Oxfordshire Transformation Programme

Pre-Consultation Business Case
(Acute Hospital Services: Phase One)

Final Version 2
(Revised following confirmation of NHS England Assurance)

10th January 2017
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Introduction

The NHS in Oxfordshire performs well compared to other parts of the country. However, like the rest of the country, the current health and social care system faces a number of challenges.

Changes in people’s health and longer life expectancy mean that the county’s services are facing demand on a scale not seen before. In addition, those people living in Oxfordshire’s most deprived communities often experience more ill health and worse outcomes than people living in more affluent areas.

While the amount of money received for the NHS locally is increasing year on year, the cost of delivering services is growing at a faster rate. The local NHS needs to be able to cope with the significant increase in activity within the budget available. If nothing changes, Oxfordshire’s NHS faces a potential funding gap of £134m million by 2020/21.

The Oxfordshire Transformation Programme was established to bring partners together to address these concerns and ensure that the people of Oxfordshire have the very best standards of care whenever and wherever they need it.

We have already begun to make changes to improve services and engage with our patients around these as they develop. However, where these changes are deemed as substantial we need to ensure our proposals are subject to a robust quality assurance process triggered by substantial change and ongoing formal public consultation. This Pre-Consultation Business Case is the first document outlining our proposals in detail.
Executive Summary

Introduction and Scope

The Oxfordshire Transformation Programme was established to bring partners together to address the challenges the health and social care system faces, including the rising demand for services and budget pressures.¹

Improvements to some services have already begun to be implemented. However, some of the proposals have the potential to result in significant change: the Transformation Programme plans to submit these to NHS England as part of a formal assurance process.

This Pre-Consultation Business Case outlines the proposals in ‘Phase One’ of the programme. This covers:

- **Critical Care at the Horton General**;
- **Acute Stroke services in Oxfordshire**;
- **Maternity services** - including obstetrics and the Special Care Baby Unit (SCBU) in North Oxfordshire (this also affects emergency gynaecology inpatient services);
- **Acute hospital services**:
  - Changing the way we use our hospital beds and increasing care closer to home in Oxfordshire;
  - Planned care services at the Horton General Hospital (including elective care, diagnostics and outpatients).

Overview of Oxfordshire

Oxfordshire is the most rural county in the South East and has a population of approximately 672,000. The population has grown by more than 10% in the last 15 years and it is expected to continue growing, due to increases in life expectancy and more people moving into the county. One third of the population, and proportionately more of those aged 65 and over, live in towns or villages of less than 10,000 people.

Oxfordshire is relatively affluent but there are pockets of deprivation in some areas of Oxford City, Banbury and Abingdon. Deprivation is linked to poorer health and higher care needs. Parts of Oxford and Banbury have significantly lower income than the local average.²

The annual spend for health and social care services across Oxfordshire is about £1.2 billion today, and is anticipated to rise to £1.3 billion by 2020/21. Despite this

¹ The Governance and Programme Management arrangements are summarised in Chapter 3. The Programme’s vision for Oxfordshire – including the proposed new models of care – is summarised in Section 1.2 of Chapter 1.
² More information on the population health needs of the county are summarised in Section 2.4 and in the supporting appendices to Chapter 2.
increase, if healthcare continues to be delivered as it is today, it is anticipated that by 2020/21 there will be a deficit of £134 million.

- **Service Provision**
  The current healthcare service model is the traditional one of primary care, acute providers, mental health providers and community providers. (See Section 2.3)

- **Policy Context**
  When developing the proposals, the Transformation Programme has taken into account the national and local policy context. This includes a consideration of the priorities in *The NHS Five Year Forward View*, Oxfordshire CCG’s commissioning priorities and the Sustainability and Transformation Plan (STP) for Buckinghamshire, Oxfordshire and Berkshire West (BOB).

**The Case for Change**

Oxfordshire has an overarching case for change that has been widely shared with partners and stakeholders. This identified seven issues which are summarised in the diagram below.

![Diagram of the overarching ‘case for change’ for the Transformation Programme](image)

This overarching ‘case for change’ is described in Chapter 4. It demonstrates that ‘doing nothing’ is not an option if the Oxfordshire population are to continue to enjoy good health. It is also crucial that access and quality issues are addressed to ensure that everyone in the area has access to high quality care when they need it.

A more detailed clinical ‘case for change’ has been developed for each of the areas. Chapter 4, therefore, also considered the case for change for the areas that are the focus of this PCBC. These look at the issues identified in the overarching case for change in more detail. They also review current performance in the light of both
national and college standards / guidance and briefly considers best practice for each area.

The Clinical Models

The proposed clinical models, and the process that was used to develop these models, are then examined in chapters 6 and 5 respectively. Clinical pathways and clinical interdependencies are also explored.

The Clinical Working Groups developing these models drew on the information from the case for change, particularly using the information on national and college standards / guidance and best practice. This should ensure that the people of Oxfordshire have the very best standards of care whenever and wherever they need it.

Meeting the NHS ‘Four Tests’ and the ‘Best Practice’ Checks

- The NHS ‘Four Tests’

  NHS England has issued guidance on how commissioners should manage major service change and the criteria that should be met. One of the key requirements is to ensure that the ‘four tests’ are embedded within the reconfiguration planning process. Chapter 7 describes how the proposals within the scope of this PCBC meet these ‘four tests’:

  - **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.

  The tests are designed to demonstrate that there has been a consistent approach to both managing change and liaising with patients and the public. Meeting the ‘four tests’ should, therefore, build confidence with the service proposals.

