services in journey time range	28%	17%	18%	20%	13%	3%	0%
Cumulative Percentage	28%	46%	64%	84%	97%	100%	100%

Source: SUS SEM

Table 49: Future travel time to maternity services by car excluding the HGH

Travel Time - Car (excluding Horton)							
Journey time (number of minutes)	0-10	11-20	21-30	31-40	41-50	51-60	>60
Number of patients reaching maternity services in journey time range	1,313	1,568	1,671	2,097	3,421	365	0
Percentage of patients reaching maternity services in journey time range	13%	15%	16%	20%	33%	3%	0%
Cumulative Percentage	13%	28%	44%	64%	97%	100%	100%

Source: SUS SEM

Table 50: Baseline travel time to maternity services by public transport including HGH

Travel Time - Public transport (including Horton)							
Journey time (number of minutes)	0-15	16-30	31-45	46-60	61-75	76-90	>90
Number of patients reaching maternity services in journey time range	574	2,451	2,153	1,744	1,723	684	1,106
Percentage of patients reaching maternity services in journey time range	6%	23%	21%	17%	17%	7%	11%
Cumulative Percentage	6%	29%	50%	66%	83%	89%	100%

Source: SUS SEM

Table 51: Future travel time to maternity services by public transport excluding HGH

Travel Time - Public transport (excluding Horton)							
Journey time (number of minutes)	0-15	16-30	31-45	46-60	61-75	76-90	>90
Number of patients reaching maternity services in journey time range	189	1,431	1,591	1,960	2,372	1,556	1,336
Percentage of patients reaching maternity services in journey time range	2%	14%	15%	19%	23%	15%	13%
Cumulative Percentage	2%	16%	31%	50%	72%	87%	100%

Source: SUS SEM

F.1.3 Women aged 15-44 in the population overall

Table 52: Baseline travel time by blue light to maternity services

	Travel Time - Blue light (including HGH)						
Journey time (number of minutes)	0-10	11-20	21-30	31-40	41-50	51-60	>60
Number of patients reaching maternity services in journey time range	3,494	2,201	2,679	1,735	498	10	760
Percentage of patients reaching maternity services in journey time range	31%	19%	24%	15%	4%	0%	7%
Cumulative Percentage	31%	50%	74%	89%	93%	93%	100%

Source: SUS SEM

Table 53: Future travel time to maternity services by blue light excluding the HGH

	Travel Time – Blue light (excluding HGH)						
Journey time (number of minutes)	0-10	11-20	21-30	31-40	41-50	51-60	>60
Number of patients reaching maternity services in journey time range	1,789	1,536	2,663	3,792	907	10	769
Percentage of patients reaching maternity services in journey time range	16%	13%	23%	33%	8%	0%	7%
Cumulative Percentage	16%	29%	52%	85%	93%	93%	100%

Source: SUS SEM

Table 54: Baseline travel time by car to maternity services by car including the HGH

	Travel Time - Car (including Horton)						
Journey time (number of minutes)	0-10	11-20	21-30	31-40	41-50	51-60	>60
Number of patients reaching maternity services in journey time range	2,936	2,145	2,527	2,682	395	0	750
Percentage of patients reaching maternity services in journey time range	26%	19%	22%	23%	3%	0%	7%
Cumulative Percentage	26%	44%	67%	90%	93%	93%	100%

Source: SUS SEM

Table 55: Future travel time to maternity services by car excluding the HGH

Travel Time - Car (excluding Horton)							
Journey time (number of minutes)	0-10	11-20	21-30	31-40	41-50	51-60	>60
Number of patients reaching maternity services in journey time range	1,325	1,749	2,220	4,411	961	8	750
Percentage of patients reaching maternity services in journey time range	12%	15%	19%	39%	8%	0%	7%
Cumulative Percentage	12%	27%	46%	85%	93%	93%	100%

Source: SUS SEM

Table 56: Baseline travel time to maternity services by public transport including HGH

Travel Time - Public transport (including Horton)							
Journey time (number of minutes)	0-15	16-30	31-45	46-60	61-75	76-90	>90
Number of patients reaching maternity services in journey time range	347	2,223	1,785	1,909	2,033	1,254	1,900
Percentage of patients reaching maternity services in journey time range	3%	19%	16%	17%	18%	11%	17%
Cumulative Percentage	3%	22%	38%	55%	72%	83%	100%

Source: SUS SEM

Table 57: Future travel time to maternity services by public transport excluding HGH

Travel Time - Public transport (excluding Horton)							
Journey time (number of minutes)	0-15	16-30	31-45	46-60	61-75	76-90	>90
Number of patients reaching maternity services in journey time range	141	1,144	1,471	2,512	2,700	1,351	2,099
Percentage of patients reaching maternity services in journey time range	1%	10%	13%	22%	24%	12%	18%
Cumulative Percentage	1%	11%	24%	46%	70%	82%	100%

Source: SUS SEM

F.1.4 Women aged 15-44 in Oxfordshire only

Table 58: Baseline travel time by blue light to maternity services

	Travel Time - Blue light (including HGH)						
Journey time (number of minutes)	0-10	11-20	21-30	31-40	41-50	51-60	>60
Number of patients reaching maternity services in journey time range	3,494	2,070	2,623	1,739	466	0	0
Percentage of patients reaching maternity services in journey time range	34%	20%	25%	17%	4%	0%	0%
Cumulative Percentage	34%	54%	79%	96%	100%	100%	100%

Source: SUS SEM

Table 59: Future travel time to maternity services by blue light excluding the HGH

	Travel Time – Blue light (excluding HGH)						
Journey time (number of minutes)	0-10	11-20	21-30	31-40	41-50	51-60	>60
Number of patients reaching maternity services in journey time range	1,789	1,528	2,628	3,665	782	0	0
Percentage of patients reaching maternity services in journey time range	17%	15%	25%	35%	8%	0%	0%
Cumulative Percentage	17%	32%	57%	92%	100%	100%	100%

Source: SUS SEM

Table 60: Baseline travel time by car to maternity services by car including the HGH

	Travel Time - Car (including Horton)						
Journey time (number of minutes)	0-10	11-20	21-30	31-40	41-50	51-60	>60
Number of patients reaching maternity services in journey time range	2,917	1,797	1,927	2,087	1,349	284	0
Percentage of patients reaching maternity services in journey time range	28%	17%	19%	20%	13%	3%	0%
Cumulative Percentage	28%	45%	64%	84%	97%	100%	100%

Source: SUS SEM

Table 61: Future travel time to maternity services by car excluding the HGH

	Travel Time - Car (excluding Horton)						
Journey time (number of minutes)	0-10	11-20	21-30	31-40	41-50	51-60	>60
Number of patients reaching maternity services in journey time range	1,306	1,563	1,667	2,087	3,406	363	0
Percentage of patients reaching maternity services in journey time range	13%	15%	16%	20%	33%	3%	0%
Cumulative Percentage	13%	28%	44%	64%	97%	100%	100%

Source: SUS SEM

Table 62: Baseline travel time to maternity services by public transport including HGH

	Travel Time - Public transport (including Horton)						
Journey time (number of minutes)	0-15	16-30	31-45	46-60	61-75	76-90	>90
Number of patients reaching maternity services in journey time range	558	2,433	2,149	1,674	1,670	681	1,077
Percentage of patients reaching maternity services in journey time range	6%	23%	21%	17%	17%	7%	11%
Cumulative Percentage	6%	29%	50%	66%	83%	89%	100%

Source: SUS SEM

Table 63: Future travel time to maternity services by public transport excluding HGH

	Travel Time - Public transport (excluding Horton)						
Journey time (number of minutes)	0-15	16-30	31-45	46-60	61-75	76-90	>90
Number of patients reaching maternity services in journey time range	188	1,425	1,587	1,952	2,360	1,548	1,332
Percentage of patients reaching maternity services in journey time range	2%	14%	15%	19%	23%	15%	13%
Cumulative Percentage	2%	16%	31%	50%	72%	87%	100%

Source: SUS SEM

F.1.5 Asian or Asian British

Table 64: Baseline travel time by blue light to maternity services

	Travel Time - Blue light (including HGH)						
Journey time (number of minutes)	0-10	11-20	21-30	31-40	41-50	51-60	>60
Number of patients reaching maternity services in journey time range	414	92	48	31	13	0	29
Percentage of patients reaching maternity services in journey time range	66%	15%	8%	5%	2%	0%	5%
Cumulative Percentage	66%	81%	88%	93%	95%	95%	100%

Source: SUS SEM

Table 65: Future travel time to maternity services by blue light excluding the HGH

	Travel Time – Blue light (excluding HGH)						
Journey time (number of minutes)	0-10	11-20	21-30	31-40	41-50	51-60	>60
Number of patients reaching maternity services in journey time range	252	83	47	202	14	0	30
Percentage of patients reaching maternity services in journey time range	40%	13%	7%	32%	2%	0%	5%
Cumulative Percentage	40%	53%	61%	93%	95%	95%	100%

Source: SUS SEM

Table 66: Baseline travel time by car to maternity services by car including the HGH

	Travel Time - Car (including Horton)						
Journey time (number of minutes)	0-10	11-20	21-30	31-40	41-50	51-60	>60
Number of patients reaching maternity services in journey time range	358	123	53	57	12	0	28
Percentage of patients reaching maternity services in journey time range	57%	19%	8%	9%	2%	0%	4%
Cumulative Percentage	57%	76%	85%	94%	96%	96%	100%

Source: SUS SEM

Table 67: Future travel time to maternity services by car excluding the HGH

	Travel Time - Car (excluding Horton)						
Journey time (number of minutes)	0-10	11-20	21-30	31-40	41-50	51-60	>60
Number of patients reaching maternity services in journey time range	206	123	48	209	17	0	28
Percentage of patients reaching maternity services in journey time range	33%	19%	8%	33%	3%	0%	4%
Cumulative Percentage	33%	52%	60%	93%	96%	96%	100%

Source: SUS SEM

Table 68: Baseline travel time to maternity services by public transport including HGH

	Travel Time - Public transport (including Horton)						
Journey time (number of minutes)	0-15	16-30	31-45	46-60	61-75	76-90	>90
Number of patients reaching maternity services in journey time range	30	301	144	64	31	22	39
Percentage of patients reaching maternity services in journey time range	5%	48%	23%	10%	5%	3%	6%
Cumulative Percentage	5%	52%	75%	85%	90%	94%	100%

Source: SUS SEM

Table 69: Future travel time to maternity services by public transport excluding HGH

	Travel Time - Public transport (excluding Horton)						
Journey time (number of minutes)	0-15	16-30	31-45	46-60	61-75	76-90	>90
Number of patients reaching maternity services in journey time range	20	175	131	168	76	22	39
Percentage of patients reaching maternity services in journey time range	3%	28%	21%	27%	12%	3%	6%
Cumulative Percentage	3%	31%	52%	78%	90%	94%	100%

Source: SUS SEM

F.1.6 Asian or Asian British in Oxfordshire only

Table 70: Baseline travel time by blue light to maternity services

Journey time (number of minutes)	Travel Time - Blue light (including HGH)						
	0-10	11-20	21-30	31-40	41-50	51-60	>60
Number of patients reaching maternity services in journey time range	414	92	48	31	13	0	0
Percentage of patients reaching maternity services in journey time range	69%	15%	8%	5%	2%	0%	0%
Cumulative Percentage	69%	85%	93%	98%	100%	100%	100%

Source: SUS SEM

Table 71: Future travel time to maternity services by blue light excluding the HGH

Journey time (number of minutes)	Travel Time – Blue light (excluding HGH)						
	0-10	11-20	21-30	31-40	41-50	51-60	>60
Number of patients reaching maternity services in journey time range	252	83	47	202	14	0	0
Percentage of patients reaching maternity services in journey time range	42%	14%	8%	34%	2%	0%	0%
Cumulative Percentage	42%	56%	64%	98%	100%	100%	100%

Source: SUS SEM

Table 72: Baseline travel time by car to maternity services by car including the HGH

Journey time (number of minutes)	Travel Time - Car (including Horton)						
	0-10	11-20	21-30	31-40	41-50	51-60	>60
Number of patients reaching maternity services in journey time range	355	122	53	57	11	0	0
Percentage of patients reaching maternity services in journey time range	59%	19%	7%	8%	4%	1%	0%
Cumulative Percentage	59%	79%	86%	94%	99%	100%	100%

Source: SUS SEM

Table 73: Future travel time to maternity services by car excluding the HGH

	Travel Time - Car (excluding Horton)						
Journey time (number of minutes)	0-10	11-20	21-30	31-40	41-50	51-60	>60
Number of patients reaching maternity services in journey time range	203	117	38	50	182	8	0
Percentage of patients reaching maternity services in journey time range	34%	20%	6%	8%	30%	1%	0%
Cumulative Percentage	34%	54%	60%	68%	99%	100%	100%

Source: SUS SEM

Table 74: Baseline travel time to maternity services by public transport including HGH

	Travel Time - Public transport (including Horton)						
Journey time (number of minutes)	0-15	16-30	31-45	46-60	61-75	76-90	>90
Number of patients reaching maternity services in journey time range	54	309	135	43	30	0	22
Percentage of patients reaching maternity services in journey time range	9%	52%	23%	7%	5%	0%	4%
Cumulative Percentage	9%	61%	84%	91%	96%	96%	100%

Source: SUS SEM

Table 75: Future travel time to maternity services by public transport excluding HGH

	Travel Time - Public transport (excluding Horton)						
Journey time (number of minutes)	0-15	16-30	31-45	46-60	61-75	76-90	>90
Number of patients reaching maternity services in journey time range	28	191	110	60	127	60	22
Percentage of patients reaching maternity services in journey time range	5%	32%	18%	10%	21%	10%	4%
Cumulative Percentage	5%	37%	55%	65%	86%	96%	100%

Source: SUS SEM

F.1.7 Black or Black British

Table 76: Baseline travel time by blue light to maternity services

Journey time (number of minutes)	Travel Time - Blue light (including HGH)						
	0-10	11-20	21-30	31-40	41-50	51-60	>60
Number of patients reaching maternity services in journey time range	82	66	32	16	6	0	20
Percentage of patients reaching maternity services in journey time range	37%	30%	14%	7%	3%	0%	9%
Cumulative Percentage	37%	67%	81%	88%	91%	91%	100%

Source: SUS SEM

Table 77: Future travel time to maternity services by blue light excluding the HGH

Journey time (number of minutes)	Travel Time – Blue light (excluding HGH)						
	0-10	11-20	21-30	31-40	41-50	51-60	>60
Number of patients reaching maternity services in journey time range	72	57	31	32	10	0	20
Percentage of patients reaching maternity services in journey time range	32%	26%	14%	14%	5%	0%	9%
Cumulative Percentage	32%	58%	72%	86%	91%	91%	100%

Source: SUS SEM

Table 78: Baseline travel time by car to maternity services by car including the HGH

Journey time (number of minutes)	Travel Time - Car (including Horton)						
	0-10	11-20	21-30	31-40	41-50	51-60	>60
Number of patients reaching maternity services in journey time range	66	79	27	26	0	0	18
Percentage of patients reaching maternity services in journey time range	31%	37%	13%	12%	0%	0%	8%
Cumulative Percentage	31%	67%	80%	92%	92%	92%	100%

Source: SUS SEM

Table 79: Future travel time to maternity services by car excluding the HGH

Travel Time - Car (excluding Horton)							
Journey time (number of minutes)	0-10	11-20	21-30	31-40	41-50	51-60	>60
Number of patients reaching maternity services in journey time range	48	79	25	44	6	0	18
Percentage of patients reaching maternity services in journey time range	22%	36%	11%	20%	3%	0%	8%
Cumulative Percentage	22%	58%	69%	89%	92%	92%	100%

Source: SUS SEM

Table 80: Baseline travel time to maternity services by public transport including HGH

Travel Time - Public transport (including Horton)							
Journey time (number of minutes)	0-15	16-30	31-45	46-60	61-75	76-90	>90
Number of patients reaching maternity services in journey time range	14	54	63	34	21	0	31
Percentage of patients reaching maternity services in journey time range	6%	25%	29%	16%	10%	0%	14%
Cumulative Percentage	6%	31%	60%	76%	86%	86%	100%

Source: SUS SEM

Table 81: Future travel time to maternity services by public transport excluding HGH

Travel Time - Public transport (excluding Horton)							
Journey time (number of minutes)	0-15	16-30	31-45	46-60	61-75	76-90	>90
Number of patients reaching maternity services in journey time range	9	46	64	41	26	0	31
Percentage of patients reaching maternity services in journey time range	4%	21%	29%	19%	12%	0%	14%
Cumulative Percentage	4%	25%	55%	74%	86%	86%	100%

Source: SUS SEM

F.1.8 Black or Black British in Oxfordshire only

Table 82: Baseline travel time by blue light to maternity services

	Travel Time - Blue light (including HGH)						
Journey time (number of minutes)	0-10	11-20	21-30	31-40	41-50	51-60	>60
Number of patients reaching maternity services in journey time range	82	66	32	16	6	0	0
Percentage of patients reaching maternity services in journey time range	41%	33%	16%	8%	3%	0%	0%
Cumulative Percentage	41%	73%	89%	97%	100%	100%	100%

Source: SUS sem

Table 83: Future travel time to maternity services by blue light excluding the HGH

	Travel Time – Blue light (excluding HGH)						
Journey time (number of minutes)	0-10	11-20	21-30	31-40	41-50	51-60	>60
Number of patients reaching maternity services in journey time range	72	57	31	32	10	0	0
Percentage of patients reaching maternity services in journey time range	36%	28%	15%	16%	5%	0%	0%
Cumulative Percentage	36%	64%	79%	95%	100%	100%	100%

Source: SUS SEM

Table 84: Baseline travel time by car to maternity services by car including the HGH

	Travel Time - Car (including Horton)						
Journey time (number of minutes)	0-10	11-20	21-30	31-40	41-50	51-60	>60
Number of patients reaching maternity services in journey time range	66	78	25	18	10	0	0
Percentage of patients reaching maternity services in journey time range	34%	40%	13%	9%	5%	0%	0%
Cumulative Percentage	34%	73%	86%	95%	100%	100%	100%

Source: SUS SEM

Table 85: Future travel time to maternity services by car excluding the HGH

Travel Time - Car (excluding Horton)							
Journey time (number of minutes)	0-10	11-20	21-30	31-40	41-50	51-60	>60
Number of patients reaching maternity services in journey time range	48	78	23	18	30	0	0
Percentage of patients reaching maternity services in journey time range	24%	40%	12%	9%	15%	0%	0%
Cumulative Percentage	24%	64%	76%	85%	100%	100%	100%

Source: SUS SE

Table 86: Baseline travel time to maternity services by public transport including HGH

Travel Time - Public transport (including Horton)							
Journey time (number of minutes)	0-15	16-30	31-45	46-60	61-75	76-90	>90
Number of patients reaching maternity services in journey time range	15	65	65	28	19	0	7
Percentage of patients reaching maternity services in journey time range	8%	33%	33%	14%	10%	0%	4%
Cumulative Percentage	8%	40%	73%	87%	96%	96%	100%

Source: SUS SEM

Table 87: Future travel time to maternity services by public transport excluding HGH

Travel Time - Public transport (excluding Horton)							
Journey time (number of minutes)	0-15	16-30	31-45	46-60	61-75	76-90	>90
Number of patients reaching maternity services in journey time range	8	58	59	36	0	8	7
Percentage of patients reaching maternity services in journey time range	5%	33%	34%	20%	0%	5%	4%
Cumulative Percentage	5%	38%	71%	91%	91%	96%	100%

Source: SUS SEM

F.1.9 Deprived communities

Table 88: Baseline travel time by blue light to maternity services

	Travel Time - Blue light (including HGH)						
Journey time (number of minutes)	0-10	11-20	21-30	31-40	41-50	51-60	>60
Number of patients reaching maternity services in journey time range	54%	43%	2%	0%	0%	0%	1%
Percentage of patients reaching maternity services in journey time range	54%	97%	99%	99%	99%	99%	100%
Cumulative Percentage	54%	43%	2%	0%	0%	0%	1%

Source: SUS SEM

Table 89: Future travel time to maternity services by blue light excluding the HGH

	Travel Time – Blue light (excluding HGH)						
Journey time (number of minutes)	0-10	11-20	21-30	31-40	41-50	51-60	>60
Number of patients reaching maternity services in journey time range	117	352	18	333	0	0	9
Percentage of patients reaching maternity services in journey time range	14%	42%	2%	40%	0%	0%	1%
Cumulative Percentage	14%	57%	59%	99%	99%	99%	100%

Source: SUS SEM

Table 90: Baseline travel time by car to maternity services by car including the HGH

	Travel Time - Car (including Horton)						
Journey time (number of minutes)	0-10	11-20	21-30	31-40	41-50	51-60	>60
Number of patients reaching maternity services in journey time range	451	352	0	18	0	0	8
Percentage of patients reaching maternity services in journey time range	54%	42%	0%	2%	0%	0%	1%
Cumulative Percentage	54%	97%	97%	99%	99%	99%	100%

Source: SUS SEM

Table 91: Future travel time to maternity services by car excluding the HGH

Travel Time - Car (excluding Horton)							
Journey time (number of minutes)	0-10	11-20	21-30	31-40	41-50	51-60	>60
Number of patients reaching maternity services in journey time range	118	352	0	351	0	0	8
Percentage of patients reaching maternity services in journey time range	14%	42%	0%	42%	0%	0%	1%
Cumulative Percentage	14%	57%	57%	99%	99%	99%	100%

Source: SUS SEM

Table 92: Baseline travel time to maternity services by public transport including HGH

Travel Time - Public transport (including Horton)							
Journey time (number of minutes)	0-15	16-30	31-45	46-60	61-75	76-90	>90
Number of patients reaching maternity services in journey time range	115	336	265	87	19	0	7
Percentage of patients reaching maternity services in journey time range	14%	41%	32%	10%	2%	0%	1%
Cumulative Percentage	14%	54%	86%	97%	99%	99%	100%

Source: SUS SEM

Table 93: Future travel time to maternity services by public transport excluding HGH

Travel Time - Public transport (excluding Horton)							
Journey time (number of minutes)	0-15	16-30	31-45	46-60	61-75	76-90	>90
Number of patients reaching maternity services in journey time range	0	117	379	232	93	0	7
Percentage of patients reaching maternity services in journey time range	0%	14%	46%	28%	11%	0%	1%
Cumulative Percentage	0%	14%	60%	88%	99%	99%	100%

Source: SUS SEM

F.1.10 Deprived communities in Oxfordshire only

Table 94: Baseline travel time by blue light to maternity services

	Travel Time - Blue light (including HGH)						
Journey time (number of minutes)	0-10	11-20	21-30	31-40	41-50	51-60	>60
Number of patients reaching maternity services in journey time range	450	352	18	0	0	0	0
Percentage of patients reaching maternity services in journey time range	55%	43%	2%	0%	0%	0%	0%
Cumulative Percentage	55%	98%	100%	100%	100%	100%	100%

Source: SUS SEM

Table 95: Future travel time to maternity services by blue light excluding the HGH

	Travel Time – Blue light (excluding HGH)						
Journey time (number of minutes)	0-10	11-20	21-30	31-40	41-50	51-60	>60
Number of patients reaching maternity services in journey time range	117	352	18	333	0	0	0
Percentage of patients reaching maternity services in journey time range	14%	43%	2%	41%	0%	0%	0%
Cumulative Percentage	14%	57%	59%	100%	100%	100%	100%

Source: SUS SEM

F.2 Stroke services

F.2.1 Population overall

Table 96: Baseline travel time by blue light to stroke services

	Travel Time - Blue light (including HGH)						
Journey time (number of minutes)	0-10	11-20	21-30	31-40	41-50	51-60	>60
Number of patients reaching stroke services in journey time range	128	136	174	117	50	0	0
Percentage of patients reaching stroke services in journey time range	21%	22%	29%	19%	8%	0%	0%
Cumulative Percentage	21%	44%	72%	92%	100%	100%	100%

Source: SUS SEM

Table 97: Future travel time to stroke services by blue light excluding the HGH

	Travel Time – Blue light (excluding HGH)						
Journey time (number of minutes)	0-10	11-20	21-30	31-40	41-50	51-60	>60
Number of patients reaching stroke services in journey time range	68	101	170	200	66	0	12
Percentage of patients reaching stroke services in journey time range	11%	16%	28%	32%	11%	0%	2%
Cumulative Percentage	11%	27%	55%	87%	98%	98%	100%

Source: SUS SEM

Table 98: Baseline travel time to stroke services by car including HGH

	Travel Time - Car (including Horton)						
Journey time (number of minutes)	0-10	11-20	21-30	31-40	41-50	51-60	>60
Number of patients reaching stroke services in journey time range	85	126	182	174	5	0	12
Percentage of patients reaching stroke services in journey time range	15%	22%	31%	30%	1%	0%	2%
Cumulative Percentage	15%	36%	67%	97%	98%	98%	100%

Source: SUS SEM

Table 99: Future travel time to stroke services by car excluding HGH

	Travel Time - Car (excluding Horton)						
Journey time (number of minutes)	0-10	11-20	21-30	31-40	41-50	51-60	>60
Number of patients reaching stroke services in journey time range	49	98	166	235	58	0	12
Percentage of patients reaching stroke services in journey time range	8%	16%	27%	38%	9%	0%	2%
Cumulative Percentage	8%	24%	51%	89%	98%	98%	100%

Source: SUS SEM

Table 100: Baseline travel time to stroke services by public transport including HGH

	Travel Time - Public transport (including Horton)						
Journey time (number of minutes)	0-15	16-30	31-45	46-60	61-75	76-90	>90
Number of patients reaching stroke services in journey time range	21	83	80	126	118	83	111
Percentage of patients reaching stroke services in journey time range	3%	13%	13%	20%	19%	13%	18%
Cumulative Percentage	3%	17%	30%	50%	69%	82%	100%

Source: SUS SEM

Table 101 Future travel time to stroke services by public transport excluding HGH

	Travel Time - Public transport (excluding Horton)						
Journey time (number of minutes)	0-15	16-30	31-45	46-60	61-75	76-90	>90
Number of patients reaching stroke services in journey time range	7	44	76	139	132	100	120
Percentage of patients reaching stroke services in journey time range	1%	7%	12%	22%	21%	16%	19%
Cumulative Percentage	1%	8%	21%	43%	64%	81%	100%

Source: SUS SEM

F.2.2 Population in Oxfordshire only

Table 102: Baseline travel time by blue light to stroke services

	Travel Time - Blue light (including HGH)						
Journey time (number of minutes)	0-10	11-20	21-30	31-40	41-50	51-60	>60
Number of patients reaching stroke services in journey time range	128	121	171	114	48	0	0
Percentage of patients reaching stroke services in journey time range	22%	21%	29%	20%	8%	0%	0%
Cumulative Percentage	22%	43%	72%	92%	100%	100%	100%

Source: SUS SEM

Table 103: Future travel time to stroke services by blue light excluding the HGH

	Travel Time – Blue light (excluding HGH)						
Journey time (number of minutes)	0-10	11-20	21-30	31-40	41-50	51-60	>60
Number of patients reaching stroke services in journey time range	68	100	170	190	54	0	0
Percentage of patients reaching stroke services in journey time range	12%	17%	29%	33%	9%	0%	0%
Cumulative Percentage	12%	29%	58%	91%	100%	100%	100%

Source: SUS SEM

Table 104: Baseline travel time to stroke services by car including HGH

	Travel Time - Car (including Horton)						
Journey time (number of minutes)	0-10	11-20	21-30	31-40	41-50	51-60	>60
Number of patients reaching stroke services in journey time range	104	93	135	124	102	24	0
Percentage of patients reaching stroke services in journey time range	18%	16%	23%	21%	18%	4%	0%
Cumulative Percentage	18%	34%	57%	78%	96%	100%	100%

Source: SUS SEM

Table 105: Future travel time to stroke services by car excluding HGH

	Travel Time - Car (excluding Horton)						
Journey time (number of minutes)	0-10	11-20	21-30	31-40	41-50	51-60	>60
Number of patients reaching stroke services in journey time range	49	83	117	121	185	27	0
Percentage of patients reaching stroke services in journey time range	8%	14%	20%	21%	32%	5%	0%
Cumulative Percentage	8%	23%	43%	64%	95%	100%	100%

Source: SUS SEM

Table 106: Baseline travel time to stroke services by public transport including HGH

