VICTORIA PRENTIS MP

Cllr Yvonne Constance
Chairman
Joint Health & Overview Scrutiny Committee
Oxfordshire County Council
County Hall
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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

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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