

Oxfordshire Transformation Programme

Pre Consultation Business Case - SECOND ADDENDUM

14th December 2016

N.B. This Addendum contains material which was provided by Oxfordshire Clinical Commissioning Group (OCCG) and health partners in response to questions raised by NHS England during the assurance process

The questions, comments and assurance points raised by NHS England are shown in bold italics. The response from OCCG is in plain text.

Section 1. Maternity Services

Question M01

Does OCCG have evidence that demonstrates capacity to accommodate the births at the John Radcliffe Hospital, modelled through using a capacity tool to ensure sufficient planning to provide a sustainable service to fully address the question in the Senate Review Section 7.2.8?

M01.1 Introduction

This section provides assurance that the maternity services across Oxford University Hospitals Foundation Trust (OUHFT) is sustainable, with the inclusion of additional women who require support and care during pregnancy, birth and the postnatal period at the John Radcliffe Hospital.

Below we outline the number of births for 2015/16, prior to the changes at the Horton General Hospital and the numbers of births during October and November 2016 at the John Radcliffe Hospital. The current figures take into account out of area women who are now booking at another Trust as a result of changes to boundaries and those women from the Banbury area choosing another provider. The configuration of beds at the John Radcliffe Hospital will be outlined; these changes were implemented as part of the contingency plan agreed when the Horton maternity service became a temporary Midwifery Led Unit.

M01.2 Activity

Total numbers of women giving birth - all OUHFT maternity sites

Measure	Data Source	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16
Mothers delivered	EPR	693	705	675	742	718	724	688

Total births - John Radcliffe Hospital

Measure	Data Source	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16
Mothers delivered	EPR	574	580	539	600	576	607	659

Numbers of elective and emergency Caesarean sections

Measure	Data source	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16
Caesarean Section	EPR	160	166	151	167	168	176	151
		23.1%	23.5%	22.4%	22.5%	23.4%	24.3%	21.9%

Note – EPR is the Electronic Patient Record system used by OUHFT

Discussion – the tables above identify that the total activity during October 2016 has reduced across OUHFT despite this historically being the busiest time of the year for births. This is mainly due to the numbers of women who have chosen to give birth in another provider organisation (obstetric unit or Midwifery Led Unit). This was expected although it was not possible to accurately predict the numbers as part of the contingency planning process.

As anticipated as part of the contingency plan the number of women giving birth at the John Radcliffe Hospital rose in October 2016 with 52 additional deliveries.

Caesarean sections rates are approximately 23% per annum although slightly less in October 2016 (21.9%); this is not statistically significant as trends cannot be determined on a monthly basis. The number of caesarean sections was similar to previous months; therefore, there was no significant impact on the maternity service at the John Radcliffe Hospital.

M01.3 Boundary changes

The decision to not accept all women from out of area is impacting on our activity; this was agreed as a temporary measure as part of the contingency plan but will be reviewed once a permanent decision has been made about the Horton General Hospital. Tertiary referrals for fetal and maternal medicine are still being accepted given OUHFT is the lead providers for specialist services.

M01.4 Bed configuration

Additional space was developed on the John Radcliffe Hospital site as part of the contingency planning to accommodate the women transferring their care from the Horton General Hospital to the John Radcliffe Hospital. The changes include:

- 2 additional triage rooms on the Maternity Assessment Unit
- 2 additional birthing rooms on the main labour ward
- 2 additional birthing rooms on the Spires Midwifery Led unit
- 8 additional antenatal/postnatal beds
- Elective LSCS have been transferred to the gynaecology theatres

M01.5 Monitoring

The senior midwifery team monitor the capacity at the John Radcliffe Hospital on a daily basis and there have been 9 occasions when the additional antenatal/postnatal beds have been utilised since 3 October 2016. The Spires MLU has been busy, this is not unexpected as the case mix of women previously giving birth at the Horton General Hospital meant that a higher proportion of these women would be able to birth in a low risk birthing environment rather than the Consultant led labour ward. The additional rooms on the Maternity Assessment Unit have been a very positive development and women are seen quickly on arrival in the department.

M01.6 Conclusion

The maternity service at the John Radcliffe Hospital has coped well since the temporary changes were put in place at the Horton General Hospital and the additional beds have ensured women are cared for safely and in an appropriate environment. If a permanent MLU is established at the Horton General Hospital, the Trust is confident that the tertiary maternity service across OUHFT will be able to continue to provide care for women of Oxfordshire and those referred to the unit for maternity care.

Question M02

Does OCCG have evidence that primary care has the capacity to undertake maternity risk assessment?

In October 2016, the Oxfordshire Local Medical Committee (LMC) received a Briefing Paper on the proposals for Maternal Risk Assessment.

The LMC accepted the proposal for GPs to undertake the medical assessment in the early part of pregnancy, including the use of a double appointment slot. In order to free GP time, it was agreed that the maternal assessment, currently undertaken by GPs at 38 Weeks, would in future be undertaken by midwives. This change has been agreed by OUHFT.

