Notice of Meeting Public Document Pack

Oxfordshire Joint Health Overview & Scrutiny Committee

Tuesday, 7 March 2017 at 10.00 am
County Hall

Membership

Chairman - Councillor Yvonne Constance OBE
Deputy Chairman - District Councillor Nigel Champken-Woods

Councillors:	Kevin Bulmer	Tim Hallchurch MBE	Alison Rooke
	Surinder Dhesi	Laura Price	Les Sibley
District Councillors:	Jane Doughty	Andrew McHugh	
	Monica Lovatt	Susanna Pressel	
Co-optees:	Moira Logie	Dr Keith Ruddle	Mrs A. Wilkinson

Notes: ***Date of next meeting:*** *6 April 2017*

What does this Committee review or scrutinise?

- Any matter relating to the planning, provision and operation of health services in the area of its local authorities.
- Health issues, systems or economics, not just services provided, commissioned or managed by the NHS.

How can I have my say?

We welcome the views of the community on any issues in relation to the responsibilities of this Committee. Members of the public may ask to speak on any item on the agenda or may suggest matters which they would like the Committee to look at. **Requests to speak must be submitted to the Committee Officer below no later than 9 am on the working day before the date of the meeting.**

For more information about this Committee please contact:

Chairman	-	Councillor Yvonne Constance OBE Email: *yvonne.constance@oxfordshire.gov.uk*
Policy & Performance Officer	-	*Katie Read Tel: 07584 909530* *Email: Katie.read@oxfordshire.gov.uk*
Committee Officer	-	*Julie Dean Tel: 07393 001089* *Email: julie.dean@oxfordshire.gov.uk*

Peter G. Clark
Chief Executive

February 2017

About the Oxfordshire Joint Health Overview & Scrutiny Committee

The Joint Committee is made up of 15 members. Twelve of them are Councillors, seven from Oxfordshire County Council, and one from each of the District Councils – Cherwell, West Oxfordshire, Oxford City, Vale of White Horse, and South Oxfordshire. Three people can be co-opted to the Joint Committee to bring a community perspective. It is administered by the County Council. Unlike other local authority Scrutiny Committees, the work of the Health Scrutiny Committee involves looking 'outwards' and across agencies. Its focus is on health, and while its main interest is likely to be the NHS, it may also look at services provided by local councils which have an impact on health.

About Health Scrutiny

Health Scrutiny is about:

- Providing a challenge to the NHS and other organisations that provide health care
- Examining how well the NHS and other relevant organisations are performing
- Influencing the Cabinet on decisions that affect local people
- Representing the community in NHS decision making, including responding to formal consultations on NHS service changes
- Helping the NHS to develop arrangements for providing health care in Oxfordshire
- Promoting joined up working across organisations
- Looking at the bigger picture of health care, including the promotion of good health
- Ensuring that health care is provided to those who need it the most

Health Scrutiny is NOT about:

- Making day to day service decisions
- Investigating individual complaints.

What does this Committee do?

The Committee meets up to 5 times a year or more. It develops a work programme, which lists the issues it plans to investigate. These investigations can include whole committee investigations undertaken during the meeting, or reviews by a panel of members doing research and talking to lots of people outside of the meeting. Once an investigation is completed the Committee provides its advice to the relevant part of the Oxfordshire (or wider) NHS system and/or to the Cabinet, the full Councils or scrutiny committees of the relevant local authorities. Meetings are open to the public and all reports are available to the public unless exempt or confidential, when the items would be considered in closed session.

If you have any special requirements (such as a large print version of these papers or special access facilities) please contact the officer named on the front page, giving as much notice as possible before the meeting

A hearing loop is available at County Hall.

AGENDA

1. Apologies for Absence and Temporary Appointments

2. Declarations of Interest - see guidance note on the back page

3. The Oxfordshire Big Health & Care Consultation: Phase 1 (Pages 1 - 86)

Stuart Bell, Chief Executive of Oxford Health NHS Foundation Trust and Chairman of the Transformation Board; David Smith, Chief Executive of the Oxfordshire Clinical Commissioning Group; and representatives from Oxford University Hospitals NHS Foundation Trust will present the proposals in Phase 1 of the Oxfordshire Big Health & Care Consultation.

The Phase 1 consultation proposals include changes to acute hospital services, namely:

- Changing the way hospital beds are used and increasing care closer to home in Oxfordshire
- Planned care (planned tests and treatment and non-urgent care) at the Horton General Hospital
- Acute stroke services in Oxfordshire
- Critical care (help 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

The Committee will examine the content of these proposals and consider their impact on patients and the public to inform its formal response to the consultation, ending 9 April 2017.

The consultation document is attached at **JHO3.**

Supporting documents, including the pre-consultation business case and travel analysis can be found at www.oxonhealthcaretransformation.nhs.uk

MORNING SCHEDULE

Written submissions from the following organisations and Members of Parliament have been received (**JHO3**):

- Oxfordshire County Council Cabinet
- A joint submission from Cherwell District Council and South Northamptonshire Council
- West Oxfordshire District Council
- Northamptonshire County Council's Health Adult Care & Wellbeing Scrutiny Committee
- Victoria Prentis, MP for North Oxfordshire
- Andrea Leadsom, MP for South Northamptonshire
- Healthwatch Oxfordshire

Members of the Public speaking or petitioning the Committee

Representatives from the following organisations will address the Committee:

- Healthwatch Oxfordshire
- Berkshire, Buckinghamshire and Oxfordshire Local Medical Committee
- Oxfordshire County Council
- Vale of White Horse District Council
- West Oxfordshire District Council

Health representatives will be invited to respond directly to any matters raised in the above statements/submissions if they so wish.

13:00 LUNCH

AFTERNOON SCHEDULE

Stuart Bell, Chief Executive of Oxford Health NHS Foundation Trust and Chairman of the Transformation Board; David Smith, Chief Executive of the Oxfordshire Clinical Commissioning Group; and representatives from Oxford University Hospitals NHS Foundation Trust will attend to answer specific questions from the Committee on the content of the proposals and their impact on patients, the public, and the local health service.

Committee members will summarise their views and feedback on the consultation proposals and a resolution to the meeting will be proposed.

The Committee's discussion and feedback on the proposals and the outcome of the meeting will formulate the Committee's formal response to the consultation, which will be submitted before 9 April 2017.

Declarations of Interest

The duty to declare…..
Under the Localism Act 2011 it is a criminal offence to
(a) fail to register a disclosable pecuniary interest within 28 days of election or co-option (or re-election or re-appointment), or
(b) provide false or misleading information on registration, or
(c) participate in discussion or voting in a meeting on a matter in which the member or co-opted member has a disclosable pecuniary interest.

Whose Interests must be included?
The Act provides that the interests which must be notified are those of a member or co-opted member of the authority, **or**

- those of a spouse or civil partner of the member or co-opted member;
- those of a person with whom the member or co-opted member is living as husband/wife
- those of a person with whom the member or co-opted member is living as if they were civil partners.

(in each case where the member or co-opted member is aware that the other person has the interest).

What if I remember that I have a Disclosable Pecuniary Interest during the Meeting?.
The Code requires that, at a meeting, where a member or co-opted member has a disclosable interest (of which they are aware) in any matter being considered, they disclose that interest to the meeting. The Council will continue to include an appropriate item on agendas for all meetings, to facilitate this.

Although not explicitly required by the legislation or by the code, it is recommended that in the interests of transparency and for the benefit of all in attendance at the meeting (including members of the public) the nature as well as the existence of the interest is disclosed.

A member or co-opted member who has disclosed a pecuniary interest at a meeting must not participate (or participate further) in any discussion of the matter; and must not participate in any vote or further vote taken; and must withdraw from the room.

Members are asked to continue to pay regard to the following provisions in the code that *"You must serve only the public interest and must never improperly confer an advantage or disadvantage on any person including yourself"* or *"You must not place yourself in situations where your honesty and integrity may be questioned…..".*

Please seek advice from the Monitoring Officer prior to the meeting should you have any doubt about your approach.

List of Disclosable Pecuniary Interests:
Employment (includes"*any employment, office, trade, profession or vocation carried on for profit or gain*".), **Sponsorship, Contracts, Land, Licences, Corporate Tenancies, Securities.**

For a full list of Disclosable Pecuniary Interests and further Guidance on this matter please see the Guide to the New Code of Conduct and Register of Interests at Members' conduct guidelines. http://intranet.oxfordshire.gov.uk/wps/wcm/connect/occ/Insite/Elected+members/ or contact Glenn Watson on **07776 997946** or glenn.watson@oxfordshire.gov.uk for a hard copy of the document.

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Oxfordshire NHS

The BIG health and care consultation

The Big Consultation

Best care, best outcomes and best value for everyone in Oxfordshire

OXFORDSHIRE TRANSFORMATION PROGRAMME
Improving your local health and care services

Oxfordshire's health and care services
The Big Consultation
Phase 1
We need to know your views

A message from Dr Joe McManners, Clinical Chair, Oxfordshire Clinical Commissioning Group.

"In June 2016, NHS organisations across Oxfordshire launched 'The Big Health and Care Conversation'. This was an opportunity for NHS leaders, doctors, nurses and other staff to discuss with the public, the voluntary sector and patient representatives the opportunities to improve healthcare for patients, the challenges the NHS is facing, and what we are doing about this.
We know that treatments including medication and surgery are always improving and the evidence about how to get the best outcomes for patients can mean changing the way we do things. We want to make sure quality of care is at the heart of what we do and this means being prepared to do things differently for the benefit of all.
We also know that lifestyle choices can affect our health. The most important are smoking, an unhealthy diet and lack of exercise, all contributing to diseases such as cancer, heart disease and diabetes. Treating these long term conditions affects people's lives as well as the NHS budget. The more we can do to prevent ill health the better for us all.

The need to help people develop healthier lifestyles to prevent some of these illnesses is becoming urgent. We are facing increased pressures on GP and hospital services. Some of our buildings and equipment are old, expensive to maintain safely and do not provide good quality care for patients. It is a struggle to recruit and keep the NHS staff we need to ensure our services are safe and high quality. We also know that the current budgets for NHS services will not cover the demand for them without changes over the next few years. All of this affects how we can provide patient care and increases the pressures on our finances.

In October 2014, NHS England published its Five Year Forward View which sets out how organisations and services need to change across England to meet these challenges. (www.england.nhs.uk/ourwork/futurenhs/)

In Oxfordshire, we set up our Transformation Programme involving people from NHS organisations and Oxfordshire County Council as well as Healthwatch Oxfordshire, to develop our thinking. The Oxfordshire Transformation Programme has considered how we want to develop and improve health services in Oxfordshire, including some immediate changes we propose to make.

Our work has also been fed into an over-arching five year plan (called a Sustainability and Transformation Plan or STP) across Buckinghamshire, Oxfordshire and Berkshire West (referred to as the BOB STP) which sets out how we plan to bring about the changes we all need to make.

The Transformation Programme is overseen by the leadership of the local NHS, but more importantly the thinking has been developed by those doctors, nurses and other NHS staff who see patients every day and who best know their needs. We have also had valuable input from patients and the public, which has helped to shape our thinking.

During the Big Health and Care Conversation, the listening exercise we carried out in 2016, many people took the time to tell us what they thought and we have used your feedback while we were developing the proposals set out in this document. It is clear that the NHS is greatly valued and that people also understand the pressures we are facing. We had many examples of people's own experiences and many ideas and suggestions for improving care. Thank you to everyone who took the time to share their views, attend events and respond to the survey.

We have now reached a point where we want to ask the public and our partners questions and seek feedback on some more specific proposals for change. In this document you will find proposals for changes to the following services:

- Changing the way we use our hospital beds and increasing care closer to home
- Planned care services at the Horton General Hospital
- Acute stroke services
- Critical care
- Maternity.

These changes are being considered now because the quality of care for patients will be affected if we delay making decisions. Furthermore, some of these services do not meet national clinical best practice recommendations.

A further set of proposed changes will be presented in a ***Phase 2*** consultation but more work is needed to develop these options before a second consultation can be launched.

We look forward to hearing more from you during this consultation.”

What do we want your views on?

This document sets out options to change some of our services. The lead commissioners for these services, Oxfordshire Clinical Commissioning Group, would like to ask you what you think. This includes anyone with an interest in the NHS – whether you are a patient, a carer or a member of the public in Oxfordshire and surrounding areas.

A number of the proposals set out in this document will be of more interest to people living in the north of the county and neighbouring areas. Some of the proposals have a wider impact and so we are keen to encourage people from across Oxfordshire and surrounding areas to give their views. We also welcome the views of our voluntary sector partners, groups representing particular communities, other public bodies and staff in health and care organisations.

The document builds on 'The Big Health and Care Conversation' launched by NHS organisations in June 2016 during which we discussed the future challenges for Healthcare in Oxfordshire and asked for your ideas, opinions and feedback. A summary of 'The Big Health and Care Conversation' and what people told us can be found on page 10 of this document and the full reports are available on our website at: www.oxonhealthcaretransformation.nhs.uk

If you are interested in how these proposals and service options have been developed and short-listed for consultation, the evidence used and financial details, you will find more information in the 'Pre-Consultation Business Case' which is also available on the consultation website: www.oxonhealthcaretransformation.nhs.uk

Further work and engagement with our GP practices to develop options has been undertaken over the past few months. It has become clear that our proposals for A&E, children's services and community-based care (including community hospitals and primary care) will benefit from continued development with a wide range of stakeholders before we launch a public consultation on any proposed service changes. Over the coming months more engagement with local groups across the county will be carried out, as well as further option development work with the public and patients.

We will, therefore, be consulting on proposed changes to services in two phases.

Phase 1 consultation

We would like your views on proposed changes to the following:

Acute hospital services (acute hospitals provide a wide range of specialist care and treatment including surgery, medical care, emergency care and tests):

- 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).

Phase 2 consultation

During the next phase of consultation we are expecting to invite your views on proposed changes to the following services in Oxfordshire:

Acute hospital services:

- A&Es in Oxfordshire
- Children's services

Community hospitals including MLUs

During this second phase we will also be looking in more detail at plans to develop primary care, which will underpin all our other changes (primary care services include GPs, nurses, healthcare assistants, community nurses and other clinicians).

This document focuses on *Phase 1* only. It includes proposals for formal public consultation on:

- changes to acute hospital bed numbers in Oxfordshire as part of a plan to provide more care out of hospital
- more planned care at the Horton General Hospital in Banbury (planned care is a term for Healthcare which has been planned in advance and which is not urgent or an emergency, such as diagnostic tests, outpatient appointments and surgery).
- stroke services in Oxfordshire
- critical care at Horton General Hospital (critical care helps people with life-threatening or very serious injuries and illnesses)
- maternity and obstetric care including obstetrics, the Special Care Baby Unit (SCBU) and emergency gynaecology inpatient services at the Horton General Hospital.

These proposals set out in *Phase 1* would involve investment in some areas and would not be at the cost of other proposals we will be discussing in the consultation for *Phase 2*.

We would like your feedback. You can give this by completing the questionnaire, coming to a meeting or writing to us. On page 43 of this document are more details about how to do this. More information about these proposals and how to give feedback is available on our consultation website at: www.oxonhealthcaretransformation.nhs.uk

Our NHS and social care services in Oxfordshire – a snapshot

Oxford University Hospitals NHS Foundation Trust (OUHFT) is responsible for acute hospital care. It runs the John Radcliffe Hospital, Churchill Hospital and the Nuffield Orthopaedic Hospital in Oxford and the Horton General Hospital in Banbury.

Oxford Health NHS Foundation Trust (OHFT) runs community and mental health services. It has facilities across Oxfordshire and runs our community hospitals.

South Central Ambulance Service NHS Foundation Trust (SCAS) runs our ambulance service**.**

Southern Health NHS Foundation Trust provides services for people with learning disabilities.

Our primary care services are run by local GPs.

Oxfordshire Clinical Commissioning Group (OCCG) buys most health services on behalf of the local population and ensures they are properly run.

Oxfordshire County Council is responsible for social care services, working with a range of providers.

Who is consulting?

The local NHS and its partners have worked together to develop the proposals outlined in this document. No decisions have been made and will not be taken until the public consultation has run its course and final proposals are put to Oxfordshire Clinical Commissioning Group's (OCCG) Board. OCCG is statutorily responsible for running this process and taking a decision once the consultation process is complete.

Why consult?

At OCCG we believe that communicating and engaging with local people is important in helping us to achieve our vision: 'by working together we will have a healthier population, with fewer inequalities, and health services that are high quality, cost effective and sustainable'.

As a commissioner of NHS health services, we also have a legal duty to involve and consult with patients, the public and local organisations when developing and considering proposals for substantial changes to these services.

However, before we can make any changes, we have to pass four tests set out by NHS England (the body responsible for setting the priorities and direction of the NHS):

1. Strong public and patient engagement.
2. Consistency with current and future need for patient choice.
3. A clear clinical evidence base.
4. Support for proposals from clinical commissioners.

In our 'Pre-Consultation Business Case' we demonstrate how we have met these tests:
www.oxonhealthcaretransformation.nhs.uk

We have also followed best practice by:

- considering the impact of changes on patients in terms of travel and access
- discussing our plans with the Oxfordshire Joint Health Overview and Scrutiny Committee and with the Health and Wellbeing Board
- carrying out an equalities impact assessment to check that our proposals do not unfairly disadvantage any groups or communities
- taking independent advice and assurance on the engagement and consultation process we are following.

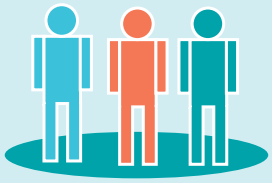
The outcome of public consultation is an important factor in health service decision making and OCCG will take all views fully into account when making a decision on each of the proposed service changes.
It is, however, one of a number of important factors that must be considered to help ensure the provision of safe, high quality care within available resources. Other factors include safety, clinical quality and evidence, financial and practical considerations. If you would like more information about the legal requirements for consultation, please visit our website at www.oxonhealthcaretransformation.nhs.uk

Challenges facing Oxfordshire health and care services and the need for change

Oxfordshire has a population of approximately 672,000. The population has grown by more than 10% in the last 15 years and it is expected to continue growing, due to people living longer, housing developments and more people moving into the county.

Oxfordshire is a relatively well-off county but there are pockets of deprivation in some areas of Oxford City, Banbury and Abingdon. Deprivation is linked to poorer health and higher care needs. People living in the most well-off areas will live nine years longer on average than people in the poorest areas of Oxfordshire.

In Oxfordshire:



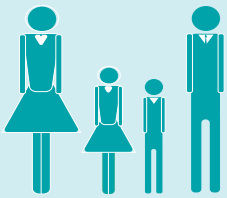
60% of adults and **25%** of Year 6 children are overweight.