	Travel Time - Public transport (including Horton)						
Journey time (number of minutes)	0-15	16-30	31-45	46-60	61-75	76-90	>90
Number of patients reaching stroke services in journey time range	26	88	128	89	108	51	92
Percentage of patients reaching stroke services in journey time range	4%	15%	22%	15%	19%	9%	16%
Cumulative Percentage	4%	20%	42%	57%	75%	84%	100%

Source: SUS SEM

Table 107: Future travel time to stroke services by public transport excluding HGH

	Travel Time - Public transport (excluding Horton)						
Journey time (number of minutes)	0-15	16-30	31-45	46-60	61-75	76-90	>90
Number of patients reaching stroke services in journey time range	0	54	102	102	128	85	101
Percentage of patients reaching stroke services in journey time range	0%	9%	18%	18%	22%	15%	18%
Cumulative Percentage	0%	9%	27%	45%	67%	82%	100%

Source: SUS SEM

F.2.3 Age 65 years or more overall

Table 108: Baseline travel time by blue light to stroke services

	Travel Time - Blue light (including HGH)						
Journey time (number of minutes)	0-10	11-20	21-30	31-40	41-50	51-60	>60
Number of patients reaching stroke services in journey time range	91	106	130	86	24	0	0
Percentage of patients reaching stroke services in journey time range	21%	24%	30%	20%	5%	0%	0%
Cumulative Percentage	21%	45%	75%	95%	100%	100%	100%

Source: SUS SEM

Table 109: Future travel time to stroke services by blue light excluding the HGH

Travel Time – Blue light (excluding HGH)							
Journey time (number of minutes)	0-10	11-20	21-30	31-40	41-50	51-60	>60
Number of patients reaching stroke services in journey time range	36	77	127	150	41	0	0
Percentage of patients reaching stroke services in journey time range	8%	18%	29%	35%	10%	0%	0%
Cumulative Percentage	8%	26%	56%	90%	100%	100%	100%

Source: SUS SEM

Table 110: Baseline travel time to stroke services by car including HGH

Travel Time - Car (including Horton)							
Journey time (number of minutes)	0-10	11-20	21-30	31-40	41-50	51-60	>60
Number of patients reaching stroke services in journey time range	76	92	139	130	0	0	0
Percentage of patients reaching stroke services in journey time range	17%	21%	32%	30%	0%	0%	0%
Cumulative Percentage	17%	38%	70%	100%	100%	100%	100%

Source: SUS SEM

Table 111: Future travel time to stroke services by car excluding HGH

Travel Time - Car (excluding Horton)							
Journey time (number of minutes)	0-10	11-20	21-30	31-40	41-50	51-60	>60
Number of patients reaching stroke services in journey time range	17	72	126	177	38	0	0
Percentage of patients reaching stroke services in journey time range	4%	17%	29%	41%	9%	0%	0%
Cumulative Percentage	4%	21%	50%	91%	100%	100%	100%

Source: SUS SEM

Table 112: Baseline travel time to stroke services by public transport including HGH

	Travel Time - Public transport (including Horton)						
Journey time (number of minutes)	0-15	16-30	31-45	46-60	61-75	76-90	>90
Number of patients reaching stroke services in journey time range	0	55	60	87	84	68	87
Percentage of patients reaching stroke services in journey time range	0%	12%	14%	20%	19%	15%	20%
Cumulative Percentage	0%	12%	26%	46%	65%	80%	100%

Source: SUS SEM

Table 113: Future travel time to stroke services by public transport excluding HGH

	Travel Time - Public transport (excluding Horton)						
Journey time (number of minutes)	0-15	16-30	31-45	46-60	61-75	76-90	>90
Number of patients reaching stroke services in journey time range	0	13	51	97	98	81	93
Percentage of patients reaching stroke services in journey time range	0%	3%	12%	22%	23%	19%	21%
Cumulative Percentage	0%	3%	15%	37%	60%	79%	100%

Source: SUS SEM

F.2.4 Age 65 years or more in Oxfordshire only

Table 114: Baseline travel time by blue light to stroke services

	Travel Time - Blue light (including HGH)						
Journey time (number of minutes)	0-10	11-20	21-30	31-40	41-50	51-60	>60
Number of patients reaching stroke services in journey time range	91	94	128	84	18	0	0
Percentage of patients reaching stroke services in journey time range	22%	23%	31%	20%	4%	0%	0%
Cumulative Percentage	22%	45%	75%	96%	100%	100%	100%

Source: SUS SEM

Table 115 Future travel time to stroke services by blue light excluding the HGH

Travel Time – Blue light (excluding HGH)							
Journey time (number of minutes)	0-10	11-20	21-30	31-40	41-50	51-60	>60
Number of patients reaching stroke services in journey time range	36	76	127	143	34	0	0
Percentage of patients reaching stroke services in journey time range	9%	18%	31%	34%	8%	0%	0%
Cumulative Percentage	9%	27%	57%	92%	100%	100%	100%

Source: SUS SEM

Table 116: Baseline travel time to stroke services by car including HGH

Travel Time - Car (including Horton)							
Journey time (number of minutes)	0-10	11-20	21-30	31-40	41-50	51-60	>60
Number of patients reaching stroke services in journey time range	76	69	102	94	72	6	0
Percentage of patients reaching stroke services in journey time range	18%	16%	24%	22%	17%	1%	0%
Cumulative Percentage	18%	35%	59%	81%	99%	100%	100%

Source: SUS SEM

Table 117: Future travel time to stroke services by car excluding HGH

Travel Time - Car (excluding Horton)							
Journey time (number of minutes)	0-10	11-20	21-30	31-40	41-50	51-60	>60
Number of patients reaching stroke services in journey time range	17	63	87	90	139	6	0
Percentage of patients reaching stroke services in journey time range	4%	16%	22%	22%	35%	1%	0%
Cumulative Percentage	4%	20%	42%	64%	99%	100%	100%

Source: SUS SEM

Table 118: Baseline travel time to stroke services by public transport including HGH

	Travel Time - Public transport (including Horton)						
Journey time (number of minutes)	0-15	16-30	31-45	46-60	61-75	76-90	>90
Number of patients reaching stroke services in journey time range	6	59	91	57	85	33	71
Percentage of patients reaching stroke services in journey time range	1%	15%	23%	14%	21%	8%	18%
Cumulative Percentage	1%	16%	39%	53%	74%	82%	100%

Source: SUS SEM

Table 119: Future travel time to stroke services by public transport excluding HGH

	Travel Time - Public transport (excluding Horton)						
Journey time (number of minutes)	0-15	16-30	31-45	46-60	61-75	76-90	>90
Number of patients reaching stroke services in journey time range	0	29	72	69	103	56	78
Percentage of patients reaching stroke services in journey time range	0%	7%	18%	17%	25%	14%	19%
Cumulative Percentage	0%	7%	25%	42%	67%	81%	100%

Source: SUS SEM

F.2.5 Males overall

Table 120: Baseline travel time by blue light to stroke services

	Travel Time - Blue light (including HGH)						
Journey time (number of minutes)	0-10	11-20	21-30	31-40	41-50	51-60	>60
Number of patients reaching stroke services in journey time range	54	77	73	57	24	0	0
Percentage of patients reaching stroke services in journey time range	19%	27%	26%	20%	8%	0%	0%
Cumulative Percentage	19%	46%	72%	92%	100%	100%	100%

Source: SUS SEM

Table 121: Future travel time to stroke services by blue light excluding the HGH

	Travel Time – Blue light (excluding HGH)						
Journey time (number of minutes)	0-10	11-20	21-30	31-40	41-50	51-60	>60
Number of patients reaching stroke services in journey time range	28	55	75	95	32	0	0
Percentage of patients reaching stroke services in journey time range	10%	19%	26%	33%	11%	0%	0%
Cumulative Percentage	10%	29%	55%	89%	100%	100%	100%

Source: SUS SEM

Table 122: Baseline travel time to stroke services by car including HGH

	Travel Time - Car (including Horton)						
Journey time (number of minutes)	0-10	11-20	21-30	31-40	41-50	51-60	>60
Number of patients reaching stroke services in journey time range	43	70	93	68	11	0	0
Percentage of patients reaching stroke services in journey time range	15%	25%	33%	24%	4%	0%	0%
Cumulative Percentage	15%	40%	72%	96%	100%	100%	100%

Source: SUS SEM

Table 123: Future travel time to stroke services by car excluding HGH

	Travel Time - Car (excluding Horton)						
Journey time (number of minutes)	0-10	11-20	21-30	31-40	41-50	51-60	>60
Number of patients reaching stroke services in journey time range	21	53	81	100	30	0	0
Percentage of patients reaching stroke services in journey time range	7%	19%	28%	35%	11%	0%	0%
Cumulative Percentage	7%	26%	54%	89%	100%	100%	100%

Source: SUS SEM

Table 124: Baseline travel time to stroke services by public transport including HGH

	Travel Time - Public transport (including Horton)						
Journey time (number of minutes)	0-15	16-30	31-45	46-60	61-75	76-90	>90
Number of patients reaching stroke services in journey time range	10	32	41	69	53	32	52
Percentage of patients reaching stroke services in journey time range	3%	11%	14%	24%	18%	11%	18%
Cumulative Percentage	3%	15%	29%	53%	71%	82%	100%

Source: SUS SEM

Table 125: Future travel time to stroke services by public transport excluding HGH

	Travel Time - Public transport (excluding Horton)						
Journey time (number of minutes)	0-15	16-30	31-45	46-60	61-75	76-90	>90
Number of patients reaching stroke services in journey time range	7	15	39	71	57	43	57
Percentage of patients reaching stroke services in journey time range	2%	5%	13%	25%	20%	15%	20%
Cumulative Percentage	2%	8%	21%	46%	65%	80%	100%

Source: SUS SEM

F.2.6 Males in Oxfordshire only

Table 126: Baseline travel time by blue light to stroke services

	Travel Time - Blue light (including HGH)						
Journey time (number of minutes)	0-10	11-20	21-30	31-40	41-50	51-60	>60
Number of patients reaching stroke services in journey time range	28	55	75	95	32	0	0
Percentage of patients reaching stroke services in journey time range	10%	19%	26%	33%	11%	0%	0%
Cumulative Percentage	10%	29%	55%	89%	100%	100%	100%

Source: SUS SEM

Table 127: Future travel time to stroke services by blue light excluding the HGH

Travel Time – Blue light (excluding HGH)							
Journey time (number of minutes)	0-10	11-20	21-30	31-40	41-50	51-60	>60
Number of patients reaching stroke services in journey time range	28	54	75	89	25	0	0
Percentage of patients reaching stroke services in journey time range	10%	20%	28%	33%	9%	0%	0%
Cumulative Percentage	10%	30%	58%	91%	100%	100%	100%

Source: SUS SEM

Table 128: Baseline travel time to stroke services by car including HGH

Travel Time - Car (including Horton)							
Journey time (number of minutes)	0-10	11-20	21-30	31-40	41-50	51-60	>60
Number of patients reaching stroke services in journey time range	99	82	125	102	0	0	0
Percentage of patients reaching stroke services in journey time range	24%	20%	31%	25%	0	0	0
Cumulative Percentage	24%	44%	75%	100%	100%	100%	100%

Source: SUS SEM

Table 129: Future travel time to stroke services by car excluding HGH

Travel Time - Car (excluding Horton)							
Journey time (number of minutes)	0-10	11-20	21-30	31-40	41-50	51-60	>60
Number of patients reaching stroke services in journey time range	21	53	79	91	27	0	0
Percentage of patients reaching stroke services in journey time range	8%	20%	29%	34%	10%	5%	0%
Cumulative Percentage	8%	27%	56%	90%	100%	100%	100%

Source: SUS SEM

Table 130: Baseline travel time to stroke services by public transport including HGH

Travel Time - Public transport (including Horton)							
Journey time (number of minutes)	0-15	16-30	31-45	46-60	61-75	76-90	>90
Number of patients reaching stroke services in journey time range	10	32	40	60	52	32	45
Percentage of patients reaching stroke services in journey time range	4%	12%	15%	22%	19%	12%	17%
Cumulative Percentage	4%	15%	30%	52%	72%	83%	100%

Source: SUS SEM

Table 131: Future travel time to stroke services by public transport excluding HGH

Travel Time - Public transport (excluding Horton)							
Journey time (number of minutes)	0-15	16-30	31-45	46-60	61-75	76-90	>90
Number of patients reaching stroke services in journey time range	7	15	39	71	56	37	46
Percentage of patients reaching stroke services in journey time range	3%	6%	14%	26%	21%	14%	17%
Cumulative Percentage	3%	8%	23%	49%	69%	83%	100%

Source: SUS SEM

F.2.7 Females overall

Table 132: Baseline travel time by blue light to stroke services

Travel Time - Blue light (including HGH)							
Journey time (number of minutes)	0-10	11-20	21-30	31-40	41-50	51-60	>60
Number of patients reaching stroke services in journey time range	74	59	101	60	26	0	0
Percentage of patients reaching stroke services in journey time range	23%	18%	32%	19%	8%	0%	0%
Cumulative Percentage	23%	42%	73%	92%	100%	100%	100%

Source: SUS SEM

Table 133: Future travel time to stroke services by blue light excluding the HGH

	Travel Time – Blue light (excluding HGH)						
Journey time (number of minutes)	0-10	11-20	21-30	31-40	41-50	51-60	>60
Number of patients reaching stroke services in journey time range	40	46	95	105	34	0	12
Percentage of patients reaching stroke services in journey time range	12%	14%	29%	32%	10%	0%	4%
Cumulative Percentage	12%	26%	55%	86%	96%	96%	100%

Source: SUS SEM

Table 134: Baseline travel time to stroke services by car including HGH

	Travel Time - Car (including Horton)						
Journey time (number of minutes)	0-10	11-20	21-30	31-40	41-50	51-60	>60
Number of patients reaching stroke services in journey time range	61	56	89	106	9	0	12
Percentage of patients reaching stroke services in journey time range	18%	17%	27%	32%	3%	0%	4%
Cumulative Percentage	18%	35%	62%	94%	96%	96%	100%

Source: SUS SEM

Table 135: Future travel time to stroke services by car excluding HGH

	Travel Time - Car (excluding Horton)						
Journey time (number of minutes)	0-10	11-20	21-30	31-40	41-50	51-60	>60
Number of patients reaching stroke services in journey time range	28	45	85	135	28	0	12
Percentage of patients reaching stroke services in journey time range	8%	14%	26%	41%	8%	0%	4%
Cumulative Percentage	8%	22%	47%	88%	96%	96%	100%

Source: SUS SEM

Table 136: Baseline travel time to stroke services by public transport including HGH

Travel Time - Public transport (including Horton)							
Journey time (number of minutes)	0-15	16-30	31-45	46-60	61-75	76-90	>90
Number of patients reaching stroke services in journey time range	11	51	39	57	65	51	59
Percentage of patients reaching stroke services in journey time range	3%	15%	12%	17%	20%	15%	18%
Cumulative Percentage	3%	19%	30%	47%	67%	82%	100%

Source: SUS SEM

Table 137: Future travel time to stroke services by public transport excluding HGH

Travel Time - Public transport (excluding Horton)							
Journey time (number of minutes)	0-15	16-30	31-45	46-60	61-75	76-90	>90
Number of patients reaching stroke services in journey time range	0	29	37	68	75	57	63
Percentage of patients reaching stroke services in journey time range	0%	9%	11%	21%	23%	17%	19%
Cumulative Percentage	0%	9%	20%	41%	64%	81%	100%

Source: SUS SEM

F.2.8 Females in Oxfordshire only

Table 138: Baseline travel time by blue light to stroke services

Travel Time - Blue light (including HGH)							
Journey time (number of minutes)	0-10	11-20	21-30	31-40	41-50	51-60	>60
Number of patients reaching stroke services in journey time range	74	55	100	58	24	0	0
Percentage of patients reaching stroke services in journey time range	24%	18%	32%	19%	8%	0%	0%
Cumulative Percentage	24%	41%	74%	92%	100%	100%	100%

Source: SUS SEM

Table 139: Future travel time to stroke services by blue light excluding the HGH

Travel Time – Blue light (excluding HGH)							
Journey time (number of minutes)	0-10	11-20	21-30	31-40	41-50	51-60	>60
Number of patients reaching stroke services in journey time range	40	46	95	101	29	0	0
Percentage of patients reaching stroke services in journey time range	13%	15%	31%	32%	9%	0%	0%
Cumulative Percentage	13%	28%	58%	91%	100%	100%	100%

Source: SUS SEM

Table 140: Baseline travel time to stroke services by car including HGH

Travel Time - Car (including Horton)							
Journey time (number of minutes)	0-10	11-20	21-30	31-40	41-50	51-60	>60
Number of patients reaching stroke services in journey time range	105	84	132	105	12	0	0
Percentage of patients reaching stroke services in journey time range	24%	19%	30%	24%	3%	0%	0%
Cumulative Percentage	24%	43%	73%	97%	100%	100%	100%

Source: SUS SEM

Table 141: Future travel time to stroke services by car excluding HGH

Travel Time - Car (excluding Horton)							
Journey time (number of minutes)	0-10	11-20	21-30	31-40	41-50	51-60	>60
Number of patients reaching stroke services in journey time range	28	44	83	130	26	0	0
Percentage of patients reaching stroke services in journey time range	9%	14%	27%	42%	8%	0%	0%
Cumulative Percentage	9%	23%	50%	92%	100%	100%	100%

Source: SUS SEM

Table 142: Baseline travel time to stroke services by public transport including HGH

	Travel Time - Public transport (including Horton)						
Journey time (number of minutes)	0-15	16-30	31-45	46-60	61-75	76-90	>90
Number of patients reaching stroke services in journey time range	11	51	37	55	64	50	43
Percentage of patients reaching stroke services in journey time range	4%	16%	12%	18%	21%	16%	14%
Cumulative Percentage	4%	20%	32%	50%	70%	86%	100%

Source: SUS SEM

Table 143: Future travel time to stroke services by public transport excluding HGH

	Travel Time - Public transport (excluding Horton)						
Journey time (number of minutes)	0-15	16-30	31-45	46-60	61-75	76-90	>90
Number of patients reaching stroke services in journey time range	0	29	36	68	74	55	45
Percentage of patients reaching stroke services in journey time range	0%	9%	12%	22%	24%	18%	15%
Cumulative Percentage	0%	9%	21%	43%	67%	85%	100%

Source: SUS SEM

F.2.9 Deprived communities

Table 144: Baseline travel time by blue light to stroke services

	Travel Time - Blue light (including HGH)						
Journey time (number of minutes)	0-10	11-20	21-30	31-40	41-50	51-60	>60
Number of patients reaching stroke services in journey time range	18	17	0	0	0	0	0
Percentage of patients reaching stroke services in journey time range	51%	49%	0%	0%	0%	0%	0%
Cumulative Percentage	51%	100%	100%	100%	100%	100%	100%

Source: SUS SEM

Table 145: Future travel time to stroke services by blue light excluding the HGH

Travel Time – Blue light (excluding HGH)							
Journey time (number of minutes)	0-10	11-20	21-30	31-40	41-50	51-60	>60
Number of patients reaching stroke services in journey time range	0	17	0	13	0	0	0
Percentage of patients reaching stroke services in journey time range	0%	57%	0%	43%	0%	0%	0%
Cumulative Percentage	0%	57%	57%	100%	100%	100%	100%

Source: SUS SEM

Table 146: Baseline travel time by car to stroke services by car including the HGH

Travel Time - Car (including Horton)							
Journey time (number of minutes)	0-10	11-20	21-30	31-40	41-50	51-60	>60
Number of patients reaching stroke services in journey time range	18	17	0	0	0	0	0
Percentage of patients reaching stroke services in journey time range	51%	49%	0%	0%	0%	0%	0%
Cumulative Percentage	51%	100%	100%	100%	100%	100%	100%

Source: SUS SEM

Table 147: Future travel time to stroke services by car excluding the HGH

Travel Time - Car (excluding Horton)							
Journey time (number of minutes)	0-10	11-20	21-30	31-40	41-50	51-60	>60
Number of patients reaching stroke services in journey time range	0	17	0	15	0	0	0
Percentage of patients reaching stroke services in journey time range	0%	53%	0%	47%	0%	0%	0%
Cumulative Percentage	0%	53%	53%	100%	100%	100%	100%

Source: SUS SEM

Table 148: Baseline travel time to stroke services by public transport including HGH

	Travel Time - Public transport (including Horton)						
Journey time (number of minutes)	0-15	16-30	31-45	46-60	61-75	76-90	>90
Number of patients reaching maternity services in journey time range	6	12	0	0	0	0	0
Percentage of patients reaching maternity services in journey time range	33%	67%	0%	0%	0%	0%	0%
Cumulative Percentage	33%	100%	100%	100%	100%	100%	100%

Source: SUS SEM

Table 149: Future travel time to stroke services by public transport excluding HGH

	Travel Time - Public transport (excluding Horton)						
Journey time (number of minutes)	0-15	16-30	31-45	46-60	61-75	76-90	>90
Number of patients reaching stroke services in journey time range	0	0	20	7	0	0	0
Percentage of patients reaching stroke services in journey time range	0%	0%	74%	26%	0%	0%	0%
Cumulative Percentage	0%	0%	74%	100%	100%	100%	100%

Source: SUS SEM

F.2.10 Deprived communities in Oxfordshire only

Table 150: Baseline travel time by blue light to stroke services

	Travel Time - Blue light (including HGH)						
Journey time (number of minutes)	0-10	11-20	21-30	31-40	41-50	51-60	>60
Number of patients reaching stroke services in journey time range	18	17	0	0	0	0	0
Percentage of patients reaching stroke services in journey time range	51%	49%	0%	0%	0%	0%	0%
Cumulative Percentage	51%	100%	100%	100%	100%	100%	100%

Source: SUS SEM

Table 151: Future travel time to stroke services by blue light excluding the HGH

	Travel Time – Blue light (excluding HGH)						
Journey time (number of minutes)	0-10	11-20	21-30	31-40	41-50	51-60	>60
Number of patients reaching stroke services in journey time range	0	17	0	13	0	0	0
Percentage of patients reaching stroke services in journey time range	0%	57%	0%	43%	0%	0%	0%
Cumulative Percentage	0%	57%	57%	100%	100%	100%	100%

Source: SUS SEM



Oxfordshire Transformation Programme Parking Survey

John Radcliffe Hospital and Horton General Hospital

June 2017

Parking Survey- Commissioned by Oxfordshire
Clinical Commissioning Group

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1. Introduction

The purpose of this document is to help inform the decision making process of Oxfordshire Clinical Commissioning Group regarding its Phase One Transformation Proposals and has been commissioned in response to the feedback around parking raised in the public consultation.

The scope of this report is to provide a record and an analysis of the traffic flow around selected John Radcliffe Hospital and the Horton General Hospital car parks and has been commissioned with the support of Oxford University Hospitals NHS Foundation Trust (OUHFT).

This document, along with the qualitative analysis undertaken by Healthwatch, will be referenced within the Phase One Decision Making Business Case (DMBC) that will be received by the CCG board in August 2017.

The content of the report includes an executive summary laying out the key findings, methodology, and final observations.

Actual data recorded for John Radcliffe Hospital can be found in Appendix B.

Actual data recorded for Horton General Hospital can be found in Appendix D.

2. Executive Summary

This report identifies a range of parking issues, on site, at the John Radcliffe Hospital at particular times and days.

Over the five survey days the John Radcliffe Hospital car parks regularly saw queues form outside the car park barriers.

The longest queues occurred between 10am and 12pm across all of the survey days, other than the Wednesday 14th June.

Thursday 15th June saw the most consistent queues, with over 10 cars waiting at eight snapshot times for Car Park 2.

For Car Park 2a, the queues were smaller but still had over five cars waiting at eight times throughout the day.

The longest queue occurred for Car Park 2 on Monday 19th June, where 16 cars were waiting to enter the car park at 11am. By 11:15am, this had reduced to 10 cars.

There were very few parking issues on site at the Horton General Hospital.

The findings from Horton General Hospital show that there are no observed congestion issues when accessing the car park. Only two queues were recorded over the five survey days, and both journeys were completed in less than 30 seconds.

Observations:

In observing length of queues forming on the surrounding roads leading into the sites, it is noted that this may be due to improvements needed to those roads, which is out of the scope of this report.¹

Suggestions:

Based on the output of the analysis, it is suggested that further traffic planning take place in order to review the access to the John Radcliffe site.

This is reflected in the Oxfordshire Transformation Programme; Phase One IIA Report.

1. Full data provided in the appendix

3. Methodology

To obtain an understanding of the parking issues, post Phase One public consultation, video surveys were conducted in June 2017 with cameras set up across each of the car parks at two OUHFT hospital sites; John Radcliffe Hospital and Horton General Hospital.

The data reported was captured at the below dates and times;

- Wednesday 14th June: 14:00-18:00
- Thursday 15th June: 10:00-15:00
- Friday 16th June: 08.00-15.00
- Monday 19th June: 08.00-15.00
- Tuesday 20th June : 07:00 -14:00

The above time period was selected to avoid school half term, Bank Holiday weekends as well as the general election and is a short snapshot of traffic flow during a typical week. In order to capture a true reflection of parking issues 'peak days' have also been selected across the OUHFT sites.

The cameras were positioned to capture the main car parks identified as having close proximity to services included within the Phase One Consultation.²

The cameras captured the area around entry barriers and observed any queues forming on surrounding roads leading into the sites.

Queue data was then collected for a 5 day period at the John Radcliffe and Horton sites. The information collected was as follows;

- Footage recorded of the time taken to access each car park from the point at joining the queue on site, plus queue length (snapshots at 15 minute intervals).
- The footage was post-processed by a reviewer and specialist software in order to generate a report. The report looked at times to access the site (journey time) and how many cars were waiting to enter the car park (queue report) at 15 minute intervals.

The results are provided and discussed in this report.

2. OUHFT Car Park Maps located in the appendix

4. Site 1 - John Radcliffe

4.1 Key Findings

The findings from the survey at the John Radcliffe Hospital site highlight issues with the traffic flow when accessing the on-site car parks.

Over the five survey days, 101 access times were recorded. Of these, 66 were completed in less than five minutes (66%), and 34 lasted more than five minutes but typically less than 10 minutes.

In general, Car Park 2a had the longest access times with 28 (55%) of its journeys completed in less than five minutes, and nine (18%) took over 10 minutes. It also recorded the three highest journey times in excess of 15 minutes.

Car Park 2 saw fewer issues around traffic flow, with 38 (76%) completing in less than 5 minutes.

The longest access time occurred on the Monday 19th June, which lasted 18:19 mins, starting at 9:57am.

The queue report highlights that entry to the site was generally clear for both Car Park 2a and Car Park 2 before 10am on all survey days.

With the exception of Wednesday 14th June, which was clear at all times, the biggest congestion issues occurred between 10am and 12pm across the remainder of the survey days.

Thursday 15th June saw the most consistent queues, with over 10 cars waiting at eight snapshot times for Car Park 2. For Car Park 2a, the queues were smaller but still had over five cars waiting at eight times throughout the day.

The longest length of queue occurred for Car Park 2 on Monday 19th June, where 16 cars were waiting to enter the car park at 11am. By 11:15am, this had reduced to 10 cars.

4.1.1 Access

The access routes captured via the cameras off of Headley Way and Osler Road.