A Maternal Medical Risk Assessment proforma was agreed with the LMC and is now in use in some practices.

Minutes of the Oxon Liaison meetings (OCCG and LMC) are taken.

Section 2. Stroke Services

Question S01

Does OCCG have evidence that demonstrates capacity to accommodate the Stroke services at the John Radcliffe Hospital?

S01.1 Current provision of stroke care

The John Radcliffe Hospital is designated as a provider of:

- hyperacute stroke care (immediate assessment of all Oxfordshire patients who present within 4 hours of stroke onset for eligibility for thrombolysis)
- acute stroke care (assessment and appropriate management of all Oxfordshire patients who presented after 4 hours of stroke onset); and
- rehabilitation stroke services.

Since 2009, the Oxford University Hospitals NHS Foundation Trust (OUHFT) (with the erstwhile Oxfordshire PCT and the OCCG) has piloted an Early Supported Discharge (ESD) service to cover the Oxford City and Bicester areas with a corridor of GP practices covered between the two, covering 41% of the population.

The bed base for the above services was as follows: John Radcliffe Hospital L 18+1 beds, Horton General Hospital 10 beds, Community Hospitals 10 beds with Early Supported Discharge having a maximum capacity of 14 patients at any one time. John Radcliffe Hospital admitted 88% of stroke admissions to OUHFT and Horton General Hospital 12%. The combined activity of confirmed strokes at John Radcliffe Hospital and Horton General Hospital was approximately 700 patients in 2014/15.

S01.2 Interventions to improve quality of care and performance

In 2015/ 16, Oxfordshire Clinical Commissioning Group (CCG) committed to securing improvements in stroke mortality through direct conveyance of all Oxfordshire patients with suspected acute stroke regardless of time of onset to the John Radcliffe Hospital.

In order to improve the quality of care and efficiency of the service, the following are proposed:

- OUHFT manage the entire stroke pathway with one Multidisciplinary team who are accountable and responsible for the whole of the stroke pathway.
- There is a single portal of entry for Oxfordshire patients with suspected acute stroke at John Radcliffe Hospital only.
- Expand to a county-wide Early Supported Discharge (ESD) increasing capacity in collaboration with Home Assessment Reablement Team (HART).

S01.3 Achieving the Single Portal of Entry to OUHFT

This will be based on the following provisions:

- All FAST positive patients (Facial drooping, Arm weakness, Speech difficulties and Time to call emergency services) regardless of time of onset will be conveyed directly to the John Radcliffe Hospital by South Central Ambulance Service (SCAS).
- All patients in whom a new diagnosis of stroke is made at Horton General Hospital, either following admission (FAST negative strokes) or while as an inpatient at Horton General Hospital for another medical condition, will be transferred to John Radcliffe Hospital, if determined to be in the patient's best interests.
- The Medical Directors of West Midlands, East Midlands and South West Ambulance Services will be contacted to ensure that their paramedics convey all potential stroke patients to the nearest Hyperacute Stroke Unit for first assessment, not Horton General Hospital, and in most cases this will not be John Radcliffe Hospital.
- It should be noted that all FAST positive patients within 4 hours of stroke onset have been directly conveyed to the John Radcliffe Hospital for assessment for eligibility for thrombolysis since 2009

The total number of patients that might reasonably be expected to be impacted by having a single portal of entry to OUHFT is approximately 80-120 a year. The new additional transfers to John Radcliffe Hospital will be considerably less than this due to the mitigation strategy for out-of-area patients, and that all patients with suspected stroke less than 4 hours from onset are already transferred to John Radcliffe Hospital by SCAS. This has been agreed in principle with SCAS with further work to follow modelling the impact on patient flows.

There is adequate capacity to care for the additional patients provided the plans to extend the ESD service county-wide are in place and fully operational and the rest of the patient pathway is managed as a seamless service. Such an approach will address the risks associated with the interdependencies along the pathway and enable effective management of patients, reduce mortality and length of stay for patients on the stroke pathway, earlier discharge home or placement and deliver a consistent higher standard of care.

S01.4 Expanding the current Early Supported Discharge (ESD) provision

The present ESD service delivers rehabilitation for patients who live within Oxford City to Bicester. An Oxfordshire ESD service, with support from the Home Assessment Reablement Team (HART), will transfer patients home who have a greater dependency than for those it presently provides therapy, resulting in more patients being discharged home with this service. It is expected that an average of 14 patients per month across Oxfordshire will be discharged from the HASU to the ESD service (additional average of 8 patients per month). Therapy assessments will happen 6 days a week (Monday to Saturday).

Question S02

Does OCCG have evidence that demonstrates support from South Central Ambulance Service (SCAS), specifically in terms of resource implications?

The Medical Director of SCAS was involved in the option development process for the revised stroke pathway. SCAS has also received the OTP travel analysis for comment and advice.

SCAS is unable to provide its formal approval for the proposed service change until its Board has considered the issue. This is expected to be early in 2017.

SCAS has not yet been able to estimate the resource implication of the proposed change to the pathway, which will affect approx. 100 - 200 patient journeys each year.