- The ‘Best Practice’ Checks

  In addition to the formal NHS ‘Four Tests’ the CCG has considered a number of other ‘best practice checks’. These are summarised in Chapter 8 and include:

  - Access and Travel Analysis
  - External Scrutiny, including HOSC and the Health and Well-Being Board
  - Meeting the Public Sector Equality Duty
  - Other Public Sector and Commissioner Duties
  - Legal Advice
Workforce, Activity, Finances and Estates

It is also important that any proposals can be practically delivered within the funding available in Oxfordshire. Part Five of this business case, therefore, considers the workforce and estates implications (Chapter 9), along with the likely impact on activity and the finances (Chapter 10). An overview of the plans for implementation of the proposals is then included in 11.

Next Steps

The approach to be taken by Oxfordshire Clinical Commissioning Group (OCCG) in terms of consulting with the public and stakeholders is outlined in Chapter 12.

The final chapter sets out the processes that will be followed after the public consultation.

Conclusion

Together this information should give a clear picture of the problems that Oxfordshire is facing in relation to critical care, stroke care, maternity services, and planned care along with the Transformation Programme’s proposed solution.

It demonstrates that the proposals are based on a strong clinical evidence base and that the CCG has a plan for how the changes can be successfully implemented within existing resources.
Part One:

VISION, SCOPE, CONTEXT AND GOVERNANCE
Chapter 1: Vision and Scope

1.1 Background

The Oxfordshire Transformation Programme is taking a collaborative ‘whole system’ approach which recognises the interdependencies between primary, community and acute care.\(^3\)

![Diagram showing the whole system scope of the Transformation Programme](image)

1.1.2 To support this six clinical workstreams and five enabling workstreams were established to engage partners from across the health and care system in considering change.

1.1.3 Clinical Workstreams

- Integrated Frail Older People and Urgent and Emergency Care for the adult population
- Mental Health, Learning Disabilities and Autism
- Elective (planned) care
- Maternity Services
- Children and Young People’s services
- Primary Care

The clinical workstreams will be reviewed as we commence Phase Two of Oxfordshire’s Transformation Programme.

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\(^3\)The programme does not, however, include NHS England services commissioned under **national contracts** such as high street dental practices, high street opticians with a contract to provide NHS general ophthalmic services, or community pharmacy services. (Although it does include any locally commissioned services from community pharmacy and opticians.)
1.1.4 Enabling Workstreams

- Public Health / Prevention
- Quality
- Finance and Activity
- Supporting functions (e.g. IM&T, workforce, estates)
- Consultation and Engagement

1.1.5 Each of the clinical workstreams have agreed a vision for how services can be improved and have developed plans to turn the vision into reality. These are described in the next section.
1.2 The Vision of the Oxfordshire Transformation Programme

1.2.1 The Overarching Vision

The agreed vision statement for Oxfordshire is: *Best Care, Best Outcomes, Best Value for all the people of Oxfordshire.* This is illustrated in the diagram below:

![Figure 1.2 – Oxfordshire’s Vision](image)

1.2.2 The Transformation Programme’s vision can also be summarised as:

- The best quality care provided to patients as close to their homes as possible
- Health professionals, working with patients and carers, with access to diagnostic tests and expert advice quickly so that the right decision about treatment and care is made
- Ensuring, as modern healthcare develops, our local hospitals keep pace, providing high quality services to meet the changing needs of our patients
- Preventing people being unnecessarily admitted to acute hospital or using A&E services because we can’t offer a better or more local alternative
- Keeping people well and encouraging people to take responsibility for their own health and care.4
- Best bed is your own bed.

1.2.3 New Service Models

Each of the clinical workstreams have agreed a vision for how services can be improved and have developed plans to turn the vision into reality.

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4 A greater focus on prevention and self-care will be made in Phase Two of the Programme.
1.2.4 Primary Care

Oxfordshire’s vision for primary care is:

To provide a 21st century modernised model of primary care that works across neighbourhoods and localities to provide enhanced primary care, extended primary care teams, and more specialised care closer to home delivered in partnership with community, acute and social care colleagues.

To ensure the sustainability of primary care and to support it to be the lynchpin of our newly transformed health and care services, new thinking is required and new models of care. The key design principles for a new model of primary care in Oxfordshire are based on care closer to home:

![Figure 1.3 – The key design principles for a new model of primary care](image)

![Figure 1.4 – The underlying model for the Transformation Programme](image)
The model aims to move care away from secondary care, wherever appropriate, to primary and community care settings, supported by greater levels of prevention and self-care. It recognises that the ‘best bed is your own bed’. These principles underline not only the primary care model, but all of the other new models developed as part of the Transformation Programme.

The model below (the ‘onion’ diagram) shows how care can be organised around populations to provide economies of scale, facilitate practices to work together through federations to share resources and share the workload to provide a better service and manage demand.

![The Population Based Approach](image)

**Figure 1.5 – The Population Based Approach**

Scaling services in this way means:

- More specialist care to be provided in the community, better aligned to other health, community, social care and voluntary organisations;
- Better use of skill mix and shared practice resources, including infrastructure;
- New primary care neighbourhoods as resilient, sustainable and scalable networks with the capability and resources to deliver a coordinated suite of health services for their population;
- Improved access to same day urgent appointments.

The new model of care for primary care ensures that the patient is receiving care at the correct place, first time, by the most appropriate person. We will develop sustainable local practices and larger, more integrated primary care
services. Segmentation of the population according to need supports planning of services at scale.