Between 2014/15 and 2015/16, there was a **3.7%** increase in the number of people (aged 17 and over) diagnosed with diabetes. It is projected that **32%** more people will have diabetes by 2030.

Forecasts show that the 85-plus population may increase by around **48%** in the period 2014 to 2026. This growth is forecast to be higher in the more rural parts of the county than in Oxford City.

In 2015/16, an extra 6,848 people attended A&E compared to the previous year; an increase of **5%** or an extra 18.7 patients per day. In the four years between April 2012 to March 2016, the number of people who attended A&E increased by 16,771 patients; a rise of **13.1%** or 46 additional patients per day.

50-60% of stroke patients have been unable to access the Early Supported Discharge Service to help their recovery.



Just **31%** of patients said they received good care managing their long term condition.

At the same time as the pressure on services is growing, advances in medical care mean that:

- more patients can be treated closer to home or in their own home, with the right support
- for some of the sickest patients, diagnosis and treatment is best carried out in a highly specialist regional centre where intensive care can be provided around the clock.

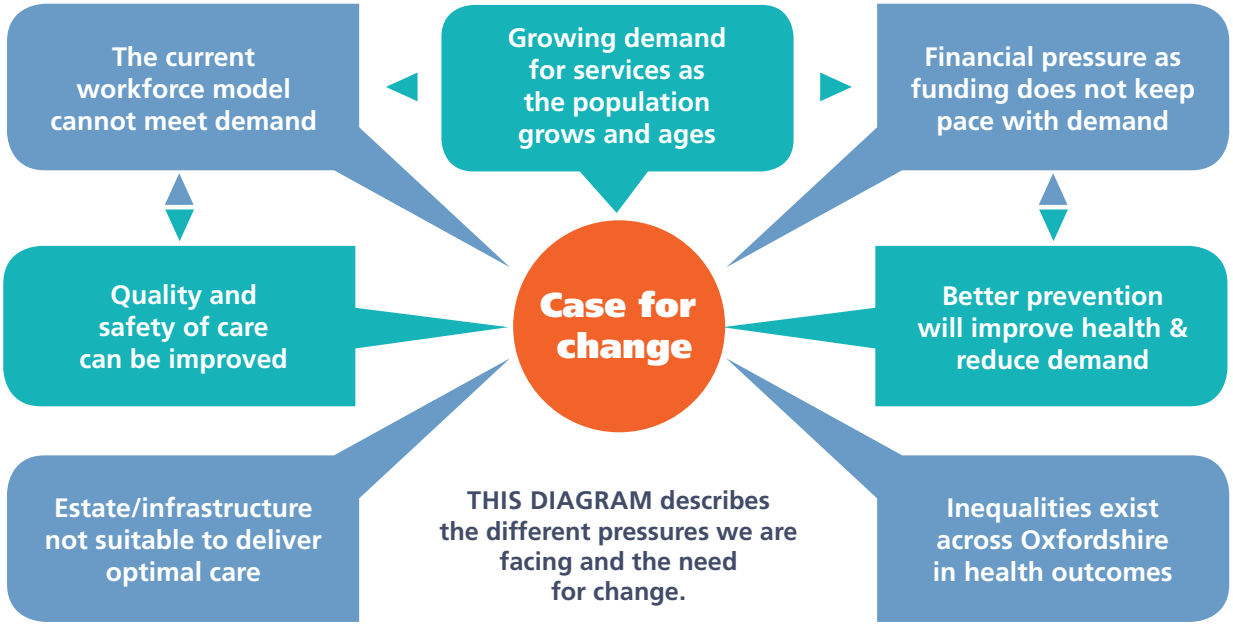
The annual spend for health and social care services across Oxfordshire is about £1.2 billion, and is anticipated to rise to £1.3 billion by 2020/21. Despite this rise, if Healthcare continues to be delivered as it is today and we change nothing, it is anticipated that by 2020/21 there will be a gap in funding of £134 million. We want to concentrate on making sure our funding supports services which are high quality so patients get the best possible care.

One of the greatest challenges for Oxfordshire's health and care system is our ability to attract, recruit and keep skilled and motivated staff in the numbers we need. This is not a challenge unique to Oxfordshire and is shared by most other areas of the country.

The challenges we face include:

- staff shortages in general practice of up to 30% (due to an ageing workforce and difficulties in recruiting younger GPs to replace those who are retiring)
- the challenge of being close to London and the high cost of living in Oxfordshire, both of which can mean other areas are more desirable to work in
- competition with other businesses, given Oxfordshire's high level of employment
- a high turnover rate of support workers who look after people in their own homes and in care homes, with a very large number of vacancies at any one time
- a national shortage of a wide range of staff including people working in emergency care, intensive and critical care, stroke care, radiography, obstetrics and paediatrics.

As a result, many of our health services rely on using expensive agency and temporary staff to keep services going. This increases pressure on finances that are already stretched. The overall quality of health services provided in Oxfordshire is good. However, there are some aspects of care that must be improved.
We need to do more to make sure that all patients receive care which meets national standards (for example waiting times for treatment). Some of our buildings and equipment are old and not fit for providing modern care. Some of them are also expensive to run and need to be replaced or improved.



Our vision

Across the NHS in Oxfordshire we have an agreed vision for how we want to improve our services:

- The best quality care provided to patients as close to their homes as possible.
- Health professionals, working with patients and carers, with access to diagnostic tests and expert advice quickly so that the right decision about treatment and care is made.
- As modern Healthcare develops, ensuring our local hospitals keep pace, providing high quality services to meet the changing needs of our patients.
- Preventing people being unnecessarily admitted to acute hospitals or using A&E services because we can't offer a better or more local alternative.
- The best bed is your own bed – people recover better at home with the right support.

"…given current pressures on the NHS, we must strive wherever possible to 'shift the curve' from high-cost, reactive and bed-based care to care that is preventive, proactive and based closer to people's homes, focusing as much on wellness as on responding to illness."

The Kings Fund: *Making our Health & Care Systems fit for an ageing population*

In addition to the care and treatment provided when we become ill, there is more we can all do to keep healthy. This includes making healthy lifestyle choices, managing long term conditions and looking after ourselves when we become unwell with minor conditions. Preventing people from becoming unwell and supporting them to adopt healthier lifestyles is a key part of our Transformation Programme.
This will be further addressed in the *Phase 2* consultation.

If you want to read more about our vision for health services in Oxfordshire, our Transformation Programme Pre-Consultation Business Case is on our website:
www.oxonhealthcaretransformation.nhs.uk/what-is-the-vision

Our listening exercise – The Big Health and Care Conversation

Over the past few years OCCG and partner organisations such as Oxford University Hospitals NHS Foundation Trust (OUHFT) and Oxford Health NHS Foundation Trust (OHFT) have worked together to make sure patients and the public have been involved in shaping proposals to develop and improve local Healthcare and been given the opportunity to have their say. Our 'Big Health and Care Conversation' built on this previous work. During this time (which began in June 2016) we organised a range of activities to give people the chance to find out more about our developing ideas, and share their views. We had feedback from a wide range of people. The OUHFT has had its own conversations with local people about services at the Horton General Hospital in Banbury. If you want to know more, please look at our engagement reports on our website www.oxonhealthcaretransformation.nhs.uk or contact us for a hard copy (contact details are on page 43 of this report).

Highlights of our listening exercise

- Three large stakeholder events involving doctors, nurses and other staff, patient representatives, local government colleagues, voluntary groups and other partner organisations.
- 12 Big Conversation public road shows and displays throughout Oxfordshire.
- A survey which was available in hard copy and online.
- Staff engagement groups.
- Discussions with a wide range of stakeholder groups, including

  Healthwatch Oxfordshire, Joint Health Overview and Scrutiny Committee, Patient Participation Groups, Patient and Public Locality Groups, Community Partnership network (Banbury), Health and Wellbeing Board, Carers Oxfordshire, Age UK Oxfordshire, college students and many more!
- Meetings with MPs, councillors and other stakeholders.
- Public/patient focus groups (including engagement with young people).

We promoted The Big Conversation to a wide range of organisations including voluntary groups, local councils and schools. Around 500 people attended events of one type or another.

257 people responded to our survey. We used a social media campaign through Twitter and Facebook and reached well over 77,000 people. The local media including BBC South Today reported on what we were doing and helped us to promote our activities and extend our reach.

Our community outreach team spoke to faith / church groups, Black and Minority Ethnic (BME) groups, Gypsy and Traveller communities, children's centres, refugee and asylum groups and health and wellbeing centres.

Local government partners and voluntary organisations such as Autism Oxford, Carers Oxfordshire, Parent Voice, MIND, Restore and Age UK circulated the information to their service users, members and carers. You can find a full account in the engagement reports on our website: www.oxonhealthcaretransformation.nhs.uk/what-is-the-vision/consultation-documents

What you said and how your views have helped to inform the options we are consulting on

You can find more information about how your feedback was used to help inform the options we are consulting on in the Pre-Consultation Business Case. In addition, we published two detailed reports on our public engagement and the feedback we received. These documents are available on our website: www.oxonhealthcaretransformation.nhs.uk/what-is-the-vision/consultation-documents

A number of common themes emerged from the engagement:

Patient safety, patient experience and patient outcomes

Patient safety was recognised by most people as most important. Some people emphasised that a positive patient experience and good health outcomes for the patient were also important and need to be highlighted in any proposals. These concerns are reflected in the proposed changes, for example in our proposals on page 27 to change the way we provide services for acute stroke patients.

More funding

There was overall acceptance that change is necessary. People said that one of the main reasons for this is due to lack of sufficient money to meet rising demands. However, many people felt there should be enough investment to enable changes to be carried out successfully. People suggested ways in which the NHS could save money by improving efficiency across all services. These concerns are reflected in the proposed changes, for example our proposals on page 17 to help people spend less time in hospital.

More local services

Patients across the county emphasised the need for more local services and believed that many appointments at Oxford-based hospitals could and should be elsewhere. Our proposals are based on providing more care locally. People were concerned about the future of community hospitals – ***Phase 2*** of our consultation will look at the proposed vision for our community hospitals.

Horton General Hospital

People emphasised the need to locate services at the Horton General Hospital to keep care close to home, although there were some concerns about the quality of some of the services and facilities. Concern was expressed about any proposals to close or downgrade A&E, because of the needs of the growing local population and the effect on the ambulance service. People were worried about the safety of women in labour and babies if changes are made to the maternity service.

Our proposals are based on ensuring that the Horton General Hospital has a long term future as a modern, safe hospital. These concerns are reflected in the proposed changes set out on page 23 to develop more local services in the Horton General Hospital. A&E proposals are not part of the ***Phase 1*** consultation. They will, however, be consulted on in the ***Phase 2*** consultation.

Transport and accessibility

Problems with transport were highlighted by patients from all areas outside Oxford City. In particular people reported that cuts to public transport have made getting to health services more difficult for residents who live in more rural locations or who are frail and elderly. The changes proposed for maternity, critical care and stroke would mean some patients needing to travel further (still within recommended travel times) but our proposals to develop more care at the Horton General Hospital and to provide more care in the community would mean that fewer people overall would be expected to travel into Oxford for care.

Leading a healthy lifestyle

A strong message from the public was for much more prevention and education for all ages on how to lead a healthy lifestyle. This will be considered in the ***Phase 2*** consultation.

Access to GPs

There were many comments about the time it takes to get a GP appointment in some surgeries. This document acknowledges this concern and sets out a vision for how primary care might develop. This will be considered in more detail in the ***Phase 2*** consultation.

Staff and recruitment

Many people recognised the difficulties in recruiting and keeping NHS staff in certain areas of health services in an expensive area like Oxfordshire. Feedback on these concerns is reflected in the proposed changes. Our proposals for maternity and critical care take account of this challenge and look at ways to use our staff more effectively.

Joining up health and social care services

Many people questioned why health and social care services were not properly joined up and highlighted the need for this to happen to support change. Ensuring that health and social care work better together is key to some aspects of our proposals – for example how we aim to improve planned care. This will be more fully considered in the ***Phase 2*** consultation.

Use of technology

Better and greater use of technology and innovation was highlighted, with criticisms that the health service is out-of-date compared with other sectors. Although we do not go into detail in this document, making sure our IT systems talk to each other and making better use of technology is essential if we are going to make necessary changes. This will feature more prominently in the ***Phase 2*** consultation.

Other common themes

People gave their feedback and comments about other services not covered in this consultation, including mental health, A&E and children's services. These will be considered in the next phase as options are developed for the ***Phase 2*** consultation.

Our vision for primary care

Primary care services are provided by staff including GPs, nurses, healthcare assistants, community nurses and other clinicians. (Primary care also includes pharmacists, dentists and optometrists, who all play an important role. Our vision focuses on staff working in general practice). As well as diagnosing and treating illness, primary care staff play a key role in helping people to stay healthy and preventing disease.

These services are the backbone of the NHS and a national strategy (General Practice Forward View 2016 www.england.nhs.uk/gp/gpfv/) sets out how primary care needs to change for the future.

The proposed new service model for primary care in Oxfordshire will be outlined in detail in a Primary Care Framework, which will be supported by the GP Forward View plans for investment. It plans to transform primary care from a predominantly reactive health system, which responds to people when they become ill, to one which significantly builds on and increases proactive support for people to improve their health and remain well. This proposed change will be essential for the sustainability of primary care and the wider health service.

Primary care will play a key role in supporting the changes we would like to make. Some of the developments here will be described in more detail in the next consultation in *Phase 2*.

Some information is shared below as it is helpful to understand the context.

Key facts

In Oxfordshire there are 600 GPs and 300 other clinical staff working in 72 GP practices that provide services for 720,000 registered patients (some patients registered with an Oxfordshire GP live outside the county, and so this number differs from the population size of Oxfordshire).

Between 70% and 80% of all Healthcare activities take place in primary care.

Oxfordshire GP practices are grouped into six localities (City, North, Northeast, Southeast, Southwest, and West).

Across Oxfordshire a significant proportion of the GP workforce is nearing retirement and there is a challenge to recruit GPs. Rising demand for care and support is causing an increasing strain, resulting in problems in recruitment and retention and pressure on the current workforce:

- In a survey carried out in Oxfordshire in 2015, 30% of practices reported an unfilled GP post
- 16% of practices reported taking over six months to recruit to a GP vacancy
- 30% of GPs are planning to retire within five years
- The out of hours service is reporting difficulties in finding GPs to fill its rotas
- It is difficult to recruit advanced nurse practitioners and expensive to train nurses for these roles.

Challenges

Primary care services in Oxfordshire come out well in national surveys, but they face the same challenges as other parts of the health and care system:

- GPs are caring for more elderly patients and for more people with a long term condition such as diabetes or dementia.
- As GPs retire, recruiting their replacements is becoming more challenging.
- In some areas, patients and the public are expressing concern about how long it takes to get an appointment with a GP.

Far more diagnosis and treatment can be provided in primary care, but it is not possible for each practice to do everything. This means practices need to work together to provide care.

What we would like to see

Our vision is to have GP practices and primary care services which:

- focus on prevention as well as treatment – helping people to lead healthy lifestyles and helping people with long term conditions to manage their own care
- identify those patients most in need of support (for example, frail elderly people or people with long term mental health conditions) and make sure they are cared for. GP practices need to work more closely with each other to extend the range of services they can offer and share specialist primary care staff such as dieticians, occupational therapists and specialist nurses.
- work closer with other parts of the health and care system, the voluntary sector and community groups so that care is more joined up
- ensure a shift of resources (money and workforce) in to the community.

We want to ensure:

- high quality and accessible primary care services for local populations
- continued investment in improving general practice buildings – we have already improved a number of practice buildings
- practices working together across neighbourhoods to provide comprehensive services
- practices working together at locality level to offer a wider range of tests (such as scans) and treatments
- primary care clinical staff providing support with colleagues across localities and across Oxfordshire for urgent care and hospital-based services
- that all patients have access to a same day urgent appointment if it's needed
- that all patients who ask for a routine appointment are able to book one within seven days if it's needed.

These proposed developments will help us to bring more care closer to home and support our other proposals to improve care.

Strengthening staffing

As well as sharing specialist staff across more than one practice, we need to:

- put more effort into recruiting more GPs
- train some GPs in specialist areas
- employ new kinds of clinical staff. For example, Associate Physicians who train at post graduate level, can see and treat patients, take medical histories, perform examinations, diagnose illnesses, analyse test results and develop plans to help patients to manage their illness.

Improving technology

We have already done much to improve technology in primary care but there is much more we can do:

- Technology can help patients with long term conditions to manage their illness, for example by monitoring how well they are doing.
- With better technology, GPs will be able to link up from the surgery to a hospital consultant meaning that some patients will not need to go to hospital.
- Better electronic sharing of health records between health and care staff will mean that anyone involved with the care of a patient will have the information they need.

We are working on the detail of our proposals for primary care and will be inviting you to share your views in the *Phase 2* consultation.

Summary of our proposals

The challenges we face in Oxfordshire and our vision for healthcare for local people have led us to propose substantial changes to the way we provide services. These are summarised in the table below:

Proposal	Impact
Changing the way we use our hospital beds and increasing care closer to home	More care out of inpatient hospital beds and improved co-ordination leading to reduced requirement for inpatient beds.
Planned care at the Horton General Hospital	More diagnostic, outpatient and elective surgery services being provided at the Horton General Hospital.
Acute stroke services in Oxfordshire	All patients diagnosed with an acute stroke would be taken immediately by ambulance to the Hyper Acute Stroke Unit (HASU) in Oxford. The Early Supported Discharge Service for patients recovering from a stroke would be extended.
Critical care at the Horton General Hospital	The sickest (Level 3) critical care patients from North Oxfordshire would be treated at the Oxford Intensive Care Units (ICUs). The Horton General Hospital should continue to have a Critical Care Unit. *Patients living in South Northamptonshire and South Warwickshire might be treated at the critical care units in hospitals in Warwick, Northampton or Milton Keynes if closer.*
Maternity and obstetric services at the Horton General Hospital	Obstetric services will be provided at the John Radcliffe Hospital in Oxford, with the Special Care Baby Unit and emergency gynaecology inpatient services. A Midwife Led Unit will be maintained at the Horton General Hospital.*(with women north of Oxfordshire also having the choice to travel to Northampton, Warwick or Milton Keynes).*

The following sections of this document describe these proposals in more detail, along with the rationale, and the benefits for patients.

Changing the way we use our hospital beds and increasing care closer to home

In this section we look at the work we have piloted on using our hospital beds in a different way and the benefits in doing this for patients.

