# Oxfordshire Transformation Programme

## Decision Making Business Case

(Phase One)

10 August 2017

Final

2 August 2017

# Part One:

## BACKGROUND AND CONTEXT

# 1. Introduction and Purpose

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

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

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

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

# 2. Background

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

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

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

## 2.1 A Phased Approach

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

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

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

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

## 2.2 Development of the Proposals

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

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

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

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

2.3 Cross-Boundary Working

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

2.4 Formal Assurance

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

The Phase One PCBC was approved (subject to receipt of NHSE assurance) in a confidential session of OCCG Board on 29 November 2016 and the proposals formally passed the NHS England assurance process on 5 December 2016.[4] In approving the PCBC, NHS England recognised that the Oxfordshire Transformation Programme had met the 'Four Tests' for service change proposals. These are:

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

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

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

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

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

the compliance of the Phase One proposals with the new 'Patient Care Test' was undertaken during the summer of 2017.[5]

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

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

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

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

2.5 The Consultation and Additional Work

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

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

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

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

## 3. Recommendations

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

1. Critical Care

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

2. Acute Stroke Services

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

3. Changes to Acute Bed Numbers

   Agree to make permanent the planned closure of 146 acute beds thereby formalising the temporary changes made as part of the 'Rebalancing the System' delayed transfer project that has been running since November 2015.[7] The implementation of this will be staged:

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

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

[6] Stroke rehabilitation beds will be considered as part of Phase Two.
[7] This final figure of 146 has been revised from the *Pre-Consultation Business Case for Phase One* when 194 bed closures were planned: more information on this is included in section 9 of this report and in the supplementary paper on the new 'Patient Care Test'.
[8] A list of these beds and the site is included in the table in section 9.1.1

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

4. Planned Care Services at the Horton General Hospital

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

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

5. Maternity Services

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

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

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

# Part Two:

## CROSS-CUTTING ISSUES

# 4. The Public Consultation

4.1 The approach to the public consultation and number of responses

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

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

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

4.2 Response to the Consultation

The consultation report, and supporting Stakeholder Response Pack, has been considered by all those involved in the Oxfordshire Transformation Programme. Sections 7 to11 of this DMBC outline the issues raised during the consultation for each individual clinical area along with the response of the relevant workstream.

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

4.3 Discussions at the OCCG Board on 20 June 2017

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

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

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

### 4.3.1 Cross-boundary working

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

- OCCG has taken steps to facilitate cross-boundary meetings (such as a system-wide ambulance workshop[10]) and to organise events outside of the formal Oxfordshire boundary (such as visiting GP surgeries in South Warwickshire and Northamptonshire during, and after, the public consultation.[11])

- OCCG has used existing formal mechanisms to engage with neighbouring areas such as the Community Partnership Network which considers the needs of patients in North Oxfordshire and the surrounding areas. Membership includes North Oxfordshire Locality GPs (NOLG), OUHFT, Oxfordshire Hospital Foundation Trust (OUHFT), Oxfordshire County Council (OCC),NHS England, Cherwell District Council, South Northamptonshire Council, Stratford on Avon District Council, Banbury Town Council, West Oxfordshire District Council (WODC), North East Oxfordshire Locality GPs (NELG), Nene CCG, Keep the Horton General Campaign, Healthwatch Oxfordshire, Age UK, Oxfordshire Joint Health Overview and Scrutiny Committee (JHOSC)

- Formal letters were sent to all neighbouring organisations both before and during the consultation to ask for their views on the potential implications for their patients. The feedback from this correspondence was included within the Phase One Consultation Report.

- During the consultation, OUHFT engaged with providers in South Warwickshire NHS Foundation Trust (SWFT) and Northamptonshire General Hospital Trust to ensure the implications of the proposals were fully understood and that support for the proposals was secured.

- During the consultation, OCCG also attended a meeting of Stratford-Upon-Avon District Council on 24 March 2017.