4.2 Journey Time

Site Name: John Radcliffe Hospital

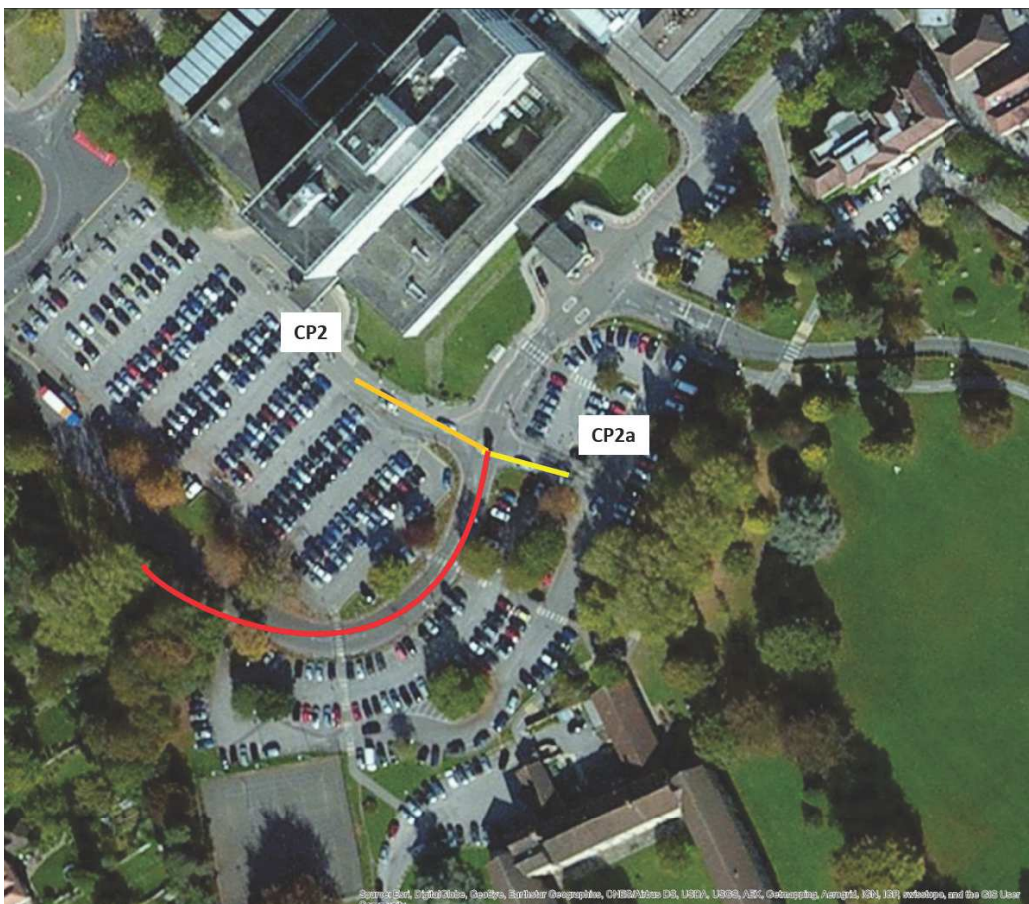
Dates of Survey:

Wednesday 14th June- Friday 16th June 2017

Monday 19th June 2017

Tuesday 20th June 2017

Location Plan: John Radcliffe Hospital Car Parks



Weather Conditions:

Date	Weather
Wednesday 14.06.2017:	Dry
Thursday 15.06.2017:	Dry and Sunny
Friday 16.06.2017:	Dry and Sunny
Monday 19.06.2017:	Dry and Sunny
Tuesday 20.06.2017:	Dry and Sunny

Queue Length Methodology:

The queue length, in vehicles, is reported at fifteen-minute intervals.

The following colour scheme was added to the queue data to show where the queue has occurred and when there is congestion. This is also related to the location plan above.

Green = No Queue

Amber/Yellow = Queue from Car Park to access road

Red = Congestion.

Figure 1. Duration of journey from time queue was joined (John Radcliffe Hospital, Car Park)

2)

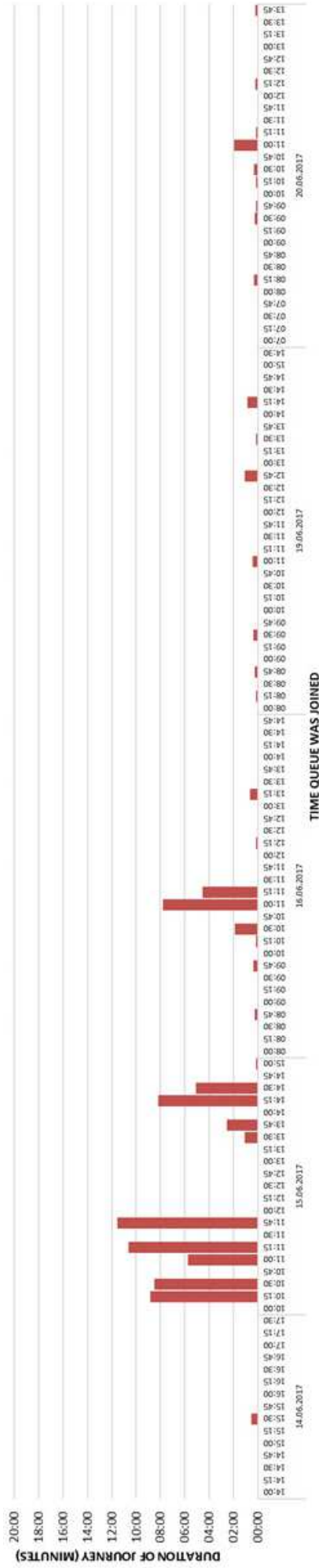
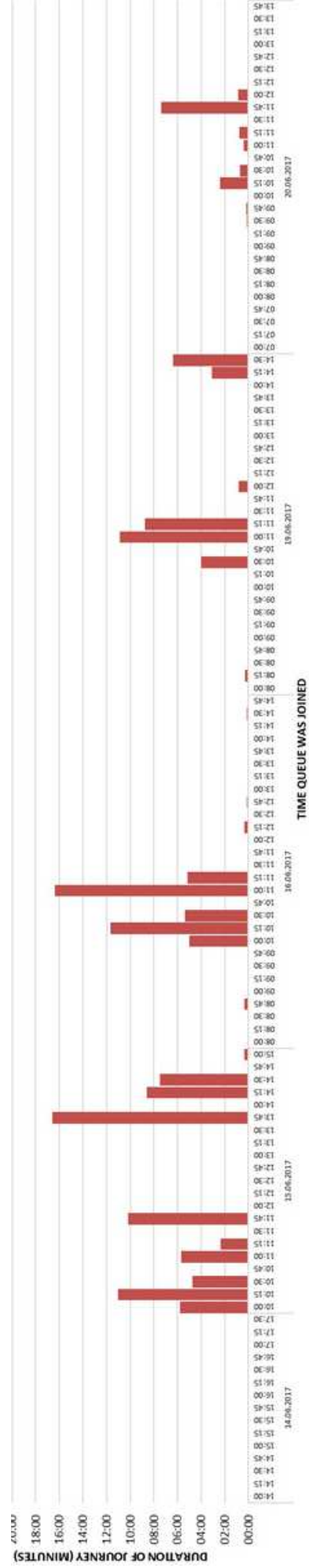


Figure 2. Duration of journey from time queue was joined (John Radcliffe Hospital, Car Park)

273a)



4.3 John Radcliffe Hospital Queue Report

Site Name: John Radcliffe Hospital

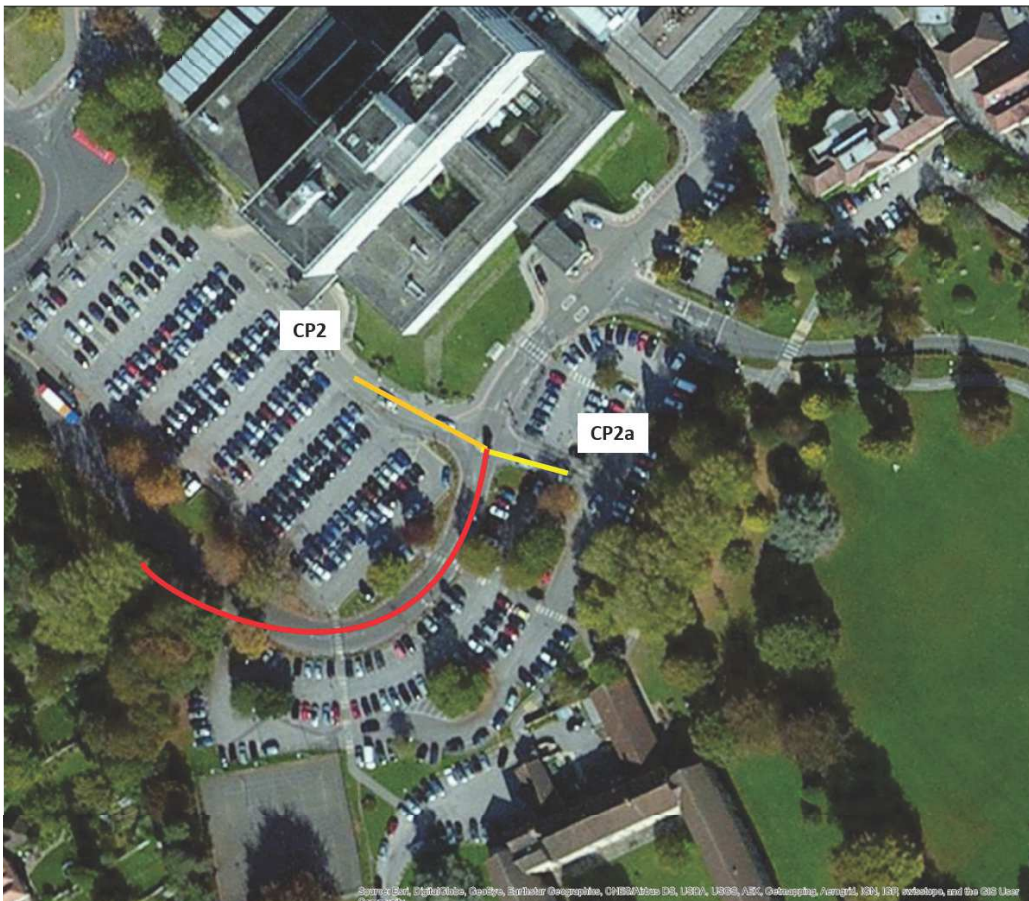
Dates of Survey:

Wednesday 14th June- Friday 16th June 2017

Monday 19th June 2017

Tuesday 20th June 2017

Survey Type: Snapshot Queue Lengths



Weather Conditions:

Wednesday 14.06.2017:	Dry
Thursday 15.06.2017:	Dry and Sunny
Friday 16.06.2017:	Dry and Sunny
Monday 19.06.2017:	Dry and Sunny
Tuesday 20.06.2017:	Dry and Sunny

Queue Length Methodology:

The queue length, in vehicles, is reported at fifteen-minute intervals.

The following colour scheme was added to the queue data to show where the queue has occurred and when there is congestion. This is also related to the location plan above.

Green = No Queue

Amber/Yellow = Queue from Car Park to access road

Red = Congestion.

Snapshot Queue Lengths - John Radcliffe Hospital

Time	Wed 14/06		Thur 15/06		Fri 16/06		Mon 19/06		Tues 19/06	
	Car Park 2	Car Park 2a	Car Park 2	Car Park 2a	Car Park 2	Car Park 2a	Car Park 2	Car Park 2a	Car Park 2	Car Park 2a
07:00									0	1
07:15									0	0
07:30									0	0
07:45									1	0
08:00					0	0	0	0	0	0
08:15					0	0	1	2	2	0
08:30					0	0	2	1	1	0
08:45					2	2	1	0	0	0
09:00					0	0	0	0	0	0
09:15					0	0	1	0	0	0
09:30					0	0	1	0	1	1
09:45					2	1	0	0	1	2
10:00			1	7	0	4	0	3	0	1
10:15			3	8	1	2	0	4	2	4
10:30			15	2	3	3	0	2	9	3
10:45			15	5	11	4	0	3	2	3
11:00			5	4	4	7	2	5	16	3
11:15			14	2	7	2	0	4	10	4
11:30			15	13	0	0	0	0	1	3
11:45			11	11	0	0	0	0	0	1
12:00			0	0	0	0	0	1	0	1
12:15			0	0	1	1	0	0	1	0
12:30			0	0	1	3	0	0	0	0
12:45			0	0	0	1	2	0	0	0
13:00			0	0	0	0	0	0	0	0
13:15			2	3	1	0	1	0	0	0
13:30			1	0	0	0	1	0	0	0
13:45			3	6	0	0	0	0	2	0
14:00	0	0	11	10	0	0	1	2		
14:15	0	0	14	9	0	0	1	4		
14:30	0	0	11	10	0	1	0	2		
14:45	0	0	3	2	0	0	0	0		
15:00	0	0	1	2						
15:15	0	0								
15:30	1	0								
15:45	0	0								
16:00	0	0								
16:15	0	0								
16:30	0	0								
16:45	0	0								
17:00	0	0								
17:15	0	0								
17:30	0	0								
17:45	0	0								

Key:
 Green = No Queue
 Amber/Yellow = Queue from Car Park to access road
 Red = Congestion.

5. Site 2 - Horton General

5.1 Key Findings

The findings from Horton General Hospital show that there was very little observed congestion when accessing the car parks.

Only two queues were recorded over the five survey days, and both journeys were completed in less than 30 seconds.

The two minor queues are picked up on the queue length snapshot table, but it is clear that there is easy access to the car park at all times.

5.1.1 Access

The access routes captured via the cameras were off of Hightown Road.

There were two access points available for the same on site car park. These access points have been suffixed with a letter and will be identified as car parks 2 and 2a.

5.2 Journey Time

Site Name: Horton General Hospital

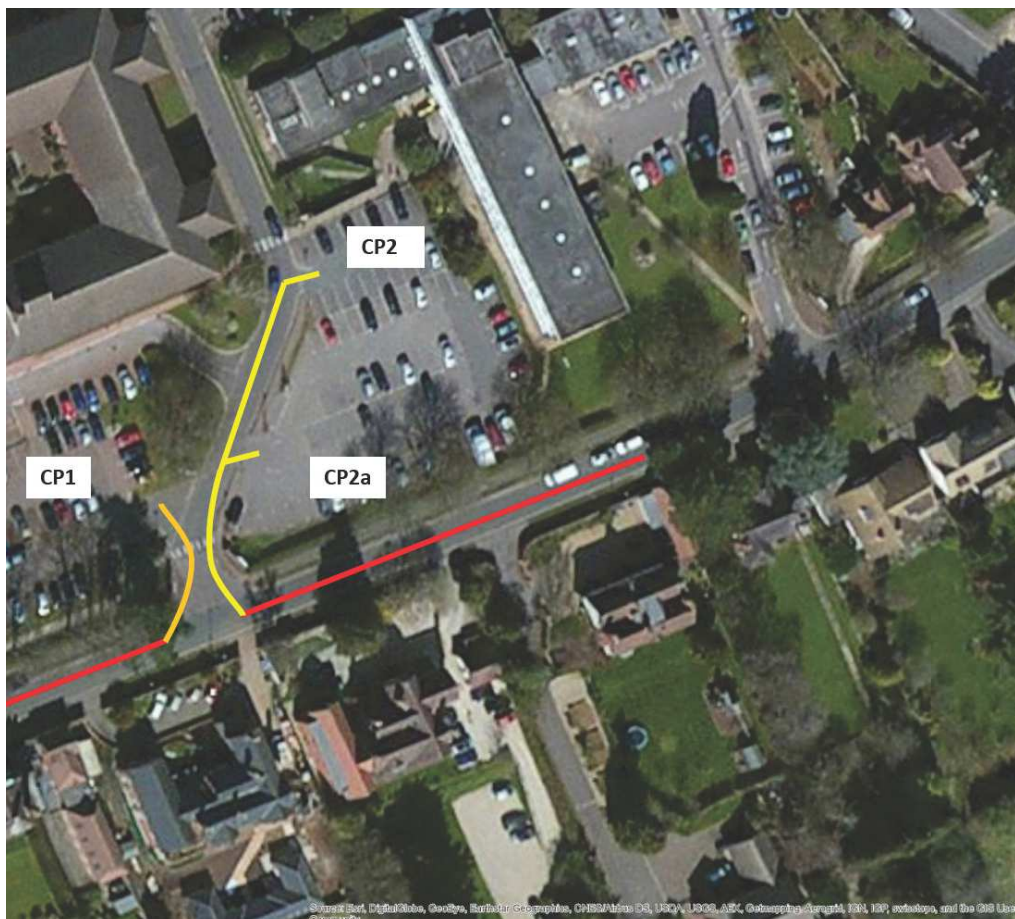
Dates of Survey:

Wednesday 14th June- Friday 16th June 2017

Monday 19th June 2017

Tuesday 20th June 2017

Location Plan: Horton General Hospital Car Parks



Weather Conditions:

Wednesday 14.06.2017:	Dry
Thursday 15.06.2017:	Dry and Sunny
Friday 16.06.2017:	Dry and Sunny
Monday 19.06.2017:	Dry and Sunny
Tuesday 20.06.2017:	Dry and Sunny

Queue Length Methodology:

The queue length, in vehicles, is reported at fifteen-minute intervals.

The following colour scheme was added to the queue data to show where the queue has occurred and when there is congestion. This is also related to the location plan above.

Green = No Queue

Amber/Yellow = Queue from Car Park to access road

Red = Congestion.

5.3 Horton General Hospital Queue Report

Site Name: John Radcliffe Hospital

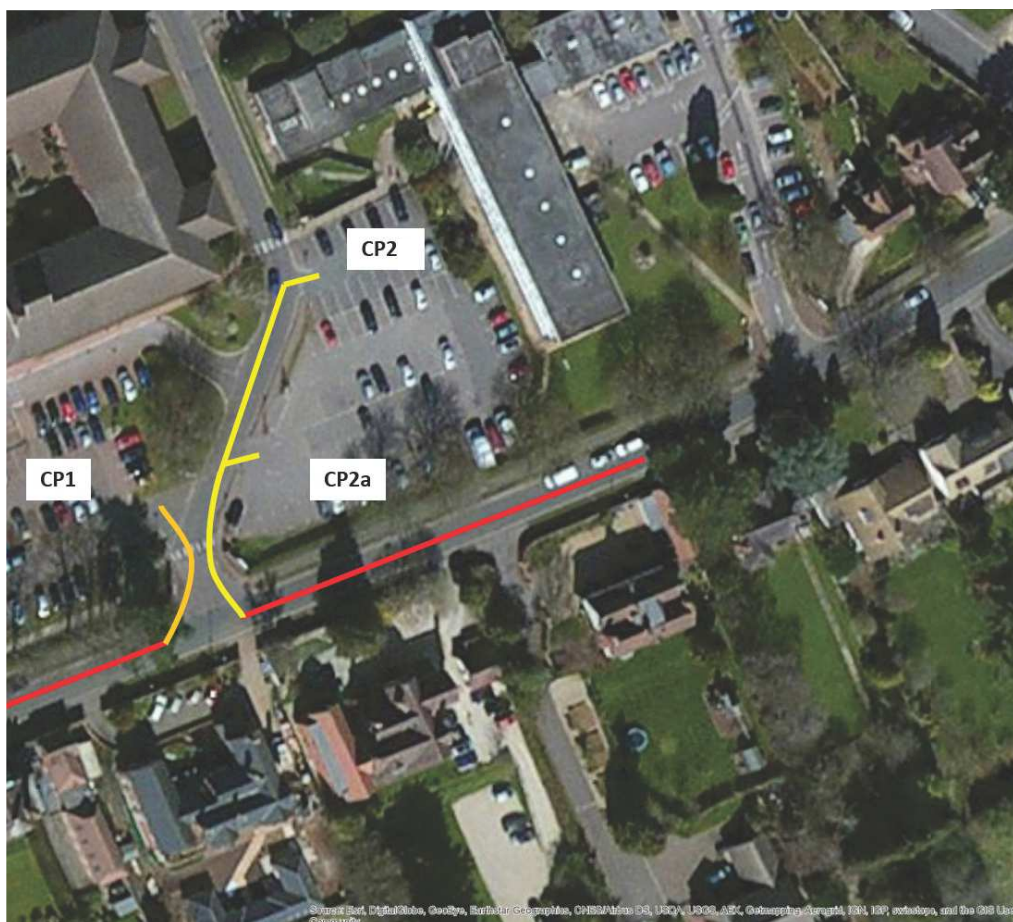
Dates of Survey:

Wednesday 14th June- Friday 16th June 2017

Monday 19th June 2017

Tuesday 20th June 2017

Survey Type: Snapshot Queue Lengths



Weather Conditions:

Wednesday 14.06.2017:	Dry
Thursday 15.06.2017:	Dry and Sunny
Friday 16.06.2017:	Dry and Sunny
Monday 19.06.2017:	Dry and Sunny
Tuesday 20.06.2017:	Dry and Sunny

Queue Length Methodology:

The queue length, in vehicles, is reported at fifteen-minute intervals.

The following colour scheme was added to the queue data to show where the queue has occurred and when there is congestion. This is also related to the location plan above.

Green = No Queue

Amber/Yellow = Queue from Car Park to access road

Red = Congestion.

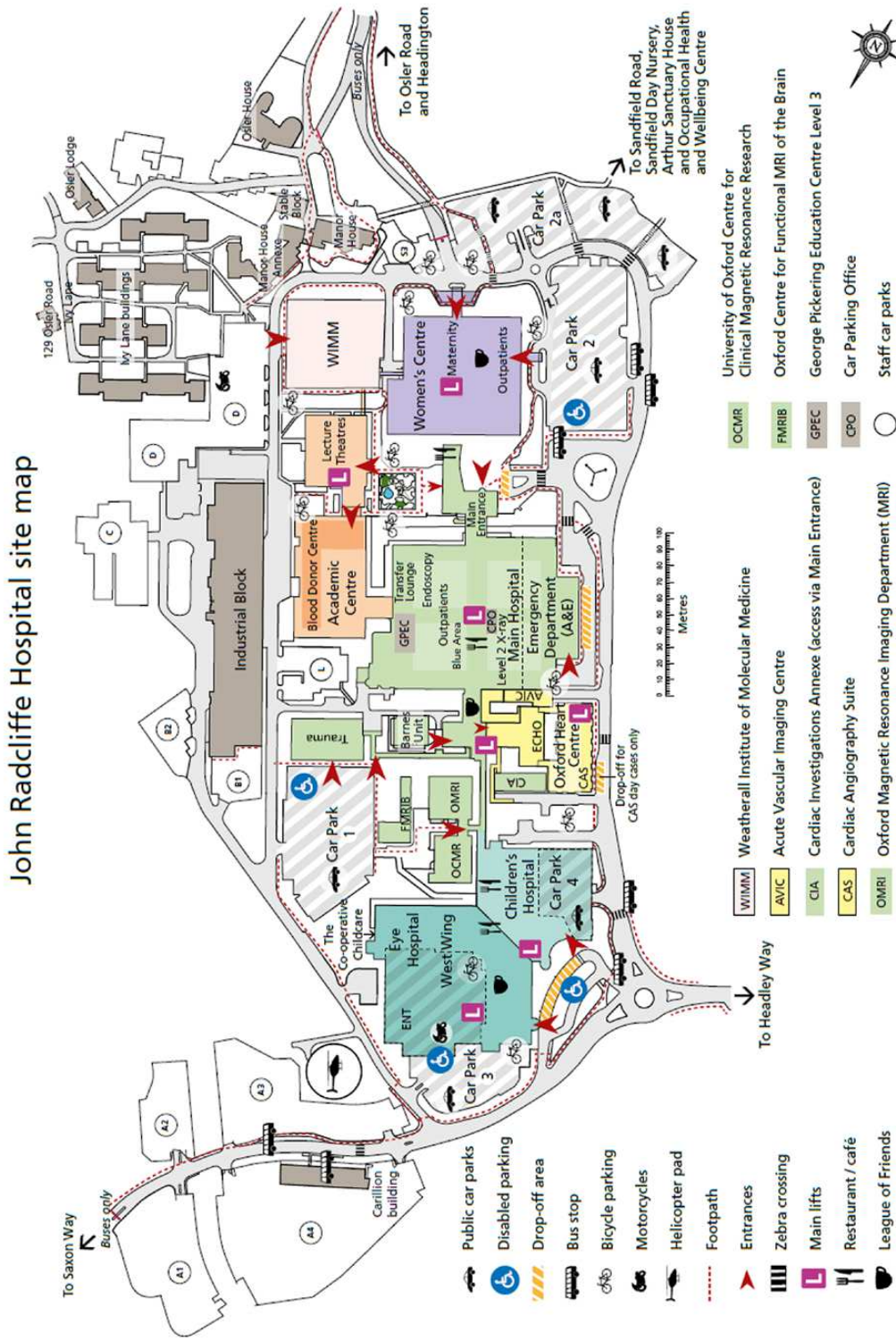
Snapshot Queue Lengths - Horton General Hospital

Time	Wed 14/06			Thur 15/06			Fri 16/06			Mon 19/06			Tues 19/06		
	Car Park 1	Car Park 2	Car Park 2a	Car Park 1	Car Park 2	Car Park 2a	Car Park 1	Car Park 2	Car Park 2a	Car Park 1	Car Park 2	Car Park 2a	Car Park 1	Car Park 2	Car Park 2a
07:00													0	0	0
07:15													0	0	0
07:30													0	0	0
07:45													0	0	0
08:00							0	0	0	0	0	0	0	0	0
08:15							0	0	0	0	0	0	0	0	0
08:30							0	0	0	0	0	0	0	0	0
08:45							0	0	0	0	0	0	0	0	0
09:00							0	0	0	0	0	0	0	0	0
09:15							0	0	0	0	0	0	0	0	0
09:30							0	0	0	0	0	0	0	0	0
09:45							0	0	0	0	0	0	0	0	0
10:00				0	0	0	0	0	0	0	0	0	0	0	0
10:15				0	0	0	0	0	0	0	0	0	0	0	0
10:30				0	0	0	0	0	0	0	0	0	0	0	0
10:45				0	0	0	0	0	0	0	0	0	0	0	0
11:00				0	0	0	0	0	0	0	0	0	0	0	0
11:15				0	0	0	0	0	0	1	0	0	0	0	0
11:30				0	0	0	0	0	0	0	0	0	0	0	0
11:45				0	0	0	0	0	0	0	0	0	0	0	0
12:00				0	0	0	0	0	0	0	0	0	0	0	0
12:15				0	0	0	0	0	0	0	0	0	0	0	0
12:30				0	0	0	0	0	0	0	0	0	0	0	0
12:45				0	0	0	0	0	0	0	0	0	0	0	0
13:00				0	0	0	0	0	0	0	0	0	0	0	0
13:15				0	0	0	0	0	0	0	0	0	0	0	0
13:30				0	0	0	0	0	0	0	0	0	0	0	0
13:45				0	0	0	0	0	0	0	0	0	0	0	0
14:00	0	0	0	0	0	0	0	0	0	0	0	0			
14:15	0	0	0	0	0	0	0	0	0	0	0	0			
14:30	0	0	0	0	0	0	0	0	0	0	0	0			
14:45	0	0	1	0	0	0	0	0	0	0	0	0			
15:00	0	0	0												
15:15	0	0	0												
15:30	0	0	0												
15:45	0	0	0												
16:00	0	0	0												
16:15	0	0	0												
16:30	0	0	0												
16:45	0	0	0												
17:00	0	0	0												
17:15	0	0	0												
17:30	0	0	0												

Key:
Green = No Queue
Amber/Yellow = Queue from Car Park to access road
Red = Congestion.