Question S03

Does OCCG have evidence that demonstrates how the Senate report section 7.2.6 should be answered for full assurance?

S03.1 Detailed plans for provision of county wide ESD and rehabilitation which is key to ensure the flow of patients through the HASU and to improve outcomes for patients

A reablement at home service was established as a pilot scheme for a wide range of patient types in North Oxfordshire in 2014. The evaluation of this pilot service was presented to the Pooled Budget Officers Group (including the County Council) in August 2016. The evaluation suggested that reablement at home was at least as effective for patients as treatment in a bedded intermediate care unit. The evaluation factors considered included length of stay and ongoing social and nursing care requirements. The home-based scheme was cheaper for each patient episode of care. The Pooled Budget Officers Group decided to extend the pilot. This is a similar model to the Early Supported Discharge (ESD) Scheme for stroke patients and the OCCG is proceeding on the basis that the same benefits would be accrued for patients through this ESD scheme.

S03.2 Documented evidence of agreement from SCAS (as S02)

The Medical Director of SCAS was involved in the option development process for the revised stroke pathway. SCAS has also received the OTP travel analysis for comment and advice.

SCAS is unable to provide its formal approval for the proposed service change until its Board has considered the issue. This is expected to be early in 2017.

SCAS has not yet been able to estimate the resource implication of the proposed change to the pathway, which will affect approximately 100 - 200 patient journeys each year.

S03.3. There are significant interdependencies throughout the whole pathway and there needs to be a shared and documented understanding of risk

OCCG accepts that there will need to be further explanation of the interdependency of the pathways and will develop a risk assessment in line with its decision about options for rehabilitation.

S03.4 Workforce planning to include the ESDs and rehabilitation provision

The OCCG (with its partners) has undertaken workforce modelling in relation to the expansion of the Early Supported Discharge (ESD) service and two options for the provision of bed-based rehabilitation. These are set out in the tables below:

County Wide ESD service providing therapy 6 days a week

Band	Role	Existing	WTE increase	total	Total cost
8	Psychologist		0.5	0.5	£22,659
7	Physiotherapist	1.0	1.0	2.0	£110,000
7	Occupational Therapist (OT)		1.0	1.0	£54,600
7	Dietician	0.5		0.5	£22,659
6	Physiotherapist	1.0	1.0	2.0	£91,100
6	OT	1.0	1.0	2.0	£91,100
6	Speech and Language Therapist (SLT)	0.4	1.6	2.0	£70,000
4	Therapy assistants	1.6 (band 3)	2.4	4.0	£108,562
3	Administration		1.0	1.0	£22,133
	Consultant	0.05	0.45	0.45	£58,500
	Total			16.85	£651,312
	Current ESD costs				£176,962
	Additional ESD costing				£474,350

Staffing for two 15 bedded stroke rehabilitation units

Band	Role	WTE for 15 beds	WTE for 2 15 bedded units	Cost one 15 unit	Cost of two 15 bedded units
	Psychology	0.5	1.0	£25,000	£50,000
7	Physiotherapists	1.0	2.0	£54,600	£110,000
7	OT	1.0	2.0	£54,600	£110,000
7	SLT	1.0	2.0	£50,000	£100,00
7	Dietician	0.5	1.0	£22,500	£45,000
6	Physiotherapist	1.0	2.0	£45,500	£91,100
6	OT	1.0	2.0	£45,500	£91,100
6	SLT	1.0	2.0	£40,000	£80,000
6	Registered nursing 24/7	5.7	11.4	£230,478	£460,957
5	Physiotherapist	1.0	2.0	£36,000	£72,000
5	OT	1.0	2.0	£36,000	£72,000
5	Registered nursing 24/7	19	38.0	£728,028	£1,456,056
3	Therapy assistants 24/7	11	22	£297,647	£595,294
	Total	44.7	89.4	£1,665,853	£3,333,506

Staffing for one 30 bedded stroke rehabilitation unit

Band	Role	WTE for 30beds	Difference in WTE For 15 versus 30 bedded units	Cost of one 30 bedded units
7	Ward manager	1.0	+ 1.0	£45,000
7	Physiotherapists	1.0	- 1.0	£54,600
7	OT	1.0	- 1.0	£54,600
7	SLT	1.0	- 1.0	£50,000

6	Registered Nurse	5.7	-5.7	£230,478
6	Physiotherapist	2.0	=	£91,100
6	OT	2.0	=	£91,100
6	SLT	1.0	-1.0	£40,000
5	Physiotherapist	3.0	+1.0	£109,000
5	OT	3.0	+1.0	£109,000
5	Registered nursing 24/7	28.5	-9.5	£1,092,042
3	Therapy assistants 24/7	22	0	£595,294
	Medical Consultants	12 PA	12PA	£156,000
	Total			£2,718,214

Sufficient capacity is available at the John Radcliffe Hospital to manage the additional patients from the Horton General Hospital (as S01).

Subsequent work streams in the transformation plan do not affect the proposals as submitted.