"10 days in a hospital bed is equivalent to 10 years lost muscle strength for people over 80 years old." *British Geriatric Society*

"Older people can lose mobility very quickly if they do not keep active. Monitor's (the former regulator for NHS Foundation Trusts) recent review highlighted a study which showed that, for healthy older adults, 10 days of bed rest led to a 14% reduction in leg and hip muscle strength and a 12% reduction in aerobic capacity: the equivalent of 10 years of life. Other studies have found a faster reduction in muscle strength of as much as 5% per day.

Older people's ability to perform everyday activities can reduce while in hospital. One study found that 12% of patients aged 70 and over saw a decline in their ability to undertake key daily activities (bathing, dressing, eating, moving around and toileting) between admission and discharge from hospital, and the extent of decline increased with age.

Older people are more likely to acquire hospital infections. Between 2008 and 2012, the Methicillin-resistant Staphylococcus aureus (MRSA) infection rate for men aged 85 years and over was 574 times greater than the rate for those aged under 45 years (301.4 compared with 0.5 per million population).
A similar pattern was observed for women."
National Audit Office, 2015 – Discharging older patients from hospital

What you said

One of our key aims over the next few years is to reduce the time patients spend in hospital for care in an emergency and increase care for people in the community or at home.

Subject to consultation, we plan to provide more diagnostics and outpatient care in community settings, away from hospitals and closer to where people live – this is what people told us they want to see during our Big Health and Care engagement listening exercise. We also plan to reduce the need for patients to be admitted to hospital in an emergency by making sure the right tests and immediate treatments are collectively available through outpatient services.

We know that many elderly people find themselves taken into an acute hospital in an emergency and then have to wait to be discharged for care at home or closer to home. An acute hospital bed is often not the best place for frail elderly people. The longer they stay in hospital, the harder it is for them to recover and the risk of infection and loss of mobility increases.

What we did

We have piloted initiatives to tackle these issues. In the summer of 2015 there were 150 people in hospital beds in Oxfordshire, including community hospital beds, who could have been better cared for elsewhere. The reasons for the delays were complicated and not just a case of lack of support for people in the community or at home. They also included:

- too many people admitted to hospital in the first place when they could have been assessed and treated then supported at home or in the community
- organisations not always working together to find the right support for patients out of hospital.

OUHFT, OHFT, Oxfordshire Clinical Commissioning Group and the County Council came together to find solutions. We have piloted some new approaches that have resulted in fewer hospital beds being needed. Staff came up with innovative ideas to tackle the problem in the short and long term. Not all of these changes happened at once and some were put in place as we learned what worked best for patients.

- A 'liaison hub' was set up which brought together experienced nurses and other staff from care organisations. Its role is to make sure that when patients are ready to leave hospital, the right care is available for them at the right time.
- Patients were moved from hospital to nursing home beds with additional therapy support and cared for by teams which included GPs, doctors and nurses and therapy and social care staff. This continued until patients were ready to either remain in a nursing home or return to their home with or without care.
- A recruitment drive was launched for care workers to support people in their own homes.

These changes mean that patients can be cared for in a range of places which are better for them than being in busy acute hospital wards.

Reducing hospital admissions

Admission to hospital increases the risk of infection and can worsen the health of older people, making it more difficult for them to return to independent living. Clinical staff have also been looking at ways to reduce the number of people who are admitted to hospital in the first place and to better join up primary, community and acute hospital care.

'Ambulatory assessment units' have already been set up in the John Radcliffe Hospital and the Horton General Hospital. These assess and treat patients with complex needs around-the-clock. As a result, patients do not need to spend time in A&E or be admitted to an acute hospital bed for overnight stays. The Emergency Multidisciplinary Units (EMUs) at Abingdon and Witney Community Hospitals assess and treat patients on a same-day basis so they do not have to be admitted to a hospital bed, which is better for patients.

Proposals are also being developed to make permanent an 'acute hospital at home' (AHAH) service, which is currently running on a pilot basis in Oxford. This supports people at home so they do not need to go into hospital. It can also support people who have left hospital, but still need some acute hospital-type care. Patients most likely to benefit are those with conditions such as pneumonia, cellulitis, serious bladder infections and acute heart failure. Senior nurses run the pilot service, supported by consultants who specialise in care for older people plus therapists, pharmacists and others. Patients can be referred to it by GPs, the ambulance service, district nurses and others.

In addition, the proposals outlined below for acute stroke services would also free up hospital beds because the Early Supported Discharge Service would mean patients spend less time in an acute hospital following a stroke.

As a result, the number of hospital beds we need has reduced and we have closed 146 acute hospital beds on a temporary basis. Initially 76 beds were temporarily closed in the winter of 2015/16, then in September 2016 a further 70 beds were temporarily closed. These beds were in Oxford (101 beds) and Banbury (45 beds) from areas including post-acute and surgical emergency units, general medicine, elective surgery, orthopaedics, and other wards at the John Radcliffe Hospital. This has freed staff to work in these new ways. In February 2017 we will be transferring the infectious diseases service from the Churchill to the John Radcliffe Hospital and during the course of 2017/18 will be carrying out building works in the acute medical wards and in neurosciences at the John Radcliffe which, along with the other changes described here, should allow us to close a further 48 beds. It also means that we will be able to improve facilities for those patients who need to spend time in a hospital bed.

Impact and benefits of the approach we have been piloting

Following the establishment of the Liaison Hub, there was an evaluation period from December 2015 to August 2016, during which time 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.
- 92.5% of respondents agreed they had been treated with dignity and respect in the move to the nursing home.

The proposed changes to acute beds are expected to result in savings of £4.9m, the vast majority of which would be reinvested in the new services described here.

For more detail about how patient experience and feedback has been used and how patients would benefit from these proposed changes, please see the Pre-Consultation Business Case which can be found on our website at www.oxonhealthcaretransformation.nhs.uk

Our preferred option and why

We would like to keep these beds closed permanently, as they are no longer needed. By closing these beds we would be able to use our resources differently to help ensure that patients are cared for in an environment right for them, often closer to their home in community settings.

Intended benefits

The intended benefits for patients are that:

- fewer people would be admitted to hospital in the first place
- if people are admitted, they would spend less time in hospital and receive care in a timely manner and closer to home.

The Horton General Hospital

Background

In this section we set out a vision for the future of the Horton General Hospital in Banbury which is part of Oxford University Hospitals NHS Foundation Trust (OUHFT) and some specific proposals to develop more services there. A long list of options was reviewed by local clinicians taking into account patient experience and feedback, the quality of care, affordability and the workforce available to deliver these services. These proposals are the result of that review. For more information, please see the Pre-Consultation business case on the website www.oxonhealthcaretransformation.nhs.uk

The Horton General Hospital in Banbury has been delivering hospital care since 1872. Over the years it has adapted to meet the changing Healthcare needs of a growing population and it still provides a vital base for a range of general hospital services to the people of North Oxfordshire and the neighbouring counties. The catchment area for the hospital is around 164,000 people. This is likely to grow to 200,000 by 2026. The hospitals in Oxford, Warwick, Milton Keynes, Coventry and Northampton also provide services for this population.

Our vision is that the Horton General Hospital will stay open and develop to become a hospital fit for the 21st century. OUHFT is planning to invest significantly in the hospital so it can continue to develop and change as healthcare evolves and meet the needs of local people.

OUHFT has worked with clinical staff to consider the challenges and options for change and set out its role in the future. The views of patients, the public and interested groups have been considered as part of this. OUHFT captured these views by surveying 900 public members of the Trust who live in North Oxfordshire and the surrounding area.

Some proposals for the Horton General Hospital are set out in this *Phase 1* consultation document (critical care, acute stroke, obstetrics, gynaecology, diagnostics and planned care). Further proposals, which include options for A&E, children's services and the use of our community hospitals, will be part of our *Phase 2* consultation and presented after they have been further developed.

Planned care at the Horton General Hospital

Over the past year, clinicians have been looking at ways to provide more planned hospital care closer to home and whether the Horton General Hospital can play a role in this.

Planned care is a term for healthcare such as tests, outpatient appointments, surgery and medical treatment which has been planned in advance and which is not urgent or an emergency. Planned care is carried out in hospitals, in community hospitals and primary care.

Many diagnostic tests and surgical and medical treatments for patients from North Oxfordshire are currently offered in Oxford, which means people have to travel there. Patients find that transport and car parking can be difficult in Oxford. Sometimes waiting times are longer than they should be as appointments for planned care can be cancelled to make way for an emergency.

Our clinical staff reviewed planned care services for patients from North Oxfordshire and where they are currently based. They recommend that the following services could be provided closer to home for these patients (and this is what patients say they want):

- Diagnostics such as Magnetic Resonance Imaging (MRI), Computerised Tomography (CT) scans and ultrasound.
- Outpatients including 'one stop shop' clinics.
- Planned day surgery and medical care.
- Assessments which are carried out before patients have planned surgery.

Clinical staff looked at whether these services should be provided in three locations:

Oxford (John Radcliffe Hospital, Churchill Hospital, Nuffield Orthopaedic Centre), Banbury (Horton General Hospital), and a third site in the west or south of the county). They also looked at providing services in two locations (Oxford and Banbury).

They reviewed these options taking account of:

- access and patient choice
- quality and safety
- staffing
- finances
- patient experience and feedback.

Facilities in the south of Oxfordshire will be considered during *Phase 2* of the consultation.

What you said

Patient feedback about the Horton General Hospital included an emphasis on the need to keep services local and the problems associated with transport for those needing to travel to Oxford.

For more detail about how patient experience and feedback has helped to inform these proposals and how patient would benefit, please see the pre-Consultation Business Case which can be found on our website at www.oxonhealthcaretransformation.nhs.uk

What we did – our preferred option and why

The preferred option is to significantly develop the services at the Horton General Hospital. This option fits in with the vision of significant developments at the Horton General Hospital, so most North Oxfordshire patients would have their 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.

Intended benefits

Subject to a detailed appraisal, the proposed changes would mean patients from North Oxfordshire and surrounding areas could benefit from:

- more services being provided at the Horton General Hospital. This would mean that fewer patients would need to travel to Oxford
- a new diagnostic unit at the Horton General Hospital, with MRI and CT scanners and ultrasound equipment to allow more people to be assessed and treated locally
- more outpatient appointments and a new modern outpatient unit at the Horton General Hospital that would include facilities for 'one stop shop' appointments. This means that every year thousands of patients would not have to attend hospital on multiple occasions. Up to 60,000 more outpatient appointments could be available at the Horton General Hospital through these changes
- the Horton General Hospital providing more chemotherapy, renal dialysis and day case surgery
- a new assessment unit for patients to be assessed locally before their operation, avoiding the need to travel to Oxford.

Up to 60,000 more appointments at the Horton General Hospital means at least 60,000 fewer journeys to Oxford

Acute stroke services in Oxfordshire

In this section we look at proposals to improve services for people who have an acute stroke in line with national clinical best practice and advice. (An acute stroke is a stroke that occurs or develops abruptly. The key feature of an acute stroke is that it starts suddenly and without warning and needs immediate treatment. Some people develop stroke-like symptoms over a period of time which need investigation).

National guidance (National Institute of Health and Care Excellence or NICE) based on clinical evidence says that patients who have suffered an acute stroke should be admitted to a specialist unit within four hours of their stroke. Following an acute stroke, immediate access to advanced tests and treatments leads to better results for patients. These include CT scanning and MRI scanning, thrombolysis (clot-dissolving drugs) and thrombectomy (physical removal of clots from the brain).

Research (The Reconfiguration of Clinical Services, Kings Fund, Nov 2014) also shows that patients do better when they are treated in large centres by a highly trained specialist team caring for larger numbers of patients. This means that staff are able to carry out enough complex procedures to maintain and improve their skills and consistently provide safe, quality care. In Oxfordshire, the John Radcliffe Hospital in Oxford has a Hyper Acute Stroke Unit (HASU). There are also HASUs in Northampton and Coventry. The Horton General Hospital does not have a HASU.

The Abingdon Community Hospital, Witney Community Hospital and the Horton General Hospital currently provide inpatient rehabilitation which includes speech and language therapy, occupational therapy and physiotherapy. Patients in Oxford and Bicester also benefit from an 'Early Supported Discharge Service', which helps patients to return to their own homes sooner so they can regain independence as quickly as possible.

At the moment most patients in Oxfordshire, including the north of the county, who have suffered an acute stroke (88%) are immediately taken to the John Radcliffe in Oxford – around 700 a year. Around 100 patients each year (12%), however, are still admitted to the Horton General Hospital, which does not have comparable diagnostics and specialist care.

Doctors and nurses in the working groups for the review of acute stroke services and the Thames Valley Clinical Senate looked at the current way in which these services are provided and options for change to improve health outcomes for patients in North Oxfordshire. They agreed that all acute stroke patients should be assessed in a HASU. They also agreed that the Early Supported Discharge Service should be available to all patients in Oxfordshire, including the north, and looked at how rehabilitation should be provided.

What you said

One of the themes that emerged from patient and public feedback was recognition of the importance of patient safety and the outcomes experienced by patients. Feedback about the Horton General Hospital included an emphasis on the need to keep services local, but also some concerns about the quality of services. The proposals for acute stroke services were developed with this feedback in mind.

For more detail about how patient experience and feedback helped to inform this option and how patients would benefit from proposed changes, please see the pre-Consultation Business Case which can be found on our website at www.oxonhealthcaretransformation.nhs.uk

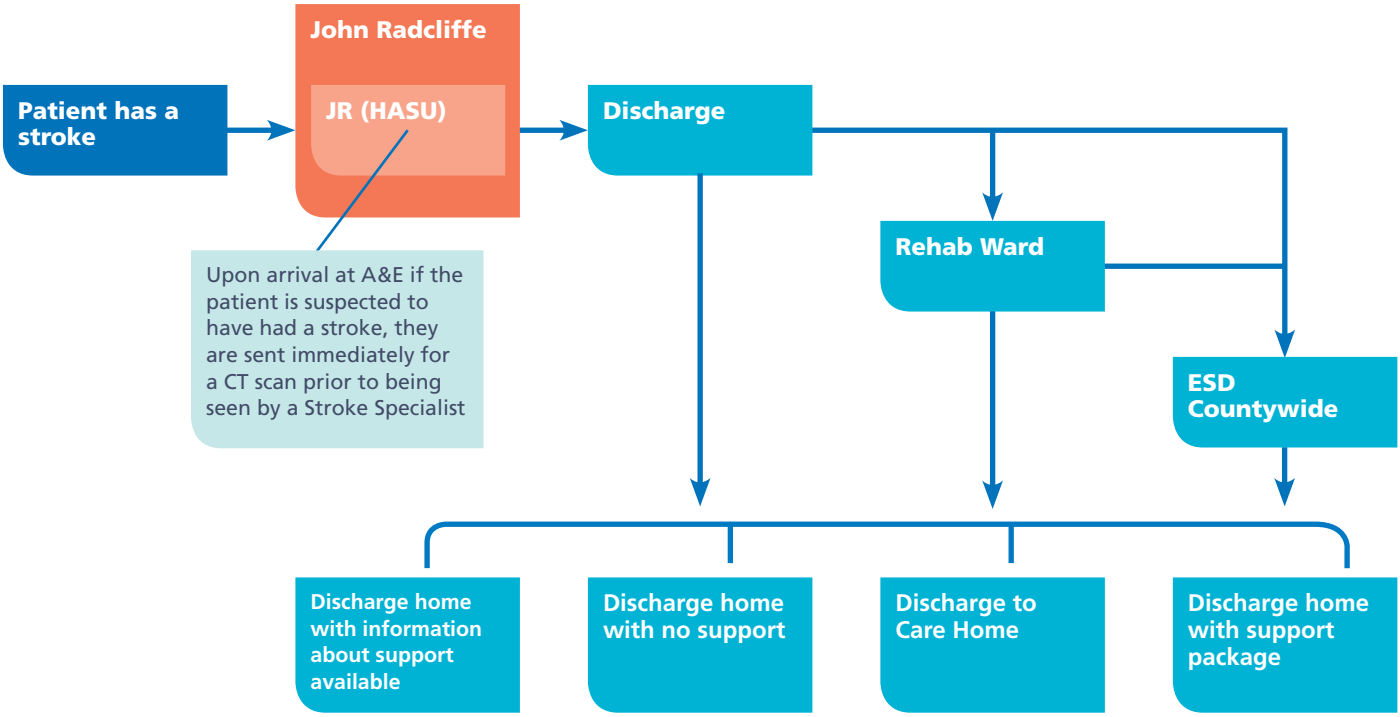
What we did – our preferred option and why

The following option was developed with patient feedback in mind:

- All patients diagnosed with an acute stroke would be taken immediately by ambulance to the nearest HASU at the John Radcliffe Hospital in Oxford. Our travel analysis which can be found on our website: www.oxonhealthcaretransformation.nhs.uk showed that nearly all patients are within 40 minutes of ambulance travel time. Those in North Oxfordshire who are closer to Northampton or Coventry Hospitals would be taken directly there.
- On average, patients could expect to be treated in a HASU for approximately 72 hours. The Early Supported Discharge Service would be extended across the county, including North Oxfordshire, so that all patients could benefit from care at home when they are ready to leave hospital – around 200 patients year would benefit from this.
- Patients who are ready to leave the HASU but not well enough to go home could be cared for and receive rehabilitation in a hospital bed away from the specialist HASU. The role of the Horton General Hospital and community hospitals in providing this care is being looked at as part of the review of community hospitals and will come under *Phase 2* of the consultation.
- Short term rehabilitation following a stroke, would continue to be provided at the Horton General Hospital.

Intended benefits

- 100 North Oxfordshire patients each year diagnosed with an acute stroke would receive care at a HASU in line with national best practice and other patients across the county.
- Around 200 patients per year would benefit from the Early Supported Discharge Service being extended across the county, to help them to return home more quickly. Short term rehabilitation would continue at the Horton General Hospital.



This diagram illustrates the way in which people would be treated after an acute stroke.

Critical care at the Horton General Hospital

In this section, we look at services for people needing critical care in North Oxfordshire (critical care helps people with life-threatening or very serious illness or injury).

Patients in hospital need different levels of care from doctors and nurses depending on how ill they are. The sickest patients require critical or intensive care, which is provided in highly specialised Intensive Care Units (ICUs). There are different levels of care, which are graded from 0 to 3, depending on the level of the support needed by the patient:

Level 0: patients whose needs can be met through normal ward care in an acute hospital

Level 1: patients at risk of their condition deteriorating, or those recently relocated from higher levels of care, whose needs can be met on an acute ward with additional advice and support from the critical care team

Level 2: patients requiring more detailed observation or intervention including support for a single failing organ system or post-operative 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 failed organ systems. This level includes all complex patients requiring support for multi-organ failure.