6. Appendix

Appendix A: John Radcliffe Hospital Car Park Map



Appendix B: John Radcliffe Hospital Journey Time Data

Dates of Survey: 14.06.2017

ID	Car park	Time queue was joined	Time Car Park was accessed	Duration of Journey
1	Car Park 2	15:29:55	15:30:26	00:00:31

Dates of Survey: 15.06.2017

ID	Car park	Time queue was joined	Time Car Park was accessed	Duration of Journey
1	Car Park 2a	09:59:02	10:04:50	00:05:48
2	Car Park 2	09:59:46	09:59:56	00:00:10
3	Car Park 2	10:13:40	10:22:29	00:08:49
4	Car Park 2a	10:14:46	10:25:48	00:11:02
5	Car Park 2a	10:28:48	10:33:32	00:04:44
6	Car Park 2	10:29:56	10:38:25	00:08:29
7	Car Park 2	10:42:00	10:51:33	00:09:33
8	Car Park 2a	10:42:58	10:47:36	00:04:38
9	Car Park 2	10:57:00	11:02:45	00:05:45
10	Car Park 2a	10:59:15	11:04:57	00:05:42
11	Car Park 2	11:13:02	11:23:40	00:10:38
12	Car Park 2a	11:14:22	11:16:44	00:02:22
13	Car Park 2	11:28:59	11:43:37	00:14:38
14	Car Park 2a	11:29:49	11:38:13	00:08:24
15	Car Park 2	11:42:39	11:54:12	00:11:33
16	Car Park 2a	11:43:00	11:53:12	00:10:12
17	Car Park 2a	13:14:11	13:16:58	00:02:47
18	Car Park 2	13:14:55	13:15:19	00:00:24
19	Car Park 2	13:30:02	13:31:07	00:01:05
20	Car Park 2a	13:43:15	13:59:50	00:16:35
21	Car Park 2	13:45:04	13:47:35	00:02:31
22	Car Park 2a	13:57:55	14:03:29	00:05:34
23	Car Park 2	13:58:59	14:04:30	00:05:31
24	Car Park 2a	14:15:13	14:23:48	00:08:35
25	Car Park 2	14:15:20	14:23:32	00:08:12
26	Car Park 2a	14:28:56	14:36:24	00:07:28
27	Car Park 2	14:30:42	14:35:47	00:05:05
28	Car Park 2a	14:42:02	14:45:57	00:03:55
29	Car Park 2	14:45:08	14:47:28	00:02:20
30	Car Park 2	14:59:56	15:00:06	00:00:10
31	Car Park 2a	14:59:58	15:00:19	00:00:21

Dates of Survey: 16.06.2017

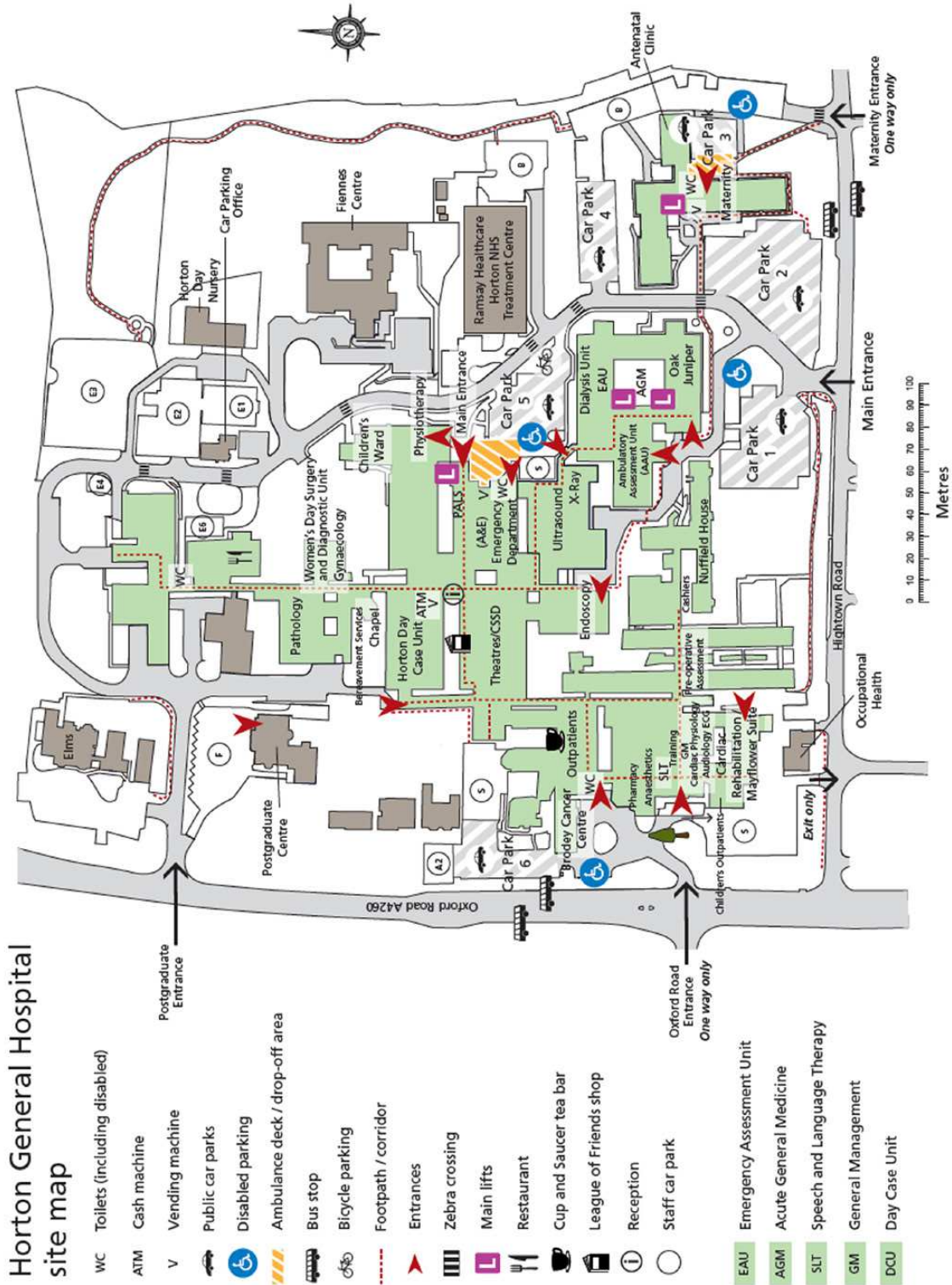
ID	Car park	Time queue was joined	Time Car Park was accessed	Duration of Journey
1	Car Park 2a	08:44:54	08:45:15	00:00:21
2	Car Park 2	08:44:56	08:45:12	00:00:16
3	Car Park 2	09:45:00	09:45:22	00:00:22
4	Car Park 2a	09:59:28	10:04:28	00:05:00
5	Car Park 2a	10:09:03	10:20:43	00:11:40
6	Car Park 2	10:14:58	10:15:08	00:00:10
7	Car Park 2	10:28:58	10:30:50	00:01:52
8	Car Park 2a	10:29:23	10:34:45	00:05:22
9	Car Park 2a	10:44:34	10:47:46	00:03:12
10	Car Park 2	10:45:01	10:51:12	00:06:11
11	Car Park 2a	10:59:15	11:15:39	00:16:24
12	Car Park 2	10:59:58	11:07:47	00:07:49
13	Car Park 2a	11:13:05	11:18:16	00:05:11
14	Car Park 2	11:14:09	11:18:40	00:04:31
15	Car Park 2a	12:14:53	12:15:14	00:00:21
16	Car Park 2	12:14:58	12:15:08	00:00:10
17	Car Park 2	12:29:48	12:29:58	00:00:10
18	Car Park 2a	12:29:53	12:30:31	00:00:38
19	Car Park 2a	12:44:51	12:45:00	00:00:09
20	Car Park 2	13:14:55	13:15:34	00:00:39
21	Car Park 2a	14:29:52	14:30:01	00:00:09

Dates of Survey: 19.06.2017

ID	Car park	Time queue was joined	Time Car Park was accessed	Duration of Journey
1	Car Park 2	08:14:58	08:15:07	00:00:09
2	Car Park 2a	08:15:04	08:15:22	00:00:18
3	Car Park 2	08:30:01	08:30:27	00:00:26
4	Car Park 2a	08:30:03	08:30:14	00:00:11
5	Car Park 2	08:44:51	08:45:07	00:00:16
6	Car Park 2	09:15:00	09:15:11	00:00:11
7	Car Park 2	09:29:58	09:30:20	00:00:22
8	Car Park 2a	09:57:01	10:15:20	00:18:19
9	Car Park 2a	10:07:02	10:18:21	00:11:19
10	Car Park 2a	10:29:34	10:33:33	00:03:59
11	Car Park 2a	10:42:00	10:50:28	00:08:28
12	Car Park 2a	10:59:42	11:10:34	00:10:52
13	Car Park 2	10:59:56	11:00:22	00:00:26
14	Car Park 2a	11:13:44	11:22:30	00:08:46
15	Car Park 2a	11:59:29	12:00:19	00:00:50
16	Car Park 2	12:44:43	12:45:47	00:01:04
17	Car Park 2	13:14:50	13:15:10	00:00:20
18	Car Park 2	13:30:01	13:30:11	00:00:10
19	Car Park 2a	13:58:45	14:11:22	00:12:37
20	Car Park 2	13:59:58	14:00:09	00:00:11
21	Car Park 2	14:14:13	14:15:04	00:00:51
22	Car Park 2a	14:14:51	14:17:58	00:03:07
23	Car Park 2a	14:29:07	14:35:30	00:06:23

Dates of Survey: 20.06.2017

ID	Car park	Time queue was joined	Time Car Park was accessed	Duration of Journey
1	Car Park 2a	06:59:45	07:00:04	00:00:19
2	Car Park 2	07:44:53	07:45:02	00:00:09
3	Car Park 2	08:15:08	08:15:25	00:00:17
4	Car Park 2	08:29:53	08:30:07	00:00:14
5	Car Park 2	09:29:52	09:30:08	00:00:16
6	Car Park 2a	09:30:00	09:30:08	00:00:08
7	Car Park 2	09:44:57	09:45:05	00:00:08
8	Car Park 2a	09:45:19	09:45:30	00:00:11
9	Car Park 2a	09:57:30	10:04:12	00:06:42
10	Car Park 2	10:16:00	10:16:09	00:00:09
11	Car Park 2a	10:17:32	10:19:56	00:02:24
12	Car Park 2a	10:32:39	10:33:21	00:00:42
13	Car Park 2	10:37:23	10:37:40	00:00:17
14	Car Park 2	10:47:39	10:47:48	00:00:09
15	Car Park 2a	10:48:26	10:52:10	00:03:44
16	Car Park 2a	11:02:53	11:03:17	00:00:24
17	Car Park 2	11:05:56	11:07:53	00:01:57
18	Car Park 2a	11:17:28	11:18:14	00:00:46
19	Car Park 2	11:19:19	11:19:28	00:00:09
20	Car Park 2	11:30:03	11:30:14	00:00:11
21	Car Park 2a	11:32:44	11:32:58	00:00:14
22	Car Park 2a	11:44:57	11:52:21	00:07:24
23	Car Park 2a	12:00:00	12:00:51	00:00:51
24	Car Park 2	12:15:01	12:15:14	00:00:13
25	Car Park 2	13:45:07	13:45:20	00:00:13



Appendix D: Horton General Hospital Journey Time Data

Dates of Survey: 14.06.2017

ID	Car park	Time queue was joined	Time Car Park was accessed	Duration of Journey
1	Car Park 2a	14:45:00	14:45:09	00:00:09

Dates of Survey: 15.06.2017

No Queues Recorded

Dates of Survey: 16.06.2017

No Queues Recorded

Dates of Survey: 19.06.2017

ID	Car park	Time queue was joined	Time Car Park was accessed	Duration of Journey
1	Car Park 1	11:15:00	11:15:21	00:00:21

Dates of Survey: 20.06.2017

No Queues Recorded



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People's experiences of travelling to hospitals in Oxford and Banbury

May 2017



Your voice in health and social care

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1 Executive summary

Healthwatch Oxfordshire was commissioned by Oxfordshire Clinical Commissioning Group (OCCG) to conduct a qualitative travel experience survey of people's experiences attending the John Radcliffe (JR) Hospital in Oxford, the Horton General Hospital (HGH) in Banbury, the Churchill Hospital, and the Nuffield Orthopaedic Centre (NOC) in Headington, Oxford. The purpose of the survey was to gain an understanding of people's experience when travelling to and, parking at, the four Oxford University Hospitals NHS Foundation Trust (OUHFT) hospital sites.

We randomly selected and spoke to 295 people over a three-week period between 8th May and 26th May 2017.

2 Summary of findings

2.1 People's experiences

Overall, people's experience of travelling to the four hospital sites was that they would have early starts to avoid traffic, leave plenty of time to queue and park, and they were stressed by the thought of the queue to get into the John Radcliffe or Churchill sites. They also observed that it took three people to make the appointment on time - driver, patient escort and patient - and the sense of 'would it all come together and will I get to my appointment on time?' ran through many of the comments.

Despite the planning needed and uncertainty about the journey and parking, most people reported that their journey felt fine, 'as expected'. Others reported that the parking experience was not fine - queuing, being let into parking areas where there were no spaces (only Blue Badge spots), the price of parking and for HGH the fact that the change machine was giving new pound coins that were not accepted by the parking meters.¹

2.1.1 Travelling by car and parking

Most people chose to travel by car and park on the hospital site. Some were pleasantly surprised, relieved, to find that the journey and parking were easier than they had expected. Many people told us that setting off and planning for the journey was a stressful time as traffic onto the site was expected to be difficult and parking a 'nightmare'.

Travel times to the hospital sites varied based on the time of day and whether people came from outside Oxfordshire (taking 1-2 hours) or within Oxfordshire taking 30 minutes to 1 hour. On arrival, the longest time taken to park varied depending on the time of day. Finding a parking space took longer between 10am and 2pm - up from under 15 minutes in the early morning to at least 30 minutes after 10am at the JR, NOC and Churchill sites. Parking at the HGH was usually achieved under 15 minutes throughout the day.

¹ Healthwatch Oxfordshire raised this with OUHT on the day and they responded within 4 hours by suspending parking meters.

The experience of parking for many people varied between easy ‘one of the good [experiences] today’ - usually early morning and most often at the HGH, to ‘horrendous’.

People from Oxfordshire generally had a total travel and parking time of between 45 and 75 minutes to all the hospital sites.

Many people who travel to hospital regularly told us of much more difficult experiences they have had on earlier visits, including missing appointments, dropping the patient off and looking for parking and not getting parked in time to be with them for the appointment. On the day one person told us:

‘...took 20 minutes [to park] ...I queued for 57 minutes from the junction...wife gone into surgery without seeing me even though I was there, just couldn’t park. It’s just horrendous...’ (JR site)

The preference to travel by car was influenced by many factors, including lack of public transport from outside of Oxford or Banbury, travel times and having to take multiple buses, the cost of public transport, and patients unable to use public transport due to illness or disability. People did comment that with more direct buses to the hospital sites and serving the hospitals later at night - both from their point of departure and park & ride sites - they would consider using them, if able so to do.

2.1.1.1 Suggestions from people using cars

People took the opportunity to make suggestions that would make their, and others’, experience better. These included the provision of nearby multi-storey car parks, off-site parking with a regular shuttle bus, car park barriers not letting people in when only Blue Badge spaces were available, better information on the park and ride buses about drop-off points, spreading appointment times to ease pressure on access and parking on site, and having direct buses from all park and ride sites to the hospitals.

3 Considerations and recommendations

The preferred choice, and often the only choice, for people attending as outpatients at the four OUHT hospital sites is to travel by car.

3.1 Horton General Hospital

At the HGH all of those who spoke to Healthwatch had arrived by car. If this is representative of most people visiting the hospital site then it has implications for the proposed expansion of outpatient and day case appointments at this hospital. People’s current experience is usually positive: easy parking and shorter journey times than using public transport (and often public transport is not an option). In our view a significant increase in the number of out-patients using the HGH will most probably have a negative impact on the patient experience of attending the site.

3.1.1 Recommendations

Part of the planning process for the development of the HGH site should include:

1. Consideration of ease of access to the site
2. A proportionate and prompt increase in parking spaces on site
3. Consideration for dedicated park and ride facilities located on the main routes into Banbury from the expected direction of travel of the 'additional' outpatients.

Without more parking and maintaining the ease of access to the hospital site it is anticipated that the move to the Horton of outpatient appointments from the Headington hospital sites will take with it the negative travel (queuing) and negative parking experiences of patients currently visiting the Headington sites.

3.2 Headington hospitals sites

Access to the Headington hospitals sites by car is at its worse mid-morning to early afternoon when most out-patient appointments are held.

Our survey did not reflect the general public's perception of getting to and parking at JR being a 'constant nightmare' to access the site and park. However, there were a sizeable number of people whose travel and parking experience had a major negative impact on their visits to the hospital.

Two frustrations voiced were queuing for parking when spaces were only available for Blue Badge holders and being given access to car parks by non-Blue Badge holders when only Blue Badge spaces were available.

Recommendations

1. OUHFT should further explore 'spreading' out-patient appointments across the day / week. This will relieve the pressure on the access routes and parking facilities, thus improving the patient experience of attending a hospital appointment.
2. OUHFT should undertake a review of the number of Blue Badge spaces available at all sites, and their use
3. OUHFT should explore a simple solution, adopted by other hospitals in the country, of a dedicated Blue Badge only parking area with separate access.

3.2.1 People's suggestions

Suggestions have been made during this survey by people visiting the JR, NOC and Churchill sites that could improve their travel and parking experience.

Healthwatch recommends that OUHFT respond to the following public suggestions:

1. Introduction of multi-storey parking: The public needs regular updates on this proposal, if only to dispel the myth or hope that one day there will be multi storey car parks that solve the queuing and parking problems.
2. Introduction of nearby off-site parking with a frequent shuttle bus running to all sites.
3. Introduction of cheaper parking fees.
4. More frequent and later direct buses from all park and ride sites and the City.

3.3 Staff parking

Some OUHFT staff expressed concerns about parking and access to public transport to the hospital site.

3.3.1 Recommendation

OCCG and OUHFT should survey staff to understand the impact of travelling to work, both by public transport and car, on recruitment and retention of staff.

4 Travel survey at four hospital sites

4.1 Background

Healthwatch Oxfordshire was commissioned by Oxfordshire clinical Commissioning Group (OCCG) to conduct a survey of patients attending the John Radcliffe (JR) Hospital in Oxford, the Horton General Hospital (HGH) in Banbury, the Churchill Hospital, and the Nuffield Orthopaedic Centre (NOC) in Headington, Oxford. The purpose of the survey was to gain an understanding of patient experience when travelling to and parking at the four Oxford University Hospitals NHS Foundation Trust (OUHFT) hospital sites.

Oxfordshire Clinical Commissioning Group (OCCG) undertook a consultation between 16th January and 9th April 2017 looking at acute hospital services, specifically:

- Changing the way we use our hospital beds and increasing care closer to home in Oxfordshire
- Planned care at the Horton General Hospital (planned care includes tests and treatment planned in advance and not urgent or emergency care)
- Acute stroke services in Oxfordshire
- Critical care (critical care helps people with life-threatening or very serious injuries and illnesses) at the Horton General Hospital
- Maternity services at the Horton General Hospital including obstetrics and the Special Care Baby Unit (SCBU).

Initial analysis by both OCCG and Healthwatch of the issues raised throughout the consultation period included concerns over travel and car parking times from Banbury and the surrounding areas to the John Radcliffe Hospital. In the south of the county travel times and parking availability and time to park at Oxford hospitals were also raised during the consultation.

This report will inform OCCG's consideration for transforming health services in Oxfordshire.

4.2 Methodology

4.2.1 Questionnaire

Using an agreed questionnaire², Healthwatch Oxfordshire:

1. Conducted face to face interviews with patients, or their representatives (carers, relatives going with patients) visiting the four hospital sites.
 - a. Interviews were conducted at the main entrance to the hospital buildings, in public areas specifically in the hospital entrances, foyer and cafés.

² Attached as Appendix F to this report

- b. Where people were unable to complete the questionnaire with the Healthwatch representative, they were offered a paper copy for self-completion with the copy to be returned to Healthwatch by free post.

4.2.2 Process

- 1 The survey was undertaken at separate times, on different days across the four hospital sites over a three-week period between 8th May and 26th May, avoiding school holidays. The survey times were divided into three blocks - 6-10am, 10am-2pm, and 2-6pm to cover different periods of the day.
- 2 Healthwatch staff undertook the face to face questionnaire, collated and analysed the results.
- 3 The survey questions were drafted and agreed by Healthwatch and OCCG and were designed to provide data on a range of areas such as considerations when making the journey, choosing a mode of transport and the impact of the journey experience to the hospital.
- 4 No personal details were collected and people were not asked to disclose any symptoms/ illness details.
 - a. However, people were given the opportunity to give their contact details if they wished to be informed of the outcome of the survey and / or wanted to be kept informed of Healthwatch's activities. This data would be recorded separately from the survey data and maintained in accordance with Healthwatch's data protection policy and procedures.

4.3 Report

The data collected was analysed and findings and recommendations are included in this Report. The report includes:

- a. Numbers of completed questionnaires by site and time of day.
- b. Analysis of questionnaires by site and time of day.
- c. Common concerns and positive statements from respondents.
- d. Recommendations to the OCCG and OUHFT when redesigning services and parking changes.

5 Main findings for each site

Over a three-week period, we spoke to 295 people at the four hospital sites (Table 1). This is 95 more people than originally planned for and is reflected across each site. Fewer people were spoken to between 2-6pm than first thing in the morning (6-10am) and mid-morning/early afternoon (10am to 2pm).

Table 1 Number of people spoken to by site and session

	HGH	JR	CH	NOC		%
7 to 10am	23	75	9	24	131	44%
10 to 2pm	32	41	20	18	111	38%
2pm - 6pm	15	12	16	10	53	18%
TOTAL	70	128	45	52	295	
Target	40	80	40	40	200	

The following sections give a summary of the main findings from the survey at each site. Appendices B to E to this report provide detail data, data analysis and people's comments for each hospital site.

5.1 John Radcliffe site (JR)

Total number of people spoken to at the John Radcliffe site (JR) was 128 over five days 8th - 17th May 2017. Healthwatch staff were present on site for three sessions - 7am-10am, 10am-2pm and 2pm-6pm. Table 2 below shows the number of people spoken to by date and session

Table 2 John Radcliffe: Number of people spoken to at each session

	8 May 2017	10 May 2017	11 May 2017	16 May 2017	17 May 2017	Total
7am-10am	19	7	16	18	15	75
10am-2pm		8	12	21		41
2pm-6pm				12		12
Total	19	15	28	51	15	128

5.2 Main findings

5.2.1 Respondent profile

57% of respondents were outpatients while most others were either going with a patient or visiting one.

79% of respondents came from within Oxfordshire.

5.2.2 Mode of travel and journey times

73% used their own car.

The main reasons given for people using a car were:

- convenience (many said it was easier, quicker or that they were being accompanied by someone who drove them);

- the lack of any public transport (around a quarter said there were no buses from where they lived);
- or the inability to use public transport because of ill health, disability or the hospital procedure (around 25% of those surveyed).

Journey times

Those coming from within Oxfordshire, 57% said it took between 30 minutes and an hour to get to the hospital. For those coming from outside Oxfordshire, 100% responding said it took between 1 and 2 hours.

When asked how the journey made them feel 79% said they felt fine and the journey was as expected. Slightly more people felt fine about it in the morning period (6-10am) than in the late morning/early afternoon (10-2pm). More of those who came later on in the morning mentioned finding queuing to get into the car parks and the experience of parking quite stressful.

5.2.3 Parking

77% parked without a blue badge.

82% of people coming from within Oxfordshire parked on the hospital premises. Most of those who didn't used park and ride services and buses. Only one person coming from outside of Oxfordshire reported parking off-site at a park and ride service. Several people commented on the lack of direct bus routes to the hospital from where they lived and the lack of dedicated bus lanes, which meant the buses got stuck in traffic.

Most people reported allowing up to 30 minutes at least to park. There were differences in how long it actually took to park that seemed to be dependent on time of day.

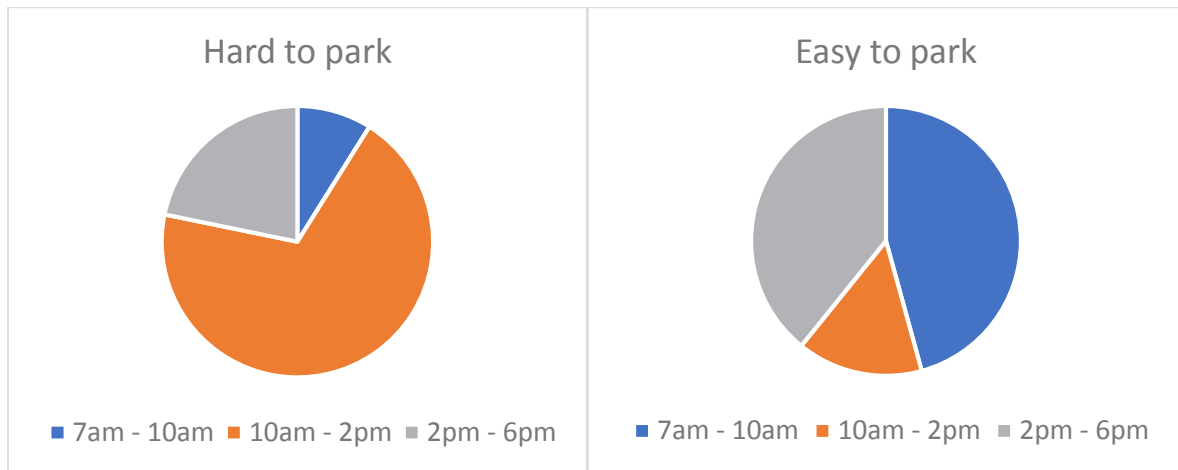
Between 6-10am - 60% of those who responded found a parking space in less than 15 minutes

Between 10am-2pm - 35% of those who responded found a space in less than 15 minutes

Between 2-6pm - 56% of those who responded found a space in less than 15 minutes.

The figures indicate that it is easier to find a space more quickly earlier in the morning as compared to late morning and early afternoon. Two people reported waiting 30 minutes to 1 hour for a parking space between 7am and 10am, whereas eight people reported waiting 30 minutes to 1 hour between 10am and 2pm and one person reported waiting for 30 minutes between 2pm and 6pm.

This variation in time taken to park is also reflected in whether people found it easy or hard to park:



5.2.4 Comments from people about their parking experience included:

- The words “stressful” and “horrendous” were commonly used to describe negative experiences of parking.

“Sat in a queue for the car park- one in one out system. It may let you in and there is still no space. Horrendous. Car park No1 works better. I always allow a good couple of hours to park.” “Stress you don't need” “Worrying and anxious” “Awful, one in one out - really stressful, especially with children, when people in pain or children in pain - it's a terrible experience.” “It's stressful, you are watching the clock ticking away”

- Some people said they left home very early- some citing 5am, or arrived very early- some citing 7am for an appointment at 8.45am. Another said they left home at 6.30am for a 9.30am appointment.
- Some said they bring two people with them- one to accompany them into the hospital and one to park.

“Difficult because you're waiting for a car to come out before you can go in. I did 6 or 7 laps of the car park waiting for a space, about a dozen other cars were doing the same thing. Stressful. Needs two adults to accompany an elderly patient- couldn't have done it on my own- I would have been a wreck.”

- Many people suggested some form of multi-storey car park to ease the pressure on existing spaces.

“I come to the hospital at least once a week- every time I have to allow at least 30 mins for parking. Would love to see a multi-storey car park built.” “It felt stressful- radio off, total concentration on. Hoping someone who leaves will tell you where they've come out of. The car park seems to have been built at an earlier time- seems to aim to discourage parking. Surprised

they only have one level car park here. Multi-storey would fit more people in.”

- There was frustration expressed at the fact that often the car park is full but there are free disabled bays. Equally, frustration was expressed at having a blue badge and empty disabled bays but still being stuck in long queues to park.
- A few people mentioned the high cost of parking.
- A patient, who was also a member of the Oxford University Hospitals Trust staff, said parking problems were having a knock-on effect on staff. They said:
“Now you have to live as far away as Milton Keynes, High Wycombe or Chipping Norton to qualify for a staff parking permit. They are taking permits off staff. It would cost £1000 to use the Park and ride for a year. Have worked at (Oxford hospital) for 11 years but will look for a new job at the end of the year when they take away my permit. Would like designated parking for staff, even if it off site and they have to ship people in.”
- One person saying he had missed his pregnant wife’s ultrasound scan.
- A suggestion was made for a dedicated park and ride for the hospital where you drop your patient off and then go off site to park and have a bus to come back in. Another said it would also ease pressure if they had off-site parking with a shuttle.
- Another said that before parking *“I queued for 57 minutes from the junction. The whole experience is stressful. On the other hand you see so many (free) disabled car parking spaces. It is terrible. I started my journey at 8.45am but was held up at the hospital. My wife has gone into surgery without seeing me even though I was here, just couldn't park. It's just horrendous- they should make a multi-storey car park.”*
- *“Was allowed into car park but couldn't find a space. It didn't bother me because I'd allowed so much time. It would have been awful for patients- the last thing you want.”*
- *“Seem to offer lots of appointments at the same time- block bookings. Have 10 people come in one go. Should stagger appointments. Stressful to visit family here and stressful to be member of nursing staff- no parking.”*
- *“Annoyed, always feel large reception looks good but more parking would have been a better use of space.”*

- *“Just waiting in queue not knowing when or if you can park car. There must be a better system.”*

5.3 Horton General Hospital (HGH) site

We spoke to 70 people at the HGH site was 70 over three days from 8th May - 10th May 2017 during the hours of 6-10am, 10am-2pm and 2pm-6pm.