Section 3. Public and Patient Support

Question P03

The consultation plan includes details of stakeholder groups to consult, however, women from the Caribbean are not included. In the equality assessment of section 8.2.2 of the PCBC, it states that mortality rates are higher in babies of mothers born in Pakistan and the Caribbean and are therefore more likely to need to give birth in the specialist obstetric unit.

Does OCCG have evidence that demonstrates how the plan should include details of consulting with these groups?

The CCG's Equality & Access Team has outreach activities with various community groups including ones working with African Caribbean women in Oxford City but we do not believe there is a group meeting in Banbury or north Oxfordshire. However, the team is actively conducting outreach through faith leaders to reach members of this community as we know approximately 3% of the fertile population are Black/African/Caribbean/Black British/Asian British/Pakistani in the Cherwell area.

In addition we are currently seeking quotes from market research companies including Ipsos Mori to generate a representative sample of responses to the consultation using the consultation questionnaire. This would be 1,000 people from across the county and would ensure seldom heard groups and people of different ages in particular are included. We will ensure this particular group is included in this work. This will ensure we have reached beyond the groups particularly motivated to engage with the consultation.

Question P06

The consultation document is quite long and technical and could benefit from being written in Plain English with simple graphics and diagrams to support understanding of the consultation, options and patient pathways. Confirmation has been received that the document is being reviewed, edited and tested to ensure these points are actioned.

Section 5.2.2, page 79 of the PCBC – this is the long list of options section but it is not clear that this is the case when reading content – the language is technical and not to the point. Content therefore needs to be much simpler to support understanding for readers. The table also needs a title and heading. This is important, as the consultation document will point to this for information on the long list of options. Consideration also needs to be given as to where else this information could be, for example on the consultation web pages.

Can OCCG review the consultation document from a position of plain English?

The consultation document and the questionnaire have been shared with Healthwatch and the patient representative on the Transformation Board. Feedback has raised concerns about the language and the need for simplification. The CCG recognises that there are some complex issues with a need for context to be explained which will be wanted by many. There is a risk that over-simplification could be translated as the CCG hiding information.

The CCG is currently working on:

- An extended glossary of terms is included in the consultation document and will be on the website to provide definitions to help aid understanding. This will include for example critical care and urgent care, obstetrics and midwife-led etc.
- Reviewing of the document to simplify language wherever possible whilst retaining the information needed to understand the issues.
- Developing the questionnaire to include summary information.
- Revising the questionnaire so it is in plain English and is supported by the glossary.
- Testing the questionnaire with a wider group of lay people.

An early draft has been provided to the designers who are developing infographics to illustrate the document. These will be shared with Healthwatch and the patient representative for any final comments before the final version is signed off for the designers

Question P08

Can OCCG review the consultation document from a position of strengthening patient benefits?

Although a number of patient benefits are referred to throughout the consultation document, this still needs to be made more obvious so those reading it can easily navigate to the benefits of each of the options being consulted on. The need for clearly detailing patient benefits' was highlighted in the formal advice from Capsticks (November 2016, section 1).

Question P09

The wider impact of each option, particularly in terms of whether this is at the cost of other services, should be clearly set out. This information is not yet included.

Does OCCG have evidence of the wider impact of the options?

P09.1 Maternity

The option to create a single site for obstetric services at the John Radcliffe Hospital and establish a midwife led unit in the north of the county has a number of implications:

- The number of potential births in the north of the county will have impact on running both a proposed MLU on the Horton General Hospital site, as per the temporary arrangements, and the MLU at Chipping Norton. The overall number of MLU's in the North is a question for consultation
- If women had to travel to the Horton General Hospital or John Radcliffe Hospital (JR) to give birth, rather than at Chipping Norton, this would add another 10-13 minutes, on average to their journey time. A quarter of women using the Chipping Norton MLU would have the same travel time. The increase in travel time and the number of women affected by the absence of a proposed Banbury MLU would be far greater.
- The consequences of the establishment of an MLU rather than an obstetric service in the North of the county is that the SCBU services at the Horton General Hospital will need to transfer to the John Radcliffe Hospital and that the emergency gynaecology services will also need to be centralised at the John Radcliffe Hospital
- Consideration of reasonable numbers of births for a sustainable MLU in the North of the county could bring consideration of similar questions for MLU provision in the south of the county in Phase Two.