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

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

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

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

### 4.3.2 Analysis of responses

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

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

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

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

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

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

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

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

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

### 4.3.3 Impact from any loss of service

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

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

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

### 4.3.4 Capacity

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

*Maternity Services*

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

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

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

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

*Critical Care*

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

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

*Acute Stroke Services*

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

*Planned Care Services at the Horton General Hospital*

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

### 4.3.5 Ambulance Services

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

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

*Critical Care and Acute Stroke Services*

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

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

*Obstetric centralisation*

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

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

*Planned Care at the Horton General Hospital*

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

*Summary*

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

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

## 5. The Integrated Impact Assessment (IIA)

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

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

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

- Health
- Equality
- Sustainability
- Travel and Access

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

## 5.1 Health Impacts

Across the clinical areas considered within Phase One, Mott MacDonald found a number of common impacts for consideration including workforce, safety and healthcare[13]:

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

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

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

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

5.2 Equality

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

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

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

5.3 Sustainability

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

5.4 Travel and Access

The IIA made the following points about travel and access:

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

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

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

5.5 Mitigations

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

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

# 6. Car Parking and Travel Analysis

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

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

6.2 Healthwatch Oxfordshire

### 6.2.1 Methodology

Healthwatch Oxfordshire conducted a travel survey of patients, relatives and carers attending the four acute hospital sites in Oxfordshire[15] in order to gain an understanding of patient experience when travelling to and, parking at, hospital sites. They randomly selected and spoke to 295 people over a three-week period between 8 May and 26 May 2017.[16]

### 6.2.2 Findings

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

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

[15] The survey included the JRH Hospital in Oxford, the HGH in Banbury, the Churchill Hospital, and the Nuffield Orthopaedic Centre (NOC) in Headington, Oxford
[16] More information on the methodology used is available in the report: Healthwatch Oxfordshire 'Oxford University Hospitals NHS Foundation Trust Travel Survey – People's experiences' May 2017

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

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

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

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

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

### 6.2.3 Healthwatch Recommendations

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

At the Horton General Hospital (HGH):

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

At the Headington hospitals sites:

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

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

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

6.3 Mott MacDonald Car Parking Survey

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

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

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

6.4 The Oxfordshire Transformation Programme's Response

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

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

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

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

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

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

# Part Three

## CLINICAL RECOMMENDATIONS

# 7. Critical Care

7.1 Recommendation

To move to a single Level 3 CCU for patients within Oxfordshire (and its neighbouring areas), located at the JRH in Oxford. The CCU at the HGH would become a Level 2 Centre, working in conjunction with the major centre[18].

### 7.1.1 The New Model of Care

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

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

7.2 What we consulted on

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

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

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

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

7.3 The issues raised in Consultation and Additional Work

### 7.3.1 Views Expressed in the Consultation

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

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

### 7.3.2 Discussions at the OCCG Board on 20 June 2017

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

### 7.3.3 Issues raised in the IIA

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

*Potential Positive Impacts*

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

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

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

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

*Potential Negative Impacts*

- Families and carers will experience increased travel time and cost in visiting patients receiving Level 3 Critical Care. Although this will be balanced against the increased quality of care the patient is likely to experience and the numbers of families impacted is low.

- The issues of travel time and cost could potentially impact on the ability of carers to provide appropriate support to the patient affecting the patients' recovery. However this will be offset by moving people back to their local hospital as soon as they are clinically fit.

- The changes could impact on OUHFT capacity at the JRH site and the capacity of SCAS if there were an increased number of transfers from HGH Level 2 CCU to the JRH Level 3 CCU.

- Resilience of the system could be affected by the reduction in the number of Level 3 Critical Care Units in the event of a large scale emergency.[20]

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

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

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

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

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

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

## 7.5 Implementation and sustainability

### 7.5.1 Implementation: Overview of key changes required

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

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

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

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

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

### 7.5.2 Workforce considerations and changes

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

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

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

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

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

### 7.5.3 Arrangements with SCAS

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

### 7.5.4 Estates changes and major changes to equipment

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

### 7.5.5 Managing the change

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

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

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

# 8. Acute Stroke Services

8.1 Recommendation

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

### 8.1.1 The New Model of Care

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

- **Admission**

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

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

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

- **Discharge**

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

- **Bed Based Rehabilitation**

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

[21] 88% of stroke admissions to OUHFT already go via the JRH including all Oxfordshire patients who present within 4 hours of stroke.
[22] Stroke rehabilitation beds will be considered as part of Phase Two.

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

8.2 What we consulted on

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

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

8.3 The issues raised in Consultation and Additional Work

### 8.3.1 Views Expressed in the Consultation

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

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

[23] August 2013; Impact on Clinical and Cost Outcomes of a Centralized Approach to Acute Stroke Care in London: A Comparative Effectiveness Before and After Model; cited by Plos One 2013; 8(8): e70420.
[24] This summary is drawn from the survey, letters received, views expressed at public meetings and gathered from other meetings. Where percentages are given, they refer to the survey results.