Table 3 Number of people spoken to at each session

	8 May 2017	9 May 2017	10 May 2017	Total
7am-10am	14	2	7	23
10am-2pm	19	2	11	32
2pm-6pm		12	3	15
Total	33	16	21	70

5.3.1 Main findings

Main findings from the Horton:

Most respondents were outpatients, mostly from within Oxfordshire and the majority used their own car.

The main reasons given for people using their own car were convenience and the lack of any public transport from where they were travelling.

5.3.2 Journey time

Most respondents said it took under 30 minutes, although for people in the 2-6pm slot it was longer, with half taking between 30 minutes and 1 hour.

A majority felt fine about the journey.

5.3.3 Parking

A majority parked without a blue badge and on the hospital premises.

The majority of respondents said it took less than 15 minutes to park and that it felt easy to park.

Most felt fine about parking with a few feeling stressed - particularly about the parking coin machines not accepting the new £1 coins. (This was raised by Healthwatch Oxfordshire (HWO) and was rectified the same day by OUHT).

5.4 Nuffield Orthopaedic Centre (NOC) site

The total number of people spoken to at the Nuffield Orthopaedic Centre (NOC) was 52 over two days 18th May and 23rd May. Healthwatch staff were present on site for three sessions on the 23rd May and two sessions on 18th May. Table 4 below shows the number of people spoken to by date and session.

Table 4 Number of people spoken to at each session

	18 May 2017	23 May 2017	Total per session
7am - 10am	12	12	24
10am - 2pm	8	10	18
2pm-6pm		10	10
Total per day	20	32	52

5.4.1 Main findings

Of those interviewed, 62% were outpatients, 50% of whom came from within Oxfordshire and 50% from outside Oxfordshire. 75% drove to hospital (either their own or a friend's or family member's car) and seven people (13%) used the Park and Ride services.

The main reasons given for people using a car were the lack of suitability of public transport because of the distance travelled, ill health or disability (50%) with only 37% saying they used a car because of convenience.

One person said "Easier with wheelchair, No trains from MK. Can't find taxis who can take wheelchair and would involve 5 busses and 3 hours!" Another commented "Takes over an hour to get here and can't use public transport anyway." One parent said using a car was the only way to bring their son in his wheelchair.

5.4.2 Journey time

Between 7am -10am- 67% of both those coming from within and outside Oxfordshire reported a journey time of between 30 minutes and 1 hour.

Between 10am to 2pm - 67% still reporting a journey time of between 30 minutes and 1 hour from within Oxfordshire, with 92% of those from outside the county reporting a journey length of more than one hour.

Between 2pm -6pm - 50% said it took them between 30 minutes and 1 hour, and 50% reported a journey length of between 1 hour and 90 minutes for those within Oxfordshire; 75% of people travelling from outside Oxfordshire reported a journey time of between 1 hour and 90 minutes.

Overall, 64% of people, when asked how the journey made them feel, said they felt fine and the journey was as expected.

5.4.2.1 Comments and suggestions included:

"I was prepared for it! Would like to have timings of buses with the appointment letter from Thornhill and the hospital. So can plan journey better. Saves sitting around for 45 minutes."

"Awful- lot of traffic- worse than normal. it was bad today, don't know why"

One person said they had to leave at 5.30am to get here at 11am and another saying the journey was fine though the parking was bad.

"Exhausted", "Stressful"

"We put ourselves out because care at the hospital is so good. it depends on time of day as to how long it takes to park."

One person, who came on a park and ride service said *“lots of things could be better. A designated hospital bus (is needed)- mum has walker and there is not enough space on the bus for the clientele it's providing a service for. People with walking aids need space and there wasn't enough space for people needing the space. The bus should also let you know what the next stop is. An elderly couple got off at the wrong stop and then had to walk back. Not enough information on the bus about the stops.”*

5.4.3 Parking

58% of those who responded to the question said they did not have a blue badge; 95% of those who responded parked on the hospital premises.

For 94% of those who responded to the question in the morning (6-10am), it took less than 15 minutes to find a parking space.

For those who responded to the question and looked to park late morning to early afternoon, between 10am-2pm, 58% reported finding a space in less than 15 minutes with 42% stating it took between 15 and 30 minutes.

For those responding to the question, and looking for a space between 2-6pm, 88% said it took them less than 15 minutes to park.

82% who responded said they found it easy to park with 18% saying they found it hard.

5.4.3.1 Comments from people about their experiences included:

“Got a space straightaway- first time ever. Normally drive around after dropping husband off. Saw on a screen in the waiting room that if you're over time with the parking you can call receptionist or nurse: what is that about? If there is help available so you don't have to keep rushing back to your car then they should publicise it better, most people wouldn't see it. If you're on your own and have to run up and down to the car if your appointment runs over, then this would be useful. All the park and ride services should have a hospital shuttle- come to the Redbridge site so there is no park and ride³. Can't we have a shuttle service like at the airports, parking away from the hospitals and then have a shuttle to hospital? For us the park and ride is no use- would take an hour to Oxford and then take a long time to get here.”

“Usually come early. If you come at noon, you have a job to park, even with the disabled badge. All the visitors are coming at that time so compete with them for space.”

“Couldn't find a parking space at 9.30am ended up on the pavement with a sign that says do not park- because there's no place. Hope I don't get a ticket, went right way round, could see cars waiting, saw pavement, used it.”

“Incredibly difficult to find parking. There are people driving round and round in the car park. There is potential for aggression and accidents when people spot a

³ Reviewing the OUHFT patient parking information on their web site it appears that there is no direct bus to the NOC from Redbridge Park & Ride, people will have to change in the City to the No 400 bus service. However, the X3 runs from the Redbridge Park & Ride site directly to the entrance at John Radcliffe Hospital

parking space becoming empty. Dropped husband off and was waiting to park. Felt there were drivers who were quite aggressive and racing into parking spaces. Suggestion- people with certified mobility problems and blue badges and frailty should be granted certificate to park at the hospital. Should be more parking for staff. Everyone else should be given instructions for the park and ride- clear instructions on what buses to catch. Buses should turn into the hospital- hard to walk from the road. Detailed instructions should be given to patients on how long it will take and how to get there. Should be dedicated park and ride for the JR. Transport should be more integrated. People would use public transport more willingly if there were more certainty.”

One patient, who is also a member of staff said “They want me to be here at 7am. If I come on the bus I have to leave home at 5am. Then I am too knackered to do a 12 hour shift from the start. I drive at the moment because I have a permit but the buses are really hard to do. If I use the park and ride and my shift finishes at 10pm there are no buses from the hospital. I have to walk to the High Street in Headington in the dark to catch a bus. Even with a permit in the afternoons can't find parking. Have to park in patients parking and risk a fine. Really need a travel survey with staff. Park and ride costs me £150 a month plus the buses don't go after 7pm. Need a multi-storey car park like other areas. Find so many patients upset about parking. At protected lunch times when you ask people to leave they get really upset because they say 'but I've struggled to park and now you're asking me to leave.”

“Parking is not too bad but the journey is really difficult. I'm 83 and husband 84- it's very hard for us to do the journey. The journey is costing us a fortune in petrol. It's a 200 mile round trip, costs £40 each way.”

“As I turned right (into the hospital)- the stress starts knowing that I might not get a space and might not be able to get to the hospital at my allocated time. You arrive in a tense situation but the relief when someone pulls out! I consider myself really lucky when I get a place because it is so difficult. Otherwise might miss appointment.”

“Always find it ok”

“Normally an issue but today was fine”

“Unusually good today. You have to get here before 9 or you've had it!”

One person said they had to leave at 5.30am to get here at 11am

“Exhausted”

“Stressful”

“We put ourselves out because care at the hospital is so good. It depends on time of day as to how long it takes to park.”

“Could have been better. Used park and ride because can never find parking here. They recommend on their website not to park here so we don't.”

One person, who came on a park and ride service said “lots of things could be better. A designated hospital bus (is needed)- mum has walker and there is not enough space on the bus for the clientele it's providing a service for. People with walking aids need space and there wasn't enough space for people needing the space. The bus should also let you know what the next stop is. An elderly couple got off at the wrong stop and then had to walk back. Not enough information on the bus about the stops.”

“Bit of a nightmare. Luckily person I was bringing- in a wheelchair- had brought her mum with her. Would have missed appointment if I had brought her on my own because I had to drop her off at the entrance and go and look for parking while her mum brought her in.”

“Hard to find a non-disabled space- as a volunteer driver I get a special permit to park in the ambulance spaces. Normally it is fine but for the first time in 6 years we had to wait for an ambulance to move. Busy today.”

“Left over 2 hours for travel and parking. Parking was not too bad- just drove round a few times. It was a matter of going round a couple of times to find a space- dozens of others were driving round. My husband dropped me off- if I were by myself I would have been stressed. But because I was dropped off I was fine.”

“Harder than usual. Had to wait for someone to come out of a disabled bay. It was ok, took a bit longer than usual but it wasn't a problem. Today people seem to be waiting for spaces, it isn't normally so bad. At the Churchill where we go often, the car park is badly arranged- people trying to get out block the way of people trying to get in.”

“Depends on time of day - at 9am, travelling and parking is horrendous”

“Today it was difficult, I found a bay eventually but it was far away and I had to walk (which is hard for me - the disabled spot is too far away for people like me) so I was late for my appointment. Usually I always get a place by the Tebbit centre but today I had to drive round and round.”

“Very relaxed. Came here on Monday and waited 12 mins for a space. I can walk on crutches now so chose side road rather than hospital car park. I can always get a space if you're prepared to wait in my 5 weeks of experience.”

5.5 Churchill Hospital site (CH)

The total number of people interviewed at the Churchill hospital site was 45 on 17th May and 22nd May. Table 5 below shows the number of people spoken to by day and session.

Table 5 Number of people spoken to at each session

	17 May	22 May	Total
7am-10am	9		9
10am-2pm	6	14	20
2pm-6pm		16	16
Totals	15	30	45

5.5.1 Respondent profile

89% of respondents were outpatients, 78% of whom came from within Oxfordshire and 22% from outside Oxfordshire.

5.5.2 Mode of transport

62% used their own or a friend's or family member's car to get to hospital and 22% used the park and ride services or a bus service. The main reasons given for people using a car were the lack of suitability of public transport because of the distance travelled, ill health or lack of availability (58%) with only 39% saying they used a car because of convenience.

5.5.2.1 Comments included:

"This is the first time I've come by car because I've got to go on to another medical appointment and I can't get to that by bus. Anyone who comes here by car otherwise is an idiot."

"More convenient"

"Because of where we live- in the middle of nowhere- it's easier to come by car"

"Public transport takes days!"

"Much easier from my place. Brings me right here from where I live."

"Because we come from Northamptonshire- and then we pick up our son from Leighton Buzzard and come here. Convenience."

"Didn't know how dad would feel when finished so we can go straight home."

"Didn't want to be upset on bus."

"Buses unreliable."

"Would have to change buses several times."

"Easier to get here [in a car] but not to park."

"Know can't get parking, mornings are bad so try and get later appointments."

"Taxi would cost £30 from Wheatley."

"Quick, bus service infrequent. Feel nervous enough anyway."

"Too far, usually do park & ride, appointment was later today."

Some of the comments by people who had used park and ride services or another bus service included:

"Warned off car park, told it is so hopeless you can't get in, website says to avoid parking."

"Easier - Oxford has really got its act together! The park and ride are very good, excellent system!"

"Usually take hospital bus but it wasn't running today because of water/road works, had to take three buses from Kidlington."

“Easier to come although will probably have to wait around to get back to park and ride.”

“Don't want the hassle of trying to park.”

5.5.3 Travel time

41% of respondents reported a journey time of between 30 minutes and one hour, 31% said it took between one hour and 90 minutes and 28% said it took less than 30 minutes.

When asked how they felt about the journey, 51% said it was fine or ok or as expected, 40% felt stressed or had difficulty with traffic and roadworks they encountered on their way to the hospital.

5.5.3.1 Comments included

“Bit busy on A34. End part of journey- held up by roadworks.”

“Doesn't worry me- used to the traffic problems”

“Wasn't too bad- queued to the Headington roundabout but it moved fairly quickly.”

“Terrible- get stressed out because of road works, motorway backed up. Leave early and know all the routes- have to get here early to park. If you leave it till 11am, it's hopeless.”

“Been amazing- came on 2 buses- straight on a bus from home and when I got to the Park and ride the 900 was standing there. Only took 45 minutes. That was excellent. If I had missed the 900 it would have been a half hour wait. It was good.”

“Terrible- such traffic problems.”

“Because I'd left plenty of time, I was alright. Left really early, otherwise I would have been really stressed.”

“It was slow but fine. Traffic was quite bad.”

“Terrible because of the weather. The M40 and the lorries in the rain- horrible.”

“Bit wet but ok”

“Fine. As expected- husband deliberately didn't park here- he dropped me and then went to get a coffee. Had to go somewhere because we were worried about finding a place to park. So didn't attempt it.”

“As expected- better!”

“Bit tiring- more so for my son. He's recovering.”

5.5.4 Parking

83% of those who responded said they did not have a blue badge and 96% of those who responded parked on the hospital premises. 74% of people said it was easy to park with 26% saying it was hard.

Between 7 -10am - 78% of those who responded said it took less than 15 minutes to find a parking space, with 22% reporting a longer wait of between 15 and 30 minutes

Between 10am-2pm - 56% reported finding a space in less than 15 minutes with 44% stating it took between 15 and 30 minutes.

Between 2-6pm - 71% said it took them less than 15 minutes to park with 29% still needing to wait between 15 and 30 minutes just to find a space.

5.5.4.1 Comments from people about their parking experiences included:

“Daughter dropped me at the door and went off to park. She said it was quite easy today but yesterday it was a nightmare at the Nuffield Orthopaedic. Got here at 9.30am and it was fine but now (noon) there are no spaces. They let you into car park and you still have to drive around.”

“Parking is not up to scratch here. I object to paying for parking my car here in the hospital. Astounded that blue badge holders also have to pay. Parking has got worse over time here. They should issue a daily parking permit valid for the whole day- I don't think you should have to pay.”

“We come early, particularly since the roadworks.”

“Been lucky today. You can go straight in or you can wait an hour to find parking. Car park too small. Car park was full- one came out so we got in. We were going into a disabled bay so we were lucky. But still had to queue with everyone, even though we can park in the disabled bay. Have a blue badge and can park in a disabled slot but still get stuck in traffic because car park was full. Once into car park, a space was available today, though it can take an hour.”

“Have a special permit to park. It would be a total nightmare without permit. Come to front of Churchill and park straight across entrance. In Banbury they are building 1000s of new houses and they want to take the hospital away- disgusting. They can do treatments there, they should.”

“It was fine, wasn't sure where I was so just followed signs to general hospital. I have been here before, if I hadn't it feels like you don't quite know where to go. For me, if the park and ride were only stopping at the hospital- coming here directly I would feel better about using it. The current park and ride isn't only for the hospital. May not be sure where to get off.”

“Once through the barrier it was quite easy, but waited outside for 20 minutes. Parking is a problem- it's pretty horrendous. £7 a day is quite a lot to pay.”

“Was ninth in the queue to get into car park. Took 15-30 mins to park.”

“Parking not in a designated bay because can't find one.”

“Can be horrendous sometimes.”

“Confusing to park; no legitimate spaces - I am probably parked illegally but other people were too.”

“Traffic was awful today, bus drivers didn't know anything because of the traffic. We booked a taxi from the park and ride, but the bus came first.”

“Once you're in, it's alright as there are 8 or 9 disabled spaces. Car park was full. Went on the phone- pushed the button on the machine and talked to security. If you tell them you have a blue badge they let you in as there are spaces in disabled bays. Car park 1- disabled parking there is always full. But no5 has spaces. Know people who have missed appointments because of the parking problem.”

“One of the good days today. Sometimes a nightmare to get a parking space. We come here regularly. Very expensive to park- considering we don't have much choice but to come here.”

“Quite familiar with it- expect it to be hard so allow time and watch people with car keys. We hate coming here because of the parking.”

“Not too bad today. Today was fine, last week was a long wait, had to queue to park for an hour. Bit tiring that was.”

“Today it has been fine, other times I take a taxi because I know it can be hard, took a chance today!”

“Normally really bad.”

“Had to come all the way into main hospital to park.”

6 Appendix A - John Radcliffe Hospital site

6.1 Morning experiences

Main findings about people's journey and parking experiences in the early morning to the John Radcliffe hospital:

Time (JR)	7 -10am
Total number of respondents	75
60% were outpatients	44 out of 75
29% were going with a patient or visiting a patient	22 out of 75
79% came from within Oxfordshire	59 out of 75
73% used own car or a friend's or family member's car	55 out of 75
Why they used a car	
The most common reason was convenience with 31% of those who had used a car citing this	17 out of 55
The other two common reasons were the lack of public transport (22%) or the inability to use public transport because of disability, ill health or hospital procedure (22%)	12 out of 55
Length of journey	
For 59% of those who responded to the question and were coming from within Oxfordshire the journey took between 30 minutes and 1 hour	32 out of 54
For 30% of those who responded and were coming from outside of Oxfordshire it took anywhere from 1 hour to more than 2 hours	4 out of 12
How they felt about the journey	
78% of those who responded felt fine about journey saying it was as expected. There were many caveats about people leaving their homes very early (some as early as 5am) and allowing plenty of time to travel (some as much as 3 hours or more), as well as planning their journey using back roads. This was common to those who came from within Oxfordshire as well as outside.	53 out of 68
Parking	
75% of those who responded to the question had parked without blue badge	45 out of 61
In terms of parking on hospital premises , there were differences in those who came from within Oxfordshire versus those who were coming from outside Oxfordshire: 78% of people coming from within Oxfordshire parked at the hospital with most who did not stating that they either used a park and ride service or another bus.	35 out of 45 15 out of 16
94% of those who came from outside of Oxfordshire parked on the hospital premises with only 1 person using a park and ride service.	
Though people often allowed 30 minutes or more to park, of those that reported how long it took them to find a space, 60% actually found a space in less than 15 minutes. 10% reported a wait of over 15 minutes; this included 2 people who had to wait between 30 minutes and 1 hour to park.	41 out of 68 6 out of 68

Time (JR)	7 -10am
Total number of respondents	75
87% of those who responded to the question from within Oxfordshire found it easy to park while 100% of those who responded to the question from outside Oxfordshire found it easy to park.	33 out of 38 15 out of 15
Comments about parking experience	
79% of those who responded to the question coming from within Oxfordshire felt their parking experience was fine on the day. However, comments included: <ul style="list-style-type: none"> • They left very early (they parked at 7am for a much later appointment for instance). • They had brought someone else to accompany the patient in addition to the driver who was then free to look for parking • Parking had been stressful in the past. • Some said there should be a multi-storey car park built as soon as possible. • Others used the word stressful and horrendous to describe previous parking experiences. • One person noted that they have a blue badge but had to queue with all the other cars to get in even though there were disabled spaces free and often when you ring the buzzer for parking assistance no one answers. • A few people mentioned the high cost of parking. • A member of the Oxford University Hospitals Trust staff said parking problems were having a knock-on effect on staff. They said that “Now you have to live as far away as Milton Keynes, High Wycombe or Chipping Norton to qualify for a staff parking permit. They are taking permits off staff. It would cost £1000 to use the Park and ride for a year. Have worked at (Oxford hospital) for 11 years but will look for a new job at the end of the year when they take away my permit. Would like designated parking for staff, even if it off site and they have to ship people in.” • Two people mentioned that difficulty in finding parking meant they almost missed their appointment, with one person saying he had missed his pregnant wife’s ultrasound scan. • One person suggested park and ride buses should have their own dedicated lane so they don’t get stuck in traffic. 	31 out of 39
100% of those who responded to the question and came from outside Oxfordshire felt their parking experience was fine. Caveats included: <ul style="list-style-type: none"> • They had left very early- one person said they left their home at 5am, another said they had arrived at 7am for an 8.45am appointment, while yet another said they left home at 6.30am for a 9.30am appointment. Another said “you have to leave yourself loads of time to find parking.” • Several people mentioned the high cost of parking. • Another suggested a dedicated park and ride for the hospital where you drop your patient off and then go off site to park and have a bus to come back in. 	15 out of 15

Time (JR)	7 -10am
Total number of respondents	75
<ul style="list-style-type: none"> Another person made a plea for a multi-storey car park. 	

Date	8 May 2017
Time (JR)	7am-10am
Total number of respondents	19
53% were outpatients	10 out of 19
32% were accompanying a patient	6 out of 19
63% came from within Oxfordshire	12 out of 19
79% used own car	15 out of 19
Why they used their own car	
From within Oxfordshire	
42% said there were either no buses, or none that ran at the early time in the morning for their appointment	5 out of 12
33% said convenience	4 out of 12
From outside of Oxfordshire	
43% said there was no alternative or public transport	3 out of 7
29% said convenience	2 out of 7
29% said the distance was the deciding factor	2 out of 7
Length of journey	
From within Oxfordshire	
50% took between 30 minutes and 1 hour	6 out 12
25% took between 1 hour and 90 minutes	3 out of 12
From outside Oxfordshire	
43% took between 30 minutes and 1 hour	3 out of 7
29% took over 2 hours	2 out of 7
How they felt about the journey	
From within Oxfordshire	
50% said it was fine or as expected	6 out of 12
33% said the journey was fine but they left very early and allowed a lot of travel time and time to park	4 out of 12
One person wondered why there was no access from the dual carriageway to the hospital. Another said "Coming in the middle of the day is really difficult. Day before it was really tough- there are not enough parking spaces- nearly missed appointment. "	
From outside Oxfordshire	
71% said it was fine or as expected though one said they had to leave at 5am and another said they had to use the back roads and plan the journey beforehand.	5 out of 7

Date	8 May 2017
Time (JR)	7am-10am
Parking	
From within Oxfordshire 50% parked without blue badge	6 out of 12
From outside Oxfordshire 86% parked without a blue badge	6 out of 7
From within Oxfordshire 50% parked on hospital premises (2 used park and ride services and 1 person used buses)	6 out of 12
From outside Oxfordshire 100% parked on hospital premises	7 out of 7
From within Oxfordshire 29% allowed less than 15 minutes to park, 29% allowed 15-30 minutes and another 29% allowed 30 minutes to an hour to park, with only 1 person allowing more than 1 hour.	2 out of 7
From within Oxfordshire it actually took 86% less than 15 minutes to park	6 out of 7
From outside of Oxfordshire 57% allowed more than 1 hour to find parking	4 out of 7
From outside Oxfordshire for 100% it actually took less than 15 minutes to park	7 out of 7
From within Oxfordshire 86% found it easy to park with 1 person saying it was hard.	6 out of 7
From outside Oxfordshire 100% said it was easy to park.	7 out of 7
Comments about parking	
From within Oxfordshire	
50% said it was fine today but pointed out that <ul style="list-style-type: none"> • they left very early (one person parked at 7am for instance) • they had brought someone else to accompany the patient as well as the driver who was then free to look for parking 	4 out of 8
25% said it was hard and they had almost missed their appointments. One person said for instance that his pregnant wife almost missed her ultrasound scan and that he had missed it because he couldn't find parking.	2 out of 8
25% had the benefit of a lift with a member of staff who had a staff parking permit or were a member of staff who had parked at another hospital close by and had walked. The member of staff said parking problems were having a knock-on effect on staff. They said that "Now you have to live as far away as Milton Keynes, Staff said had to live at High Wycombe or Chipping Norton to qualify for a staff parking permit. They are taking permits off staff. It would cost £1000 to use the Park and ride for a year. Have worked at the (Oxford hospital) for 11 years but will look for a new job at the end of the year when they take away my permit. Would like designated parking for staff, even if it off site and they have to ship people in. The other person said that they live in Watlington and without the lift they would have to rely on a bus that only went once every hour from there.	2 out of 8

Date	8 May 2017
Time (JR)	7am-10am
From outside Oxfordshire	
100% said it was fine today but several pointed out that they had left very early- one person said they left their home at 5am, another said they had arrived at 7am for an 8.45am appointment. Another said you have to leave yourself loads of time to find parking. 2 people mentioned the high cost of parking.	7 out of 7

Date (JR)	10 May 2017
Time	7am-10am
Total number of respondents	7
43% were outpatients	3 out of 7
29% were going with a patient	2 out of 7
100% came from within Oxfordshire	7 out of 7
57% used own car and one person used the park and ride, and one used family/friend's car	4 out of 7
Why they used own car	
One person said it was easiest, 1 person said it was because of an early appointment and they were bringing a patient, one person said the bus takes too long for a child with special needs and one person said it was too early to use their bus pass	
43% said the park and ride, getting a lift or coming on foot was the easiest option	3 out of 7
Length of journey	
For 80% of people who answered the question the journey took less than 30 minutes	4 out of 5
How they felt about the journey	
80% felt fine about journey	4 out of 5
Parking	
67% parked without blue badge	4 out of 6
83% parked on hospital premises	5 out of 6
75% allowed between 30 minutes and 1 hour to park	3 out of 4
60% actually took less than 15 minutes to park	3 out of 5
40% actually took between 30 minutes and 1 hour to park	2 out of 5
80% said it was easy to park	4 out of 5
Comments about parking	
80% said it was fine today but it had been stressful in the past. 40% said there should be a multi-storey car park built as soon as possible. Others used the word stressful and horrendous to describe previous parking experiences.	4 out of 5

Date (JR)	11 May 2017
Time	7am-10am
Total number of respondents	16
50% were outpatients	8 out of 16
50% were accompanying a patient	8 out of 16
69 % came from within Oxfordshire	11 out of 16
75% used own car	12 out of 16
Why they used this means of transport	
From within Oxfordshire	
55% said they couldn't use public transport because of disability, the hospital procedure or illness	5 out of 9
44% said there was no public transport	4 out of 9
From outside of Oxfordshire	
60% said convenience while one person said there was no other way and one said the distance	3 out of 5
Length of journey	
From within Oxfordshire	
63% took between 30 minutes and one hour	7 out of 11
From outside Oxfordshire	
40% took between 1 hour and 90 minutes	2 out of 5
How they felt about the journey	
From within Oxfordshire	
60% said it was fine or as expected	6 out of 10
30% said the journey made them feel stressed	3 out of 10
One person said the bus routes through Oxford really need improvement.	
From outside Oxfordshire	
80% said it was fine or as expected though one said they had to leave very early and another said they had to use the back roads and plan the journey beforehand.	4 out of 5
Parking	
From within Oxfordshire 75% parked without blue badge	6 out of 8
From outside Oxfordshire 100% parked without a blue badge	5 out of 5
From within Oxfordshire 100% parked on hospital premises	8 out of 8
From outside Oxfordshire 100% parked on hospital premises	5 out of 5
From within Oxfordshire 50% allowed 30 minutes to an hour to park	4 out of 8
From within Oxfordshire it actually took 89% less than 15 minutes to park	7 out of 8
From outside Oxfordshire for 100% it actually took less than 15 minutes to park	5 out of 5
From within Oxfordshire 89% found it easy to park with 1 person saying it was hard.	7 out of 8
From outside Oxfordshire 100% said it was easy to park.	5 out of 5

Date (JR)	11 May 2017
Time	7am-10am
Comments about parking	
From within Oxfordshire	
89% said it was fine today but pointed out that <ul style="list-style-type: none"> they have a blue badge but had to queue with all the other cars to get in even though there were disabled spaces and often when you ring the buzzer no one answers for parking assistance the cost is high 	7 out of 8
One person suggested park and ride buses should have their own dedicated lane so they don't get stuck in traffic.	
From outside Oxfordshire	
100% said it was fine today but several pointed out that they had left very early- one person said they left their home at 6.30am for a 9.30am appointment, another mentioned the high cost of parking. Another suggested a dedicated park and ride for the hospital where you drop your patient off and then go off site to park and have a bus to come back in while another person made a plea for a multi-storey car park.	7 out of 7

Date (JR)	16 May 2017
Time	7am-10am
Total number of respondents	18
78% were outpatients	14 out of 18
89 % came from within Oxfordshire	16 out of 18
61% used own car	11 out of 18
22% used a friend's or family member's car	4 out of 18
Why they used this means of transport	
From within Oxfordshire	
31% said they couldn't use public transport because of disability, illness or that there were no direct buses	5 out of 16
31% said that was how the person accompanying them chose to travel	5 out of 16
1 person came on the bus and pointed out that there were no direct buses from Blackbird Leys to the hospital	
Length of journey	
From within Oxfordshire	
63% took between 30 minutes and 1 hour	10 out of 16
How they felt about the journey	
From within Oxfordshire	
81% said it was good, fine or as expected	13 out of 16
Parking	

Date (JR)	16 May 2017
Time	7am-10am
80% parked without blue badge	12 out of 15
From within Oxfordshire 85% parked on hospital premises	11 out of 13
From outside Oxfordshire 100% parked on hospital premises	2 out of 2
From within Oxfordshire 67% allowed 15 to 30 minutes to park	8 out of 12
From within Oxfordshire it actually took 50% less than 15 minutes to park	6 out of 12
From within Oxfordshire it actually took 33% between 15 to 30 minutes to park	4 out of 12
From within Oxfordshire 83% found it easy to park with 2 people saying it was hard.	10 out of 12
From outside Oxfordshire 100% said it was easy to park.	2 out of 2
Comments about parking	
From within Oxfordshire	
83% said it was fine today	10 out of 12

Date (JR)	17 May 2017
Time	7am-10am
Total number of respondents	15
60% were outpatients	9 out of 15
87 % came from within Oxfordshire	13 out of 15
53% used own car	8 out of 15
40% used a bus including park and ride	6 out of 15
Why they used this means of transport	
88% who used a car said convenience	7 out of 8
30% who used buses said it was to avoid parking at the hospital	2 out of 6
One person used a taxi because they got no response from a volunteer driver scheme	
Length of journey	
60% took between 30 minutes and 1 hour	9 out of 15
27% took between 1 hour and 90 minutes	4 out of 15
How they felt about the journey	
73% said it was ok, fine or as expected	11 out of 15
One person said "OK in the morning and mid day. In the evening not very good. Sometimes the bus does not show up after 8pm." Another said the taxi cost them £40 each way.	
Parking	
75% parked without blue badge	6 out of 8
75% parked on hospital premises	6 out of 8
71% allowed less than 15 minutes to park	5 out of 7

Date (JR)	17 May 2017
Time	7am-10am
100% took less than 15 minutes to park	7 out of 7
100% said it was easy to park	7 out of 7
Comments about parking	
86% said their parking experience was ok though one person said that to be here for 3 days was costing them more than £20 in parking.	6 out of 7

6.2 Main findings about people's experience at JR from 10am to 2pm

Time (JR)	10am-2pm
Total number of respondents	41
63% were outpatients	26 out of 41
80% came from within Oxfordshire	33 out of 41
71% used own car or a friend's or family member's car	29 out of 41
20% used buses	8 out of 41
Why they used a car	
The most common reason was convenience with 50% of those who had used a car citing this	14 out of 28
The other two common reasons were the lack of public transport (25%) or the inability to use public transport because of disability, ill health or hospital procedure (26%)	7 out of 28 6 out of 23
Length of journey	
59% of those who responded and came from within Oxfordshire the journey took between 30 minutes and 1 hour	20 out of 34
The picture was more mixed for those coming from outside and the numbers of people were much smaller than those from within Oxfordshire but two people said between 1 hour and 90 minutes and two said more than two hours.	
How they felt about the journey	
73% of those who responded felt fine about journey saying it was as expected. Caveats included the fact that: <ul style="list-style-type: none"> • People found parking/queuing stressful. • Some people felt the buses in Oxford were terrible. • One person said the journey had been horrendous the Friday before. 	
Parking	
80% of those who responded to the question had parked without blue badge	24 out of 30
87% of people coming from within Oxfordshire parked at the hospital. Those that did not stated that they got someone to drop them off.	20 out of 23
100% of those who came from outside of Oxfordshire parked on the hospital premises.	