P09.2 Critical Care

- The changes to critical care are predicated on an analysis that shows that over the last 3-5 years the demand for critical care at the Horton General Hospital has reduced patients with myocardial infarction and major trauma are taken directly to services in the centre of Oxford. In addition emergency services were relocated to Oxford in 2013
- This has reduced the number of patients requiring Level 3 critical care at the Horton General Hospital.
- Reports, CQC and ICNARC, have highlighted quality of care and patient safety concerns
- The Critical Care Unit (CCU) is supported by an anaesthetic model rota. This second medical rota will be maintained in order to support the Emergency Department at the Horton General Hospital and offer early treatment advice in the event of a deteriorating patient in the hospital
- There is a clinical interdependency however with Accident and Emergency Services and the model for this service is to be consulted on in Phase Two
- However, the presence of a Level 2 CCU at the Horton General Hospital will support Phase One plans to increase the amount of elective surgery in the North of the County

P09.3 Stroke

- The clinical evidence for the centralisation of Hyper Acute Stroke Services has been assessed as being significant and there is clear clinical agreement that all appropriate stroke patients in Oxfordshire should be conveyed directly to a HASU at the John Radcliffe Hospital
- The planned changes have been assessed as delivering an improvement in stroke mortality. Further patient benefits will be delivered by the roll out of county wide Early Supported Discharge, currently available in two of our six localities, which will improve rehabilitation outcomes and reduce inequality in access to clinical effective care
- This could have an impact on the future configuration of in-patient rehabilitation beds in Phase Two
- If plans for the HASU are unsuccessful it will have an impact on the availability of beds that will impact on the flow of acute patients through the system with a consequence for the management of Delayed Transfers of Care

P09.4 Planned Care

- The provision of planned care closer to patients homes, including elective care, diagnostics and outpatients, represents a benefit for patients, primarily in the North of the County, reducing travel times and parking problems, increasing access and reducing waiting times

- It precedes the model of ambulatory care that will be provided in the South of the County in Phase Two
- There is an interdependency with the development of primary care skills and capacity in managing patients with long term conditions that is also part of Phase Two developments
- It is dependent on the presence of Level 2 Critical Care services at the Horton General Hospital

P09.5 Development of Ambulatory Care Services

- Oxfordshire health and social care providers developed a joint plan to enable patients who no longer needed acute medical care to move from a hospital setting into a nursing home. The benefits for patients are that their needs are met more appropriately whilst they wait either to be transferred home with community based support or to a permanent care home placement
- These changes enable a shift to ambulatory care, as opposed to bed based care, and supports the management of the expected increase in hospital admission due to winter illnesses affecting the elderly and those with chronic conditions
- This has facilitated the re-alignment of 194 acute beds (a reduction of 76 beds in Phase One and then 118 in Phase Two as part of the 'Rebalancing the System' delayed transfers project
- Reversing the changes would increase the level of patients delayed in a hospital bed, increase the risk of hospital acquired infection and have a potential to reduce patients mobility, confidence and their ability to live independently
- There is an interdependency between the movement and reconfiguration of acute hospital beds and the ability of OUHFT to reorganise its services for improvements to the stroke pathway

Can OCCG review the consultation document from a position of strengthening the description of the wider impact?

The consultation document has been strengthened to describe the wider impacts outlined above.

Comment P10

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

This legal advice was written before OCCG had revised the option appraisal chapter. This chapter was re-written on the back of legal advice.

For critical care and stroke OCCG has identified one single viable option for each of these services.

In the consultation document on page 24 and 26 the option rationale is explained.

For obstetrics OCCG has described that it is no longer able to deliver obstetrics at Horton General Hospital and the all obstetric services will be provided at the John Radcliffe Hospital. Illustrative examples are provided for MLU services in the north of the county

Can OCCG review the consultation document from a position of identifying where further information can be accessed?

Although there is a short list of options in the PCBC in section 5.2.3 table 5.5, there is not a long list of options.

OCCG has published material on a dedicated Transformation website to support the programme. This includes information about the case for change and reports on the engagement so far. We will highlight this more clearly in the consultation document for those that want more information.

Documents that will be available on the CCG Transformation website for the consultation include:

- Consultation Strategy
- Consultation Document
- Consultation Questionnaire
- Press releases
- Poster
- Pre Consultation Business Case
- Travel analysis
- Details of public meetings
- Consultation presentation

Additional point 1

Need for a revised consultation document that reflects feedback from NHS England that includes the consultation questions.

The consultation document is being revised to reflect this point.

Additional point 2

The Stage 2 Assurance Checkpoint meeting highlighted a need for evidence on how patient and public views have been considered by clinicians to help inform the development of options and narrowing of these to a short list for

consultation. Evidence of this is provided for maternity within the PCBC addendum on pages 40-42 (feedback from patients/public and what the response to this was in terms of informing the options) – this information is needed for the other areas being consulted on.

OCCG has reviewed all the evidence and that set out below is the best summary of how public feedback has influenced our plans.

The patient and quality benefits were considered for each of our proposals. These are summarised in the tables below:

Critical Care

Because we know...	We will...	And the benefit will be...
<p>More patients want the best quality of care delivered across the Urgent and Emergency care system within Oxfordshire</p>	<ul style="list-style-type: none"> - Ensure that Urgent and Emergency Care Services are NICE guidance compliant - Redesign pathways to incorporate more integrated ways of working by centralised centre for excellence approaches - Develop an effective information sharing ensures there are accurate records available to both primary care services and Secondary care services at the time of need. - Address inequalities in Health Outcomes such as seen at the Critical Care Units - Ensure that staff work in an environment where they are able to maintain and develop their clinical skills (e.g. intubation) 	<ul style="list-style-type: none"> - Patients receive the best practice and quality of care across the Urgent Care Pathways. - A centre for excellence provides opportunities for stay to learn and train in multiple disciplines and best practices - A maintainable workforce - GP's in primary care are always up to date with a patients care needs and treatment plans, straight from the clinical staff. - Better, more consistent outcomes for patients treated in CCU - Increased staff job satisfaction.