Working at scale within multidisciplinary teams alongside outreach community and acute clinicians and social care staff requires a co-ordinated workforce plan that addresses Oxfordshire’s key challenges in recruiting and retaining people. A wide range of functions currently undertaken by general practice could be better done by other healthcare professionals or at other community locations. We will evaluate new roles such as physicians’ assistants and new and novel ways of attracting staff to work in Oxfordshire, such as GP Fellow schemes. Self-care with the support of the local community pharmacist will enable and empower patients to better self-care. GP workload will be reduced as many tasks are taken up by another professional or in another way.

Technology will be central to ensuring general practice is sustainable in the future. This will include shared records systems, or technology to monitor conditions, doses or treatment. The use of new technology will make it easier to access health advice, to book an appointment, to order repeat prescriptions. It will also support different types of interaction between patient and professional and will help make sure information systems are interoperable between organisations. Patients will be empowered by records access. Technology will help teams work better together, more remote monitoring and a more coordinated flow of information.

In summary, the features of the new model are:

1. General practice will continue to be population based;
2. General Practice will support public health initiatives for the prevention of disease in their population;
3. The general practice patient record will be a central comprehensive record for medical information relating to the patient;
4. Decisions around planning of general practice to improve patient care will happen at scale;
5. All patients will have access to a same day urgent appointment if clinically appropriate;
6. All patients requesting a routine appointment will be able to book one within seven days if clinically appropriate;
7. High-intensity patients will have a named accountable GP who will be responsible for making sure that their care is appropriately provided for 24 hrs a day seven days a week;
8. All patients diagnosed with a long-term condition will be offered individualised support to manage their condition;
9. General practice will maintain the vast majority of prescribing;
10. General practice will be mindful of health inequalities and strive to promote schemes which reduce variation across the whole of Oxfordshire.

These features will mean that primary care will remain sustainable, patient access and satisfaction will improve, self-care will be supported, skill mix will be optimised, and more care will be undertaken in non-hospital settings.

To implement the new model requires effective workforce planning, good collaboration between health care professionals, and realigning care delivery around the scaled and stratified populations described above.

1.2.5 Urgent and emergency care

Our vision is for accessible and highly responsive services that provide integrated physical and mental care to put the patient at the centre. It delivers the right care at the right time and maximises the potential for survival and good recovery. The right clinician expertise would be available with the right facilities to deliver treatment or support to self-manage including the latest information technology to enable best care. Clinicians would be supported to make decisions that ensure that care takes place in an ambulatory setting when appropriate and embrace the approach that ‘the best bed is your own bed’.

The diagram below represents all patients within the health economy across Oxfordshire. Stratifying patients supports the development of key models of care for each of the group of patients and the outcomes desired for each group.
1. **General health support**: Many patients within Oxfordshire are mostly healthy and require contact with a GP or medical professional at irregular intervals. Their needs will be met through primary care, enhanced as described earlier.

2. **Complex patients**: There is an increasing risk in managing these patients as they have a complex range of morbidity including mental and physical health, which could result in an acute hospital admission if not appropriately supported. Therefore we will deliver greater proactive support of patients and introduction of increased early education programmes; better assessment and meeting of mental health needs; GP support to care homes; easier access to and more support from services for dementia; better palliative care in home and community settings.

3. **Unstable frail**: Patients that are unstable frail (mostly older people) are at an increased risk of requiring bed based care or treatment in an ambulatory setting. We will ensure better front-line clinical support for such patients, supported by immediate knowledge of available resources, relevant information, lab results and access to the patient’s electronic record. They will be able to book patients directly into clinics. Decision support will help appropriately direct patients to the most effective pathway.

4. **Acutely Unwell**

   The highest level of need is for those patients who are acutely unwell and require immediate medical assistance from a specialist service. Patients that fit within this category include Stroke patients, End of Life and Major Trauma. These patients are generally treated in an acute setting or a Community Hospital.
### 1.2.6 Planned Care

*Our vision is to have accessible, local where possible, high quality integrated services that put patients ‘at the centre’. We will deliver the right care at the right time in the patients’ pathway, in a ‘one stop shop’ where appropriate, with the right clinician for treatment or support for self-management, including the latest information technology to enable best care.*

To improve outpatient and diagnostic services, we will:

- Skill-up clinical staff to provide as much medical, surgical and psychological care as possible in the community away from our main hospitals;
- Deliver outpatient care including pre-operative assessment as a “one stop shop”, to reduce stress, inconvenience and time taken out of the day;
- Increase the availability of a wider range of diagnostics in the community;
- Utilise other technology to ensure patients can manage and monitor themselves where possible in a fully informed way;
- Ensure shared electronic care records across a range of providers and include people’s social care records to deliver seamless joined up care;
- Focus on reducing preventable diseases;
- Improve access to psychological and psychiatric care for people with physical health problems who need it;
- Ensure some services are accessible by patients via self-referral, such as physiotherapy, podiatry etc.

New methods of delivery provide opportunities for delivering care closer to patient’s homes enabling people to live well increasing number of patient with long-term conditions.

![The Planned Care Pyramid](image-url)

*Figure 1.8 – The Planned Care Pyramid*
Given the volume and complexity of patients seen in primary care and the ambition to have increasing volumes of care delivered ‘closer to home’, there is a need to develop a model which encompasses a ‘primary care plus’ element to deliver care outside of a hospital setting but beyond the scope that is normally delivered under the core GP contract. This is as ‘co-ordinated care’ and will include a range of supporting diagnostics and procedures.