### 8.3.2 Discussions at the OCCG Board on 20 June 2017

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

### 8.3.3 Issues raised in the IIA

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

*Potential Positive Impacts*

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

*Potential Negative Impacts*

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

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

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

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

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

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

8.5 Implementation and sustainability

### 8.5.1 Current Position

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

# 9. Changes to Acute Bed Numbers

9.1 Recommendation

To agree to make permanent the closure of 146 acute beds thereby formalising the temporary changes made as part of the 'Rebalancing the System' delayed transfer project that has been running since November 2015.[25] The implementation of this will be staggered:

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

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

### 9.1.1 The New Model of Care

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

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

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

The central aims of this initiative were to:

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

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

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

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

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

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

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

### 9.1.2 Alternative Provision

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

This alternative provision includes the following:

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

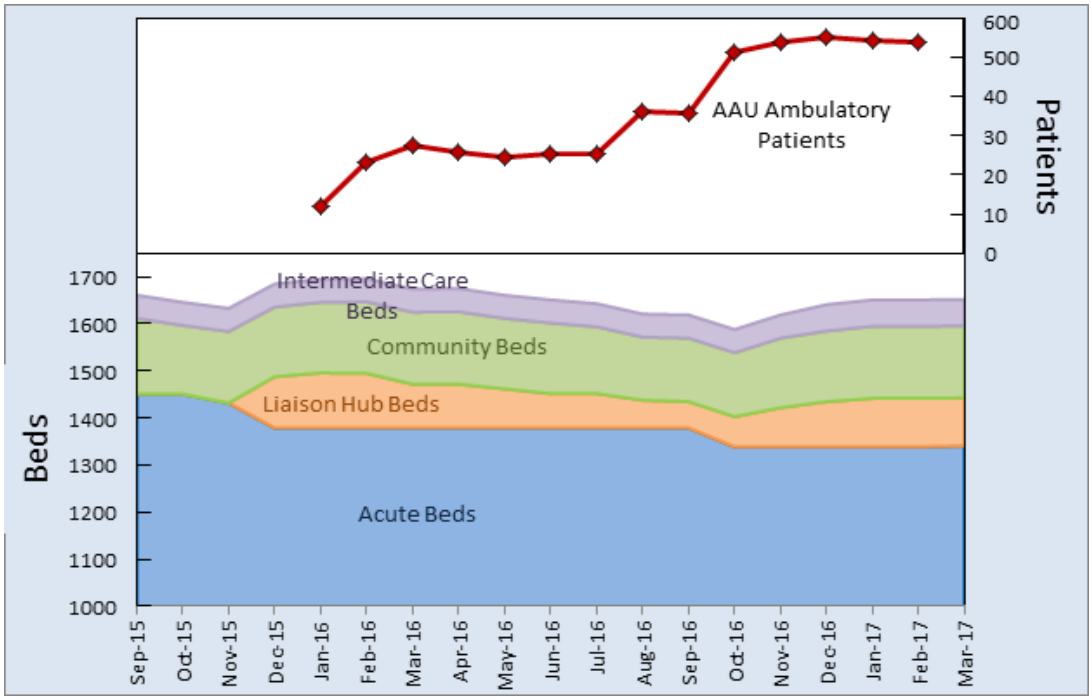
To enable effective pathways for patients, these services are overseen by a Clinical Coordination Centre that is based at the JRH.

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

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

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

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




9.2 What we consulted on

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

9.3 The issues raised in Consultation and Additional Work

**9.3.1 Views Expressed in the Consultation**

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

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

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

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

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

### 9.3.2 Discussions at the OCCG Board on 20 June 2017

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

### 9.3.3 Issues raised in the IIA`

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

*Potential Positive Impacts*

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

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

*Potential Negative Impacts*

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

9.4 <u>The Oxfordshire Transformation Programme's Response to the issues raised</u>

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

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

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

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

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|---|---|---|
| | | pathway that will focus on care closer to home, including integrated care around the ambulatory model. |

9.5 The new 'Patient Care Test'

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

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

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

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

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

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

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

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

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

9.6 Implementation and sustainability

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

# 10. Planned Care at the Horton General Hospital

10.1 Recommendation

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

### 10.1.1 The Model of Care

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

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

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

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

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

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

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

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

10.2 What we consulted on

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

10.3 The issues raised in Consultation and Additional Work

**10.3.1 Views Expressed in the Consultation**

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

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

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

- 78% agreed with introducing a new Outpatient Unit with a 'one stop shop' clinic for appointments.