The sickest patients from across Oxfordshire needing critical care are taken directly to the ICUs in the John Radcliffe and Churchill Hospitals in Oxford. The Horton General Hospital has a six bedded Critical Care Unit (CCU), which has traditionally served a number of purposes including providing Level 3 critical care in two of its six beds.

Over the past five years at the Horton General Hospital, the numbers of patients needing Level 3 care has fallen. This is because patients needing emergency surgery, emergency cardiac care or who have suffered a major trauma are taken directly to the John Radcliffe for specialist treatment. The number of patients needing intubation and ventilation (artificial help with breathing) has fallen by nearly a third in the past five years. In 2015/16, 488 patients were admitted to the Horton General Hospital CCU. Only 41 of these patients (or less than 10%) needed Level 3 critical care.

This presence of only a small number of the sickest patients means that doctors and nurses do not get many opportunities to keep up their skills, an issue which has been raised by the Care Quality Commission (the independent regulator of health and social care services). This also means that it is difficult to recruit enough nurses and the CCU does not meet national guidelines for staffing numbers (Guidelines for the Provision of Intensive Care Services (GPICS) published by the Intensive Care Society in 2015). All these combine to reduce the CCU's ability to provide high quality care to the sickest patients and to achieve the best outcomes for patients.

What you said

One of the themes that emerged from the feedback received was recognition of the importance of patient safety and the outcomes experienced by patients. Feedback about the Horton General Hospital included an emphasis on the need to keep services local, but also some concerns about the quality of services.

For more detail about how patient experience and feedback helped to form this option and how patients would benefit from proposed changes. Please see the Pre-Consultation Business Case which can be found on our website at www.oxonhealthcaretransformation.nhs.uk

What we did – our preferred option and why

The view of doctors and nurses is that the Horton General Hospital should continue to have a CCU, caring for patients at risk of deterioration, and Level 2 critical care patients, as this is the safest option.

If all critical care patients were cared for in Oxford, over 500 more North Oxfordshire patients would need to go to Oxford. The majority of these could be cared for at the Horton General Hospital in an appropriately resourced Level 2 critical care facility. The current facilities in the ICUs in Oxford do not have the capacity to look after these extra patients

Instead, we propose that only the Level 3 critical care patients from North Oxfordshire are treated at the Oxford ICUs and that the Horton General Hospital continues to treat Level 2 patients. This would mean up to an additional 40 Level 3 patients a year would be treated in Oxford rather than in Banbury. Patients living in South Northamptonshire and South Warwickshire might be treated at the critical care units in hospitals in Warwick, Northampton or Milton Keynes if closer.

Intended benefits

- Where appropriate, North Oxfordshire patients needing up to Level 2 critical care would be treated at the Horton General Hospital, Banbury, limiting the numbers of patients who have to travel for care.
- A small number of the sickest patients needing critical care Level 3 would receive treatment at a highly specialised Intensive Care Unit in Oxford.*Patients living in South Northamptonshire and South Warwickshire might be treated at the critical care units in hospitals in Warwick, Northampton or Milton Keynes if closer.*

The BIG health and care consultation

Up to 40 Patients each year would need to be cared for in Oxford rather than Banbury

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

Maternity and obstetric services in North Oxfordshire

In this section we consider our maternity and obstetric services in North Oxfordshire and what services should be provided for women and their families. We concentrate on the maternity service at the Horton General Hospital because of the challenges we are currently facing. We will be asking for feedback on proposals for Midwife Led Units (MLUs) and maternity services across Oxfordshire in ***Phase 2*** of our consultation later in the year.

The vision is to 'provide high quality, sustainable, safe maternity services that achieves healthy outcomes for women and babies'.

The aim is to ensure the care during pregnancy enables a woman to make informed decisions based on her needs, having discussed matters fully with the health care professionals involved in her care. This aim will meet the recommendation in 'Better Births' (National Maternity Review, 2016) to provide personalised care to every woman in Oxfordshire by offering choice and continuity of care throughout the pregnancy, birth and postnatal period.

Our aim is to:

- support more women to access a low-risk environment of their choice with midwifery support.
- provide on going assessment for women throughout pregnancy so that potential problems can be addressed
- improve access to specialist maternity services for women who have more complex pregnancies. This includes women who are expecting twins, who have diabetes or who are very obese as well as support for women who have mental health issues and who may need specialist care throughout the pregnancy and afterwards
- ensure woman have a full choice of birth options
- ensure every woman can access the right part of the maternity service and to be cared for by the right professional.

Every year around 8,500 women give birth in Oxfordshire. Most women have a low risk pregnancy and are cared for by the midwifery teams during the antenatal, labour and postnatal period; this is entirely appropriate and safe. Some women will require care from the consultant led team throughout their pregnancy and labour. To enable women to have the right care a number of options are available so women and their partners can choose the most appropriate setting to give birth.

Women in Oxfordshire and surrounding areas have the choice to give birth in:

- an obstetric unit at the John Radcliffe Hospital in Oxford which is resourced to care for women who have a complex pregnancy or choose to give birth in this facility. The obstetric unit at the Horton General Hospital has temporarily changed to an MLU due to difficulties with doctor cover. The John Radcliffe Hospital has a neonatal intensive care unit for new born babies requiring intensive or specialist care
- the Spires Midwife Led Unit (MLU) in Oxford which is an alongside unit at the John Radcliffe Hospital. A third of women in North Oxfordshire choose to give birth in Oxford either in the obstetric unit or the Spires MLU
- a free standing Midwife Led Unit located in Chipping Norton (The Cotswold Maternity Unit), Wantage, Wallingford and Banbury
- at home with the support of community midwives
- an obstetric unit outside Oxfordshire. These include units in Northampton, Warwick, Milton Keynes the Royal Berkshire Hospital in Reading, the Great Western Hospital in Swindon and Stoke Mandeville Hospital in Aylesbury.

Women are seen regularly and continually assessed during their pregnancy to monitor the health and wellbeing of both mother and baby. Advice is given about appropriate options of care including place of birth.

There is very good evidence that women who give birth in an MLU experience less clinical intervention than women who give birth in an obstetric unit. However, we understand some women and their partners may be concerned about being transferred during labour to an obstetric unit. Transfers in labour from an MLU to an obstetric unit are not unusual and will be taken into account during the discussion between the midwife and the woman, considering the clinical risk factors at the time. Reviewing clinical research evidence, this approach is shown to not affect how well mothers or their babies do. The Birthplace Study, conducted by the National Perinatal Epidemiology Unit (NPEU) at the University of Oxford in 2011, showed that there is very little difference in outcomes for women with a low-risk pregnancy. Sadly around four births in every 1,000 result in a stillbirth irrespective of where the woman gives birth.

The challenges

"There is a need to be mindful that choice has to be delivered in a realistic manner, balancing wants and needs with what is clinically safe and affordable and what resources can be made available without destabilising other services."

Royal College of Obstetrics and Gynaecologists (RCOG) – High Quality Women's healthcare: A proposal for change

We currently face significant challenges in the way we provide maternity services in the north of Oxfordshire and therefore we must consider the future provision of services at the Horton General Hospital. In ***Phase 2*** we will be seeking views about making the interim MLU permanent in Banbury. In 2015/16 there were 1,466 births at the Horton General Hospital.

The Royal College of Obstetricians and Gynaecologists advises NHS hospitals about the safe level of care for obstetric units. They recommend that units which see fewer than 2,500 births should be subject to additional risk and staffing assessments to ensure patient safety. Obstetric doctors develop and maintain their skills throughout their careers. In units with low numbers of births it is difficult for them to care for enough women to keep their skills up to date which is a matter of patient safety and it is a risk. Population predictions show that even with the maximum possible growth in population and births over the next 20 years, this will not be sufficient to meet the 2,500 threshold.

In 2013 the Horton General Hospital lost its ability to provide obstetric training for doctors not yet qualified as consultants because of low numbers of births. This means that the Horton General Hospital can only continue to run an obstetric service with enough qualified consultants or non-training middle grade doctors. Nationally there is a shortage of obstetric consultants and middle grade doctors. It is particularly hard to recruit staff to work at the Horton General Hospital because of the low number of births in the unit. OUHFT has continued to try hard to recruit more obstetric staff but until now has not been successful.

In August 2016 OUHFT made the decision to temporarily suspend the obstetric led service at the Horton General Hospital because of difficulties in recruiting doctors and therefore not being able to provide a safe maternity service. The unit temporarily became an MLU from October 2016.

The decision involved the following temporary changes:

- A temporary stand-alone Midwife Led Unit opened at the Horton General Hospital and obstetric care for pregnant mothers stopped being provided on site. Women from North Oxfordshire and the Brackley area who need to deliver in an obstetric unit can choose to give birth at the John Radcliffe in Oxford or in Northampton, Warwick or Milton Keynes hospitals (with women requiring specialist care continuing to receive it in Oxford as before).
- Women can choose to give birth at one of the MLUs: at the Horton General Hospital, the Spires, Cotswold Maternity Unit in Chipping Norton (CMU), Wantage or Wallingford.
- The Special Care Baby Unit was transferred to the John Radcliffe Hospital because this kind of care is only provided alongside obstetric units.

This change had an impact on the small number of women from North Oxfordshire, who need inpatient care for a gynaecological problem. These women require around the clock specialist medical care which was previously provided by the obstetric and gynaecology doctors also covering the maternity service. During the temporary service change, these patients are being admitted to the gynaecological unit at the John Radcliffe Hospital in Oxford. However, the day-case service, emergency gynaecology service and the early pregnancy service remains at the Horton General Hospital.

What you said

We know that people in North Oxfordshire and surrounding areas value the services at the Horton General Hospital but during our engagement they also told us that patient safety was important to them. Clinicians are concerned that even if they could recruit enough obstetric staff, the situation would not be sustainable and is likely to lead to another emergency closure. We want to make sure that we commission only safe services for patients.

Feedback from patients, public and clinicians has been gathered in a number of ways in the months leading up to the consultation and has been summarised in a number of documents. Recognising the particular concerns and strong views expressed about potential changes to maternity services in North Oxfordshire, below is a summary of the feedback received and how it has been used in helping to inform the preferred option set out in this document.

For more information on this, please see the Pre-Consultation Business Case and the reports on public engagement from June to August 2016 and September to November 2016, which can be found at our website at www.oxonhealthcaretransformation.nhs.uk

You said	We did
Concerns about the maternity service at the Horton General Hospital if it was to move to Oxford, and also of the ability of the Oxford based services to then cope with the additional patients.	National evidence demonstrates that Midwife Led Units (MLUs) are regarded as safe settings for low risk women to give birth and that they have been shown to be as safe as obstetric units for women and their babies (Birthplace Study, 2014). The proposed changes would ensure that all women in Oxfordshire receive an 'Early Maternal Medical Risk Assessment' that would help them make an informed choice about the best and safest birth choices for them. Work with maternity focus groups showed that we don't provide enough information about MLUs and the benefits of choosing to birth at one. The way in which services would be designed would ensure women have access to all the information they need to make informed choices. This could be supported by digital technology (like apps for example) so women could access the information in a way that best suits them.
Support groups for families on managing childhood illnesses appropriately could help with prevention.	The proposed changes would have prevention as a priority throughout and post pregnancy. We would build in support for postnatal women so they feel able to confidently look after themselves and their baby. The important role of Health Visitors and GPs would be factored into the new service.
The need to keep the Horton General Hospital and its services such as maternity, particularly with an expanding local population.	The proposed changes take into consideration the predicted increases in births due to planned housing developments. Analysis shows that even with these increases, the Horton General Hospital would see fewer than 2,500 births and be subject to the additional risk and staffing assessments required for small obstetric units to ensure patient safety. Irrespective of the numbers of births, OUHFT would not have enough doctors to staff the unit. This makes it unsafe for current and future demand and an unviable option for the future.
The need to listen and engage more with parents and families.	Three focus groups were held in October 2016 where we were able to listen and engage with women who had recently given birth in Oxfordshire. We heard some wonderful stories about women's experiences of the care they had received and we also had some good discussions about what could be done differently. We heard how important breastfeeding support is to women and how important postnatal care is. On the back of this feedback we have committed to expanding our offer of postnatal support and we understand that specialist breastfeeding support is crucial to this. We recognise that we do not routinely listen and engage with parents and families who use maternity services and we will be considering how we can improve this.

What we did – considering possible solutions

Given this background, clinical staff have reviewed a number of possible solutions to tackle the challenges.

Possible solution	Appraisal
A round-the-clock rota of non-consultant obstetric doctors (still in training).	Training approval for medical trainees in obstetrics has been withdrawn from the Horton General Hospital site. Health Education England, which is responsible for training, has made it clear that there are no circumstances under which this will be restored because the unit does not care for enough women in labour and because there are not enough trainees to fill posts. Currently, 24% of trainee posts are vacant. This is not a viable option.
A round-the-clock rota of middle grade obstetric doctors not in training.	OUHFT has tried to recruit non-trainee middle grade doctors, but has not been successful. The OUHFT introduced a rota of eight Clinical Research Fellows in 2012. By early 2016 this had become unsustainable and an alternative was developed of nine doctors working across the John Radcliffe Hospital site and the Horton General Hospital to make the posts more attractive. At the time of the temporary closure only two of the nine posts required for a round-the-clock rota had been successfully filled. At the beginning of January 2017 only three doctors were in post. This is not a viable option
A round-the-clock rota of trained consultants at both the Horton General Hospital and the John Radcliffe Hospital.	An additional 22 consultants are required to safely manage obstetric units at both the John Radcliffe Hospital and the Horton General Hospital. There is a national shortage of obstetric consultants so this is not a viable option.
The Horton General Hospital to provide an elective caesarean section service for all appropriate pregnant women across Oxfordshire. Women from North Oxfordshire with a low risk pregnancy to give birth at the CMU at Chipping Norton.	This was an option proposed by a member of the public. It is the opinion of clinical staff that this is not safe for many reasons including the absence of vital support services and medical staff. It would, furthermore, compromise the ability to care for the highest risk pregnancies in North Oxfordshire and the rest of the county. This is not a viable option.

In addition to the issues relating to obstetric care, there is a need to review our balance of investment to improve Oxfordshire's maternity services. Technology is under-used and there is a need to make more use of community based diagnostics and electronic patient care records.

What we did: our preferred option for obstetrics and why

As a result of this appraisal, clinical staff at the OUHFT, the clinicians on the working group and the Thames Valley Clinical Senate agreed that none of the above solutions could ensure a safe, high quality obstetric unit at the Horton General Hospital and propose the model detailed below.

The proposal is that although most antenatal obstetric care can still be provided at the Horton General Hospital, all women with a higher risk pregnancy would give birth at the John Radcliffe in Oxford (with women north of Oxfordshire also having the choice to travel to Northampton, Warwick or Milton Keynes).

What is the impact and intended benefits of this proposed model of care?

Women would continue to have the option to give birth in an obstetric unit at the John Radcliffe Hospital in Oxford, in the Spires MLU at the John Radcliffe Hospital, in one of the stand-alone MLUs at the Horton General Hospital, Chipping Norton, Wantage and Wallingford or at home, although this will be subject to further discussion in ***Phase 2***. This would ensure that women continue to have choice in where they give birth. We anticipate that this option would result in between 200 to 500 women a year choosing to use the MLUs at the Horton General Hospital. The proposed facilities at the Horton General Hospital have the capacity to care for up to 500 women in labour each year.

The MLUs in North Oxfordshire would be able to cope with any increase in demand. There would be an increased number of antenatal, postnatal and breastfeeding clinics at the Horton General Hospital. These services are already available at Chipping Norton and other MLUs.

All women in North Oxfordshire and surrounding areas who need obstetric care in childbirth would have to travel further either to Oxford or to an other obstetric unit in Northampton, Warwick or Milton Keynes. This would also apply to any mothers and babies needing to transfer during labour or after birth. **A single obstetric led labour ward at the John Radcliffe would ensure that there are always enough staff available and importantly that there are enough births to maintain medical skills and run a safe service now and for the future.**

Some women would transfer from the MLUs in North Oxfordshire to the obstetric unit in Oxford at the start of labour or during labour because the woman changes her mind or because there is a clinical need. The Birthplace Study, conducted by the National Perinatal Epidemiology Unit (NPEU) at the University of Oxford found that the transfer rate, for mothers who were in their second or subsequent pregnancy, to an obstetric unit was 12% for home births, 9.4% for a stand-alone MLU and 12.5% for an MLU alongside an obstetric unit.

Additional consequences of this change are that the Special Care Baby Unit would move permanently to the John Radcliffe Hospital and a small number of women needing emergency gynaecology inpatient services would need to travel to Oxford.

The options for Midwife Led Units in North Oxfordshire

The obstetric unit at the John Radcliffe Hospital would be supported by two options for providing MLUs, which are described as illustrative examples below. Both ensure that women would continue to have a choice of the type of unit where they can give birth. We are not consulting on this proposal relating to MLUs now and OCCG will include firm proposals for all the Oxfordshire MLUs in ***Phase 2*** of the Consultation.

Example model 1 (two Midwife Led Units in North Oxfordshire):

The first example model would propose that there would be two Midwife Led Units in North Oxfordshire, one in Chipping Norton and one in Banbury. This would mean women in Chipping Norton would still be able to choose their local hospital to give birth under the care of midwives and similarly women in the Banbury area could choose the same at the Horton General Hospital. Women from both areas wanting to give birth under the care of an obstetrician, or in a Midwife Led Unit co-located with an obstetric unit would need to travel to Oxford or to a nearer unit in Northampton, Warwick or Milton Keynes. This example would:

- replace the obstetric unit with a MLU at the Horton General Hospital on a permanent basis, (this would include investment in buildings and facilities)
- centralise all emergency gynaecology inpatient services at the John Radcliffe in Oxford on a permanent basis
- move the Special Care Baby Unit from the Horton General Hospital to the John Radcliffe on a permanent basis
- develop more antenatal clinics and classes for women at the Horton General Hospital so that they can be assessed locally
- develop more postnatal provision at the Horton General Hospital
- keep the Cotswold MLU in Chipping Norton as another option for women.

Example model 2 (one Midwife Led Unit in North Oxfordshire):

The second example would propose one MLU for pregnant women in North Oxfordshire and that this would be at the Horton General Hospital in Banbury. This would mean closing the Cotswold MLU at Chipping Norton and women would need to travel to another MLU to give birth. However, the majority of care, including antenatal, postnatal and breastfeeding clinics would continue to be provided by local midwife teams in Chipping Norton Hospital.