Time (JR)	10am-2pm
<p>56% of those who responded allowed between 15 and 30 minutes to find a space while another 33% allowed between 30 minutes and 1 hour.</p> <p>For those that reported how long it actually took to find a space, 35% reported that it took less than 15 minutes, 31% reported it took between 15 and 30 minutes and another 31% said between 30 minutes and an hour.</p>	<p>15 out of 27 9 out of 27</p> <p>9 out of 26 8 out of 26 8 out of 26</p>
<p>70% of those who responded to the question found it hard to park.</p>	<p>19 out of 27</p>
<p>Comments about parking experience included:</p> <ul style="list-style-type: none"> • It would be easier if people could be dropped off right outside the door. It would also ease pressure of they had off-site parking with a shuttle. • Fed up with long queue. • Very hard to find a space. After entering the car park it took 20 minutes. Before that I queued for 57 minutes from the junction. The whole experience is stressful. On the other hand you see so many (free) disabled car parking spaces. It is terrible- started journey at 8.45am but was held up at the hospital. Wife has gone into surgery without seeing him even though he was here, just couldn't park. It's just horrendous- they should make a multi-storey car park • Just join the queue. As expected- disappointing. I come to the hospital at least once a week- every time I have to allow at least 30 mins for parking. Would love to see a multi-storey car park built. • Was allowed into car park but couldn't find a space. It didn't bother me because I'd allowed so much time. It would have been awful for patients- the last thing you want. • Sat in a queue for the car park- one in one out system. It may let you in and there is still no space. Horrendous. Car park 1 works better. I always allow a good couple of hours to park • Seem to offer lots of appointments at the same time- block bookings. Have 10 people come in one go. Should stagger appointments. Stressful to visit family here and stressful to be member of nursing staff- no parking. • It felt stressful- radio off, total concentration on. Hoping someone who leaves will tell you where they've come out of. The car park seems to have been built at an earlier time- seems to aim to discourage parking. The cost to us in terms of fuel, time and the environment is enormous. Surprised they only have one level car park here. Multi-storey would fit more people in. • Difficult because you're waiting for a car to come out before you can go in. I did 6 or 7 laps of the car park waiting for a space, about a dozen other cars were doing the same thing. Stressful. Needs two adults to accompany an elderly patient- couldn't have done it on my own- I would have been a wreck. 	

Time (JR)	10am-2pm
<ul style="list-style-type: none"> • Annoyed, always feel large reception looks good but more parking would have been a better use of space • Just waiting in queue not knowing when or if you can park car, must be a better system • Stress you don't need • Worrying and anxious • Awful, one in one out - really stressful, especially with children, when people in pain or children in pain - it's a terrible experience. • It's stressful, you are watching the clock ticking away 	

6.2.1 Findings from mid-morning to early afternoon at John Radcliffe site (10:00-2pm)

Date (JR)	10 May 2017
Time	10.00am-2pm
Total number of respondents	8
75% were outpatients	6 out of 8
75% came from within Oxfordshire	6 out of 8
50% came in a friend's or family member's car with 25% used their own car	4 out of 8
In total 75% used a car	6 out of 8
Why they used a friend's or family member's car	
60% said convenience	3 out of 5
40% said there were no buses	2 out of 5
Length of journey	
86% took between 30 minutes and one hour to make their journey	6 out of 7
How they felt about the journey	
50% felt fine about journey	4 out of 8
38% said it was fine but parking/queuing for parking was stressful	3 out of 8
Parking	
57% parked with a blue badge	4 out of 7
83% parked on hospital premises	5 out of 6
60% allowed 15-30 minutes to park	3 out of 5
50% took less than 15 minutes to park with 33% taking between 30 minutes and one hour	
67% said it was easy to park	4 out of 6
Comments about parking	
50% said it was fine	3 out of 6
One person said they were fed up because of the long queue to park, one said they were upset because they couldn't pick the patient up outside the door. Another said "It would be easier if people could be dropped off right outside the door. It would also ease pressure of they had off-site parking with a shuttle."	

Date (JR)	11 May 2017
Time	10am-2pm
Total number of respondents	12
50% were outpatients	6 out of 12
42% were either going with a patient or accompanying a patient	5 out of 12
67 % came from within Oxfordshire	8 out of 12
83% used own car or a friend's or family member's car	10 out of 12
Why they used this means of transport	
50% said convenience	5 out of 10
50% said they couldn't use public transport because of disability, the hospital procedure or a lack of available transport	5 out of 10
From outside of Oxfordshire	
75% said there was no public transport	3 out of 4
Length of journey	
From within Oxfordshire	
50% took between 30 minutes and 1 hour	4 out of 8
38% took less than 30 minutes	3 out of 8
From outside Oxfordshire	
50% took between 1 hour and 90 minutes	2 out of 4
One person took between 30 minutes and one hour and one took between 90 minutes and two hours	
How they felt about the journey	
From within Oxfordshire	
75% said it was fine or as expected	6 out of 8
One person who used the bus said Oxford was a terrible city for buses.	
From outside Oxfordshire	
100% said it was fine or as expected though one said it was horrendous on the Friday before.	4 out of 4
Parking	
From within Oxfordshire 86% parked without blue badge	6 out of 7
From outside Oxfordshire 100% parked without a blue badge	3 out of 3
From within Oxfordshire 83% parked on hospital premises	5 out of 6
From outside Oxfordshire 100% parked on hospital premises	3 out of 3
From within Oxfordshire 60% allowed 30 minutes to an hour to park	
From within Oxfordshire 40% said it took between 15 and 30 minutes to park with others reporting a range from under 15 minutes to more than one hour.	2 out of 5
From outside Oxfordshire	
100% allowed between 30 minutes and one hour but for 66% it took less than 15 minutes to park	3 out of 3 2 out of 3
From within Oxfordshire 100% said they found it hard to park.	5 out of 5
From outside Oxfordshire 67% found it hard to park.	2 out of 3

Date (JR)	11 May 2017
Time	10am-2pm
Comments about parking	
From within Oxfordshire	
<p>100% said it was hard to find parking, even the person who dropped his wife off and then went to look for parking on local side roads. Comments included:</p> <ul style="list-style-type: none"> • Very hard to find a space. After entering the car park it took 20 minutes. Before that I queued for 57 minutes from the junction. The whole experience is stressful. It is terrible- started journey at 8.45am but was held up at the hospital. Wife has gone into surgery without seeing me even though I was here, just couldn't park. It's just horrendous- they should make a multi-storey car park. • Just join the queue. As expected- disappointing. I come to the hospital at least once a week- every time I have to allow at least 30 mins for parking. Would love to see a multi-storey car park built. • Was allowed into car park but couldn't find a space. It didn't bother me because I'd allowed so much time. It would have been awful for patients- the last thing you want. • Sat in a queue for the car park- one in one out system. It may let you in and there is still no space. Horrendous. Car park 1 works better. Today wasn't too bad. I always allow a good couple of hours to park. 	
From outside Oxfordshire	
<ul style="list-style-type: none"> • It felt stressful- radio off, total concentration on. Hoping someone who leaves will tell you where they've come out of. The car park seems to have been built at an earlier time- seems to aim to discourage parking. The cost to us in terms of fuel, time and the environment is enormous. How does it work for local people when people come in from outside? Royal Berks has a multi-storey car park. Surprised they only have one level car park here. Multi-storey would fit more people in. • Difficult because you're waiting for a car to come out before you can go in. Did 6 or 7 laps of the car park waiting for a space, about a dozen other cars were doing the same thing. Stressful. Needs two adults to accompany an elderly patient- couldn't have done it on my own- I would have been a wreck. 	

Date (JR)	16 May 2017
Time	10am-2pm
Total number of respondents	21

Date (JR)	16 May 2017
Time	10am-2pm
67% were outpatients	14 out of 21
29% were either going with a patient	6 out of 21
90 % came from within Oxfordshire	19 out of 21
62% used a car either their own and a friend's or family member's	13 out of 21
29% used buses	6 out of 21
Why they used this means of transport	
For those who used a car	
62% said convenience	8 out of 13
23% said they there was no public transport available One person they could not use public transport because of their wife's health	3 out of 13
For those who used buses	
33% said buses were the only way they could get to hospital	2 out of 6
33% said it was to avoid the stress of parking at the hospital	2 out of 6
All six people who used buses got off at a hospital bus stop and four used the X13	
Length of journey	
From within Oxfordshire	
53% took between 30 minutes and 1 hour	10 out of 19
32% took between 1 hour and 90 minutes	6 out of 19
From outside Oxfordshire	
100% took more than 2 hours	2 out of 2
How they felt about the journey	
76% said it was fine today or as expected though 2 out of the 16 people said the parking was stressful	16 out of 21
Parking	
85% parked without blue badge	11 out of 13
92% parked on hospital premises	12 out of 13
77% allowed 15 minutes to 30 minutes to park	10 out of 13
38% took 15 to 30 minutes to park and another 38% took 30 minutes to an hour to park	5 out of 13
77% said it was hard to park	10 out of 13
Comments about parking	
69% said it was stressful being stuck in a long queue of traffic. Comments included: <ul style="list-style-type: none"> • Awful, one in one out - really stressful, especially with children, when people in pain or children in pain - it's a terrible experience. • Just waiting in queue not knowing when or if you can park car, must be a better system 	

6.2.2 Findings from late afternoon to evening - John Radcliffe Hospital site

Date (JR)	16 May 2017
Time	2-6pm
Total number of respondents	12
67% were visiting patients	8 out of 12
25% were outpatients	3 out of 12
75 % came from within Oxfordshire	9 out of 12
75% used own car	9 out of 12
Why they used this means of transport	
From within Oxfordshire	
67% said convenience	4 out of 6
One person said there were no buses	
From outside of Oxfordshire	
100% said convenience	3 out of 3
Length of journey	
From within Oxfordshire	
44% took less than 30 minutes	4 out of 9
From outside Oxfordshire	
100% took between 1 hour and 90 minutes	3 out of 3
How they felt about the journey	
83% said it was fine or as expected	10 out of 12
Parking	
From within Oxfordshire 83% parked without blue badge	5 out of 6
From outside Oxfordshire 100% parked without a blue badge	3 out of 3
From within Oxfordshire 100% parked on hospital premises	6 out of 6
From outside Oxfordshire 100% parked on hospital premises	3 out of 3
56% allowed 15-30 minutes to park	5 out of 9
56% actually took less than 15 minutes to park	5 out of 9
78% said it was easy to park	7 out of 9
89% said their parking experience had no impact on them	8 out of 9

7 Appendix B - Horton General Hospital site

7.1 Summary

Total number of people spoken to at the Horton: 70

Number of people spoken to at each session:

	Date: 8 May 2017	Date: 9 May 2017	Date: 10 May 2017	Total per session
Session 7am-10am	14	2	7	23
Session 10am-2pm	19	2	11	32
Session 2pm-6pm		12	3	15
Total per day	33	16	21	

7.2 Main findings from the Horton:

- Total number of people spoken to was 70.
- Most respondents were outpatients
- Most respondents came from within Oxfordshire
- A majority used their own car.
- The main reasons given for people using their own car were convenience and the lack of any public transport from where they were travelling.
- Journey time for the majority was under 30 minutes though for people in the 2-6pm slot it was longer with half taking between 30 minutes and one hour.
- A majority felt fine about the journey.
- A majority parked without a blue badge and on the hospital premises.
- For a majority it took less than 15 minutes to park and they said it felt easy to park.
- Most felt fine about parking with a few feeling stressed- particularly about the coin machines not accepting the new £1 coins. This was raised by Healthwatch Oxfordshire (HWO) and was rectified as a result of HWO intervention.

Some of the comments from people included:

- “Usually takes between 30min and 1 hour to park and it is usually hard. Waiting 40 mins is stressful- that's what I usually wait. Also expensive.”
- Several people raised the problem with the parking machines not accepting the new £1 coins. “The machine did not take the new £1 coin and I only found this out after they found a space. So had to leave car park and return after obtaining old coins.” Another said “stressful because machine won't accept new £1 coins. Had to change £10 into lots of 20p. What are the old and people who can't see or walk well supposed to do?”

- “Bit stressful, went round and round, had to park on grass.”
- “I work at the JR, parking is fine for my early or night shift but if I am on a late or a study day then I can drive around for an hour looking for a staff space that have to pay for. It's impossible.”
- “Costs £2.80, why are the sick and dying made to pay?” and “expensive”
- “Don't let it (parking) stress me - just wanted to leave. If I had had an appointment, not a walk-in clinic I would have been stressed.”
- “Always stressful wondering if I can get a space.”
- “Stressed. Parking meter is broken and having to go and pay in the other car park.” And “very stressful- nightmare, ticket machines not working.”
- “Didn't worry because we had a lift- normally very difficult to park with only one disabled bay by Fiennes. Expensive parking fines.”
- “Had no idea how long I'd be here so bought 4 hours parking. Pay by contactless card helpful.”
- “Not always easy. Jolly pleased so easy today.”
- “I am wheelchair bound. My husband pushed me from A&E to Outpatients. He was in the JR Cardiac ward two weeks ago.”
- “Friend dropped me off and is waiting for me to call. Previous experience have found it VERY difficult to park.”

7.3 Morning experiences

Main findings about people's journey and parking experiences in the early morning to the Horton hospital:

Time (HGH)	7.00am-10am
Total number of respondents	23
70% were outpatients	16 out of 23
78% came from within Oxfordshire	18 out of 23
78% used own car	18 out of 23
Number of people who gave reasons for using own car	14
Why they used own car	
43% said convenience	6 out of 14
21% said there was no public transport or that a car was the only way to get there	3 out of 14
14% said they could not use public transport because of reasons such as a disability	2 out of 14
Length of journey	
For 52% it took less than 30 mins	12 out of 23
For 39% it took between 30 minutes and 1 hour	9 out of 23
How they felt about the journey	
74% felt fine about journey	17 out of 23
Parking	
83% parked without blue badge	19 out of 23
91% parked on hospital premises	21 out of 23
52% allowed less than 15 mins to park	11 out of 21
24% allowed 15-30mins	5 out of 21
21% allowed 30 mins to an hour	3 out of 14

Time (HGH)	7.00am-10am
For 78% it actually took less than 15 mins to park	18 out of 23
83% said it was easy to park	19 out of 23
Comments about parking	
43% said it was fine or good today	10 out of 23
24% mentioned cost in some form- either that they found it difficult to have to pay in advance when they did not know their length of stay or felt it was too expensive or that they would like free parking.	5 out of 21
Other comments included the fact that parking can be a nightmare in the afternoon,4 people felt it was better than having to park at an Oxford hospital, and concern that the pay machines wouldn't take the new £1 coins (this was addressed by HWO)	

7.3.1 Day by day

Date (HGH)	8 May 2017
Time	7.00am-10am
Total number of respondents	14
71% were outpatients	10 out of 14
71% came from within Oxfordshire	10 out of 14
79% used own car	11 out of 14
Number of people who gave reasons for using own car	5 out of 11
Why they used own car	
40% said convenience	2 out of 5
40% said inability to use public transport for reasons such as disability	2 out of 5
Length of journey	
For 57% it took less than 30 mins	8 out of 14
For 43% it took between 30 minutes and 1 hour	6 out of 14
How they felt about the journey	
71% felt fine about journey	10 out of 14
1 person mentioned traffic and another frustration with the pay machines	
Parking	
86% parked without blue badge	12 out of 14
93% parked on hospital premises	13 out of 14
21% allowed 15-30mins	3 out of 14
21% allowed 30 mins to an hour	3 out of 14
For 86% it actually took less than 15 mins to park with only 1 person taking between 15 and 30 mins	12 out of 14
86% said it was easy to park	12 out of 14

Date (HGH)	8 May 2017
Time	7.00am-10am
Comments about parking	
29% said it was fine or good today	4 out of 14
29% said it was better than having to park at an Oxford hospital	4 out of 14
29% mentioned cost in some form- either that they found it difficult to have to pay in advance when they did not know their length of stay or felt it was too expensive or that they would like free parking.	4 out of 14
Other comments included the fact that parking can be a nightmare in the afternoon and concern that the pay machines wouldn't take the new £1 coins (this was addressed by HWO)	

Date (HGH)	9 May 2017
Time	7.00am-10am
Total number of respondents	2
50% were outpatients	1 out of 2
100% came from within Oxfordshire	2 out of 2
50% used own car and 50% friends or family car	1 out of 2
Number of people who gave reasons for using own car	2 out of 2
Why they used own car	
50% were staff (so came in own car)	1 out of 2
50% said no buses so had someone drop them	1 out of 2
Length of journey	
For 50% it took between 30 mins and 1 hour	1 out of 2
For member of staff it took between 1 hour and 90 minutes	1 out of 2
How they felt about the journey	
50% felt fine about journey	1 out of 2
Member of staff felt frustrated by journey	1 out of 2
Parking	
100% parked without blue badge	2 out of 2
100% parked on hospital premises	2 out of 2
100% said it took less than 15 minutes to park	2 out of 2
100% said it was easy to park	2 out of 2
Comments about parking	
Both said it was easy to park	

Date (HGH)	10 May 2017
Time	7.00am-10am
Total number of respondents	7
71% were outpatients	5 out of 7

Date (HGH)	10 May 2017
Time	7.00am-10am
86% came from within Oxfordshire	6 out of 7
86% used own car	6 out of 7
Number of people who gave reasons for using own car	7 out of 7
Why they used own car	
57% said convenience	4 out of 7
Other reasons included the fact that there were no direct buses (14%), own car was the only way to get to the Horton (14%) and one person (14%) had used a volunteer driver scheme.	1 out of 7
Length of journey	
For 57% it took less than 30 mins	4 out of 7
For 29% it took between 30 minutes and 1 hour	2 out of 7
For 14% it took between 1 hour and 90 mins	1 out of 7
How they felt about the journey	
86% felt fine about journey	6 out of 7
Parking	
71% parked without blue badge	5 out of 7
86% parked on hospital premises	6 out of 7
57% allowed less than 15 mins to park	4 out of 7
29% allowed 15-30mins	2 out of 7
For 57% it actually took less than 15 mins to park	4 out of 7
For 29% it actually took between 15 and 30 mins	2 out of 7
71% said it was easy to park while 14% found it hard to park	5 out of 7
Comments about parking	
57% said their parking experience had no impact on them	4 out of 7
14% person said parking was stressful- drove round and round, parked on grass	1 out of 7
14% felt negative about cost	1 out of 7

7.4 Mid- morning to afternoon experiences:

Date (HGH)	8 May 2017
Time	10.00am-2pm
Total number of respondents	19
79% were outpatients	15 out of 19
89% came from within Oxfordshire	17 out of 19
95% used own car	18 out of 19
Number of people who gave reasons for using own car	17 out of 18
Why they used own car	
39% said convenience	7 out of 18
22% said it was the only way to get there or that there was no public transport	4 out of 18
17% said they were bringing children who then had to go back to school	3 out of 18
Length of journey	
For 63% it took less than 30 mins	12 out of 19

Date (HGH)	8 May 2017
Time	10.00am-2pm
For 37% it took between 30 minutes and 1 hour	7 out of 19
How they felt about the journey	
95% felt fine about journey	18 out of 19
One person said it was stressful	
Parking	
95% parked without blue badge	18 out of 19
95% parked on hospital premises	18 out of 19
32% allowed less than 15 mins to park	6 out of 19
47% allowed 15-30mins	9 out of 19
89% it took less than 15 mins to park	16 out of 18
94% said it was easy to park	16 out of 17
Comments about parking	
61% said it was fine or had no impact on them	11 out of 18
22% said it made them stressed because of time available, the coin machine not working or having to drive around to find a space.	4 out of 18

Date (HGH)	9 May 2017
Time	10.00am-2pm
Total number of respondents	2
100% were outpatients	2 out of 2
100% came from within Oxfordshire	2 out of 2
50% used own car and 50% friends or family car	1 out of 2
Number of people who gave reasons for using own car	1 out of 1
Why they used own car	
The person said no buses	1 out of 1
Length of journey	
For 100% it took less than 30 minutes	2 out of 2
How they felt about the journey	
50% felt fine about journey	1 out of 2
50% felt stressed that they might be admitted	1 out of 2
Parking	
50% parked without blue badge	1 out of 2
Both (100%) parked on hospital premises	2 out of 2
50% allowed less than 15 minutes to park	1 out of 2
50% allowed 15-30 minutes to park	1 out of 2
50% said it actually took less than 15 mins to park	1 out of 2
50% said it too 15-30 minutes to park	
50% said it was easy to park	1 out of 2

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Date (HGH)	9 May 2017
Time	10.00am-2pm
50% said it was hard to park	1 out of 2
Comments about parking	
One said it was very stressful to park and the other said it was fine because they had a lift	

Date (HGH)	10 May 2017
Time	10.00am-2pm
Total number of respondents	11
82% were outpatients	9 out of 11
55% came from within Oxfordshire	6 out of 10
100% had used own car	10 out of 10
Number of people who gave reasons for using own car	8 out of 10
Why they used own car	
25% said convenience	2 out of 8
25% said there were no buses to take	2 out of 8
25% said they could not use public transport because it was too far or because of a disability	2 out of 8
Length of journey	
For 55% it took less than 30 minutes	6 out of 11
For 45% it took between 30 mins and 1 hour	5 out of 11
How they felt about the journey	
80% felt fine about journey	8 out of 10
20% felt stressed by the journey	2 out of 10
Parking	
90% parked without blue badge	9 out of 10
91% parked on hospital premises	10 out of 11
45% allowed less than 15 minutes for parking	5 out of 11
64% took less than 15 minutes to park	7 out of 11
73% said it was easy to park	8 out of 11
Comments about parking	
64% said it had no impact on them or it was fine	7 out of 11
18% said it made them anxious	2 out of 11
One person mentioned the machine did not take new £1 and the stress that caused.	

Main findings about people's journey and parking experiences in the mid-morning to afternoon sessions at the Horton hospital:

Time	10.00am-2pm
Total number of respondents	32
81% were outpatients	26 out of 32
81% came from within Oxfordshire	25 out of 31
94% used own car	29 out of 31
Number of people who gave reasons for using own car	26 out of 29
Why they used own car	

Time	10.00am-2pm
Total number of respondents	32
35% said convenience	9 out of 26
26% said there was no public transport or that a car was the only way to get there	7 out of 27
19% said they could not use public transport because of reasons such as a disability or bringing children for an appointment	5 out of 26
Length of journey	
For 63% it took less than 30 mins	20 out of 32
For 37% it took between 30 minutes and 1 hour	12 out of 32
How they felt about the journey	
87% felt fine about journey	27 out of 31
Parking	
90% parked without blue badge	28 out of 31
94% parked on hospital premises	30 out of 32
38% allowed less than 15 mins to park	12 out of 32
48% allowed 15-30mins	10 out of 21
77% took less than 15 mins to park	24 out of 31
83% said it was easy to park	25 out of 30
Comments about parking	
58% said it was fine or good today	18 out of 31
23% said it was stressful with several mentioning the coin machines that would not take the new £1 coins	7 out of 31

7.5 Late afternoon to evening:

Date (HGH)	8 May 2017
Time	2pm-6pm
Total number of respondents	1
Came in ambulance so discounted	

Date (HGH)	9 May 2017
Time	2pm-6pm
Total number of respondents	12
90% were outpatients	9 out of 10
92% came from within Oxfordshire	11 out of 12
83% used own car	10 out of 12
Number of people who gave reasons for using own car	10 out of 10
Why they used own car	
40% said convenience	4 out of 10
30% said there was no public transport	3 out of 10
20% said it was the quickest way to travel	2 out of 10
Length of journey	

Date (HGH)	9 May 2017
Time	2pm-6pm
For 27% it took less than 30 mins	3 out of 11
For 45% it took between 30 minutes and 1 hour	5 out of 11
For 27% it took between 1 hour and 90 minutes	3 out of 11
How they felt about the journey	
83% felt fine about journey	10 out of 12
One person said they felt tired	
Parking	
75% parked without blue badge	9 out of 12
100% parked on hospital premises	12 out of 12
58% allowed less than 15 mins to park	7 out of 12
33% allowed 15-30mins	4 out of 12
For 75% it actually took less than 15 mins to park	9 out of 12
For 25% it took 15-30 minutes to park	3 out of 12
82% said it was easy to park	9 out of 11
Comments about parking	
33% said they were happy with the experience or had no impact on them	4 out of 12
33% said it was stressful because meters/coin machines not working/not taking new £1	4 out of 12
1 person suggested contactless for payments and 17% (2 out of 12) said they were happy not to have had to pay as the machines weren't working	

Date (HGH)	10 May 2017
Time	2pm-6pm
Total number of respondents	3
67% were outpatients	2 out of 3
67% came from within Oxfordshire	2 out of 3
100% used own car	3 out of 3
Number of people who gave reasons for using own car	3 out of 3
Why they used own car	
67% said convenience	2 out of 3
33% said there was no public transport	1 out of 3
Length of journey	
33% took less than 30 mins	1 out of 3
67% took between 30 minutes and 1 hour	2 out of 3
How they felt about the journey	
67% felt fine about journey	2 out of 3

Date (HGH)	10 May 2017
Time	2pm-6pm
Parking	
67% parked without blue badge	2 out of 3
67% parked on hospital premises	2 out of 3
33% allowed less than 15 mins to park	1 out of 3
33% allowed 15-30mins to park	1 out of 3
33% allowed 30mins-1 hour	1 out of 3
For 67% it actually took less than 15 mins to park	2 out of 3
100% said it was easy to park	3 out of 3
Comments about parking	
67% said it was fine	2 out of 3
One person said "I do however, work at the JR, parking is fine for my early or night shift but if I am on a late or a study day then I can drive around for an hour looking for a staff space that have to pay for. It's impossible."	