Stroke

Because we know...	We will....	And the Benefits will be...
<p>Patients need access services quickly and receive the best possible care for them</p>	<ul style="list-style-type: none"> - Improve patients access to the hyper acute stroke unit for all Oxfordshire patients - Ensure all patients that are suspecting of having a stroke or TIA will receive a CT Scan within 1 hour of arrival at The Hyper Acute Stroke Unit - Consultant physician with responsibility for stroke across the whole pathway - Continuing education programmes for staff 	<ul style="list-style-type: none"> - Better accessibility for Stroke Patients to the right treatment for them - Increased Access to diagnostics in a timely fashion - Specialist staff with best practice training and clear understand of patient needs
<p>Patients want to know what will happen throughout, while their health needs are cared for.</p>	<ul style="list-style-type: none"> - Define clear and concise pathways for patients to understand what will happen at each step of the way - Work with our providers to ensure smooth management of referrals and movement throughout the Stroke Pathway - Stroke specialist Multidisciplinary team meetings at least weekly to plan patient care with discharge planning 	<ul style="list-style-type: none"> - Patients will be clear on the person accountable for their treatment along with what will happen next. - Improving access to Stroke services will help cut down on waiting times, which will improve clarity around how and when a patient's health needs will be addressed - Through integration and closer working, patients will have consistency of clinical staff.
<p>Patients don't want to have to travel backwards and forwards to the Acute hospital sites for routine appointments following a non-elective spell.</p>	<ul style="list-style-type: none"> - Increase the skills, coverage and capacity within our Early Supported Discharge Service 	<ul style="list-style-type: none"> - Expanding services such as Early Supported Discharge for stroke, allows rehabilitation services to be delivered within a patients home reducing patient travel and extended stays within a hospital bed.
<p>More patients are experiencing mental health problems</p>	<ul style="list-style-type: none"> - Integrate mental health trained nurses into the wards in the acute hospitals - Increase mental health nurse training for nurses in the on the front door. 	<ul style="list-style-type: none"> - Improved resilience and mental wellbeing of patients - Effective management of patients with exacerbating mental health conditions - Patients with both mental and physical ailments are treated by a team containing mental health trained nursing with access to senior clinical mental health staff.

		- Improved access to the right level of support for every patient in Oxfordshire requiring support for mental health concerns.
More patients are becoming unwell while waiting for packages of care or other services while awaiting discharge from an Acute or Community Hospital Bed.	<ul style="list-style-type: none"> - Working with the providers to develop effective discharge pathways - Redesigning existing services to effectively support the discharge of patients across the County - Commissioning and deliver of cost effective long term support and follow up for stroke patients including health and social need reviews, communication support, return to work support and support to self-manage longer term rehabilitation. 	<ul style="list-style-type: none"> - Reduced numbers of patients in community hospital beds, experiencing worsening conditions - Patients receive high quality rehabilitation and treatment within their own bed. - Services work alongside social care support packages, carers and family members to ensure patient's needs are fully met.
More patients want the best quality of care delivered across the Stroke Pathway in Oxfordshire	<ul style="list-style-type: none"> - Ensuring Stroke Services and Pathways are NICE guidance compliant - Redesigning pathways to incorporate more integrated ways of working by centralised centre for excellence approaches 	<ul style="list-style-type: none"> - Patients receive the best practice and quality of care across the Stroke Pathways. - A centre for excellence provider opportunities for stay to learn and train in multiple disciplines and best practices - A maintainable workforce

Changes to Bed Numbers

Because we know...	We will...	And the benefit will be...
More patients are becoming unwell while waiting for packages of care or other services while awaiting discharge from an Acute or Community Hospital Bed.	<ul style="list-style-type: none"> - Working with the providers to develop effective discharge pathways - Redesigning existing services to effectively support the discharge of patients across the County - Consolidate progress on DTOC - Formalise and expand the Liaison Hub 	<ul style="list-style-type: none"> - Reduced patients in acute and community hospital beds, experiencing worsening conditions - Patients receive high quality rehabilitation and treatment within their own bed. - Services work alongside social care support packages, carers and family members to ensure patient's needs are fully met. - Patients avoiding unnecessary admission to acute bed. - Patients returning home

Because we know...	We will...	And the benefit will be...
		earlier. - More effective and efficient use of intermediate care beds.