In primary care we will:

- Develop primary care plus to care for patients closer to home;
- Supplement existing primary care through increased access to diagnostics, support from secondary care expertise, telemedicine and better communication, better pathways for end of life care, and better management of mental health co-morbidities;
- Substitute locally accessible services for outpatient procedures;
- Develop specially trained GPs and other staff to provide more services in community settings;
- Expand the referral management hub.

Co-ordinated planned care centres will be developed to support one-stop-shops, outpatient procedures, day case work, and investigations including CT and MRI. The centres will support primary care and the availability of a multidisciplinary assessment for patients will help to achieve earlier diagnosis of some cancers.

Elective procedures will be improved, with higher day case rates, reduced lengths of stay, better pre-operative support for fitness for surgery, fewer cancellations due to separation of planned surgery work from emergency, reduced readmissions, lower levels of healthcare acquired infection. Ring-fencing of elective work, incentivised contracts and relocation of some work to new settings will facilitate these improvements. We will develop end to end pathways for the high volume procedures to ensure they are embedded and well communicated. A generic best practice model for planned care inpatient surgery is proposed below:
Improvements in elective pathways will be made by applying the lessons of recent reviews into best practice, bringing about productivity gains and cost reductions.

Work is underway to understand the Right Care indicators relevant to planned care and long term conditions (LTCs). These areas are cancer and tumours (focus on screening, care planning and treatment waits), respiratory (asthma, COPD, and prevention), neurology (epilepsy) and cardiovascular (prevalence, blood pressure, heart failure, chronic kidney disease).

For improvement of cancer treatment, better care planning will be supported with the Oxfordshire Summary Care Record. The ACE early diagnosis programme will be evaluated. Diagnostics will be improved, and there will be better support for mental health and well-being alongside psychological care for cancer patients. Prevention programmes will be supported, as will ‘survivorship’ for people who have had cancer.

Overall, the new model for planned care will have the following features and benefits:

- Care would be delivered closer to home with access to ‘acute’ services delivered in a local setting;
- Increased access to real time consultant advice from GP practices;
- Care being delivered as a “one stop shop”, meaning less delay between steps in the clinical pathway so that patients make less visits to outpatients and achieve a diagnosis and treatment plan more quickly;
- More patients being treated and managed by their GPs where appropriate;
• 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;
• Earlier identification of cancer through better access to diagnostics and advice at primary care level and quicker access to cancer services when needed;
• 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;
• Less need to travel to hospital sites for outpatient appointments;
• Joined up care using shared care records across all providers;
• Better co-ordination of care with patients being clear about the clinical pathway at the outset and clear agreed management plans;
• Use of decision making tools to ensure the right treatment is chosen by the individual patient and appointments are not wasted;
• Reduction in preventable diseases through earlier intervention;
• Better local management of chronic diseases enabling people to live well at home;
• Quicker access to acute services when needed;
• Reduction in unplanned admissions;
• Increased patient satisfaction and experience;
• Fewer complications and hospital acquired infections;
• Early intervention to ensure best outcomes for those patients who would otherwise present later.

Successful change will require workforce recruitment and retention whilst changing roles, responsibilities and potentially where people work on a daily basis. Estates must be reconfigured to deliver the changes as it is unclear if current sites would be able to accommodate the new model.

1.2.7 Maternity

Our vision is for the right woman to get into the right part of the maternity service and to be cared for by the right professional. The aim is for every woman to experience personalised care from early medical risk assessment through to birth and beyond. It encompasses real choice and continuity of care throughout the pregnancy, birth and postnatal period.

![Personalised Care Diagram]

Figure 1.10 – Maternity Model of Personalised Care
A new model of care for maternity services has been described for a woman’s journey through the three stages of pre-conceptual care, antenatal and birth and postnatal care:

**Clear pre-conceptual offer** – support to improve health through reduced smoking, weight control, and reduced alcohol consumption; targeted specialist care to those who need it;

**Early medical risk assessment** – improved assessment processes, supported by shared records and improved IT

**Evidence based pathways for low risk care** – improved overall assessment of risk will allow the correct pathway of care to be identified

**Evidence based pathways for high risk care** – centralising specialist services to meet increased demand and maintain high standards of safety and quality

**Informed choice for all women birth options** – each woman will have a personalised care plan, and be provided with unbiased information to help them make informed choices; and home birth, midwife-led care and obstetric care will be offered in accordance with choice and risk assessment

**Expanded offer of postnatal support** – an online ‘menu’ of services so women can receive the support and information they need in the place most appropriate for them

**Integrated perinatal mental health service** – timely evidence-based specialist perinatal mental health care locally throughout the ante and postnatal period.

The features and benefits of this model will be to:

- 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;
- 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;
- Continue to provide all four choices for place of birth to women in Oxfordshire as per NICE guidance;
- 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;
- 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 Maternity Support workers to support women postnatally including breastfeeding support;

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;

GPs will maintain responsibility for the management of long term conditions and ensuring medication prescribed is safe for a pregnant or breastfeeding woman;

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);

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;

Develop capacity for community based diagnostics;

Make sure Midwife Led Units are in areas of greatest demand now and in the future;

Promote Midwife Led Units as the preferred place of birth for low risk women;

Identify high risk women early on in pregnancy and direct them to the right person/team to deliver their care;

Implementing the model will require changes to:

Service reconfiguration countywide to ensure there is the right estate with the right capacity;

Workforce development.