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

### 10.3.2 Discussions at the OCCG Board on 20 June 2017

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

### 10.3.3 Issues raised in the IIA

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

*Potential Positive Impacts*

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

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

*Potential Negative Impacts*

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

10.4 <u>The Oxfordshire Transformation Programme's Response to the issues raised</u>

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

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

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

10.5 Implementation plans and sustainability

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

### 10.5.1 Phase 1: Maximise existing capacity

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

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

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

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

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

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

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

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

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

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

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

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

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

### 10.5.4 Workforce – consideration and changes

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

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

### 10.5.5 Estates Changes

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

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

### 10.5.6 Timescales for Implementation

| ACTION | ELEMENTS | INDICATIVE TIMEFRAMES |
|---|---|---|
| Phase 1: Use of existing capacity | • Theatres/CT | 2017/18 |
| Phase 2: Use of the ISTC | • Phase 1<br>• Phase 2 | 2017/18<br><br>From 2018/19 |
| Phase 3: Provision of a new Outpatient and Diagnostic Facility | | |
| Development of operational models and development of final detailed design | • Confirm volume and range of outpatient at speciality/sub-speciality level that can be transferred<br>• Confirm volume by modality of diagnostic imaging that can be transferred<br>• Development of detailed schedules for operational delivery<br>• Assess staffing implications<br>• Equipment – Schedules of new equipment and transferable equipment to developed | 2019/20 |
| Scheme approvals | Full Business Case approval by :<br>• OCCG<br>• OUHFT<br>• NHSI | By end of 2019/20 |
| Construction/Go Live | Completion of :<br>• Enabling works<br>• Construction of new centre<br>• Associated site works | 2020 onwards |

# 11. Maternity Services

11.1 Recommendation

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

### 11.1.1 The New Model of Care

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

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

The model will move Oxfordshire to an increasing number of Consultant hours on the labour ward, in line with the latest Royal College guidance[29]. By concentrating the Consultant workforce in one large unit, with the added complexity of a tertiary centre, and by employing the same rota system which has proved sustainable in Manchester, it is anticipated that this will attract the desired extra 7 consultants required to achieve 24/7 Consultant presence on the labour ward at the JR. A key finding from the 'Each Baby Counts' report [30] [31](looking into neonatal deaths and brain injuries) was the necessity for senior oversight of activity on the delivery suite. A sustainable 24/7 consultant rota will be crucial in providing this oversight and improving the quality of maternity

[29] RCOG (2016) 'Providing Quality Care for Women: Obstetrics and Gynaecology Workforce'
[30] Marian Knight, Jane Henderson, Jennifer J Kurinczuk. Evidence Review to Support the National Maternity Review 2015; Report 3: Systematic review and case studies to assess models of consultant resident cover and the outcomes of intrapartum care; and two international case studies of the delivery of maternity care. Oxford: National Perinatal Epidemiology Unit, University of Oxford. 2015.

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

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

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

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

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

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

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

11.2 What we consulted on

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

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

11.3 The issues raised in Consultation and Additional Work

**11.3.1 Views Expressed in the Consultation**

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

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

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

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

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

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

### 11.3.2 Discussions at the OCCG Board on 20 June 2017

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

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

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

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

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

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

### 11.3.3 Issues raised in the IIA

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

*Potential Positive Impacts*

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

*Potential Negative Impacts*

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

11.4 <u>The Oxfordshire Transformation Programme's Response to the issues raised</u>

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

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

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

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

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

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

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

[36] SCAS letter 31.7.2017

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

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

### 11.4.1 The Obstetrics Option Analysis

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

The maternity workstream's members revised the long list of options and then assessed this list using the evaluation criteria set out in the OUHFT Horton Strategic Review in May 2016, see table below[38]:

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

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

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

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

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

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

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

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

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

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

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

11.5 Implementation and sustainability

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

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

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

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

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

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

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

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

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**Quality improvements in new model of obstetric care**

