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.**