1.2.8 Children

Our vision is to be the best place in England for children and young people to grow up in. We will work with every child and young person to give them the best start in life and to develop the skills, confidence and opportunities they need to achieve their full potential.

To realise the vision, prevention will form a cornerstone; promoting health and building resilience in all children and young people, keeping them safe and well, achieving better health and wellbeing outcomes and reducing inequalities.
Two areas of particular focus will be:

- Childhood obesity
- Mental wellbeing for children.

The current model of service has evolved over the last 20 years and health care services for children in Oxfordshire are still heavily reliant on hospital based services. With more than 78,000 outpatient appointments\(^5\) for children every year there is concern that we are still using hospitals to treat conditions that could be dealt with more appropriately in other settings. The vast majority of appointments take place in the hospitals in Headington and this includes about 10,000 appointments in Headington for children from north Oxfordshire. There are other emerging problems that need to be considered.

Primary care is under tremendous pressure in terms of capacity, confidence and skills\(^6\). There is no dedicated child health specialist expertise in the community and families tell us that whilst care received in hospital and community services is good, it is often disjointed, uncoordinated and not user-friendly. The demand for Child and Adolescent Mental Health Services (CAMHS) is rising relentlessly and urgent work is already underway to increase capacity and to encourage earlier intervention and support. With increasing pressure on Council resources there is more need for the NHS to strengthen prevention and early intervention services.

In developing a model fit for the future we need to consider the following:

<table>
<thead>
<tr>
<th>Because we know...</th>
<th>We will...</th>
<th>And the benefit will be...</th>
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| We need to focus more on prevention | - Radically upgrade prevention activity with a focus on childhood obesity and mental wellbeing.  
- Promote integration of universal and specialist services through multi-disciplinary team (MDT) working. | - Prevention in childhood presents the biggest opportunity to change outcomes for children not just in childhood but throughout their life.  
- Multi-disciplinary meetings and specialist outreach will allow for earlier identification and preventative action to be taken. |
| More children are living with | - Develop integrated teams that provide a ’one stop shop’ where | - A more coordinated and integrated service, |

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\(^5\) Outpatient data for 2014 – 2016 provided by OUH  
\(^6\) Facing the Future: Together for child health. RCPCH 2015
| Chronic Long-Term Conditions<sup>7</sup> | Investigations, consultation and therapeutic interventions can happen within one day.  
- Base these teams and provide outpatient appointments in community settings so care can be delivered closer to home. | Delivered closer to home which reduces the frequency and travel time of appointments. |
| --- | --- | --- |
| More Children are experiencing mental health problems<sup>8</sup> | - Invest and embed preventative initiatives to protect the mental wellbeing of children  
- Implement the Oxfordshire CAMHS Transformation Plan | Improved resilience and mental wellbeing of our children today and as they grow into adulthood.  
- Improved access to the right level of support for every child in Oxfordshire requiring support for mental health concerns. |
| More Children are attending A&E with minor illnesses and injuries<sup>9</sup> | - Work with partners in Public Health and across the NHS to ensure parents understand the best course of action when their child is unwell.  
- Develop paediatric skills and knowledge within Primary Care and improve access through same day and extended hours clinics.  
- Urgent care for children will be easier to access, more joined-up, preventative and proactive | More children are cared for at home or in their community.  
- Families and carers will be supported to look after their children if needed so that they can reach their full potential at home, school and at play. |
| Children’s health services are too reliant on hospital based services | - Form integrated child health teams that are based away from the acute hospital and closer to home.  
- Develop paediatric skills and knowledge within Primary care, with improved access, to enable minor illnesses and injuries to be managed in the community.  
- Hold outpatient clinics away from the acute hospital site where possible, instead holding them in community settings including special schools. | Services are delivered in a more appropriate setting for the child and more conveniently located for parents and carers to access and travel to. |

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<sup>7</sup> Children and Young Peoples Needs Analysis, Oxfordshire Health Observatory 2014  
<sup>8</sup> Oxfordshire CAMHS Transformation Plan 2015  
<sup>9</sup> Facing the Future together for Child Health RCPCH 2015
There is no dedicated child health specialist expertise in the community

- Develop specialist outreach so GPs can gain specialist knowledge/advice from paediatric consultants.
- Hold MDT meetings, attended by a consultant paediatrician and community healthcare professionals who can identify, discuss and agree effective case management of vulnerable children, keeping as much of their care as possible in the community.
- GPs and community healthcare professionals will develop paediatric skills and knowledge which in turn will increase their confidence to manage more children in the community.
- Links will be formed between primary and secondary care, improving communication and confidence between professionals.

Services are disjointed and uncoordinated

- Develop integrated pathways of care which will facilitate quicker diagnosis and treatment/management of care
- Better use of technology including digital records, telemedicine and e-consultations will allow for better flow of information between professionals providing care to a child and quicker access to specialist advice.
- Children will receive the right care, in the right place from the right person
- Appropriate information will be shared faster through better use of technology avoiding parents having to repeat information at each appointment.