Maternity Services

Because we know...	We will...	And the benefit will be...
Insufficient resource is directed at pre-conceptual care ¹	<ul style="list-style-type: none"> - Focus pre-conceptual care on the top three preventable factors; smoking, maintaining a healthy weight and alcohol. - Support GPs to provide targeted and specialist support to women with existing medical conditions 	<ul style="list-style-type: none"> - Early targeted interventions significantly improve clinical outcomes for women. - Women will be directed to specialist support (e.g. smoking cessation) prior to conception or earlier in pregnancy which could result in longer term better health outcomes for both woman and baby during and beyond pregnancy
There is insufficient resource for managing perinatal mental health ²	<ul style="list-style-type: none"> - Develop an integrated perinatal mental health team offering targeted advice, support and direct intervention to reduce the impact of perinatal mental health problems on women and their babies 	<ul style="list-style-type: none"> - An integrated team working closely with all health professionals involved in the maternity pathway will improve early identification and better management of perinatal mental health problems. - Effective management and treatment will result in better outcomes for women and their babies - Reduced likelihood of maternal death from perinatal mental health issues.
We need more focus on informed choice ³	<ul style="list-style-type: none"> - Continue to provide all four choices for place of birth to women in Oxfordshire as per NICE 	<ul style="list-style-type: none"> - Women will receive the right care, by the right person in the right place for them

¹ Better Births: National Maternity Review. NHS England 2016

² Five Year Forward View DH London 2016

³ Better Births: National Maternity Review. NHS England 2016

Because we know...	We will...	And the benefit will be...
	<p>guidance</p> <ul style="list-style-type: none"> - Women will be provided with unbiased information to help them make informed choices to include in their personal care plan. - Women will be given the opportunity to make decisions about their care that balances choice with clinical safety and operational capacity 	<ul style="list-style-type: none"> - Women will feel empowered to make decisions about the care they want to receive and where they want to give birth - Full offer of choice options for all Oxfordshire women with decisions made on the basis of informed choice - Improved 'patient' experience resulting in higher CQC survey scores
We have significant workforce challenges	<ul style="list-style-type: none"> - Centralise the scarce consultant workforce to create specialist teams to focus on the high risk births that need their care - Better utilise the midwifery workforce by providing 121 midwife care in low risk labour, with early labour assessments to revise risk management if necessary - Utilise MSWs to support women postnatally including breastfeeding support 	<ul style="list-style-type: none"> - Better outcomes for high risk women through continuity of specialist care - Better outcomes (including less medical intervention during labour) for low risk women - Improved postnatal 'offer' that supports women, and their partners, as they transition to parenthood - A clinically safe and sustainably model of care
There is no clearly defined role for primary care	<ul style="list-style-type: none"> - Focus GP's expertise in providing opportunistic and planned pre-conception counselling and support for women of child bearing age with a focus on preventable factors and women with pre-existing conditions - Ensure all women are consistently and effectively screened and medically risk-assessed by their GP as early as possible in pregnancy 	<ul style="list-style-type: none"> - GPs, who have insight and knowledge of a woman, and her family, are best placed to carry out the initial medical risk assessment - GP's skills and knowledge are utilised in the most appropriate manner - The initial risk assessment is with a professional a woman is familiar with and so she is more likely to

Because we know...	We will...	And the benefit will be...
	<ul style="list-style-type: none"> - GPs will maintain responsibility for the management of long term conditions and ensuring medication prescribed is safe for a pregnant or breastfeeding woman 	disclose important information that may be relevant to her pregnancy
Inconsistent medical risk assessment ⁴	<ul style="list-style-type: none"> - Ensure all women are screened and medically risk assessed by their GP (as above) as soon as possible in pregnancy - Ensure robust policies and procedures for midwives to identify and escalate women when there is a perceived change in risk (antenatal, intrapartum and postnatal) 	<ul style="list-style-type: none"> - Consistent medical risk assessment resulting in early identification of problems and better outcomes for mother and baby - Clear and effective risk assessment underpins informed choice and the decisions women will make about their care
Some estate remains unfit for purpose	<ul style="list-style-type: none"> - Reconfigure services to meet the needs of the population 	<ul style="list-style-type: none"> - Improved patient experience throughout the birth and postnatal period.
We under-utilise technology	<ul style="list-style-type: none"> - Seek to develop existing IT systems to enable a woman's notes to be held electronically and accessed by all professionals involved in her care - Look to the use of apps and other solutions to support women 	<ul style="list-style-type: none"> - Fast and easy access to a woman's care records including risk assessments and birth preferences - Women and healthcare professionals will not be reliant on women physically carrying their notes with them to every appointment - Community diagnostics will enable more antenatal care to be delivered closer to home
Midwife-led care delivers ⁵ the best outcomes for low risk women	<ul style="list-style-type: none"> - Make sure MLUs are in areas of greatest demand now and in the future - Expand capacity in the 	<ul style="list-style-type: none"> - Better outcomes for low risk women and their babies including less medical intervention

⁴ NICE QS22 Sep-12

⁵ <http://www.birthchoiceuk.com/Professionals/BirthChoiceUKFrame.htm> & <http://www.birthchoiceuk.com/Professionals/statistics.htm>