If the Cotswold MLU were to close, the current accommodation costs could be reinvested in maternity care elsewhere in Oxfordshire to improve the quality of the service. Facilities would still be needed for antenatal and postnatal services at the Chipping Norton Hospital, including breastfeeding clinics, but some accommodation costs would still be saved.

Some women in North and West Oxfordshire who currently use the Cotswold MLU would have to travel further to a MLU elsewhere. The average increase in travel time would be 15 to 17 minutes.

This example would mean we would:

- replace the obstetric unit at the Horton General Hospital with a Midwife Led Unit on a permanent basis (this would include investment in buildings and facilities)
- centralise all emergency gynaecology inpatient services at the John Radcliffe Hospital in Oxford on a permanent basis
- move the Special Care Baby Unit from the Horton General Hospital to the John Radcliffe Hospital in Oxford on a permanent basis
- develop more antenatal clinics and classes for women at the Horton General Hospital so that they can be assessed locally
- develop more postnatal provision at the Horton General Hospital
- continue to provide postnatal, ante-natal and breastfeeding clinics in Chipping Norton Hospital
- close the Midwife Led Unit in Chipping Norton Hospital.

Conclusion

In this consultation document we have set out the way in which we plan on developing health and care services in Oxfordshire and our proposals to change some of these services. Our aim is that patients receive the best quality care in the right place at the right time.

We have also given an overview of other areas where our doctors, nurses and managers are still developing ideas for possible change (***Phase 2*** of our consultation). When they become firm proposals there will be further public consultation.

Now is your opportunity to find out more, have your say and tell us what you think.

The consultation

Our formal public consultation will run from 16 January 2017 until 9 April 2017 across Oxfordshire and surrounding areas. Once the public consultation has finished OCCG will consider all feedback. OCCG will commission independent support to thoroughly and comprehensively analyse all responses to the consultation and publish a report detailing this. OCCG has also asked an external organisation to assess the impact of the proposed changes. Once all this feedback has been considered alongside patient-safety factors and clinical best practice, OCCG will need to consider what changes it wants to make and how specific clinical services are arranged or how the health and social care system might support specific groups in the community. The decision-making business case will then be considered by the OCCG Governing Body for a final decision. As well as taking into consideration the outcome of the public consultation, the OCCG Governing Body will need to consider other factors, including safety, clinical quality and evidence, financial and practical considerations.

How can you have your say?

During the consultation there will be lots of opportunities to find out more and share your views.
This will include opportunities to talk to the doctors and nurses who have developed these proposals.
Further information on all of these proposals and details of events and opportunities to get involved can be found on our website: www.oxonhealthcaretransformation.nhs.uk. You will also find there more information about the work of the Transformation Board, the pre-consultation Business Case and other supporting documents.

We will be:

- publicising the consultation as widely as we can including through advertising, the media and social media – if you can help with this by sharing information with your local community or organisation then please let us know and we can provide you with consultation documents and surveys
- contacting people who have already said they are interested in getting involved in healthcare issues, including members of OCCG's Talking Health and OUHFT and OHFT membership
- running public roadshows and events across the county and in neighbouring areas, such as South Northamptonshire and South Warwickshire
- asking you what you think through surveys and focus groups and inviting feedback
- holding discussions with patient and voluntary groups – if you are a member of a group which might be interested then please let us know
- using our website to encourage feedback: www.oxonhealthcaretransformation.nhs.uk

We welcome all responses to this consultation. We need to receive them by midnight on 9 April 2017.
You can respond by completing the questionnaire available on our website and send it back to us Freepost

If you would like this document in a different language or an audio, braille, large text or an Easy Read format, please call 01865 334638 or email cscsu.talkinghealth@nhs.net

Communications and Engagement Team,
Oxfordshire Clinical Commissioning Group
Freepost RRRKBZBTASXU
Jubilee House
5510 John Smith Drive
Oxford
OX4 2LH

Talking Health is our online public involvement service. Register and complete the online survey at:
https://consult.oxfordshireccg.nhs.uk

Email us: cscsu.talkinghealth@nhs.net
Phone us on 01865 334638

Write to us:
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Jubilee House
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Visit our website: www.oxonhealthcaretransformation.nhs.uk

Appendix

Glossary of terms used in this document:

Acute hospitals: large hospitals which provide a wide range of specialist care and treatment for patients. This includes consultation with specialist clinicians (consultants, nurses, dieticians, physiotherapists and a wide range of other professionals); emergency treatment following accidents; routine, complex and life-saving surgery; specialist tests, therapies and procedures. Acute hospitals vary in the range of services available. Some include an A&E. Others provide planned care which can include specialist care.

Acute Hospital at Home: a care team, made up of consultants, specialist nurses and other allied health professionals, which provides an alternative to hospital for frail older people.

Ambulatory Assessment Unit: is a service in a hospital which provides urgent assessment and treatment of adults who are unwell but may not necessarily need to be admitted to hospital.

Community hospitals: smaller local hospitals which offer local care and often include rehabilitation services after a stroke or surgery, some outpatient appointments, x-ray facilities, physiotherapy and hearing tests.

Critical care: care given within specialist units in the hospital (Critical Care Unit) by specially trained staff and designed to closely monitor and treat patients with very serious or life threatening conditions. This care can be given in an emergency, such as after a road accident, or in a planned way, for example after major heart surgery.

Critical Care Unit (CCU): see Critical care

Early Supported Discharge Service: the Early Supported Discharge Service team provides an early, intensive rehabilitation service for stroke patients which helps them leave hospital more quickly and return to their own homes with support from community teams so they can regain their independence as soon as possible.

Emergency Multidisciplinary Unit (EMU): usually found at a community hospital and will rapidly assess any patient who has been seen by, for example, a GP, community nurse or ambulance paramedic who feels that further assessment is needed. EMUs do not assess patients with suspected heart attacks, strokes, head injuries or those who may need surgery.

Five Year Forward View: the NHS Five Year Forward View, published in October 2014 by NHS England, sets out a strategy for the future of healthcare nationally and locally.

Health and Wellbeing Board: key leaders from the health and social care services work together to improve the health and wellbeing of local people and reduce health inequalities.

Healthwatch Oxfordshire: the local section of a national consumer watchdog for patients which aims to improve health and social care.

Hyper Acute Stroke Unit (HASU): this provides initial investigation, specialist treatment and care immediately following a stroke. Patients are treated in the HASU until medically stable and fit for transfer to their local stroke rehabilitation unit for on-going inpatient care or until fit for discharge home.

Middle grade doctors: qualified doctors who are not consultants. Some may choose to train to be consultants; others will choose to remain as middle grade doctors.

Midwife Led Unit: birthing centres or midwifery units run by midwives without the medical facilities of a hospital. They can be next to a main hospital maternity unit ('alongside') or completely separate from hospital (stand alone).

Obstetric care: obstetrics is a medical specialty focusing on pregnancy, childbirth and post childbirth care. Women who need the care of an obstetrician or need an epidural (which can only be delivered by an anaesthetist under the care of an obstetrician) would need to give birth in an obstetric unit.

Oxfordshire Clinical Commissioning Group: was established on 1 April 2013, as part of the reorganisation of NHS commissioning following the passage of the Health and Social Care Act 2012. We are responsible for buying health services on behalf of everyone living in Oxfordshire.

Oxfordshire Joint Health Overview and Scrutiny Committee (HOSC): looks at the work of local health services including the Clinical Commissioning Group and hospital trusts. The Committee acts as a 'critical friend' by suggesting ways that health related services might be improved. The HOSC also looks at the way the health service interacts with social care services, the voluntary sector, independent providers and other council services to jointly provide better health services to Oxfordshire residents and improve their wellbeing.

On behalf of Oxfordshire County Council, the HOSC has responsibility to "review and scrutinise any matter relating to the planning, provision and operation of the health services in its area" and to make referrals to the Secretary of State about proposals where it considers proposals for service change, or consultations, have been inadequate.

Patient Participation Group: patient representatives from a local GP practice who advise and inform the practice on what matters most to patients and help identify solutions to problems as a 'critical friend'.

Planned care: healthcare such as tests, outpatient appointments and surgery which has been planned in advance and which is not urgent or an emergency. Planned care is carried out in hospitals, in community settings such a community hospitals and in primary care.

Pre-consultation business case: sets out the reasons why healthcare services have to be transformed – the 'case for change ' – how the transformation could look, how it could affect patients and how much it could cost.

Primary care: most people's first point of contact with health services, e.g. GPs dentists, pharmacists or optometrists.

Stroke: strokes vary in their severity. Some people can suffer from a mini or mild stroke which means they may be at risk of a more severe stroke in the future. People suffering from an acute or severe stroke need specialist hospital care and treatment very quickly in order to maximise their chances of survival and recovery.

Talking Health: Oxfordshire Clinical Commissioning Group's online service where patients and the public can get involved with and influence local health services and decisions
www.oxfordshireccg.nhs.uk/get-involved/talking-health/

Transformation Programme: was launched in early 2016 to drive forward the changes in the health and social care system in Oxfordshire in response to rising demand for services. The Transformation Board which oversees the programme is made up of health and social care leaders.

The BIG health and care consultation

Join Talking Health:

Talking Health

Talking Health is our online public involvement service. You can register by post or online.
You can tell us exactly what you are interested in and how you want to be involved.
https://consult.oxfordshireccg.nhs.uk

Visit our website:
www.oxonhealthcaretransformation.nhs.uk

facebook.com/OxfordshireCCG/
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Email us cscsu.talkinghealth@nhs.net
Write to us Communications and Engagement Team,
Oxfordshire Clinical Commissioning Group
Freepost RRRKBZBTASXU
Jubilee House
5510 John Smith Drive
Oxford
OX4 2LH

OXFORDSHIRE COUNTY COUNCIL

County Hall
New Road
Oxfordshire County Council
OX1 1ND

Members of Oxfordshire Joint Health Overview and Scrutiny Committee

Cllr Judith Heathcoat
Cabinet Member for Adult Services

21 February 2017

Dear Members of the Oxfordshire Joint Health Overview and Scrutiny Committee,

Cabinet view of the Oxfordshire Clinical Commissioning Group's consultation on the Oxfordshire Transformation Programme for NHS services

We write on behalf of the county council's Cabinet who discussed this week the Clinical Commissioning Group's proposals for the future of health services in Oxfordshire.

Please find attached the report prepared by the council's leadership team which informed our discussion. The report provides a comprehensive assessment of the CCG's proposals and their potential impact on council services and the public. We think this will provide useful background information for you in your consideration of the proposals. Cabinet approved the recommendations in the report with a slight amendment (as set out below).

The Cabinet is RECOMMENDED to

- Welcome the opportunity to comment on this consultation, acknowledge the difficulties faced by NHS services locally as presented in the OCCGs case for change, but on balance not to support the proposals based on the lack of information on the impact on council services ***and that of the public.***

- Present its views and the officer's assessment to the Oxfordshire Health Overview and Scrutiny Committee meeting on 7th March.

- Present a report on its views to the County Council meeting on 21st March to gather further comment.

Our intention is that Cllr Heathcoat present the Cabinet's views at the HOSC meeting on March 7th for you to consider as part of your call for evidence.

Yours sincerely

Cllr Ian Hudspeth, Leader of the Council
Cllr Mrs Judith Heathcoat, Cabinet Member for Adult Social Care

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Division(s): All

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CABINET – 21 FEBRUARY 2017

RESPONSE TO OXFORDSHIRE CLINICAL COMMISSIONING GROUP'S CONSULTATION ON THE OXFORDSHIRE TRANSFORMATION PROGRAMME FOR NHS SERVICES

Report from the Council Leadership Team

Introduction

1. The Oxfordshire Clinical Commissioning Group (OCCG) launched the first phase of its consultation on the future of Oxfordshire Health and Care Services on January 16th 2017. The consultation document and supporting pre-consultation business case can be found on the OCCG website https://consult.oxfordshireccg.nhs.uk/consult.ti/BigconsultationPhase1/consultationHome

2. Oxfordshire County Council is key stakeholder and a consultee in the process and has until 9th April to respond to the consultation- though the council may wish to respond in advance of the pre-election period.

3. This report has been prepared by the county council's leadership team and combines professional perspectives from across all our services including children's and adults' social care, highways, environment and economy, public health and fire and rescue services.

4. Officers have considered the proposals in the consultation document and present here their professional views on the possible impacts on our services and local people based on the information in the consultation document.

5. By way of context, it is important to acknowledge the challenges faced by the local NHS as set out in their case for change document. The NHS is a national organisation and the autonomy local authorities enjoy has not been extended in the same way to health services. This means that these proposals are influenced by national policy and are also overseen by NHS England and are inevitably a blend of local and national policy.

6. All county council services have been asked to consider the consultation proposals and the potential impact they may have on services and on the public. Some of the issues are generic and some are specific to particular service areas.

Consultation approach

7. We welcome the production of this consultation, but note that we had expected it to begin in October 2016 and to be structured as a single set of proposals with options. The consultation was then delayed and has now been produced as a partial consultation. It is unfortunate that there have been delays in getting the proposals out to public consultation and that this has resulted in two phases of consultation.

8. We acknowledge this phasing is due to a number of factors; a desire to debate existing temporary service closures as a matter of urgency, the sheer scale of the task involved in producing the proposals, and because of a requirement for NHS England to approve the proposals prior to consultation. The phasing clearly affects the coherence of the proposals making it difficult for partner organisations to assess their impact and to see a total vision for the future of health services in the county. It also makes the consultation feel less transparent to communities.

9. Our view is that the lack of options presented in the consultation document makes it difficult to consider different alternatives for future services. Options were presented earlier in the engagement phase leading up to the consultation, so it is unfortunate that they have not come through in these proposals.

10. We feel that the inception of Sustainability and Transformation Plans (STP) by the NHS at national level requiring clinical commissioning groups to work together across larger geographical 'footprints' (in our case the Buckinghamshire, Oxfordshire and Berkshire West- 'BOB') has not been helpful. These were created and imposed nationally by NHS England after the process of re-shaping Oxfordshire's services had begun. The interplay between a 'BOB STP' and an Oxfordshire consultation remains unclear and confusing both for professionals and for the public.

11. The consultation proposals as they stand are unlikely to satisfy the concerns of people in some parts of the county. People in the north of the county for example, are unlikely to find that the service changes described affecting the Horton Hospital offer a clear enough view of the future functioning of that hospital in its entirety.

12. Many of the proposals draw on specialist clinical evidence and opinion. The county council officers will not attempt to debate purely clinical judgements.

Vision for the future of the Horton Hospital

13. We understand that smaller hospitals across the country are facing similar pressures to those faced locally by the Horton Hospital. A clear vision for the future of such hospitals is urgently needed. However, because of the way the proposals are structured, and because there is no discussion of community and primary care services in this consultation, it is not possible to see an overall proposal for the detailed future composition and functions of the Horton Hospital in Banbury. However it is clear from the document that there is a future for the Horton as a health care facility with more diagnostic, outpatient and elective surgery appointments offered.

14. This is a vital issue for local people and is therefore a serious deficiency in the consultation document. Smaller hospitals are vulnerable to a 'domino effect', i.e. a diminution in one service tends to lead to a diminution in related services. In this case, changing maternity services, intensive care services and the bed-stock at the Horton may have knock-on effects on anaesthetics,

paediatrics and accident and emergency services. These possible impacts are not covered by this consultation.

Maternity services in North Oxfordshire

15. The consultation contains a clear proposal to make permanent the current temporary withdrawal of consultant obstetric services at the Horton Hospital. The Oxfordshire Joint Health Overview and Scrutiny Committee (HOSC) agreed to refer the temporary closure to the Secretary of State on 2nd February.

16. It should be noted that there are a number of difficulties with the way the information on maternity services is presented in the consultation:

a. Maternity services are not stand-alone as described above. The knock-on effects to other services and any additional community support are not covered. The impact on these services therefore cannot be assessed through these proposals and so a coherent assessment of the impact on local services in Banbury is not possible.

b. There is no clear information in the consultation about the extent to which the OCCG, the two major trusts, the ambulance service, Deaneries (which oversee the training and placement of junior doctors) and primary care organisations have come together with neighbouring services in Northamptonshire and Warwickshire to discuss wider solutions to maternity and related services for the people of Banbury and the surrounding area. This was a key recommendation of the Independent Review Panel in 2008 which did not support the then Oxford Radcliffe Hospitals NHS Trust's proposals to reconfigure services in paediatrics, obstetrics, gynaecology and the special care baby unit (SCBU) at the Horton Hospital.

c. The document also comments on the future of midwifery-led obstetric care in the north of the county, saying that a second consultation will discuss the future of midwifery-led obstetric units in Banbury and Chipping Norton. However these services are excluded from this consultation which makes coherent assessment of maternity services in the north of the county difficult.

Reducing hospital bed numbers across the County

17. The consultation document proposes to close, or make permanent existing closures of hospital bed stock. We understand that this is intended to help prevent admission and also to reduce potentially harmful long stays in hospital through the strengthening of community services. However, reducing bed-stock is a potentially significant issue, as there has been a national and local trend for some time to reduce hospital bed numbers. The UK already has lower numbers of beds than comparable European countries and the evidence is not yet available to conclude that this is an appropriate shift at the scale proposed.

18. Some reduction in bed numbers may be justified if suitable alternatives are put in place in the community in advance of the closures. Because the consultation does not touch on NHS services in the community and general practice, it is not possible to model the impact of this change.

19. At a time when pressures on emergency departments are rising and delayed transfers of care remain a cause for concern, it may be premature to make these changes. It may be more sensible for Oxfordshire to adopt a 'wait and see' policy on this issue until the impact of bed closures proposed in other parts of the country can be properly evaluated.

Stroke Services and Critical Care

20. The proposal to care for a modest number of patients per year in Oxford instead of Banbury (around 100 stroke cases per year and 41 critical care patients) on grounds of improved clinical quality is reasonable taken in isolation. However, again, the concern would be the 'domino-effect' on other services at the Horton, and these are not detailed in the consultation, making it difficult to comment on proposal in its totality.

Disadvantage and inequalities

21. There is little discussion of issues of disadvantage and inequalities in the consultation. Equality of access is touched on, but not inequality in terms of social disadvantage. The Health and Wellbeing Board's independent Commission on Health Inequalities has recently reported and points to high levels of social disadvantage, particularly in parts of Banbury and Oxford. The consultation does not set out how these proposals would be adjusted to reduce inequalities which is a core duty of the NHS.

Adult Social Care

22. The underlying principle in the proposals of care closer to home is an idea we support in principle. However, there are times in the acute phase of an illness or in cases requiring complex care or post-op care when a hospital bed may be the best place to be, followed by appropriate discharge to properly organised support as soon as practicable. Again, the proposals do not contain the detail we would need about community services for us to have a sensible understanding of their impact on adult social care.