Children are growing up in a digital age

- Make better use of technology through electronic records, skype consultations, self-help apps and mediated chatrooms.
- Children will be able to engage with health services in the way they have come to expect.
- Self-help apps and mediated chatrooms will allow, encourage and support children to self-care

1.2.9 Mental health, learning disability and autism

The vision for mental health, learning disability and autism is essentially to continue with the developments already under way. The focus is to address those areas that are not wholly addressed in our current contracts and commissioning intentions - including older people with functional mental illness and children and younger people in transition.
Figure 1.13 – Focus areas for mental health, learning disability and autism

It will deliver the following outcomes:

• A dedicated 24/7 urgent care pathway for those people with mental health problems, learning disability and/or autism in distress or at risk and consistent access for people with urgent needs across the mental health and learning disability spectrum;

• A system wide approach to managing clinical risks around mental health problems, learning disability and/or autism in distress which could also support mental health presentations in other settings including around dementia;

• A primary care response to support the management of people who do not engage with specialist services, and/or who need social support to enable them to manage stress factors that contribute to poor mental well-being and/or who have complex presentations that compromise our ability to manage long term conditions and their use of the urgent care system; these services are likely to be needed amongst people with particular needs around deprivation and/or isolation;

• The needs of people with dementia, and the mental health needs of people with physical health problems are considered in the urgent, planned and primary care sections of this plan.

The new care model encompasses:

• A life course approach to managing mental ill-health to support the transition of people from childhood and adolescence to adulthood and should also support healthy aging in the older population;

• Access to services in an emergency - a response that works on the basis that wherever someone with a mental health-style crisis presents to the health, social care or emergency services they should be routed through to triage, assessment and where necessary treatment that is able to meet their needs;

• A system wide approach to managing clinical risks around mental health problems, learning disability and/or autism in distress - to increase the capability of our systems to understand, support and manage the particular needs of people, with better staff training, awareness, greater psychological and psychiatric expertise, information sharing;

• A primary care response to support the management of people who do not engage with specialist services - a level of support to primary care for the care and management of high users of primary care services, closer to their own home; behavioural support, information/advice and social prescribing and specialist psychological and psychiatric expertise for more complex patients, either delivered directly or in partnership with the patient’s GP.
The new model will deliver and ensure:

- A single front door for people with urgent mental health presentations that gets people to the right service at the right time and reduces pressure elsewhere in the system;
- Improving outcomes for people at times of transition, from children’s to adult services and from adult to older adult services;
- Improving outcomes for people living with autism and for people with behaviours that challenge, including a reduction in in-patient admissions;
- Better prevention in primary care;
- More children and young people will have access to preventative mental health services and support, as prevention and promotion interventions during childhood and adolescence are particularly cost-effective;
- Improving physical health of people with mental health issues, learning disability and/or autism;
- More effective use of mainstream health services, with a reduction in the need for specialist services;
- Reduction in in-patient admissions and better management of mental and physical health needs in the community;
- Increasing the use of personalised care where that supports better outcomes;
- The continued strengthening and development of the innovative psychological medicine service at the OUH that secures the fully integrated treatment of patients with both physical and mental health needs;
- Integration of the commissioning and provision of mental health and substance misuse.

The key dependencies for the programme of work to deliver these improvements above will be:

- The willingness and ability of providers and other agencies to embrace the role of supporting people with mental health problems, learning disability and/or autism in mainstream settings;
- Clinical and other stakeholder views on the effectiveness and impact of revising age barriers across the life course of mental illness;
- Developing interoperable systems and protocols that support the single from door for people with urgent presentations.
1.3 Scope

Our Approach:

There are three areas where the Transformation Programme’s proposals could result in significant service change:

1. **Acute Hospital Services**
   Changes are proposed in three areas:
   - Urgent and Emergency Care, including:
     - emergency and critical care facilities
     - stroke care
     - changes to the way we use our hospital beds and increasing care closer to home
   - Planned Care (Elective Care, Diagnostics and Outpatients)
   - Maternity Services

2. **Community Hospital Services**
   The Transformation Programme is developing new models of care in community settings that are expected to result in:
   - More people being supported in their own homes and less reliance on inpatient beds in supporting rehabilitation after treatment;
   - More consistent urgent care in local settings.

   These changes in model are likely to impact on what services are required in community hospitals in the future. It is therefore expected that some of the options for delivering those changes will result in specific proposals for change in relation to the community hospital infrastructure across Oxfordshire.

3. **Primary Care**
   We need to support provision of primary care services to address the 4% per annum rise in demand and the sustainability issues. The aim is for changes to primary care to proceed along the same timeline as proposed service changes in other areas. Resourcing and capacity in primary and community care must be strengthened to enable people to be supported close to home. If any change is substantial to patients this too will be consulted upon and would feature as part of phase two.

1.3.1 Phasing

To make the process manageable, proposals for change will be submitted for scrutiny by NHS England in a phased process.

1.3.2 Phase One: Acute Services

The changes around acute hospitals will be submitted in two phases. The first will focus on those areas where there are the most pressing concerns about workforce,
patient safety and healthcare (for example, where temporary changes have been made) or where the proposed changes have been piloted.

This includes:

- **Critical care at the Horton General**;
- **Acute stroke services in Oxfordshire**;
- **Maternity services** - including obstetrics and the Special Care Baby Unit (SCBU) in North Oxfordshire (this also affects emergency gynaecology inpatient services)
- **Acute hospital services**
  - changes to bed numbers in order to reduce delayed transfers of care and move to an ambulatory model of care;
  - planned care services at the Horton General Hospital (including elective care, diagnostics and outpatients). Planned care proposals have the potential to significantly increase the services available to patients in north Oxfordshire.