Because we know...	We will...	And the benefit will be...
	alongside MLU - Promote MLUs as the preferred place of birth for low risk women	during birth
High risk women achieve better outcomes when cared for by specialist teams ⁶	- Identify high risk women early on in pregnancy and direct them to ensure the right person/team to deliver their care - Deliver outpatient care more locally where possible - Deliver a single obstetric unit with consultant staffing 24/7 as per RCOG standards.	- Specialist obstetric team available 24/7 (labour ward) in order to improve clinical outcomes for women with the most complex pregnancies both in Oxfordshire and from outside Oxfordshire. - A sustainable consultant workforce, leading the number and complexity of births required to enable them to maintain and develop their specialist knowledge.
Women tell us we should improve our postnatal support and particularly access to specialist breastfeeding support	- Develop a postnatal offer that matches women's expressed needs with support including specialist support where required	- Improved infant mother attachment - Improved breastfeeding continuation rates

Planned Care

Benefit	How will it be assessed?
Care would be delivered closer to home with access to traditionally 'acute' services delivered in a local setting.	Number of patients seen within their locality or place of choice
Increased access to real time consultant advice from GP practices to support management in primary care to reduce referrals.	Introduction of telephone advice system for high volume specialities. Monitor usage of system including pick up by secondary care Reduction in outpatients
Care being delivered as a "one stop shop", meaning less delay between steps in the clinical pathway so that patients make fewer visits to outpatients to achieve a diagnosis and an agreed treatment plan in shorter timescale.	Improved patient experience. Fewer follow ups Better self-management and ownership of care plans by patients reflected in a specific questionnaire
More patients being treated and managed by their GPs where appropriate	Less referrals to outpatients Improved patient experience

⁶ Better Births: National Maternity Review. NHS England 2016

Reduced waiting time for outpatient appointments as capacity is freed up by more efficient clinical pathways and more patients being treated within a primary care plus model	Achievement of RTT and cancer waits Audit of pathways Referrer satisfaction Patient experience
Early care planning for patients to take over their care where appropriate	Improved patient experience Fewer follow ups Better self-management and ownership of care plans by patients reflected in a specific questionnaire
Earlier identification of cancer through better access to diagnostics and advice at primary care level and quicker access to cancer services when needed	GP and health care professional's education attended. Appropriate use of new pathways demonstrated through audit
Access to a wider range of diagnostic tests in the community making it easier for patients to attend and quicker for clinician's to act on the results.	Increased uptake of community diagnostics Audit of usage and appropriateness Introduce point of care testing where possible and monitor usage
Less need to travel to hospital sites for outpatient appointments	Travel times Number of patients seen within their locality or place of choice
Joined up care using shared care records across all providers so improving communication and reducing duplication.	Availability of shared records for all professionals and patients
Better co-ordination of care with patients being clear about the clinical pathway at the outset and clear agreed management plans	Number of patients with an agreed care/treatment plan Patient experience Monitoring system for pathways Availability of shared records
Use of decision making tools to ensure the right treatment is chosen by the individual patient and appointments aren't wasted because of poor communication and lack of understanding.	Number of patients with an agreed care/treatment plan Decision making process in place Patient experience Referrer experience Availability of shared records for all professionals and patients
Reduction in preventable diseases through earlier intervention	Use of programmes such as NDPP Uptake of weight management by practice and speciality Uptake of smoking cessation Uptake of exercise offers
Better local management of chronic diseases enabling people to live well at home with good education and self-management	Number of people requiring secondary care for their LTC Admissions to hospital for a LTC related condition Uptake of education for LTCs Number of patients with agreed care /treatment plan
Quicker access to acute services when needed	Use of pathways audit Use of communication systems email, telephone etc.
Reduction in unplanned admissions	Admissions to hospital audit

Increased patient satisfaction ⁷ and improved experience	Patient satisfaction/experience surveys Focus groups for specific areas
Less complications and hospital acquired infections	Complication rate Infection rates
Early intervention to ensure best outcomes for those patients who would otherwise present later.	Uptake of prevention programmes Referrers to prevention
Reduce variation by taking a population approach for LTCs to improve outcomes for patients	Number of people requiring secondary care for their LTC Admissions to hospital for a LTC related condition Uptake of education for LTCs Number of patients with agreed care /treatment plan Report on practice variation
Trust and OCCG meeting NHS RTT, diagnostics and cancer standards.	Performance against standards
Use of Best Practice Tariffs ⁸ to drive up quality	Pathways where best practice taken up Assessment of next steps for those that haven't been implemented
Reduce inequalities in areas of deprivation	Change in uptake of health care in areas of deprivation Change in uptake of prevention services Targeted services to ensure uptake in key areas e.g. those not attending LTC yearly checks, education and assess impact

⁷ CQC patient satisfaction survey 2001

⁸ Best Practice Tariffs (BPT) are one of the enablers for the NHS to improve quality, by reducing unexplained variation and universalising best practice. With best practice defined as care that is both clinical and cost effective, these tariffs will also help the NHS deliver the productivity gains required to meet the tough financial challenges ahead. A specific model has been developed for each of the service areas, each tailored to the characteristics of clinical best practice in that area, as well as the availability, quality and flow of data.