23. We cannot model the impact on Adult Social Care without more information about patient flow, i.e. there is no modelling included that reflects the assumptions made about patients' expected length of stay or their acuity, so we cannot translate bed numbers into estimates of patient flow and the impact on adult social care.

24. *Workforce*
The proposals assume a free flow of health and social care staff and the proposals do not address clearly the significant and unique workforce challenges in Oxfordshire.

25. The Council estimates that the 15,000 strong adult social care workforce needs to grow by up to 750 jobs per year to 2025 just to keep pace with rising demand from our ageing population (this figure excludes workforce turnover which increases significantly the gap between workforce supply and demand). This growth rate is higher than the national average reflecting local demography, and is not helped by the county's very low unemployment rates and high average house prices. Increasing demands as assumed in the proposal, coupled by a shift of care into the community, are likely to significantly increase this figure but the lack of detail in the document means we cannot estimate the level of increase.

26. Whilst Adult Social Care has been a key partner in the development of the Discharge Liaison Hub and initiatives designed to 'rebalance the system' and reduce delayed transfers of care, these were predicated on the transfer of healthcare staff into the community which proved to be more difficult to achieve than originally envisaged. Should further proposals come forward to describe new ways of providing community support through NHS staff, it will be important to ensure in advance that staff are willing to work in community settings.

27. *Impact on carers*
The proposals make no reference to the impact of the proposals on family carers and this must be considered as a deficiency in the consultation.

Children's Services

28. The consultation proposes that the Horton Hospital will have the capacity to care for 200-500 women per year in labour in a midwife led unit. Compared with previous numbers of births at the Horton we can therefore anticipate that approximately 1000 additional births will occur in Oxford or out of county.

29. Not all of these mothers are Oxfordshire residents, but for those who are amd are referred to our social care service, social workers in Oxfordshire's north assessment team would need to travel to assess mothers and/or conduct strategy meetings. In addition, the Oxford social care team may need to take on additional work. This is hard to quantify but may put further pressure on services already struggling to meet demand and lead to higher caseloads and impact on increasing social worker recruitment difficulties.

30. This means that if mothers use other hospitals across county boundaries there may be difficulties managing cases across these borders with processes being less well integrated.

31. In summary, due to the splitting of the consultation into two phases we do not currently have the full picture of future maternity and children's services in the county and cannot therefore fully assess the impact on the Council's children's services.

Planning and Infrastructure

32. 100,000 new homes are needed within Oxfordshire in the period 2011-31, of which around 85,000 remain to be built. The NHS's proposals need to be developed as an integral part of this growth to ensure that health provision is coordinated alongside areas/corridors of growth and infrastructure provision, particularly transport.

33. This should take full account of the scale and location of new housing being planned for in existing/emerging Local Plans and the locations of likely future growth. Consideration should then be given to how the resulting increase in population will impact on demands for health services. This will no doubt include the need for new facilities and a rationalisation of old ones. The phase one proposals do acknowledge this but it is unclear if the full potential impact has been taken fully into account.

34. The proposals will clearly lead to changes to travel patterns for patients, staff and visitors. Whilst some figures are provided on travel pattern changes, the total, combined effects of all the proposals are not quantified. Some of the proposals would reduce the number of patients, staff and visitors needing to travel to Oxford for healthcare services, whilst other proposals would appear to increase that number.

35. Car parking at the hospital sites is generally used to its full capacity already and the residential areas around the hospitals have controlled parking zones. Unless there were an increase in the amount of car parking provided, which county council officers would advise against, additional trips would have to be made by an alternative mode. The proposals make no reference to this.

36. The document proposes a significant move of outpatient and day case work to Banbury. This presents a challenge to the existing highway infrastructure as problems in the town would compromise access to the Horton were it to experience such an increase.

37. These proposals will have some impact on the overall NHS estate. As a community leader with a large property portfolio we are currently undertaking a series of 'place reviews' to identify opportunities to make better use of our assets and join up with other partners. We would encourage the NHS to actively join in this process to identify ways we can deliver services in a more joined up way.

38. We would propose to invite NHS partners to participate fully in detailed discussions about planned growth through the masterplanning exercises that we are undertaking. Given the lack of detail about implications on Oxford and Banbury in terms of increased/decreased journeys we would encourage the relevant organisations to engage with us as the highways authority over travel plans.

Summary

39. We welcome the opportunity to comment on this consultation document and to continue to work with NHS colleagues on shaping future services for the county. The NHS faces serious challenges and its services interlock with many services provided by the Council. It is therefore useful to have concrete proposals to debate through a full public consultation. In summary the views of council officers are:

A. It is difficult to assess the proposals as we only have a partial picture of future services in this first phase. The lack of information about community services and general practice services means that the impact on council services cannot be accurately quantified. This applies to council services across the board from social care to highways.

B. It is not clear that the substantial growth forecast for the county has been fully considered in the development of these proposals and it is key concern of officers that the changes may lead to an inadequacy of provision in the future.

C. The proposals to reduce hospital bed numbers permanently at this scale seem premature without being specific about the strengthened community services which would be needed and it is suggested that a 'wait and see' policy is adopted pending national evaluation of similar schemes.

D. The document does not give a sufficiently comprehensive vision for the future of services at the Horton Hospital and in particular to maternity services in the north of Oxfordshire, and so, again, it is not possible to draw firm conclusions about the future overall 'shape' of the Horton or the impact on council services in the north of the county from the information presented.

Recommendation

40. The Cabinet is **RECOMMENDED** to

- Welcome the opportunity to comment on this consultation, acknowledge the difficulties faced by NHS services locally as presented in the OCCGs case for change, but on balance not to support the proposals based on the lack of information on the impact on council services.

- Present its views and the officer's assessment to the Oxfordshire Health Overview and Scrutiny Committee meeting on 7 March 2017.

- Present a report on its views to the County Council meeting on 21 March 2017 to gather further comment.

Report from the Council Leadership Team
Contact Officers: Senior Policy Officer, Claire Phillips
February 2017

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A Joint Cherwell District Council/South Northamptonshire Council Submission to the Oxfordshire Joint Health and Overview Scrutiny Committee Meeting on 7 March 2017

A Review of the Oxfordshire Clinical Commissioning Group's Big Consultation Stage 1 Process

Thank you for the opportunity to present the views of Cherwell District Council (CDC) and South Northamptonshire Council of the Oxfordshire Clinical Commissioning Group's (OCCG) Big Consultation process. These will hopefully contribute to the Committee's review of the stage 1 consultation process.

As the Committee have heard previously, CDC has a number of very real issues underpinned by the huge and widespread concern of local people from North Oxfordshire, South Northamptonshire and South Warwickshire about the two stage consultation process and the proposals for service change at the Horton General Hospital (HGH).

The Councils acknowledge the challenges faced by the NHS and as a consequence the need for change. Some of the stage 1 proposals are sound in principle eg acute stroke services and planned care and but the benefit of these is somewhat lost in a flawed consultation process. Whilst the Councils welcome the opportunity to contribute, they believe that the split consultation process is flawed sufficiently for it to be halted. This is due to a confused and unclear two stage process, incomplete information, inconsistency with the pre consultation engagement process and inadequate service implications and options analysis. As a consequence, the Council urges the Committee to request an alternative single comprehensive whole system consultation process.

There are many aspects to this complicated process which the Council requests the Committee to consider in its review of the stage 1 consultation exercise. These have been considered by the Councils and grouped into three - consultation process concerns, concerns over some of the stage 1 proposals and further general issues.

1. Consultation Process Concerns

Confused and unclear two stage consultation process

The two stage process has a number of interdependencies and whilst stage 1 concentrates on the HGH, the overall service make-up of the HGH cannot be determined until well after the end of the unspecified date of the second stage consultation. Because of the way the proposals are structured and that community and primary care services are not detailed in the stage 1 consultation, it is not possible to see an overall proposal for the future make up and functions of the HGH and its relationship with the wider health and social care sector.

In addition, there are several stage 1 proposals which are influenced by and will influence the stage 2 content. This therefore does not lend itself to informed and intelligent consideration which is a fundamental requirement of consultation.

To demonstrate this confusion, the following draws out the stage 1 and 2 linkages

- Maternity at the Horton is in stage 1 of the consultation but Maternity Led Units (MLU) is in stage 2. Surely it makes far more sense to consider the whole maternity service together so that consultees can understand the Oxfordshire wide picture?
- It is unsatisfactory to split obstetrics in stage 1 from paediatrics in stage 2 in view of close working relationship between the two disciplines. The same argument could apply to obstetrics and accident & emergency (A&E) as both are dependent on anaesthetic services so should be considered together.
- The changed use of acute hospital beds which also requires increasing care closer to home is in stage 1 but community hospitals which should feature in care closer to home solutions are in stage 2. This difficulty is compounded by the absence of proposals concerning primary health care which would have to be the principal means of reducing the rates of attendances at emergency departments and possibly the rates of emergency admissions.
- Planned care away from Oxford is in stage 1 but community hospitals which should logically be part of community based diagnostics and outpatient services are in stage 2.
- The principle behind the change to acute stroke care is sound but this is in stage 1 when the model for the early supported discharge/rehabilitation service for stroke patients is in stage 2 and includes the provision of community hospital inpatient services and the HGH.

Lack of understanding of a whole HGH service

The two stage consultation process is inconsistent with the pre-consultation engagement exercise undertaken by the OUHFT where despite the unpalatable nature of the emerging proposals, at the very least the HGH was being considered as a whole. In this way, the inter-relationship between the different clinical services, so vital for a general hospital, could be understood and seen as a whole. Now we are faced with a disaggregation of services through this two stage process where the clinical inter-relationships are broken. This is wrong and unacceptable.

Unavailability of all relevant consultation documents

The pre-consultation Business Case is a substantial 235 page document which has 30 appendices listed to support its content. As of 22 February 2017, over five weeks after the consultation process commenced, none of these appendices have been made available on the OCCG Big Consultation website. The Council has had to request copies directly and even then, was told that they are very bulky and difficult to send electronically. To date, only those appendices specifically requested have been made available and despite a request that all 30 be placed on the OCCG website, this has still not occurred. This appears to be an attempt to restrict the availability of relevant consultation information

Cross boundary issues and unclear effects for patients in South Northamptonshire and South Warwickshire

At the Oxfordshire Joint HOSC meeting held in November 2016, the Committee stated that the geographical detail should be easily identifiable so that the public can be clear about proposed changes to services in their locality. This has not occurred with the degree of clarity which is required.

There has been an inadequate consideration of a whole system approach to cross boundary issues. Banbury is less than two miles from both Northamptonshire and Warwickshire which means that a very significant proportion of the 170,000 users of the HGH come from outside Oxfordshire. Whilst there appears to have been dialogue between the acute service providers of the three county areas, we are informed that only recently has there been dialogue at the commissioning, STP, primary care and social care levels. This is too little and too late and should have been undertaken before the consultation process commenced so that clarity for affected patients could be provided.

This is an important issue as the patient flow to and from the HGH requires a whole system approach for planned care, early supported discharge service for stroke rehabilitation and changing the way hospital beds are used all of which are in stage 1. The proposals and their implications for all current patients have not therefore been properly considered which means that when residents affected by these proposals ask questions about the implications for them, the answers are either unclear or not available.

Specific examples of the lack of clarity include the following

- The consultation proposal to increase planned care at the HGH appears to apply to Oxfordshire residents only as there is consistent reference to North Oxfordshire only in the main consultation document. It is therefore uncertain whether those patients from outside Oxfordshire who previously travelled to Oxford for their planned care can in future still receive this at the HGH.
- The proposal to take immediately all patients diagnosed with acute stroke to the Hyper Acute Stroke Unit in Oxford and the extension of early supported discharge service also appears to be applicable to North Oxfordshire residents only. This is unclear for South Northamptonshire and South Warwickshire residents currently served by the HGH as the consultation document states that *'those in North Oxfordshire who are closer to Northampton or Coventry Hospitals would be taken there'* which implies all South Northamptonshire and South Warwickshire residents will not use the Oxfordshire acute stroke services in the future and some North Oxfordshire residents would also be taken elsewhere.
- Uncertainty is further reflected in the proposal for the level 3 critical care patients where they will be taken to Oxford whereas *'patients living in South Northamptonshire and South Warwickshire might be treated at the critical care units in hospitals in Warwick, Northampton or Milton Keynes if closer*'.
- The proposal to undertake all obstetric services at Oxford with a MLU only unit retained at the HGH includes the statement that '*women north of Oxfordshire also having the choice to travel to Northampton, Warwick or Milton Keynes'.* This is clear for South Warwickshire patients who currently use or had intended to use the HGH but not at all clear for South Northamptonshire patients who have the HGH as their closest hospital or are equidistant with Northampton and Milton Keynes or even closer to the John Radcliffe Hospital (JRH) than those hospitals. It should also be noted that the JRH is closer for Brackley residents than for Banbury residents.

Such lack of cross boundary clarity is causing confusion and undermines the stage 1 consultation process.

Misleading maternity information

No information is provided to consultees to inform them as to what higher risk pregnancies actually means. Young people and future first-time parents reading the Big Consultation document are likely to think that “higher risk pregnancies” refers to only a very small number of births. The consultation document states that “most women have a low risk pregnancy and are cared for by the midwifery teams during the antenatal, labour and postnatal period”. In this context where a MLU is proposed for the HGH, it is misleading to say that “most women … are cared for by the midwifery teams during … labour”. A substantial proportion (c40%) of births involves epidurals which cannot be done at a MLU which means that all women who have or want an epidural will have to travel to the JRH. The key point here is that most women who wish to have an epidural would not consider themselves to be “higher risk”. This has not been explained in the consultation documents.

When the HGH had an obstetric service last year, there were approximately 120 births per month there. Between 3 October 2016 and 31 January 2017 there have been 61 planned births at the MLU. Further, of those 61 births planned to take place in the HGH MLU, 24 of them had to be transferred to the JRH during or immediately after labour. Thus, the numbers actually using the HGH MLU only are very small indeed. The Big Consultation document does not convey the proposed radical change in localness of services, i.e. when HGH had obstetrics services around 120 women gave birth in that local hospital each month, whereas without an obstetric service the experience of the last few months indicates that less than 10 women will give birth solely in HGH’s MLU each month. That means that of local women who could previously (prior to the suspension of obstetric service) give birth at the HGH, if the proposal in the Big Consultation is implemented, over 90% of those local women will not be able to give birth there. The Big Consultation document does not give that impression at all and is therefore misleading.

The experience of 39% of current HGH MLU mothers and babies who need emergency transport to Oxford also supports the retention of the 24 hour ambulance service at the HGH which is said to be under review.

Insufficient implementation detail and incomplete business case

There is no clear timeline of events if these stage 1 proposals are implemented to ensure that the chaotic parking arrangements at the Oxford hospitals will be resolved before the further proposed transfer of acute services to Oxford and ahead of any planned care improvements elsewhere in Oxfordshire.

The current car parking provision at the HGH is often at capacity and therefore offering an additional 90,000 patient appointments to the HGH will require additional car parking provision at the site for c 350 cars daily. There is no evidence or clarity in the pre-consultation Business Case that funding for this requirement has been provided. This means that the stage 1 Business Case is incomplete.

Likewise, there is no evidence or clarity in the pre-consultation Business Case that funding has been allocated for improved car parking to address the current chaotic and unacceptable situation at the JRH.

2. Concern Over the Stage 1 Consultation Proposals

No overall plan or coherence for the HGH

There is no overall plan and vision for the HGH which the public can understand. The consultation statement regarding 'fit for the 21st century' and 'investment' is too generic as it does not say what this means in terms of actual services at the hospital which is what the public needs to know. The two stage process confuses this further as it is clear that the future range of services delivered from the HGH cannot be determined until well after the end of the second stage consultation whenever that is.

Lack of evidence and rigour in finding an alternative obstetrics model

The Oxford University Hospitals Foundation Trust (OUHFT) has not considered with sufficient rigour an alternative obstetric model which integrates fully the JRH and HGH operations to overcome the loss of training accreditation. It repeatedly hides behind the 2,500 births training accreditation threshold issue. However, whilst the threshold in itself should be challenged, it should be acknowledged that the withdrawal of training accreditation was a combination of not only birth numbers at the HGH but other training regime requirements which were sub-standard at the time accreditation was removed.

There are several small birth number obstetric units in England comparable to the c1,400 births at the HGH. As the Royal College of Obstetricians and Gynaecologists 2015 Census indicated, there are several English maternity units with around or below 2,000 births pa and still training junior and usually middle grade doctors. It should be noted that none of these hospitals in England support years 6 and 7 of higher specialist training, but all support years 1 to 5. Where they train only junior doctors, these are indicated with *. Those which are part of larger NHS Trusts with maternity units elsewhere are marked +.

Maternity Unit	Birth number (rounded)
Epsom General +	1900
East Cheshire	2100
Princess Royal, Haywards Heath +	2000
Dorset County, Dorchester	2200
Yeovil District	1500
George Eliot, Nuneaton	2000
Alexandra, Redditch +	1900
Hereford County	1700
Airedale	2250
Bassetlaw District +	1500
Harrogate District	2100
Scarborough +	1600

There are also other such units which are under pressure for amalgamation or closure. It is acknowledged however that this picture is changing with the advent of STPs. Those identified to date are:

Furness General +	1200
West Cumberland +	1250

South Tyneside	1300
Barnstaple District	1650

In addition there are 10 units in Wales, Northern Ireland and Scotland with annual birth numbers under 2,000. It should be noted that none of these hospitals support years 6 and 7 of higher specialist training, but all support years 1 to 5.

Therefore, there is evidence of small birth units of less than 2,500 births sustaining their training whether as part of larger trust or fee-standing. This picture also calls into question the consistency across the country of the application of birth units having to have 2,500 births minimum to be considered for training accreditation.

The Council questions the resolve within the OUHFT to really explore with vigour a fully integrated single obstetrics service operating across the HGH and JRH sites made up of a large number of consultants and middle grade doctors with a high class training ethos delivering a minimum of 7,500 births per year. This needs to be the basis of challenge to the Health Education England assertion of the 2,500 site based training accreditation birth minimum in order to retain local HGH obstetric services for the residents of North Oxfordshire and surrounding areas.

This approach is also supported by the fact that the Council believes that the OUHFT has not considered sufficiently the number of North Oxfordshire and surrounding births. The Council has examined the current and significant increase in future population projections, made some conservative assumptions and built in a modest quantum for West Oxfordshire, South Warwickshire and South Northamptonshire. This leads to the conclusion that there could be close to 2,000 births now and c2,500 by 2021.

This means that the OUHFT with the international status and size it has, can if so minded make a strong Oxfordshire case for an integrated obstetrics model across the JRH and HGH.