1.3.3 Phase Two:

**Acute Services**:

Phase Two of the work looking at acute hospital services will focus on:

- The provision of **Emergency Departments** in Oxfordshire;
- **Children's Services** including the current processes for assessment and the provision of in-patient paediatric beds.

**Community Hospitals**:

This will include all current service to be provided in community hospitals, including the future configuration of midwife led units (MLU’s) and maternity services across Oxfordshire.

The work on both the acute and community hospitals is based on the same overall Oxfordshire wide models of care being developed within the Transformation Programme. The teams supporting the programmes are working closely together to ensure that synergies and interdependencies between the two elements are identified and managed.

Changes to the provision of primary care services, which are coincident with the service changes planned to be consulted upon in Phase Two, are a necessary foundation for the successful implementation of service changes in acute and community care.
### 1.3.4 Summary of Scope and Phasing

The scope of Phases One and Two of the formal public consultation are summarised in the table below:

**Table 1.1: Scope of Phases One and Two of the formal public consultation**

<table>
<thead>
<tr>
<th>Options</th>
<th>Clinical Services</th>
<th>Phase 1 Scope</th>
<th>Phase 2 Scope</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Urgent and Emergency Care</strong></td>
<td>Emergency Department (ED)</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>GP urgent care with Minor Injuries Unit (open out of hours)</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>ED and Integrated Urgent Care Centre (24/7)</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>Non-elective inpatient</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>Ambulatory Care Model</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Non-elective inpatient surgery</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>Delayed Transfer of Care</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td><strong>Stroke Care</strong></td>
<td>Acute stroke treatment</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Early Supported Discharge</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation Beds</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td><strong>Critical Care</strong></td>
<td>Level 3 (current)</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Level 2</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td><strong>Diagnostics (Horton)</strong></td>
<td>Current (limited)</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td></td>
<td>New diagnostic facility with increased capacity</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Outpatients (Horton)</td>
<td>Current Provision</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>---------------------</td>
<td>-------------------</td>
<td>---</td>
<td></td>
</tr>
<tr>
<td>New outpatient facility for transfer of existing Headington Clinics</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Both Obstetric and Midwifery care</td>
<td>✓</td>
<td>tbc</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Planned Care: Surgery</th>
<th>Elective inpatient surgery</th>
<th>✓</th>
</tr>
</thead>
<tbody>
<tr>
<td>Day case surgery</td>
<td>✓</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Planned Care: Medicine</th>
<th>Elective inpatient admissions</th>
<th>✓</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elective day treatment</td>
<td>✓</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Long term conditions</th>
<th>Cardiology; bladder &amp; bowel; MSK; ENT; diabetes; SCAN pathway</th>
<th>In commissioning intentions – anticipated to have full engagement and if any substantial change then will be subject to public consultation</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Maternity</th>
<th>Free standing midwifery-led unit (North)</th>
<th>✓</th>
</tr>
</thead>
<tbody>
<tr>
<td>Free standing midwifery-led unit (South)</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Special Care Baby Unit (SCBU)</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Emergency gynaecology surgery</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Increase in maternity clinics (antenatal, postnatal and breastfeeding etc.)</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Children’s Services</th>
<th>Paediatric inpatients</th>
<th>✓</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paediatric SSPAU/Clinical decision unit (16 or 24 hours per day)</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Paediatric elective day case care</td>
<td>Increase in paediatric day case care</td>
</tr>
<tr>
<td>---------------------------</td>
<td>-----------------------------------</td>
<td>--------------------------------------</td>
</tr>
<tr>
<td><strong>Primary care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>New model of primary care provision</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| **Primary care**          |                                   |                                      |                                                      |
Chapter 2: Strategic Context

2.1 Overview

2.1.1 Oxfordshire is the most rural county in the South East and has a population of approximately 672,000. The population has grown by more than 10% in the last 15 years and it is expected to continue growing, due to increases in life expectancy and more people moving into the county. One third of the population, and proportionately more of those aged 65 and over, live in towns or villages of less than 10,000 people.

2.1.2 Oxfordshire is relatively affluent but there are pockets of deprivation in some areas of Oxford City, Banbury and Abingdon. Deprivation is linked to poorer health and higher care needs. Parts of Oxford and Banbury have significantly lower income than the local average.

2.1.3 Oxford has a global reputation for its world-class university and its workforce is amongst the most highly qualified in England.

2.1.4 Oxfordshire has one County Council and five District Councils.

2.1.5 It is recognised that the services under consideration within this document also provide services for communities that border Oxfordshire. This is particularly the case in relation to the Horton General Hospital which provides a range of local acute services for people in South Northamptonshire and South Warwickshire.

2.2 Funding

The annual spend for health and social care services across Oxfordshire is about £1.2 billion today, and is anticipated to rise to £1.3 billion by 2020/21. Despite this increase, if healthcare continues to be delivered as it is today, it is anticipated that by 2020/21 there will be a deficit of £134 million.

2.3 Current Service Provision

The current healthcare service model is the traditional one of primary care, acute providers, mental health providers and community providers.