Main findings about people's journey and parking experiences in the late afternoon to evening sessions at the Horton hospital:

Time (HGH)	2pm-6pm
Total number of respondents	15
85% were outpatients	11 out of 13
87% came from within Oxfordshire	13 out of 15
87% used own car	13 out of 15
Number of people who gave reasons for using own car	13 out of 13
Why they used own car	
46% said convenience	6 out of 13
31% said there was no public transport or that a car was the only way to get there	4 out of 13
20% said it was quickest	2 out of 10
Length of journey	
29% took less than 30 mins	4 out of 14
50% took between 30 minutes and 1 hour	7 out of 14
27% took between 1 hour and 90 minutes	3 out of 11
How they felt about the journey	
80% felt fine about journey	12 out of 15
Parking	
73% parked without blue badge	11 out of 15
93% parked on hospital premises	14 out of 15
83% allowed less than 15 mins to park	8 out of 15
33% allowed 15-30mins	3 out of 15
73% took less than 15 mins to park	11 out of 15
25% took 15-30 minutes to park	3 out of 12
86% said it was easy to park	12 out of 14
Comments about parking	

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Time (HGH)	2pm-6pm
40% said it was fine	6 out of 15
33% said it was stressful with several mentioning the coin machines that would not take the new £1 coins	4 out of 12

8 Appendix C - Churchill Hospital site

8.1 Morning experiences:

Date (CH)	17 May 2017
Time	7-10am
Total number of respondents	9
89% were outpatients	8 out of 9
89% came from within Oxfordshire	8 out of 9
67% used own car while 22% used patient transport	6 out of 9 2 out of 9
Why they used their own car	
67% said public transport is not suitably because of ill health or lack of availability	4 out of 6
33% said it was because of convenience	2 out of 6
Length of journey	
44% took between 30 minutes and 1 hour	4 out of 9
33% took between 1 hour and 90 minutes	3 out of 9
How they felt about the journey	
56% mentioned problems with traffic and the roadworks, though some said they were expecting this and one person said they left early to make it on time. Comments included: <ul style="list-style-type: none"> • “Bit busy on A34. End part of journey- held up by roadworks.” • “Doesn't worry me- used to the traffic problems” • “Wasn't too bad- queued to the Headington roundabout but it moved fairly quickly.” • “Terrible- get stressed out because of road works, motorway backed up. Leave early and know all the routes- have to get here early to park. If you leave it till 11am, it's hopeless.” • “Been amazing- came on 2 buses- straight on a bus from home and when I got to the Park and ride the 900 was standing there. Only took 45 minutes. That was excellent. If I had missed the 900 it would have been a half hour wait. It was good.” • “Terrible- such traffic problems.” • “Because I'd left plenty of time, I was alright. Left really early, otherwise I would have been really stressed.” • “It was slow but fine. Traffic was quite bad.” 	6 out of 9
Parking	
71% of those who responded had parked without a blue badge	5 out of 7
100% of those had driven had parked on the hospital premises (in addition 2 had used Patient transport and 1 had used the 900 park and ride service)	6 out of 6

Date (CH)	17 May 2017
Time	7-10am
In terms of time allowed to find parking, 50% said they allowed less than 15 minutes and 50% said they allowed between 30 minutes and 1 hour.	3 out of 6 3 out of 6
71% said it took less than 15 minutes to find parking with 29% reporting a wait of between 15 and 30 minutes.	5 out of 7 2 out of 7
From within Oxfordshire 71% found it easy to park with two people saying it was hard.	
100% of those who responded to the question said they had found it easy to find parking.	4 out of 4
<p>Comments about parking included:</p> <ul style="list-style-type: none"> • “Daughter dropped me at the door and went off to park. She said it was quite easy today but yesterday it was a nightmare at the Nuffield Orthopaedic. Got here at 9.30am and it was fine but now (noon) there are no spaces. They let you into car park and you still have to drive around.” • “Parking is not up to scratch here. I object to paying for parking for parking my car here in the hospital. Astounded that blue badge holders also have to pay. Parking has got worse over time here. They should issue a daily parking permit valid for the whole day- I don't think you should have to pay.” • “We come early, particularly since the roadworks.” • “Been lucky today. You can go straight in or you can wait an hour to find parking. Car park too small. Car park was full- one came out so we got in. We were going into a disabled bay so we were lucky. But still had to queue with everyone, even though we can park in the disabled bay. Have a blue badge and can park in a disabled slot but still get stuck in traffic because car park was full. Once into car park, a space was available today, though it can take an hour.” • “Have a special permit to park. It would be a total nightmare without permit. Come to front of Churchill and park straight across entrance. In Banbury they are building 1000s of new houses and they want to take the hospital away- disgusting. They can do treatments there, they should.” • “It was fine, wasn't sure where I was so just followed signs to general hospital. I have been here before, if I hadn't it feels like you don't quite know where to go. For me, if the Park and Ride were only stopping at the hospital- coming here directly I would feel better about using it. The current Park and ride isn't only for the hospital. May not be sure where to get off.” 	

Date (CH)	17 May 2017
Time	7-10am
<ul style="list-style-type: none"> “Once through the barrier it was quite easy, but waited outside for 20 minutes. Parking is a problem- it's pretty horrendous. £7 a day is quite a lot to pay.” 	

8.2 Mid- morning to afternoon experiences:

Date (CH)	17 May 2017
Time	10am-2pm
Total number of respondents	6
66% were outpatients and 33% were going with a patient	4 out of 6 2 out of 6
83% came from outside Oxfordshire	5 out of 6
In total 83% used a car with one person using the 700 park and ride bus	5 out of 6
60% of people said they used a car because of the length of time it would take to travel to the hospital by public transport from where they lived. 40% said it was convenience. Comments included: <ul style="list-style-type: none"> “This is the first time I've come by car because I've got to go on to another medical appointment and I can't get to that by bus. Anyone who comes here by car otherwise is an idiot.” “More convenient” “Because of where we live- in the middle of nowhere- easier to come by car” “Public transport takes days!” “Much easier from my place. Brings me right here from where I live.” “Because we come from Northamptonshire- and then we pick up our son from Leighton Buzzard and come here. Convenience.” 	3 out of 5 2 out of 5
Length of journey	
50% said it took between 30 minutes and 1 hour, while 33% said it took more than 1 hour and one said it took less than 30 minutes.	3 out of 6
How they felt about the journey 66% said the journey was ok or as expected. 33% felt more negative about it. Comments included: <ul style="list-style-type: none"> “Terrible because of the weather. The M40 and the lorries in the rain- horrible.” “Bit wet but ok” “Fine. As expected- husband deliberately didn't park here- he dropped me and then went to get a coffee. Had to go somewhere because we were worried about finding a place to park. So didn't attempt it.” “As expected- better!” “Bit tiring- more so for my son. He's recovering.” 	4 out of 6 2 out of 6

Date (CH)	17 May 2017
Time	10am-2pm
Parking	
75% of those who responded did not have a blue badge.	3 out of 4
80% of those who used a car parked on the hospital premises. One person had her husband drop her. She said "Husband deliberately didn't park here- he dropped me and then went to get a coffee. Had to go somewhere because we were worried about finding a place to park. So didn't attempt it."	4 out of 5
75% allowed between 30 minutes and one hour to park.	3 out of 4
50% took less than 15 minutes and 50% took between 15 and 30 minutes.	2 out of 4 2 out of 4
75% said they found it easy to find a parking space.	3 out of 4
<p>Comments about parking included:</p> <ul style="list-style-type: none"> • "Once you're in, it's alright as there are 8 or 9 disabled spaces. Car park was full. Went on the phone- pushed the button on the machine and talked to security. If you tell them you have a blue badge they let you in as there are spaces in disabled bays. Car park No 1- disabled parking there is always full. But no5 has spaces. Know people who have missed appointments because of the parking problem." • "One of the good days today. Sometimes a nightmare to get a parking space. We come here regularly. Very expensive to park- considering we don't have much choice but to come here." • "Quite familiar with it- expect it to be hard so allow time and watch people with car keys. We hate coming here because of the parking." • "Not too bad today. Today was fine, last week was a long wait, had to queue to park for an hour. Bit tiring that was." 	

Date (CH)	22 May 2017
Time	10am-2pm
Total number of respondents	14
93% were outpatients	13 out of 14
57 % came from Oxfordshire with 43% coming from outside Oxfordshire	8 out of 14 6 out of 14
57% used own car or a friend's or family member's car with 29% using a bus or park and ride service	8 out of 14 4 out of 14
Reason for choice of transport 50% of those who used a car said it was because public transport was not appropriate for them. They said: <ul style="list-style-type: none"> • "Didn't know how dad would feel when finished so we can go straight home." 	4 out of 8

Date (CH)	22 May 2017
Time	10am-2pm
<ul style="list-style-type: none"> • “Didn’t want to be upset on bus.” • “Buses unreliable.” • “Would have to change buses several times.” <p>38% said they used a car because of convenience. Comments included: “Easier to get here [in a car] but not to park.”</p> <p>The 3 people who had used the park and ride services also said it was to enable them to avoid driving and parking. Comments included:</p> <ul style="list-style-type: none"> • “Warned off car park, told it is so hopeless you can’t get in, website says to avoid parking.” • “Easier - Oxford has really got its act together! The Park & Ride are very good, excellent system!” 	3 out of 8
Length of journey	4 out of 11
36% reported a journey time of less than half an hour and 36% reported a journey time of between one hour and 90 minutes.	4 out of 11
How they felt about the journey	
63% said the journey was ok or fine	5 out of 8
38% reported feeling stressed.	3 out of 8
83% had parked without a blue badge.	5 out of 6
100% of those who responded had parked on hospital premises.	6 out of 6
67% allowed less than 15 minutes to park	4 out of 6
33% allowed 15-30 minutes to park	2 out of 6
60% took less than 15 minutes to park while 40% took between 15 and 30 minutes.	3 out of 5 2 out of 5
50% said it was easy to park and 50% said it was hard.	3 out of 6 3 out of 6
Comments about parking: <ul style="list-style-type: none"> • “Was 9th in the queue to get into car park. Took 15-30 mins to park.” • “Parking not in a designated bay because can’t find one.” • “Can be horrendous sometimes.” • “Confusing to park; no legitimate spaces - I am probably parked illegally but other people were too.” • “Traffic was awful today, bus drivers didn’t know anything because of the traffic. we booked a taxi from the park and ride, but the bus came first.” 	

8.3 Main findings about people’s experience from 10am to 2pm

Time (CH)	10am-2pm
Total number of respondents	20
85% were outpatients	17 out of 20

Time (CH)	10am-2pm
55% came from outside Oxfordshire and 45% from within Oxfordshire	11 out of 20 9 out of 20
65% used own car or a friend's or family member's car 25% used a bus or park and ride service	13 out of 20 5 out of 20
Why they used a car	
38% of respondents said they used a car because of convenience (quicker, easier) 31% said public transport was not appropriate and 23% said it was too far to travel on public transport. Comments included: <ul style="list-style-type: none"> • “This is the first time I've come by car because I've got to go on to another medical appointment and I can't get to that by bus. Anyone who comes here by car otherwise is an idiot.” • “More convenient” • “Because of where we live- in the middle of nowhere- easier to come by car” • “Public transport takes days!” • “Much easier from my place. Brings me right here from where I live.” • “Because we come from Northamptonshire- and then we pick up our son from Leighton Buzzard and come here. Convenience.” • Didn't know how dad would feel when finished so we can go straight home.” • “Didn't want to be upset on bus.” • “Buses unreliable.” • “Would have to change buses several times.” • “Easier to get here [in a car] but not to park.” 	5 out of 13 4 out of 13 3 out of 13
25% of people used the park and ride services or a bus and comments included: <ul style="list-style-type: none"> • “Warned off car park, told it is so hopeless you can't get in, website says to avoid parking.” • “Easier - Oxford has really got its act together! The park and ride are very good, excellent system!” 	5 out of 20
Length of journey	
29% said it took them less than 30 minutes 29% said it took them between one hour and 90 minutes 18% reported a journey time of between 30 minutes and one hour.	5 out of 17 5 out of 17 3 out of 17
How they felt about the journey: 64% reported feeling fine or ok about the journey while 36% reported feeling stressed. Comments included: <ul style="list-style-type: none"> • “Terrible because of the weather. The M40 and the lorries in the rain- horrible.” • “Bit wet but ok” • “Fine. As expected- husband deliberately didn't park here- he dropped me and then went to get a coffee. Had to go somewhere because we were worried about finding a place to park. So didn't attempt it.” • “As expected- better!” 	9 out of 14 5 out of 14

Time (CH)	10am-2pm
<ul style="list-style-type: none"> • “Bit tiring- more so for my son. He’s recovering.” 	
Parking	
80% of those who responded to the question had parked without blue badge	8 out of 10
91% of respondents parked on hospital premises. One person said her husband dropped her off.	10 out of 11
40% allowed less than 15 minutes to park 30% allowed 30 minutes to 1 hour 20% allowed 15 to 30 minutes.	4 out of 10 3 out of 10 2 out of 10
56% took them less than 15 minutes to park 44% said it took between 15 and 30 minutes to park.	5 out of 9 4 out of 9
60% found it easy to park 40% said it was difficult.	6 out of 10 4 out of 10
<p>Comments about parking experience included:</p> <ul style="list-style-type: none"> • “Was 9th in the queue to get into car park. Took 15-30 mins to park.” • “Parking not in a designated bay because can’t find one.” • “Can be horrendous sometimes.” • “Confusing to park; no legitimate spaces - I am probably parked illegally but other people were too.” • “Traffic was awful today, bus drivers didn’t know anything because of the traffic. we booked a taxi from the park and ride, but the bus came first.” • “Once you’re in, it’s alright as there are 8 or 9 disabled spaces. Car park was full. Went on the phone- pushed the button on the machine and talked to security. If you tell them you have a blue badge they let you in as there are spaces in disabled bays. Car park 1- disabled parking there is always full. But no5 has spaces. Know people who have missed appointments because of the parking problem.” • “One of the good days today. Sometimes a nightmare to get a parking space. We come here regularly. Very expensive to park- considering we don’t have much choice but to come here.” • “Quite familiar with it- expect it to be hard so allow time and watch people with car keys. We hate coming here because of the parking.” • “Not too bad today. Today was fine, last week was a long wait, had to queue to park for an hour. Bit tiring that was.” 	

8.4 Late afternoon to evening:

Date (CH)	22 May 2017
Time	2pm-6pm
Total number of respondents	16

Date (CH)	22 May 2017
Time	2pm-6pm
94% were outpatients	15 out of 16
88 % came from within Oxfordshire	14 out of 16
56% used their own car 31% used buses and park and ride services Two people used taxis.	9 out of 16 5 out of 16
Why they used this means of transport	
44% of those using a car cited convenience as a reason for using one. One said they had never had a problem parking. Other comments included: <ul style="list-style-type: none"> • “Know I can't get parking, mornings are bad so try and get later appointments.” • “Taxi would cost £30 from Wheatley.” • “Quick, bus service infrequent. Feel nervous enough anyway.” • “Too far, usually do park & ride, appointment was later today.” 	4 out of 9 5 out of 16
People using a bus/ park and ride service said: <ul style="list-style-type: none"> • “Usually take hospital bus but it wasn't running today because of water/road works, had to take three buses from Kidlington.” • “Easier to come although will probably have to wait around to get back to park and ride.” • “Don't want the hassle of trying to park.” 	
The two people who used taxis said it was to avoid parking and to reduce the amount of walking necessary.	
Length of journey	
46% of respondents reported it took them between 30 minutes and 1 hour 31% said it took less than 30 minutes 23% reported a journey time of between 1 hour and 90 minutes.	6 out of 13 4 out of 13 3 out of 13
How they felt about the journey	
71% felt fine about their journey 29% said they felt stressed or anxious as a result of their journey	10 out of 14 4 out of 14
Parking	
100% of those who responded said they had not parked with a blue badge	7 out of 7
100% of those who responded said they had parked on hospital premises	9 out of 9
44% allowed less than 15 minutes to park 44% allowed between 15 to 30 minutes to park	4 out of 9 4 out of 9
78% reported that it took less than 15 minutes to park 22% took between 15 and 30 minutes to park.	7 out of 9 2 out of 9
78% said it was easy to park 22% said it was difficult to park.	7 out of 9 2 out of 9
56% felt their parking experience had no impact on them. Comments included: <ul style="list-style-type: none"> • “Today it has been fine, other times I take a taxi because I know it can be hard, took a chance today!” • “Normally really bad.” 	5 out of 9

Date (CH)	22 May 2017
Time	2pm-6pm
<ul style="list-style-type: none"> • “Had to come all the way into main hospital to park.” 	

8.5 Main findings at Churchill hospital site

Total number of people spoken to at the Churchill was 45

Number of people spoken to at each session:

	17 May 2017	22 May 2017	Total per session
Session 7am - 10am	9		9
Session 10am-2pm	6	14	20
Session 2pm-6pm		16	16
Total per day	15	30	45

Main findings from the Churchill:

Total number of people spoken to were 45.

89% of respondents were outpatients.

78% of respondents came from within Oxfordshire

22% from outside Oxfordshire.

62% used their own or family or friend’s car to get to hospital

22% used the park and ride services or a bus service.

The main reasons given for people using a car were the lack of suitability of public transport because of the distance travelled, ill health or lack of availability (58%), with 39% saying they used a car because of convenience.

Comments included:

- This is the first time I've come by car because I've got to go on to another medical appointment and I can't get to that by bus. Anyone who comes here by car otherwise is an idiot.”
- “More convenient”
- “Because of where we live- in the middle of nowhere- easier to come by car”
- “Public transport takes days!”
- “Much easier from my place. Brings me right here from where I live.”
- “Because we come from Northamptonshire- and then we pick up our son from Leighton Buzzard and come here. Convenience.”
- Didn't know how dad would feel when finished so we can go straight home.”

- “Didn't want to be upset on bus.”
- “Buses unreliable.”
- “Would have to change buses several times.”
- “Easier to get here [in a car] but not to park.”
- “Know can't get parking no, mornings are bad so try and get later appointments.”
- “Taxi would cost £30 from Wheatley.”
- “Quick, bus service infrequent. Feel nervous enough anyway.”
- “Too far, usually do park and ride, appointment was later today.”

Some of the comments by people who had used park and ride services or another bus service included:

- “Warned off car park, told it is so hopeless you can't get in, website says to avoid parking.”
- “Easier - Oxford has really got its act together! The Park & Ride are very good, excellent system!”
- “Usually take hospital bus but it wasn't running today because of water/road works, had to take 3 buses from Kidlington.”
- “Easier to come although will probably have to wait around to get back to park and ride.”
- “Don't want the hassle of trying to park.”

41% of respondents reported a journey time of between 30 minutes and one hour 31% took between one hour and 90 minutes
28% took less than 30 minutes.

When asked how they felt about the journey

51% said it was fine or ok or as expected

40% felt stressed or had difficulty with traffic and roadworks they encountered on their way to the hospital.

Comments included:

- “Bit busy on A34. End part of journey- held up by roadworks.”
- “Doesn't worry me- used to the traffic problems”
- “Wasn't too bad- queued to the Headington roundabout but it moved fairly quickly.”
- “Terrible- get stressed out because of road works, motorway backed up. Leave early and know all the routes- have to get here early to park. If you leave it till 11am, it's hopeless.”
- “Been amazing- came on 2 buses- straight on a bus from home and when I got to the Park and ride the 900 was standing there. Only took 45 minutes. That was excellent. If I had missed the 900 it would have been a half hour wait. It was good.”
- “Terrible- such traffic problems.”
- “Because I'd left plenty of time, I was alright. Left really early, otherwise I would have been really stressed.”
- “It was slow but fine. Traffic was quite bad.”
- “Terrible because of the weather. The M40 and the lorries in the rain- horrible.”

- “Bit wet but ok”
- “Fine. As expected- husband deliberately didn't park here- he dropped me and then went to get a coffee. Had to go somewhere because we were worried about finding a place to park. So didn't attempt it.”
- “As expected- better!”
- “Bit tiring- more so for my son. He's recovering.”

83% of those who responded to the question said they did not have a blue badge.

96% of those who responded had parked on the hospital premises.

Between 6-10am - 78% took less than 15 minutes to park, with 22% reporting a longer wait of between 15 and 30 minutes

Between 10am-2pm - 56% took less than 15 minutes, with 44% stating it took between 15 and 30 minutes.

Between 2-6pm - 71% took them less than 15 minutes to park, with 29% taking between 15 and 30 minutes

74% said it was easy to park, with 26% saying it was difficult

Comments from people about their experiences included:

- Daughter dropped me at the door and went off to park. She said it was quite easy today but yesterday it was a nightmare at the Nuffield Orthopaedic. Got here at 9.30am and it was fine but now (noon) there are no spaces. They let you into car park and you still have to drive around.”
- “Parking is not up to scratch here. I object to paying for parking for parking my car here in the hospital. Astounded that blue badge holders also have to pay. Parking has got worse over time here. They should issue a daily parking permit valid for the whole day- I don't think you should have to pay.”
- “We come early, particularly since the roadworks.”
- “Been lucky today. You can go straight in or you can wait an hour to find parking. Car park too small. Car park was full- one came out so we got in. We were going into a disabled bay so we were lucky. But still had to queue with everyone, even though we can park in the disabled bay. Have a blue badge and can park in a disabled slot but still get stuck in traffic because car park was full. Once into car park, a space was available today, though it can take an hour.”
- “Have a special permit to park. It would be a total nightmare without permit. Come to front of Churchill and park straight across entrance. In Banbury they are building 1000s of new houses and they want to take the hospital away- disgusting. They can do treatments there, they should.”
- “It was fine, wasn't sure where I was so just followed signs to general hospital. I have been here before, if I hadn't it feels like you don't quite know where to go. For me, if the Park and Ride were only stopping at the hospital- coming here directly I would feel better about using it. The current Park and ride isn't only for the hospital. May not be sure where to get off.”
- “Once through the barrier it was quite easy, but waited outside for 20 minutes. Parking is a problem- it's pretty horrendous. £7 a day is quite a lot to pay.”
- “Was ninth in the queue to get into car park. Took 15-30 mins to park.”
- “Parking not in a designated bay because can't find one.”
- “Can be horrendous sometimes.”

- “Confusing to park. There were no legitimate spaces. I am probably parked illegally but other people were too.”
- “Traffic was awful today, bus drivers didn't know anything because of the traffic. We booked a taxi from the park and ride, but the bus came first.”
- “Once you're in, it's alright as there are 8 or 9 disabled spaces. Car park was full. Went on the phone- pushed the button on the machine and talked to security. If you tell them you have a blue badge they let you in as there are spaces in disabled bays. Car park 1- disabled parking there is always full. But no5 has spaces. Know people who have missed appointments because of the parking problem.”
- “One of the good days today. Sometimes a nightmare to get a parking space. We come here regularly. Very expensive to park- considering we don't have much choice but to come here.”
- “Quite familiar with it- expect it to be hard so allow time and watch people with car keys. We hate coming here because of the parking.”
- “Not too bad today. Today was fine, last week was a long wait, had to queue to park for an hour. Bit tiring that was.”
- “Today it has been fine, other times I take a taxi because I know it can be hard, took a chance today!”
- “Normally really bad.”
- “Had to come all the way into main hospital to park.”

9 Appendix D - Nuffield Orthopaedic Centre

9.1 Morning experiences:

Date (NOC)	18 May 2017
Time	7am-10am
Total number of respondents	12
83% were outpatients	10 out of 12
83% came from within Oxfordshire	10 out of 12
75% used own car	9 out of 12
Within Oxfordshire 70% used their own car	7 out of 10
100% of people coming from outside Oxfordshire used their own car	2 out of 2
Why they used their own car	
From within Oxfordshire	
43% said they were unable to use public transport because of ill health or disability	3 out of 7
43% said there was no public transport available or it was impossible on public transport	3 out of 7
From outside of Oxfordshire	
100% said there was no alternative or no public transport for them at all	2 out of 2
Length of journey	
From within Oxfordshire	
60% took between 30 minutes and 1 hour	6 out of 10
30% took between 1 hour and 90 minutes	3 out of 10
From outside Oxfordshire	
One person took between 30 minutes and one hour and one more than two hours	
How they felt about the journey	
From within Oxfordshire	
60% said it was fine, as expected, or a bit better than expected.	6 out of 10
40% felt negatively about their journey citing traffic and road works as the problem.	4 out of 10
From outside Oxfordshire	
100% felt stressed by the journey	2 out of 2
Parking	
57% from within Oxfordshire parked with blue badge	4 out of 7
50% from outside Oxfordshire parked with a blue badge	1 out of 2
100% from within Oxfordshire who used a car parked on hospital premises	7 out of 7
100% from outside Oxfordshire parked on hospital premises	2 out of 2
60% from within Oxfordshire allowed 30 minutes to an hour to park	3 out of 5
86% from within Oxfordshire took less than 15 minutes to park	6 out of 7
From outside of Oxfordshire one person allowed 15-30 minutes and one person less than 15 minutes to find parking	

Date (NOC)	18 May 2017
Time	7am-10am
100% from outside Oxfordshire took less than 15 minutes to park	2 out of 2
71% from within Oxfordshire found it easy to park	5 out of 7
One from outside Oxfordshire person found it easy to park while the other found it hard to park. (Gone into figures again????)	
Comments about parking	
From within Oxfordshire	
<ul style="list-style-type: none"> 43% said it was fine and that had found a space easily. 	3 out of 7
<ul style="list-style-type: none"> One person said “Got a space straightaway- first time ever. Normally drive around after dropping husband off. Saw on a screen in the waiting room that if you're over time with the parking you can call receptionist or nurse what is that about? If there is help available so you don't have to keep rushing back to your car then they should publicise it better, most people wouldn't see it. If you're on your own and have to run up and down to the car if your appointment runs over, then this would be useful. All the park and ride services should have a hospital shuttle- come to the Redbridge site so there is no park and ride. Can't we have a shuttle service like at the airports, parking away from the hospitals and then have a shuttle to hospital? For us the p and r no use- would take an hour to oxford and then take a long time to get here.” 	2 out of 7
<ul style="list-style-type: none"> 29% said they had come early to find a space. One person said “Usually come early. If you come at noon, you have a job to park, even with the disabled badge. All the visitors are coming at that time so compete with them for space.” 	2 out of 7
<ul style="list-style-type: none"> 29% said they found it difficult to park. One person said “Couldn't find a parking space at 9.30am ended up on the pavement with a sign that says do not park- because there's no place. Hope I don't get a ticket, went right way round, could see cars waiting, saw pavement, used it.” Another said “Incredibly difficult to find parking. There are people driving round and round in the car park. There is potential for aggression and accidents when people spot a parking space becoming empty. Dropped husband off and was waiting to park. Felt there were drivers who were quite aggressive and racing into parking spaces. Suggestion- people with certified mobility problems and blue badges and frailty should be granted certificate to park at the hospital. Should be more parking for staff. Everyone else should be given instructions for the park and ride- clear instructions on what buses to catch. Buses should turn into the hospital- hard to walk from the road. Detailed instructions should be given to patients on how long it will take and how to get there. Should be dedicated park and ride for the JR. Transport should be more integrated. People would use public transport more willingly if there were more certainty.” 	