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

[39] Calculation used:
7,500 Oxfordshire births per year
20 minute midwife appointments x 3 additional appointments per woman = 7,500 additional hours ~ 3.85 WTE midwives.
This would be the maximum impact of the changes as not all women will require all appointments (at least one of the appointments is for nulliparous women only and some women will give birth prior to their 38 week appointment)

| Improvement | Impact | Cost | Over and above what is already delivered? |
|---|---|---|---|
| d) Increase dedicated Consultant hours of presence on the obstetric labour ward to facilitate the recommendations of Each Baby Counts report | A sustainable consultant workforce, leading the number and complexity of births.<br>Adequate clinical exposure to enable them to maintain and develop their specialist knowledge. | *Would need additional 7 WTE Consultant Obstetrician*<br><br>This would provide 168 hours cover in a sustainable manner as per the model introduced at St Mary's Hospital in Manchester (9 consultants covering daytime on call including weekends and 16 consultants covering night time on call)[40]. OUHFT has recently re-advertised for consultants using this model and has received a better response. | Yes.<br>Consultant hours on JR labour ward was at 92 hours in June 2017 but increased to 108 hours for July and August and is anticipated to go up further to 114 hours by the end of September when the final new consultant is in post. |
| e) OUH Consultants will provide more clinics for high risk women at the Horton | Reduced travel times and easier access for approximately 400 women[41] who would have previously received their antenatal care at the JRH because of assessed risk. | Cost neutral | Antenatal Clinics held twice a week at HGH and a Day Assessment Unit is operational throughout the week (according to OUH Contingency Plan).<br><br>If the number of consultants have increased to cover Ob labour ward (see d) above) there would be staff to increase the general Antenatal clinic x1 and could introduce some specialist services<br>At HGH.<br>1.Diabetic ANC<br>2.High risk Fetal /maternal med clinic<br>3.Perinatal mental health ANC. |

[40] See NPEU report
[41] Figure taken from Horton Strategic Review (OUH, 2016)

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

# Part Four:

## ACTIVITY AND FINANCE

# 12. Activity

## 12.1 Activity Assumptions

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

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

The model underlying the projected growth in demand for health and social care services[42] is described in the PCBC and is based upon the following key assumptions:

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

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

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

## 13. Finance

13.1 Purpose and Approach

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

13.2 Summary PCBC Financials

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

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

   In this scenario:

   a. The projected deficit for the Trust was £27.3m by 2020/21

   b. The projected capital expenditure requirement was £106m, being the increase inpatient bed and diagnostic capacity required to meet expected increases in demand.

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

   Under this scenario:

   a. The projected deficit for the Trust reduced to £16.2m in 2020/21; an improvement of £11.1m.

   b. Projected capital expenditure was £127m, to reflect further reconfiguration of bed capacity across the Trust together with additional diagnostic capacity and reconfiguration of outpatient facilities, mainly at the HGH site.

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

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

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

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

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

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

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

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

13.3 Impact of DMBC Recommendations

**13.3.1 Critical Care**

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

**13.3.2 Acute Stroke Services**

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

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

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

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

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

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

**13.3.3 Changes to Acute Bed Numbers**

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

***Summary position of the PCBC***

The summary position presented in the PCBC is as follows:

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

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

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

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

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

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

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

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

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

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

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

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

***New financial modelling based on current bed closures***

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

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

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

Savings from ward bed changes:

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

OUHFT Service investments have been:

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

Commissioner Investment has been:

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

Summary financial impact for OUHFT:

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

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

**Sustainability of the Alternative Provision:**

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

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

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

2. Since the commencement of the programme:
    a. the average length of stay for patients over the age of 65 has fallen from 3 days to 2.5 days
    b. the % of non-elective admissions with Same Day Discharge, has increased from 30% to 37%

3. The number of patients treated in the AAU has risen to 540 per month

4. At the same time there has been a growth in the number of non-elective admissions, and a significant growth in emergency department attendances of 18% over the past 30 months. [44]

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

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

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

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

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

### 13.3.4 Planned Care Services at the Horton General Hospital

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

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

**Comparison of Capital Requirements for Oxfordshire Phase 1 PCBC**

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

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

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

### 13.3.5 Maternity Services

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

13.4 Summary

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

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

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

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

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

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

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

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

# Part Five:

## THE ‘BEST PRACTICE’ CHECKS AND CONCLUSION

## 14. Legal Advice and Other 'Best Practice' Checks

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

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

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

## 15. Conclusion

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

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

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

Appendix A: Supporting Documents

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

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

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

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

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

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

   - *The minutes of the Thames Valley Clinical Senate for their meeting on 6 June2017*
   - *The recommendations from the Thames Valley Clinical Senate meeting 26 July 2017*

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

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

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

5. Healthwatch Oxfordshire ***'Oxford University Hospitals NHS Foundation Trust Travel Survey – People's experiences'*** May 2017
   *This report summarises the methodology and findings of Healthwatch Oxfordshire's travel survey conducted in May 2017.*

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