Incomplete proposals for planned care

The proposals for increased planned care at the HGH in principle are welcomed especially given that an estimated 90,000 planned care episodes for the people of North Oxfordshire can take place at the HGH thereby avoiding a long and tortuous journey to Oxford. This of course also has the added benefit of potentially reducing the congestion and car parking difficulties at the Oxford hospitals but no information has been made available to assess the extent to which this would benefit the car parking chaos at the JRH in particular.

What is of concern however is the lack of implementation detail in relation to the critical issue of timing of the investment for car parking to avoid creating another car parking and congestion issue at the HGH. The lack of clarity and the relevance of this to current patients in South Northamptonshire and South Warwickshire as identified above along with the absence of funding in the pre-consultation Business Case for car parking improvements at the HGH to accommodate such increased use when the hospital car parks are already running to near capacity, is a major concern to the feasibility of the planned care proposals. In addition, there is the uncertainty as to when and whether these proposals would become reality meaning that access

and congestion at the JRH would become even more difficult after services had been transferred there, for a number of years at a minimum.

This proposal whilst welcomed in principle has clearly been rushed, has not been fully thought through and is causing local concern.

Travel time and parking

The geography and transport infrastructure of North Oxfordshire, South Northamptonshire and South Warwickshire particularly to Oxford for secondary healthcare purposes results in excessive travel and car parking time. Public transport options are limited and declining and the peripheral city location of the JRH means that most visitors and patients to the JRH have no option but to travel by car if they have one.

More emergencies and more maternity cases must find their way to the JRH site if the stage 1 proposals are implemented. These will require follow-up and potentially further diagnostics which will make yet more demands on the capacity at the JRH. Access there is significantly worse than it was at the time of the Independent Reconfiguration Panel report in 2008. The City of Oxford road system is massively congested at peak times and since the JRH sits on the periphery of the city, those travelling there must end up going by road, whether by public transport or private car. The County Council's own estimates indicate that travel time for residents of the most deprived ward in Banbury is at least 50 minutes. Those who finally reach the JRH then have the ritual of queuing for prolonged periods to park or sit in the queue in a 'bus, since they are caught in the parking congestion as well. There appear to be attempts, but no clear plans to alleviate this problem.

The travel survey currently underway by Victoria Prentis MP is indicating hundreds of patient experiences averaging between 1.5 and 2 hours for the combined travel by car plus parking from Banbury and surrounding areas to the JRH. Over the past month, 265 people have responded with their recent patient experience. These responses are indicating;

- Current average travel and parking time combined: 1 hour 40 minutes
- Current average travel time: 1 hour 25 minutes
- Average parking time: 15 minutes (but parking time does vary significantly from 5 minutes, to up to 60 minutes)

The expectation for additional North Oxfordshire patients to travel to Oxford is therefore unreasonable on travel grounds alone.

Implications of the Banbury deprivation demographic

Regrettably, there are neighbourhoods in Banbury which according to national indicators and census information are regarded as deprived and in which there is clear evidence of poorer health and higher care needs. The CCG correctly state that the BME population in Banbury which is higher than the national average is more likely than the general population to suffer stroke and obstetrics complications and are more likely to need to give birth in an obstetric unit. Yet it is these very services which are being eroded at the Horton. Reference is made to meeting the Public Sector Equality Duty but the statement regarding the Oxfordshire Health Inequalities

Commission's report is out of date, there are no assessment of these proposals on vulnerable and poorer Banbury families as a whole as a consequence of the recent significant public transport cuts and no evidence of having taken into account in the stage 1 proposals these specific demographic and health needs of Banbury.

The detailed equality impact assessments for the stage 1 proposals were one of the 30 appendices which the OCCG has only recently issued to the Councils. In it, again reference is made to the BME population in Banbury which is more likely than the general population to suffer stroke and obstetrics complications. However, no attempt appears to have been made to consider the specific implications of this in the proposals other than targeted pre-conceptual care. The issue is merely acknowledged but the full implications not sufficiently addressed. This is not good enough for local people and needs to be reconsidered.

Likewise, the majority of the equality impact assessments make no acknowledgement of the greater concentration of health related deprivation, the higher levels of disability, the higher levels of emergency hospital admissions, the higher levels of people 10 to 64 and over 65 with limiting long term illnesses and the higher levels of poverty in parts of Banbury. All these aspects affect the demand for local healthcare services and access to them. Only one equality impact assessment (acute care) adequately acknowledged the detrimental impact to those who unfortunately have greater healthcare needs than most and identified measures which could assist. However, these measures do not feature in the consultation proposals.

3. General Concerns

Previous Independent Reconfiguration Panel (IRP) recommendations

The IRP in 2008 concluded that transferring obstetric, paediatric (including special care and emergency gynaecology services) did not provide an accessible or improved service to the people of North Oxfordshire and surrounding areas. Since that time, travel and access to the JRH has become even more difficult. The current proposals being considered will offer worse services to patients in the HGH's 170,000 catchment.

The IRP determined that these changes were being driven by "future medical staffing constraints not by providing a better service for local people" which is where we are today, the only difference being that removing Level 3 critical care and hyper-acute stroke have been substituted in the first round for general paediatrics.

The IRP also recommended that the OUHFT and the then PCT carry out further work to determine the service arrangements and investment needed to retain and develop services at the Horton, develop a clear vision for children's and maternity services within an explicit strategy for services for north Oxfordshire and to develop clinically integrated practice across the Horton, JRH and Churchill sites as well as developing a wider clinical network. The provider and commissioners in Oxfordshire have in these proposals ignored these recommendations which have contributed to the argument that some services at the Horton are unsustainable.

Piecemeal removal of acute services from the HGH

There has been a gradual erosion of acute services at the HGH no better exemplified by the piecemeal loss of bed and service reductions which have already occurred. Local people see the two stage consultation process as a continuation of this piecemeal erosion.

2011 G ward - 12 beds gynaecology and breast surgery.

- This became day case (gynaecology only) as it was argued that 2/3 beds were usually taken up by overflow patients from other specialties. 4 beds were allocated on E ward for gynaecology patients needing an overnight stay.

2013 + E Ward - 18 general surgery beds (4 of these for gynaecology) and 6 day case

- Sometime from 2013 onwards, this ward became day case only at the time of cessation of emergency general surgery in January 2013.

2016 F ward - 25 trauma beds closed

- Oak ward had 36 general medical beds converted to 18 trauma, 18 medical but the medical beds were for short stay only which meant the loss of 25% of standard beds for general medicine.

Local concern is compounded by the pre-consultation engagement process where the OUHFT adopted a sensible whole hospital approach which resulted in three emerging but largely downgrading service options for the HGH. Options 2 and 3 proposed a range of different and largely downgraded services levels which are consistent with the stage 1 consultation proposals. Local people are therefore expecting this consistency to feature in stage 2 for A&E and paediatric service in particular which will further undermine the acute care capability of the HGH.

Despite the OCCG arguing that none of the removal of acute services in the stage 1 proposals will undermine any of the remaining services, there is a very real likelihood that the HGH A&E and possibly paediatric services will also go, either undermined by the reduction in acute services at the site proposed by stage 1 or by the threat to their continuing viability caused by the prolonged uncertainty created by the two stage consultation.

To make matters worse, the OCCG Chairman at the Oxfordshire Joint HOSC meeting on 3 February 2017 stated the need to look at all acute services together. Clearly such a statement applies only to the JRH element of the stage 2 consultation process and not the acute services at the HGH or Oxfordshire as a whole. This is both wrong and unfair.

A&E capacity

The consultation document refers to the success in reducing acute beds in OUHFT by 194, principally by systematically placing patients fit to leave hospital in care homes and their own homes. However, the health system has had extreme difficulty since the New Year in accommodating emergency admissions and coping with attendees at A&E departments. Without radical changes to primary care and in

social care there is no reason why the year on year increases in people presenting for acute emergency care will not continue. The stage 1 consultation proposals therefore make this position worse.

Conclusion

The stage 1 consultation therefore is deeply deficient in several respects:

- It offers no clear picture as to the services residents of North Oxfordshire and surrounding areas can expect in the future, only stating what it is proposed they will not have.
- It contains misleading and inadequate information which is causing confusion, heightened concern and is undermining the effectiveness of the consultation process.
- It leaves other acute services at HGH weakened and open to fail or to be withdrawn at some time in the future
- It does not address the fact that nothing will happen for the foreseeable future about reducing demand for acute hospital services, but instead offers a few ambitious statements about primary health care being the "backbone" of the service without the benefit of any plans as to what is to be done to stiffen the backbone and have it absorb demand
- It makes access worse at the JRH site which the IRP in 2008 found was even then insufficiently accessible to local residents
- It demonstrates a lack of will to find a better obstetrics solution for the HGH and Oxfordshire as a whole.
- It displays a degree of contempt for consultees by asking them to state preferences for planned care service at HGH when there are no full plans or inadequate capital to put them into effect. This of course means that the problems of access at the JRH will be present for years to come.

Cherwell District Council calls on the Oxfordshire Joint HOSC to;

- **Halt the stage 1 consultation process and call for a whole system Oxfordshire wide consultation to occur which includes cross boundary clarity for patients;**

- **Halt any further loss of hospital beds in Oxfordshire until the whole system consultation process has been completed which should include a realistic assessment of future A&E demand; and**

- **Task the OCCG with a rigorous and comprehensive appraisal of a fully integrated JRH and HGH obstetric service and to challenge robustly the 2,500 birth limit per site based on inconsistent nationwide application, patient safety and a world class integrated two site training regime.**

Cllr JEANETTE BAKER
Portfolio Holder for Leisure, Health & Tourism
Telephone: 01993-861000
Fax: 01993-861450
E-mail: jeanette.baker@westoxon.gov.uk

Council Offices
Woodgreen,
WITNEY,
Oxfordshire,
OX28 1NB
Tel: 01993 861000
www.westoxon.gov.uk

WEST OXFORDSHIRE
DISTRICT COUNCIL

Chair Cllr Yvonne Constance & Committee Members
Health Overview & Scrutiny Committee
c/o Katie Read, Policy Officer
Oxfordshire County Council
County Hall
New Road
Oxford
OX1 1ND

Our Ref: JB/MS

21 February 2017

Dear Cllr Constance & Committee Members

Scrutiny of the Oxfordshire Health and Care Transformation Phase 1 Proposals

This Council recognises and supports Oxfordshire Clinical Commissioning Group's (OCCG) aspiration, through its Transformation Programme, to improve services and find ways to enable local people to easily access the services they need while demand for these services is rapidly increasing. We also recognise that West Oxfordshire will experience a significant increase in demand over the next few years as its population increases. Furthermore, West Oxfordshire will also have proportionately more older people for whom travel to the JR is difficult. We therefore fully support the aspiration within the Programme for more services to be available to people closer to their homes, including improved diagnostic and specialist provision.

In light of this, our response for HOSC consideration to the STP phase 1 proposals is as follows:

1. Community Hospital provision

While there is no proposal for reducing the services available at Witney Community Hospital within the Phase 1 consultation, the proposals for centralising acute stroke care at the HASU at the JR as well as level 3 critical care, make the provision of intermediate and rehabilitation services at Witney Community Hospital and The Horton General Hospital vital so that West Oxfordshire residents can access services close to their homes. In light of this, we will be responding to the consultation making it clear that we would ONLY support the proposals set out on the understanding that:

- there would be NO reduction of care in West Oxfordshire put forward in STP Phase 2 proposals.
- STP Phase 2 proposals include an increase in parking availability at the JR that at least matches the number of increased visits there will be to specialist services centralised at the JR as part of the Phase 1 proposals.

2. Maternity and first aid provision

Given the developments coming to West Oxfordshire, including increased numbers of homes, as well as increases in population in North Oxfordshire, we strongly support the continued provision of a midwife led maternity unit in Chipping Norton. Furthermore we would not support the removal of the First Aid Unit at Chipping Norton if this is proposed in Phase 2. There MUST be recognition that while we understand that centralisation of specialist functions can enable effective use of resources, it is not reasonable to expect people in rural areas to travel into Oxford for routine and less serious conditions.

Maintaining both maternity provision and first aid provision will go some way to enabling residents, particularly West Oxfordshire's fast growing elderly population, to access services reasonably close to their homes.

3. District Council involvement in STP development

We feel strongly that the process regarding such fundamental changes to the healthcare of our residents should be open and transparent. While we appreciate the current Phase 1 consultation opportunity, we feel strongly that as a Council and key partner we have not played a full enough part in the development of these proposals. We have attended information sharing events with other stakeholders, but have not been able to input sufficiently on the needs and issues particular to our district and our residents.

District authorities are closely linked to their local communities including town and parish councils. We run a great deal of services to support our local residents, we set out proposals for growth in the district and we offer financial support to third sector organisations that offer a wide range of health and wellbeing services to our local residents.

In light of all this, we hope we will have a greater opportunity to participate more fully in the development of phase 2 proposals and ensure they link with local needs and aspirations. To this end we would like consideration to be given to the addition of District authorities to the STP Board.

Yours sincerely

JG Baker

CLLR JEANETTE BAKER
Portfolio Holder for Leisure, Health & Tourism

Northamptonshire County Council

Cllr Yvonne Constance OBE
Chairman Oxfordshire Joint Health Overview &
Scrutiny Committee
Oxfordshire County Council
County Hall
New Road
Oxford OX1 1ND

Please ask for: Jenny Rendall
Tel: 01604 367560
Our ref:
Your ref:
Date: 20 February 2017

Dear Councillor Constance

Re: Scrutiny of the Oxfordshire Health and Care Transformation Phase 1 proposals

In response to your recent letter regarding the above, I have discussed this with a member of the Northamptonshire County Council's Health, Adult Care and Wellbeing Scrutiny Committee who lives close to the borders with Oxfordshire and therefore both he and his constituents are affected by these proposals. Our comments are as follows:

- The Sustainability and Transformation Plan (STP) is split into 2. Consultation times, dates and locations were quite inaccessible with only one held in South Northamptonshire mid-morning on a Monday and none on at a weekend so working people would have found it difficult to attend.

- The consultation appears to be overly focused on Oxfordshire with Northamptonshire and other areas being of secondary concern despite many users of Oxfordshire Health Services living in the surrounding areas. Also communication on the consultation was not considered to have been adequately wide. For instance, Milton Keynes had not been consulted despite their hospital being suggested as having capacity for residents alongside other hospitals such as Northampton General and the Royal Berkshire.

- Regarding the plan to downgrade the Horton Hospital in Banbury: This is considered to be ill-advised at a time when Banbury and the surrounding villages are growing rapidly. There are plans to build 30,000 more houses in the Cherwell District of North Oxfordshire which is taking place without any improvement in the infrastructure there will inevitably be further journey delays resulting in missed appointments and a waste of doctors' time. Added to this are the new houses

Northamptonshire County Council
Democratic Services
Room 144 County Hall
Northampton NN1 1DF
w. www.northamptonshire.gov.uk
t. 01604 367560
f. 01604 236223
e. Jrendall@northamptonshire.gov.uk

being built in the part of South Northamptonshire where people use the Horton as the nearest hospital. Plans need to be future proof to take account of the growing population throughout the area.

- Apart from the distance from the Banbury area, parking at the John Radcliffe Hospital in Oxford can be difficult sometimes taking as long as an hour to park. Any further increase in the number of cars would make it impossible. 'Park and Ride' is an option but not really for expectant mothers, the elderly or disabled.

- In the event of a reduction in the facilities at the Horton Hospital Northampton would be an alternative to the John Radcliffe but this is 30 miles from the villages in the extreme South of this county. Factors like this could considerably increase the pressure on the ambulance service.

- Although I appreciate that some specialized treatments can be provided only by main hospitals such as the John Radcliffe I consider that it is essential that everyday healthcare, such as maternity, A&E, and general surgery, to continue to be provided at the Horton. Horton Hospital had been previously discussed by an independent reconfiguration panel in 2008 which felt changes to obstetrics would damage accessibility of services. Emergency situations cannot be properly addressed by having to travel to Oxford particularly at peak traffic times and it is inevitable that delays will have tragic consequences.

- There had been inadequate consideration to 'low risk mothers' who developed complications. Examples given include umbilical cords around a baby's neck, emergency caesareans and low oxygen supplies.

- One reason why it is proving difficult to recruit consultants and doctors to serve at the Horton is self-induced by the fact that the Oxford University Hospital Trust continually suggest that there may be no long term future for them at Banbury.

I trust this is of assistance.

Yours sincerely

Councillor Phil Larratt
Chairman – Health Adult Care & Wellbeing Scrutiny Committee

VICTORIA PRENTIS MP

Cllr Yvonne Constance
Chairman
Joint Health & Overview Scrutiny Committee
Oxfordshire County Council
County Hall
New Road
Oxford OX1 1ND

22 February 2017

Dear Yvonne

Further to your recent letter, please find enclosed my comments on the Oxfordshire Transformation Programme Phase One consultation. I am grateful for the opportunity to put forward a written submission to be circulated to all members ahead of your special meeting at the beginning of March.

Yours

Victoria

Victoria Prentis MP

Westminster Office
House of Commons
London
SW1A 0AA
Tel: 020 7219 8756

Constituency Office
Heyford Park House
Upper Heyford
Bicester OX25 5HD
Tel: 01869 233 685

Online
victoria.prentis.mp@parliament.uk
www.victoriaprentis.com
@victoriaprentis
www.facebook.com/victoriaprentis

Submission to JHOSC regarding Oxfordshire Transformation Programme Phase One consultation by Victoria Prentis MP

1. Process

1.1. The Committee is aware of the concerns held by myself and my colleagues about the splitting of the consultation into two parts. As was made clear in our letter dated 16 November 2016, I feel very strongly that the public should be able to understand and respond to the plan put forward in its entirety. The Clinical Commissioning Group may have been asked by HOSC to consult on some of its proposals, but in my view any service change could have been paused until the complete Transformation Programme document was prepared. By splitting the consultation in two, the clarity of the plan has been diluted and become confused.

1.2. The Pre-Business Consultation Case quite clearly states that the Transformation Programme "is taking a collaborative 'whole system' approach which recognises the interdependencies between primary, community and acute care." Despite this, and having looked closely at the Phase One consultation document, it is clear that it is impossible to understand the full implications of the proposals without knowing what will be put forward in Phase Two.

1.3. For example, while my constituents may welcome increased chemotherapy and dialysis services at the Horton, they are not given any indication of the potential impact this may have on the provision of other services at the hospital. Moreover, it is suggested that community hospitals will play a part in the proposed changes to acute stroke services. Yet the future of our community hospitals will not be looked at until Phase Two. It is extremely difficult for my constituents to be asked to respond to the consultation in this piecemeal fashion.