Date (NOC)	18 May 2017
Time	7am-10am
<p>One member of staff said</p> <ul style="list-style-type: none"> • They want me to be here at 7am. If I come on the bus I have to leave home at 5am. Then I am too knackered to do a 12 hour shift from the start. I drive at the moment because I have a permit but the buses are really hard to do. If I use the park and ride and my shift finishes at 10pm there are no buses from the hospital. I have to walk to the High street in Headington in the darkness to catch a bus. Even with a permit in the afternoons can't find parking. Have to park in patients parking and risk a fine. Really need a travel survey with staff. Park and ride costs me £150 a month plus the buses don't go after 7pm. need a multi-storey car park like other areas. Find so many patients upset about parking. At protected lunch times when you ask people to leave they get really upset because they say 'but I've struggled to park and now you're asking me to leave.'" 	
<p>From outside Oxfordshire, both people had comments about their experience:</p> <ul style="list-style-type: none"> • "Parking is not too bad but the journey is really difficult. I'm 83 and husband 84- it's very hard for us to do the journey. The journey is costing us a fortune in petrol. It's a 200 mile round trip, costs £40 each way." • "As I turned right (into the hospital)- the stress starts knowing that I might not get a space and might not be able to get to the hospital at my allocated time. You arrive in a tense situation but the relief when someone pulls out! I consider myself really lucky when I get a place because it is so difficult. Otherwise might miss appointment." 	

Date (NOC)	23 May 2017
Time	7am -10am
Total number of respondents	12
50% were outpatients, and 25% were going with a patient	6 out of 12 3 out of 12
58% came from within Oxfordshire	7 out of 12
42% came from outside Oxfordshire	5 out of 12
83% used their own car or a friend's or family member's car	10 out of 12
86% from within Oxfordshire used their own car	6 out of 7
80% from outside Oxfordshire used their own car	4 out of 5
Why they used their own car	
100% from within Oxfordshire said it was the easiest and quickest option	5 out of 5
75% of those outside Oxfordshire said it was it was too far to travel by public transport	3 out of 4
Length of journey	
86% from within Oxfordshire took within 30 minutes to an hour	6 out of 7

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Date (NOC)	23 May 2017
Time	7am - 10am
From outside Oxfordshire for 60% it took between 30 minutes and one hour	3 out of 5
How they felt about the journey	
66% from within Oxfordshire felt ok about their journey 33% said it was a difficult journey.	4 out of 6 2 out of 6
60% from outside Oxfordshire felt ok about their journey	3 out of 5
Parking	
100% from within Oxfordshire and outside Oxfordshire who parked did not have a blue badge	5 out of 5 4 out of 4
83% from within Oxfordshire parked on hospital premises 100% of those who used a car from outside Oxfordshire parked on hospital premises	5 out of 6 4 out of 4
50% from within Oxfordshire allowed less than 15 minutes to park 100% took less than 15 minutes to park	5 out of 5
50% from outside Oxfordshire allowed less than 15 minutes 100% took less than 15 minutes to park.	4 out of 4
100% of people said it was easy to park	9 out of 9
Comments about parking	
83% from within Oxfordshire said it was fine to park. Comments included: <ul style="list-style-type: none"> • “Always find it ok” • one person mentioned the high cost of parking • two people said it had been hard to park in the past • And one person said it was better than parking at the JR 	5 out of 6
100% from outside Oxfordshire felt it was fine to park Comments included: <ul style="list-style-type: none"> • “Normally an issue but today was fine” • “Unusually good today. You have to get here before 9 or you've had it!” 	4 out of 4

Main findings about people’s journey and parking experiences in the early morning at the NOC:

Time (NOC)	7am - 10am
Total number of respondents	24
67% were outpatients	16 out of 24
62.5% came from within Oxfordshire	15 out of 24
37.5 came from outside Oxfordshire	9 out of 24
79% used own car or a friend’s or family member’s car	19 out of 24
Why they used a car	
61% cited the lack of public transport, being too unwell to use public transport or having too far to travel to use public transport. 27% of this group said convenience was the reason for choosing to use a car.	11 out of 18 5 out of 18
Length of journey	
67% took 30 minutes to one hour (this includes those from within and outside Oxfordshire who responded to the question).	16 out of 24

Time (NOC)	7am - 10am
How they felt about the journey	
57% felt the journey was as expected. One person said “I was prepared for it! Would like to have timings of buses with the appointment letter from Thornhill and the hospital. So can plan journey better. Saves sitting around for 45 minutes.”	13 out of 23
43% of people felt negative about their journey. One person said they were “shattered” after their journey, another said “Awful- lot of traffic- worse than normal. it was bad today, don't know why”	10 out of 23
Parking	
72% parked without a blue badge	13 out of 18
95% of people who used cars parked on the hospital premises	18 out of 19
94% found parking in less than 15 minutes.	
Comments about parking experience	
83% of those who responded to the question said it had been easy to find parking.	15 out of 18
61% of those within Oxfordshire felt fine about their parking experience. Comments included:	8 out of 13
<ul style="list-style-type: none"> • “Got a space straightaway- first time ever. Normally drive around after dropping husband off. Saw on a screen in the waiting room that if you're over time with the parking you can call receptionist or nurse what is that about? If there is help available so you don't have to keep rushing back to your car then they should publicise it better, most people wouldn't see it. If you're on your own and have to run up and down to the car if your appointment runs over, then this would be useful. All the park and ride services should have a hospital shuttle- come to the Redbridge site so there is no park and ride. Can't we have a shuttle service like at the airports, parking away from the hospitals and then have a shuttle to hospital? For us the p and r no use- would take an hour to oxford and then take a long time to get here.” • “Usually come early. If you come at noon, you have a job to park, even with the disabled badge. All the visitors are coming at that time so compete with them for space.” • “Couldn't find a parking space at 9.30am ended up on the pavement with a sign that says do not park- because there's no place. Hope I don't get a ticket, went right way round, could see cars waiting, saw pavement, used it.” • “Incredibly difficult to find parking. There are people driving round and round in the car park. There is potential for aggression and accidents when people spot a parking 	

Time (NOC)	7am - 10am
<p>space becoming empty. Dropped husband off and was waiting to park. Felt there were drivers who were quite aggressive and racing into parking spaces. Suggestion- people with certified mobility problems and blue badges and frailty should be granted certificate to park at the hospital. Should be more parking for staff. Everyone else should be given instructions for the park and ride- clear instructions on what buses to catch. Buses should turn into the hospital- hard to walk from the road. Detailed instructions should be given to patients on how long it will take and how to get there. Should be dedicated park and ride for the JR. Transport should be more integrated. People would use public transport more willingly if there were more certainty.”</p> <ul style="list-style-type: none"> • “Always find it ok” <p>One person mentioned the high cost of parking Two people said it had been hard to park in the past</p> <p>One person said it was better than parking at the JR</p>	
<p>100% From outside Oxfordshire, felt fine about their parking experience. Comments included:</p> <ul style="list-style-type: none"> • “Parking is not too bad but the journey is really difficult. I'm 83 and husband 84- it's very hard for us to do the journey. The journey is costing us a fortune in petrol. It's a 200 mile round trip, costs £40 each way.” • “As I turned right (into the hospital)- the stress starts knowing that I might not get a space and might not be able to get to the hospital at my allocated time. You arrive in a tense situation but the relief when someone pulls out! I consider myself really lucky when I get a place because it is so difficult. Otherwise might miss appointment.” • “Normally an issue but today was fine” • “Unusually good today. You have to get here before 9 or you've had it!” 	4 out of 4

Mid- morning to afternoon experiences:

Date (NOC)	18 May 2017
Time	10am - 2pm
Total number of respondents	8
50% were outpatients and 50% were going with a patient	4 out of 8 4 out of 8
63% came from outside Oxfordshire	5 out of 8
50% in total used a car	4 out of 8
40% from outside Oxfordshire used their own car	2 out of 5

Date (NOC)	18 May 2017
Time	10am - 2pm
40% used the park and ride 20% used a taxi	2 out of 5 1 out of 5
67% from within Oxfordshire used their own car 33% used the park and ride	2 out of 3 1 out of 3
The two people from outside Oxfordshire who used their own car said they did it for convenience.	2 out of 5
The two who used park and ride services said it was to avoid parking at the hospital (one person chose to park at the park and ride and take a taxi to bring her dad, on crutches, to the hospital and yet avoid parking)	2 out of 5
one person used a volunteer driver scheme.	1 out of 5
100% of those from within Oxfordshire used their own car because they could not use public transport because of mobility problems.	3 out of 3
The person who used the park and ride service said it was “purely to get me out of parking, let alone driving through Oxford.”	1 out of 3
Length of journey	
60% from outside Oxfordshire took between one hour and 90 minutes 40% said it took more than two hours	3 out of 5 2 out of 5
33% from within Oxfordshire took less than 30 minutes	1 out of 3
33% between 30 minutes and one hour	1 out of 3
33% between 90 minutes and two hours	1 out of 3
How they felt about the journey	
80% from outside Oxfordshire, felt fine about their journey with one person saying they had to leave at 5.30am to get here at 11am.	
67% within Oxfordshire felt fine about the journey	2 out of 3
Parking	
67% from outside Oxfordshire did not have a blue badge 33% had a blue badge.	2 out of 3 1 out of 3
50% from within Oxfordshire had a blue badge 50% did not have a blue badge	
100% from outside of Oxfordshire who came in their own car parked on hospital premises.	3 out of 3
For those from within Oxfordshire 50% parked on hospital premises 50% parked on a nearby road	1 out of 2 1 out of 2
60% allowed less than 15 minutes to park. 100% from outside Oxfordshire took 15-30minutes to park 100% from within Oxfordshire took less than 15 minutes to park.	3 out of 5
67% from outside of Oxfordshire found it difficult to park	2 out of 3
Comments about parking included: <ul style="list-style-type: none"> “Bit of a nightmare. Luckily person I was bringing- in a wheelchair- had brought her mum with her. Would have 	

Date (NOC)	18 May 2017
Time	10am - 2pm
<p>missed appointment if I had brought her on my own because I had to drop her off at the entrance and go and look for parking while her mum brought her in.”</p> <ul style="list-style-type: none"> • “Hard to find a non-disabled space- as a volunteer driver I get a special permit to park in the ambulance spaces. Normally it is fine but for the first time in 6 years we had to wait for an ambulance to move. Busy today.” • “Left over 2 hours for travel and parking. Parking was not too bad- just drove round a few times. It was a matter of going round a couple of times to find a space- dozens of others were driving round. My husband dropped me off- if I were by myself I would have been stressed. But because I was dropped off I was fine.” • “Harder than usual. Had to wait for someone to come out of a disabled bay. It was ok, took a bit longer than usual but it wasn't a problem. Today people seem to be waiting for spaces, it isn't normally so bad. At the Churchill where we go often, the car park is badly arranged- people trying to get out block the way of people trying to get in.” 	

Date (NOC)	23 May 2017
Time	10am-2pm
Total number of respondents	10
90% were outpatients	9 out of 10
70 % came from outside Oxfordshire	7 out of 10
80% used own car or a friend's or family member's car	8 out of 10
20% used their car and then a park and ride service	2 out of 10
Why they used a car	
71% cited convenience	5 out of 7
Length of journey	
100% from within Oxfordshire took between 30 minutes and one hour	3 out of 3
57% from outside Oxfordshire took between one hour and 90 minutes	4 out of 7
29% took more than two hours	2 out of 7
How they felt about the journey	
100% from within Oxfordshire said it was fine or not too bad	3 out of 3
50% from outside Oxfordshire found it ok. One person said it was exhausting, one described the journey as “stressful” and one said “We put ourselves out because care at the hospital is so good. It depends on time of day as to how long it takes to park.”	3 out of 6
Parking	
One person from within Oxfordshire only responded and said they did not park with a blue badge.	
83% from outside Oxfordshire parked with a blue badge.	5 out of 6
33% from within Oxfordshire parked on hospital premises	1 out of 3
100% from outside Oxfordshire parked on hospital premises	6 out of 6
67% from outside Oxfordshire allowed 15-30 minutes to park	4 out of 6
50% from within Oxfordshire allowed 15-30minutes	1 out of 2

Date (NOC)	23 May 2017
Time	10am-2pm
67% from outside Oxfordshire took less than 15 minutes to park 33% took between 15 and 30 minutes.	4 out of 6 2 out of 6
100% from within Oxfordshire found it easy to park.	2 out of 2
83% from outside Oxfordshire found it easy to park.	5 out of 6
Comments about parking	
From within Oxfordshire	
Comments included: <ul style="list-style-type: none"> “Two weeks ago it took me one and a half hours to park at the Churchill. There seemed to be spaces in the staff area.” 	2 out of 2
60% from outside Oxfordshire, felt their parking experience had no impact on them. Comments included: <ul style="list-style-type: none"> “Depends on time of day - at 9am, travelling and parking is horrendous” “Today it was difficult, I found a bay eventually but it was far away and I had to walk (which is hard for me - the disabled spot is too far away for people like me) so I was late for my appointment. Usually I always get a place by the Tebbit Centre but today I had to drive round and round.” 	

9.2 Main findings about people’s experience from 10am to 2pm

Time (NOC)	10am-2pm
Total number of respondents	18
72% were outpatients	13 out of 18
67% came from outside Oxfordshire	12 out of 18
67% used own car or a friend’s or family member’s car	12 out of 18
28% used a park and ride services	5 out of 18
Why they used a car	
58% cited convenience.	7 out of 12
The other frequently given reason was the inability to use public transport because of disability or ill health.	
38% of people used the park and ride services to avoid parking at the hospital	3 out of 8
Length of journey	
58% from outside Oxfordshire took between one hour and 90 minutes. 33% took more than two hours.	7 out of 12 4 out of 12
67% of those within Oxfordshire took between 30 minutes and one hour.	4 out of 6
How they felt about the journey	

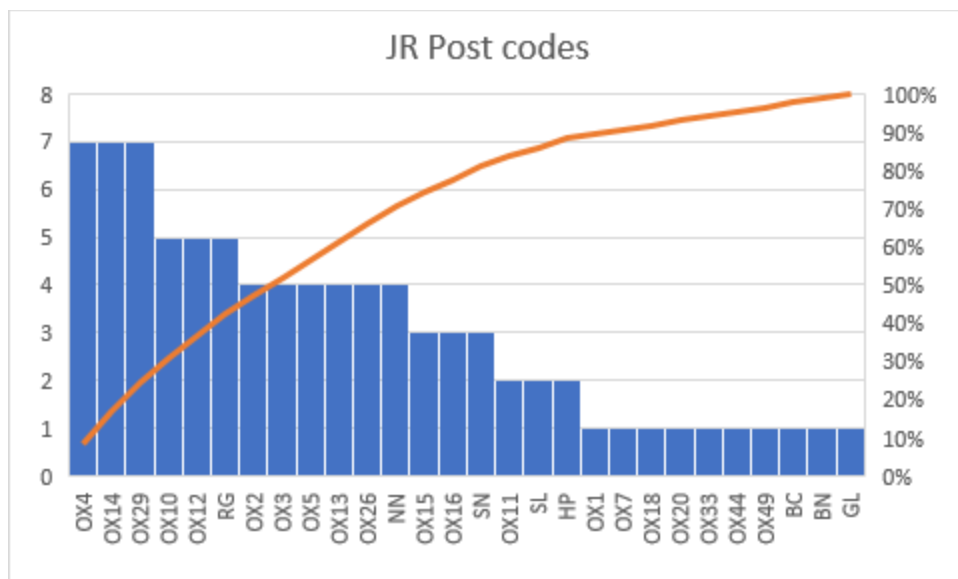
Time (NOC)	10am-2pm
64% from outside Oxfordshire felt fine about their journey. 83% from within Oxfordshire felt fine about their journey.	7 out of 11 5 out of 6
Parking	
58% parked with a blue badge	7 out of 12
75% from within Oxfordshire parked at the hospital. One person saying parked on a nearby road.	3 out of 4
100% from outside of Oxfordshire parked on the hospital premises.	9 out of 9
58% took less than 15 minutes to park 42% took between 15 and 30 minutes to park	7 out of 12 5 out of 12
69% found it easy to park.	9 out of 13
31% found it difficult to park.	4 out of 13
<p>Comments about parking experience included:</p> <ul style="list-style-type: none"> • “Bit of a nightmare. Luckily person I was bringing- in a wheelchair- had brought her mum with her. Would have missed appointment if I had brought her on my own because I had to drop her off at the entrance and go and look for parking while her mum brought her in.” • “Hard to find a non-disabled space- as a volunteer driver I get a special permit to park in the ambulance spaces. Normally it is fine but for the first time in 6 years we had to wait for an ambulance to move. Busy today.” • “Left over 2 hours for travel and parking. Parking was not too bad- just drove round a few times. It was a matter of going round a couple of times to find a space- dozens of others were driving round. My husband dropped me off- if I were by myself I would have been stressed. But because I was dropped off I was fine.” • “Harder than usual. Had to wait for someone to come out of a disabled bay. It was ok, took a bit longer than usual but it wasn't a problem. Today people seem to be waiting for spaces, it isn't normally so bad. At the Churchill where we go often, the car park is badly arranged- people trying to get out block the way of people trying to get in.” • Depends on time of day - at 9am, travelling and parking is horrendous” • “Today it was difficult, I found a bay eventually but it was far away and I had to walk (which is hard for me - the disabled spot is too far away for people like me) so I was late for my appointment. Usually I always get a place by the Tebbit centre but today I had to drive round and round.” • “Very relaxed. Came here on Monday and waited 12 mins for a space. can walk on crutches now so chose side road rather than hospital car park. can always get a space if you're prepared to wait in my 5 weeks of experience.” 	

9.3 Late afternoon to evening:

Date (NOC)	23 May 2017
Time	2pm-6pm
Total number of respondents	10
100% were outpatients	10 out of 10
50 % came from within Oxfordshire 50% from outside Oxfordshire	5 out of 10 5 out of 10
80% used either their own car or a friend's or family member's car. 20% used Patient Transport.	8 out of 10 2 out of 10
Why they used this means of transport	
50% from within Oxfordshire said it was easier 50% said they were being accompanied by the driver	2 out of 4 2 out of 4
75% from outside of Oxfordshire said it was too far for public transport or there was no suitable public transport. One person said "Easier with wheelchair, No trains from Milton Keynes. Can't find taxis who can take wheelchair and would involve five busses and three hours!" .	3 out of 4
Length of journey	
50% from Oxfordshire took between 30 minutes and one hour 50% took between one hour and 90 minutes. 75% from outside Oxfordshire took between 1pnehour and 90 minutes and 1oneperson saying it took between 90 minutes and two hours.	2 out of 4 2 out of 4 3 out of 4 1 out of 4
63% in total took between one hour and 90 minutes	5 out of 8
How they felt about the journey	
75% from outside Oxfordshire said it was fine 75% from within Oxfordshire said it was fine	3 out of 4
Parking	
50% parked with a blue badge	3 out of 6
100% from within Oxfordshire parked on hospital premises	4 out of 4
100% from outside Oxfordshire parked on hospital premises	4 out of 4
63% allowed less than 15 minutes to park	5 out of 8
88% took less than 15 minutes to park	7 out of 8
100% said it was easy to park	8 out of 8
100% said their parking experience had no impact on them.	8 out of 8

10 Appendix E - Postcodes of visitors to the 4 hospital sites

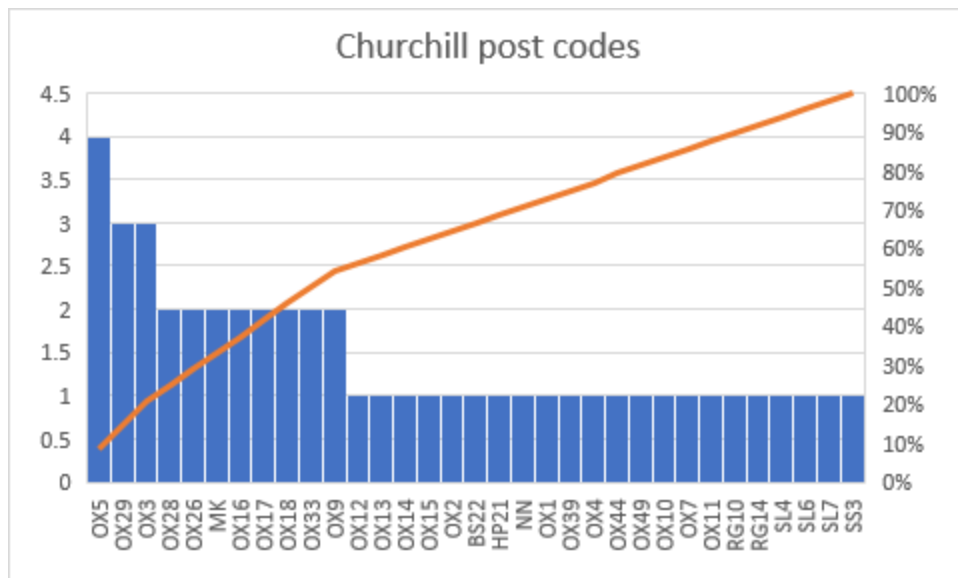
10.1 John Radcliffe site



28 different post codes

Majority from within Oxfordshire

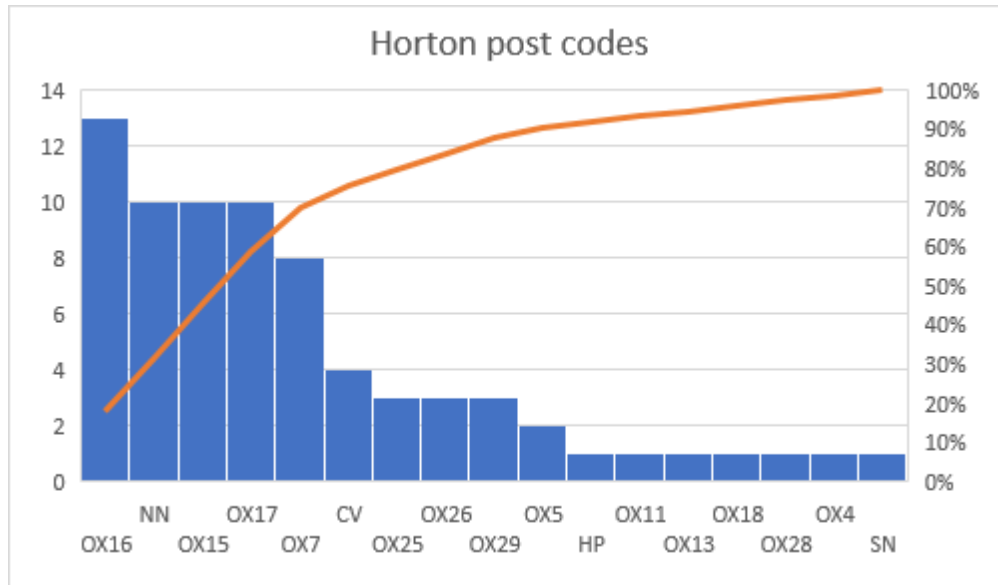
10.2 Churchill site



33 different postcodes

Majority within Oxfordshire

10.3 Horton General Hospital site

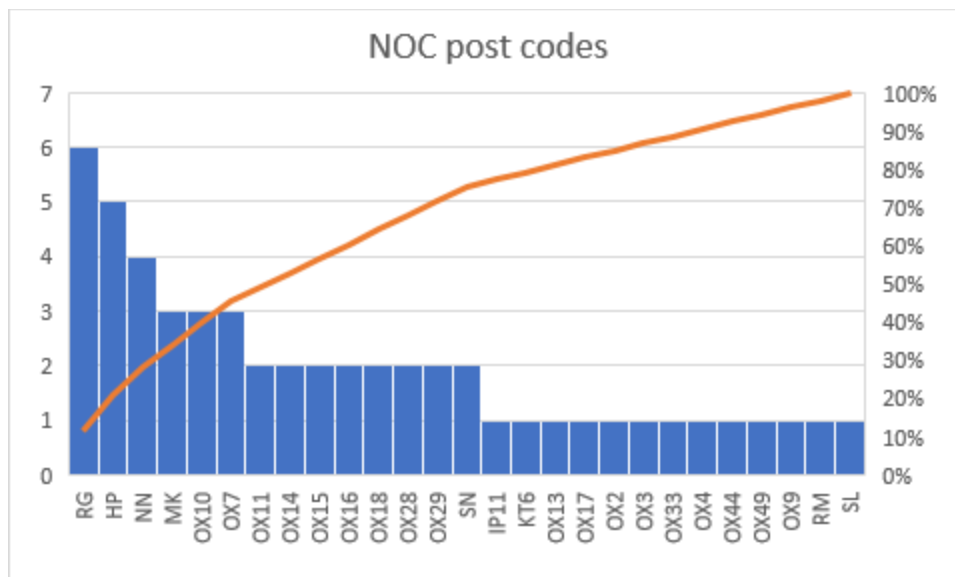


17 different post codes

Significant minority from Northamptonshire (10/69)

Principal areas: Banbury town and surrounding villages

10.4 Nuffield Orthopaedic Centre site



27 different post codes

47% outside of Oxfordshire

10.5 Oxfordshire post codes and surrounding counties



11 Appendix F - Questionnaire



Tell us your experience of travel and parking at the hospital today

Healthwatch Oxfordshire believes that people's experience of getting to their hospital appointment or visiting relatives and friends is very important as it can influence their overall wellbeing.

These questions will take no more than five minutes of your time.

Do take this, complete it when you can and send it back to us. We want to hear from you -

it will cost nothing as is free post.

Healthwatch Oxfordshire will publish a report on the findings of this survey. The Oxfordshire Clinical Commissioning Group (the organisation that pays for our hospital services), and Oxford University Hospitals NHS Foundation Trust will hear your voice.

Once again, thank you very much for your time.

A. Your journey to hospital	
Please tell us the date:	
and arrival time:at the hospital	
1. Which department or ward are you visiting?	
Which hospital did you visit? (please tick)	2. Are you: (please tick one)
John Radcliffe Hospital <input type="checkbox"/>	Inpatient <input type="checkbox"/>
Churchill Hospital <input type="checkbox"/>	Outpatient <input type="checkbox"/>
Nuffield Orthopaedic Centre <input type="checkbox"/>	Going with a patient <input type="checkbox"/>
Horton General Hospital <input type="checkbox"/>	Visiting a patient <input type="checkbox"/>
	Other <input type="checkbox"/>
3. What is the first part of <u>the post code</u> or name of town or village from where you set off from today?	
.....	
Please turn to page 2	

4. How did you travel to hospital today? You can tick more than one box			
Own Car	<input type="checkbox"/>	Foot	<input type="checkbox"/>
Friends' or Family Car	<input type="checkbox"/>	Bus	<input type="checkbox"/>
Bicycle	<input type="checkbox"/>	Car + Park and Ride	<input type="checkbox"/>
Motorcycle / scooter	<input type="checkbox"/>	Taxi	<input type="checkbox"/>
		Train	<input type="checkbox"/>
		Volunteer Car Scheme	<input type="checkbox"/>
		Patient Transport service	<input type="checkbox"/>
Why did you choose to use this form of transport?	4b If you travelled by bus which service did you use?		
	Where did you get off the bus?		
	Hospital bus stop <input type="checkbox"/> Away from hospital <input type="checkbox"/>		
5. How did it take you to travel to hospital?			
30 min – 1 hour	<input type="checkbox"/>	More than 2 hours	<input type="checkbox"/>
1 hour – 90 minutes	<input type="checkbox"/>	I do not know	<input type="checkbox"/>
Less than 30 min	<input type="checkbox"/>	90 minutes – 2 hours	<input type="checkbox"/>
6. How did your journey make you feel?			
B. Your experience of parking at the hospital			
7. Have you travelled with a blue badge today? Yes <input type="checkbox"/> No <input type="checkbox"/>			
8. Did you park on the hospital premises? Yes <input type="checkbox"/> No <input type="checkbox"/>			If No, Why did you choose this?
If no, where did you park? Local public car park <input type="checkbox"/>			
Nearby road <input type="checkbox"/> Private land <input type="checkbox"/>			
9. How much time did you allow for parking?			
Less than 15 min	<input type="checkbox"/>	30min - 1 hour	<input type="checkbox"/>
15-30 min	<input type="checkbox"/>	More than 1 hour	<input type="checkbox"/>
10. How long did it actually take to park your car?			
30min - 1 hour	<input type="checkbox"/>	I do not know, someone else parked the car	<input type="checkbox"/>
60 - 90 min	<input type="checkbox"/>	I missed my appointment today because I could not park in time	<input type="checkbox"/>
Less than 15 min	<input type="checkbox"/>	90min - 2 hours	<input type="checkbox"/>
15-30 min	<input type="checkbox"/>	Over 2 hours	<input type="checkbox"/>
11. Did you find it easy or hard to find a parking space? Easy <input type="checkbox"/> Hard <input type="checkbox"/>			
12. How has your parking experience affected you?			Please return using the Freepost envelope provided. Thank you!