1.4. I also remain deeply concerned about what level of involvement other health providers in surrounding counties have had in drawing up and being consulted on the plans.

Hospitals in Northampton, Coventry, Warwick and Milton Keynes are all mentioned in the document. I have been told that conversations have been had with all interested parties. However no evidence has been provided to demonstrate that this is the case. I know that my Parliamentary colleagues in the relevant constituencies have not been contacted about the proposals and their potential impact on service provision in their own area.

1.5. Other elected officials from surrounding areas have also been left in the dark. I have been told by a councillor in Warwickshire that his Overview and Scrutiny Committee invited the Oxfordshire Clinical Commissioning Group to a meeting to hear about their Transformation Programme plans. The Committee did not receive a reply. I have sought assurances from those overseeing the Transformation Programme that they have liaised with surrounding areas but this simply does not seem to be the case.

2. Content

2.1. The consultation document is inconsistent. In Dr McManners' foreword he states that:

> *"in this document you will find proposals for changes to the following services: changing the way we use our hospital beds and increasing care closer to home; planned care services at the Horton General Hospital; acute stroke services; critical care, and; maternity."*

2.2. This statement implies that proposals for critical care and maternity are Oxfordshire wide when they only relate *specifically* to the Horton General Hospital. As a result, Dr McManners' foreword is confusing and unclear. It is just one example of a lack of attention to detail.

2.3. The Second Addendum contains questions, comments and assurance points raised by NHS England. Comment P10 states:

"In line with formal advice from Capsticks (November 2016, section D) an initial long list of all potential options that has been reduced through application of relevant threshold/evaluation criteria is 'needed for the public consultation to show full and proper consultation of options to the public. It should also indicate, briefly, why certain options have not been proceeded with.' This information is not included in the consultation document, so reference to where this information is/how people can access it, could be included as a signposting mechanism."

2.4. The CCG's response to this is that there is only one viable option for critical care and stroke, and that it is no longer able to deliver obstetrics at the Horton General Hospital. This is simply not good enough. The consultation document should at least set out the possible options and those that were explored so people can make an informed judgment. Even if the section of the Pre-Consultation Business Case is used to fulfil this criteria, it is not signposted clearly in the consultation document. In my opinion it does not adequately satisfy the advice from Capsticks.

2.5. In only presenting preferred options it is impossible for my constituents to make an educated and informed contribution to the engagement exercise. The Pre-Consultation Business Case may have been provided to supplement the main consultation document but the length (235 pages) is prohibitive to the majority. As it stands, the consultation document presents a fait accompli.

2.6. It is impossible to undertake a proper assessment of the proposals when the evidence base is lacking. While the document recognises the changing demographic, there is no proper analysis of the growth figures for our area versus the number of beds needed.

2.7. While I accept the premise that people are broadly better out of hospital, there will always be circumstances when frail older people need a hospital bed. It is essential that they receive any hospital care closer to home, where possible, not least because partners and close family members are often elderly themselves and find travelling

difficult. The same group find it hard to engage with consultation exercises such as these.

2.8. *Travel analysis*

2.8.1. Geography and travel times are my principal concerns. The John Radcliffe is too far and inaccessible for many of those living in North Oxfordshire. It is unreasonable to centralise service provision at the John Radcliffe without adequately and properly considering the repercussions for those in the north of the county. I am genuinely fearful that labouring mothers will have no option but to give birth on the side of the road. Using Google Maps and blue light transfer times to justify decisions is misleading, particularly when the majority of those giving birth will travel to hospital in their own private vehicle. Patient safety is paramount.

2.8.2. The travel analysis underlying the assumptions in the consultation document is fundamentally flawed. It is based on average times provided by Google Maps rather than real experiences. No consideration is given to the time taken to find a car parking space or for people to get to the specific department. From the preliminary results of my own travel survey, it is taking those from the north of the county to travel an average of 87 minutes from their homes to the John Radcliffe. On top of this, parking times at the John Radcliffe vary from 10 minutes to 50 minutes, with 9 respondents stating it has taken them 60 minutes to park (based on 274 responses).

2.8.3. Not one of the twenty Oxfordshire Specific Validations used to prove the robustness of the data in the travel analysis is a location within my North Oxfordshire constituency, where the Horton General Hospital is based. I made this point at the Community Partnership Network meeting on 16 December 2016, and reiterated it at a meeting with the Chief Executives and my Parliamentary colleagues on 5 January 2017. At the time, David Smith told me that the data would be changed to include some locations within my constituency. This has not happened.

2.8.4. The Mapping Scenarios provided are confusing. They show the same data for public transport versus private transport but the key varies in each. For example, dark blue on the public transport map denotes 75-90 minutes whereas the same colour is used to denote 50-60 minutes for private vehicles. Meanwhile, the two tables with the Oxfordshire Specific Validations are meant to show the off peak and peak journey times. However, both tables state the Source columns (3 and 4) show Off Peak travel times. Again, this lack of attention to detail invalidates the underlying empirical evidence used to support the consultation proposals.

2.9. By splitting the consultation and only putting forward a partial vision of health service organisation in Oxfordshire it is not possible to understand how services are interrelated. Insufficient regard is given to the inevitable domino effect. Specifically, removing obstetric services at the Horton General Hospital will have an impact on the future sustainability of the anaesthetics rota, as well as training accreditation of the speciality. A reduced anaesthetics rota will jeopardise all acute services provided at the site. It is disingenuous to not make this clear in the consultation documents, and makes it impossible to properly engage with the exercise.

2.10. *Maternity and obstetric services at the Horton General Hospital*

2.10.1. Despite providing explanations of critical care and acute care in the main body of the consultation document, a definition of consultant-delivered services is noticeably lacking. Pain relief options at midwife-led units versus consultant-delivered units are not explained. The word 'epidural' only appears once in the document, in the glossary on the final page (which is not signposted anywhere else). It does not feature in the Pre-Consultation Business Case. There is no explanation that mothers wishing to have a range of pain relief options available to them – including an epidural – would have to deliver at the John Radcliffe or another consultant-delivered service. Nor is it mentioned that those who choose to have an epidural during labour will have to be transferred. For me, this is a fatal omission and seriously devalues the consultation exercise.

2.10.2. Information about ambulance provision at the Horton in the event of a transfer is noticeably lacking in the consultation document. The Pre-Business Consultation Case refers to a static ambulance situated at the Horton General Hospital. However, at one of the public meetings it was suggested that this would be removed should the service permanently become a midwife led unit. At another meeting attendees were told that it would remain. It is misleading to not mention transfer arrangements to those attempting to understand the implications of any service change.

2.10.3. The Pre-Consultation Business Case mentions that the "maximum time for all the population to reach a suitable hospital by blue light is 31 minutes". However, in my own discussions with the Chief Executive of South Central Ambulance Service I have been that the average time is 41 minutes and 59 seconds. He has also told me that SCAS collect minimal data on blue light transfers. Evidence on transfers is critical, particularly as recent statistics from the Trust indicate that 1 in 4 mothers choosing to deliver at the Horton General Hospital since the unit was downgraded have had to be transferred during labour. Four of these transfers took place after the birth of baby, but before the placenta was delivered. The idea of having to transfer at this stage of labour is horrifying to me.

2.10.4. Capacity at the John Radcliffe and other hospitals mentioned in the consultation document (including Warwick, Northampton General and Milton Keynes) is a serious concern of mine. We have been told that the Horton General Hospital used to see approximately 1500 births per year which is approximately 29 births per week. Since the suspension and up until 31 January 2017, there have been just 61 in total i.e. 3 a week. If this continues, the unit will see no more than 190 births per year. Where the remaining 1310 births take place will have a serious impact on those units the mothers go to. This is before projected population growth is taken into account.

2.10.5. The consultation suggests that the downgrade of the maternity unit is unavoidable because of recruitment issues. However, I remain convinced that the Trust could do more in their search for obstetricians. Offers to help make job

advertisements more appealing, for example by providing school bursaries to the children of obstetricians, have not been explored. Recruitment agencies have not been involved. I also feel that the Trust could have worked more collaboratively with Health Education England and the Deanery to find a creative solution to the training accreditation issue used to justify the suspension. Enabling the rotation of obstetricians around the Trust's sites, or giving expectant mothers in Bicester a choice between the Horton General Hospital and the John Radcliffe to increase births at the former could remedy the problem.

3. Engagement

3.1. Consultation has fallen short of the "strong public and patient engagement" health service commissioners must demonstrate when undertaking major service change.

3.2. Public meetings have not been well organised. Many have been organised during the day. Attendees have to wait to be allocated a place, and are not told the location until then. While the meetings are well-attended, the demographic of these groups is not representative of the local population. Specifically, it has been apparent that those most likely to use maternity services have been underrepresented at the meetings.

3.3. The messages disseminated at each of the meetings has fluctuated. For example, on one occasion we were told that static ambulance provision would be removed from the Horton should the maternity unit be downgraded, yet at the following meeting attendees were told that the ambulance provision would remain. At the first public meeting in Banbury, it was implied that closing Chipping Norton MLU to increase births at the Horton was an option. However, at the subsequent meeting in Chipping Norton, it was categorically stated that this was not being considered at this stage as maternity provision in the north of the county was to be considered as part of Phase Two.

3.4. A video setting out the proposed changes is misleading. Just as there is no mention in the consultation document about epidurals (see 2.10.1.), the video also omits to mention them. It simply differentiates between high risk and low risk pregnancies without giving any further information to distinguish the two. Personally, I would not

describe a pregnancy as high-risk simply because a mother wants to have a range of pain relief options available to her during labour. Epidural rates have doubled in the past few decades and are now approaching 40%. For some Trusts it is almost double that. Failure to make this clear and mention pain relief options in the video is a key flaw in the engagement exercise.

3.5. I have received a huge number of complaints from constituents concerned about a flyer that was posted through their door regarding the proposals. Many expressed dismay that it had arrived after local public meetings had been held. My own flyer arrived two weeks after the Banbury meeting took place.

3.6. Given their role in commissioning, it is vital for GPs to contribute to the consultation exercise. Anonymity of response – to ensure they can put forward their full and frank views on the proposals – is essential. While seeking assurances from the CCG that this would be the case, I was told that all GP practices had received paper copies of the consultation response document, as well as the online link. The online link does not provide anonymity; the paper copy will ensure this is possible. I know of at least two practices in my own constituency which have not received the paper document.

3.7. The Pre-Consultation Business Case Second Addendum asks specifically about consulting stakeholder groups mentioned in the equality assessment. In their response, the CCG states that:

"the team is actively conducting outreach through faith leaders to reach members of this community as we know approximately 3% of the fertile population are Black/African/Caribbean/Black British/Asian British/Pakistani in the Cherwell area."

3.8. Engagement with the large Kashmiri population which is based in Banbury is an ongoing concern for me. I raised it at the Community Partnership Network meeting on 3 February 2017 and specifically asked about what work was being done to reach out to them. I followed up this enquiry with an email the following week offering assistance. Despite assurances that I would be kept updated, I am yet to see any evidence of active engagement with this cohort.

4. Conclusion

4.1. The Pre-Business Consultation Case makes clear that before any major service change is undertaken, health commissioners must demonstrate that they have complied with the 'four tests' set by NHS England:

- Strong public and patient engagement
- Consistency with current and prospective need for patient choice
- A clear clinical evidence base
- Support for proposals from clinical commissioners

4.2. It is my opinion that the Transformation Programme Phase One consultation document does not pass these four tests. Public and patient engagement has been inadequate; by omitting details of potential options, current and prospective need for patient choice has been severely restricted; the clinical evidence base is flawed and it does not provide accurate statistics; and, I know from discussions I have had with some clinical commissioners that their support is, at best, lukewarm.

4.3. It is deeply worrying that on some of the occasions I have requested information about the consultation exercise, the answers I have been given differ from what I have since discovered has in fact happened. The various failings of the engagement exercise are examples of this. Given the quantity of misinformation it is difficult to gauge the truth of other aspects of the consultation.

4.4. This consultation is, in my view, fatally flawed. True consultation involves offering options on which the consultees can comment having seen the evidence they need to make informed choices. This is not the case here. I believe this consultation must be stopped. I urge HOSC to do everything in their power to ensure that this is the case.

Victoria Prentis MP

22 February 2017

ANDREA LEADSOM MP

HOUSE OF COMMONS
LONDON SW1A 0AA

Cllr Yvonne Constance OBE
Chairman
Oxfordshire Joint Health Overview & Scrutiny Committee
Oxfordshire County Council
County Hall
New Road
Oxford
OX1 1ND

19th February 2017

Ref: AL/TG/1702

Dear Yvonne

I understand that on the 7th March 2017 the Oxfordshire Joint Health Overview and Scrutiny Committee (OJHOSC) plans to scrutinise the proposals in Oxfordshire Clinical Commissioning Group's (OCCG) phase one consultation of their Sustainability & Transformation Plan.

Given that the outcomes of this debate will shape OJHOSC's formal response to the OCCG consultation, ending 9th April, I should like to submit comments and concerns that have been raised with me by my constituents in South Northamptonshire who use services at the Horton General Hospital.

Many have written to me to share their heart-warming stories of the excellent care and attention they have received from staff at the Horton hospital, and I should like to add my own thanks to those staff as well.

However, my constituents are particularly concerned, overwhelmingly so, about the journey times to the John Radcliffe from South Northamptonshire. This is separate from, but related to, the "blue-light" journeys from the MLU at the Horton. These correspondents have queried what would have happened to mother and child had they had to travel the long distances to the JR in an emergency, and whether their own children would have survived the journey. Examples included umbilical cords around necks, births within 15 minutes of arriving at the Horton, emergency caesareans, low oxygen supplies, and so on.

It is simply unacceptable that the OCCG may be putting the lives of mother and baby at risk through these travel times. We all know that traffic on the roads in and around Brackley, Banbury, Oxford and the surrounding area can be extremely slow.

This leads onto my second point. There seems to be a lack of consideration for what you might term "low risk mothers with complications". I understand that low risk mothers are being advised they can use the MLU at the Horton in future, and high risk mothers will be cared for

through the obstetrics unit at the John Radcliffe, but the low risk mothers who subsequently develop complications are almost an afterthought in this process.

What are these mothers expected to do if they need to get from somewhere like Greatworth or Edgcote to an obstetrics unit in Oxford, but the A43 is slow or closed for whatever reason and traffic has diverted, as it will, onto the local road network?

Further, I have constituents who have been advised that they should arrive with an hour to spare to find a parking space. This is the last thing that any mother, regardless of her condition, is wanting to hear. What about the fathers, or those accompanying, who may very well miss the moment of birth because they were driving round the car park?

Banbury and its surrounding environs are in a state of expansion, with significant new housing going up in the next few years. The growing population is going to lead to a large increase in pressure on the JR, and my constituents ask what forward planning is being undertaken to futureproof this?

My constituents feel that the closure of obstetrics at the Horton amounts to a loss of choice in their area, and that as South Northants residents they have been treated as an inconvenience to the consultation process; it has been badly undertaken.

It is exceptionally difficult for my constituents to understand the whole STP given that it is being split into two halves across a vast and unwieldy timescale. Further, the consultation times, dates and locations themselves are not accessible to all – there is only one in South Northamptonshire (held mid-morning on a Monday), and none on a weekend. This makes it very difficult for working people (including myself) to attend one of the sessions.

Thank you for allowing me to put my constituents' concerns to your committee, and I confirm that you are welcome to publish this submission alongside others as part of your papers.

With best wishes,

Andrea

The Rt Hon. Andrea Leadsom MP
Member of Parliament for South Northamptonshire

Healthwatch Oxfordshire Report to Health Overview and Scrutiny Committee 7th March 2017

Phase 1 Oxfordshire Health and Care Transformation Consultation Plan

1 Oxfordshire Transformation Consultation meetings – The Big Consultation, Phase 1

Healthwatch Oxfordshire staff have attended all the public consultation events held to date and concerns raised by the members of the public, include:

- *What is the 'real' future of Horton General Hospital?*
- *How can we properly comment on the closure of hospital beds when we are not told how the 'closer to home' care will be delivered and how this might impact on Phase 2 of the 'Big Consultation'?*
- *What is going to happen in the second phase to community hospitals?*

The panel of experts at every meeting has been quite open about problems facing the NHS – rising demand, predicted shortage of money if 'we do nothing', change in demographic, workforce recruitment and retention. When the future of the Horton has been raised, panel members have been optimistic in stating plans for development of the site, increased numbers of outpatients and day cases (for north Oxfordshire patients) etc. However, this approach does not appear to have allayed fears / suspicions by some attending the 'Big Consultation' events, nor help individuals when deciding how to respond to the consultation exercise, and we believe that is because of insufficient detail being given by the authorities.

People are asking questions that are not addressed in the current consultation documents including about the impact on parking if the more outpatient appointments are delivered from the Horton; and the capacity in community hospitals and the care sector to support the 'closer to home' health care strategy.

Healthwatch Oxfordshire has written to both Oxfordshire Clinical Commissioning Group (OCCG) and Oxford University Hospitals NHS Foundation Trust (OUHT) asking them to publish their plans for the Horton General hospital 'so that the consultation can be meaningful, or postpone the consultation until the Oxfordshire health transformation plan for the rest of the county is worked through in detail so that consultation is meaningful'.

2 Social care

An obvious gap in the information supplied in the Big Consultation documents has been any reference to the impact on social care, third sector partners and carers by the drive to 'closer to home' delivery of care. The decision by Oxfordshire County Council (OCC) Cabinet on 21st February 'not to support the proposals based

on the lack of information on the impact on council services' focused on their concerns.

The impact on the voluntary sector, and stated willingness of the sector to work with partners through the transformation were confirmed at the Healthwatch Voluntary Sector Forum in February.

Healthwatch is concerned that were the second phase of consultation (that could include community hospitals, primary care – GPs, care in the community), developed without active input by Oxfordshire County Council and third sector partners that a similar response will be forthcoming from OCC.

3 Summary

Healthwatch Oxfordshire would have preferred a single health and social care transformation consultation.

However, to support the public in their response to the current consultations Healthwatch believes that the publication of the overall plans for the Horton General Hospital is key to achieving an informed response to the questions asked in the current consultation programme. These plans, even in very draft form should also be included in the engagement process prior to the second phase consultations,

Healthwatch Oxfordshire want to see a Phase 2 consultation that is presented as a joint health and social care transformation document. The current draft OCCG timetable for the launch of Phase 2 of the transformation consultations is due to begin in November 2017. Surely this is sufficient time for the commissioners and providers to work together to achieve a health and social care transformation plan that will present the people of Oxfordshire with a system wide vision for the future on which to be consulted?