2.3.1 Commissioning and Primary Care

There is one Clinical Commissioning Group, Oxfordshire CCG, made up of 72 GP Practices which are organised into six localities:

- **North** – 12 practices covering Banbury, Bloxham, Chipping Norton, Cropredy, Deddington and Hook Norton. It has a patient population of 109,322. (15%)
- **North East** – 7 practices covering Bicester, Kidlington and Yarnton, Woodstock and Islip. It has a patient population of 81,852. (11%)
- **Oxford City** – 22 practices covering Oxford City, Kennington and Botley. It has a patient population of 209,155. (29%)
- **South East** – 10 practices covering Wheatley, Sonning Common, Thame, Wallingford, Henley on Thames. It has a patient population of 92,200. (13%)
- **South West** – 12 practices covering Abingdon, Clifton Hampden, Berinsfield, Didcot, Wantage and Farringdon. It has a population of 144,133. (20%)
- **West** – 9 practices covering Witney, Carterton, Eynsham, Charlbury, Burford and Bampton. It covers a patient population of 81,194 (11%)

The locations of the GP Practices are shown in Figure 2.1 below.
2.3.2 Acute Hospital Provision

Oxford University Hospital NHS Foundation Trust (OUHFT), one of the largest NHS teaching trusts in the UK, is responsible for acute hospital provision in the area. They operate four hospitals in the county. Three are in Oxford:

- **The John Radcliffe Hospital** which includes the Children's Hospital, West Wing, Eye Hospital, Heart Centre and Women's Centre
- **The Churchill Hospital**
• The Nuffield Orthopaedic Centre

OUHFT also runs the Horton General Hospital in Banbury, north Oxfordshire, which is a small District General Hospital (DGH) with 24/7 A&E, acute geriatric beds, obstetrics and 130 overnight beds across various specialities, taking into account temporary closures.

2.3.3 Community Services

Oxford Health NHS Foundation Trust delivers community and mental health services for the area. This includes eight community hospitals which range in scale from 12-50 beds. Some have advanced urgent care close to home while others are more traditional with bed-based care for step down. The Community Hospitals are:

• Abingdon Community Hospital
• Bicester Community Hospital
• Didcot Community Hospital
• Oxford City Community Hospital (The Fullbrook)
• Wallingford Community Hospital
• Wantage Community Hospital
• Witney Community Hospital

In addition to these hospitals there are intermediate care beds in the Chipping Norton buildings run by the Order of St John. This provides intermediate care beds, a NHS midwife led unit, and a range of other community services.

The locations of the acute and community hospitals are included in Figure 2.2 on the next page.

2.3.4 Ambulance

The area is covered by the South Central Ambulance Trust.
2.4 Population Health Needs

2.4.1 A growing and ageing population

Oxfordshire’s population is ageing with more people living longer but often with one or more long term conditions. As such older people are likely to require more health and social care and the impact of the needs of an ageing
population is manifested as increasing demand on GPs, pressure on hospital beds, social services and delayed transfers of care. This creates a significant demographic challenge:

- Around 17% of the population are over 65, rising to 25% of residents over 65 in 13 of Oxfordshire's wards;
- The 85 plus population is set to increase by around 7,800 people (48%) between 2014 and 2026;\(^\text{10}\)
- An increasingly ethnically diverse ageing population, meaning that the pattern of disease will change. For example, people from parts of Asia and the Indian sub-continent are more prone to develop diabetes and its complications at lower levels of obesity;
- 61,000 people in Oxfordshire providing some level of informal care to a relative or friend, many aged 50-64 years old.

The proportion of older people differs from place to place across the county.

### 2.4.2 Housing development

The population of Oxfordshire is also expected to grow as a result of housing developments. Population projections have been produced based on each district council’s local plan. These intentions are summarised in the table below:

<table>
<thead>
<tr>
<th>South Oxfordshire District Council</th>
<th>Increasing housing development around Didcot (55% of the total) plus Thame, Henley and Wallingford, with growth also in larger settlements like Sonning Common, Berinsfield and Chinnor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cherwell District Council local plan</td>
<td>The bulk of proposed development will be around Bicester and Banbury</td>
</tr>
<tr>
<td>Vale of White Horse District Council</td>
<td>planning for 20,560 homes and 23,000 jobs together with the infrastructure to support the growth</td>
</tr>
<tr>
<td>Oxford City Council</td>
<td>revising their local plan</td>
</tr>
<tr>
<td>West Oxfordshire District Council</td>
<td>submitted a revised local plan- no update on potential areas for housing development is yet available</td>
</tr>
</tbody>
</table>

**Figure 2.3: Housing Intentions in the District Council Local Plans**

\(^{10}\) ONS population estimates/Oxfordshire County Council Research and Intelligence long-range projections (autumn 2014)
2.4.3 Disability, Morbidity and Mortality

Oxfordshire tends to be relatively healthy compared with other parts of the country. Levels of disability are low, compared to national averages, but around 90,000 residents report being limited in their daily activities.

Around 11,000 adults in Oxfordshire are predicted to have a learning disability, based on national prevalence estimates (Public Health England, 2012). Of these, around 2,300 are likely to have a learning disability that is either moderate or severe (Institute for Public Care, 2015) and by 2025 numbers are forecast to increase by 5%.

In 2014/15 there were around 2,600 GP-registered patients recorded as having learning disabilities in Oxfordshire (Quality and Outcomes Framework 2014/15). In the same year 2,311 people with learning disabilities were eligible for health support from the specialist learning disability health service, with 820 service users having an open health referral. People with learning disabilities are disproportionately likely to have a comorbid mental health condition and / or autistic spectrum condition (ASC).

Common conditions include high blood pressure, diabetes, asthma, and common mental health disorders like depression and anxiety. The rate of diabetes prevalence (4.9% Oxfordshire) remains below the average rates for England (6.4%) and the south (5.8%) but is rising.

Oxfordshire is similar to the national picture in terms of leading causes of death in males and females. Dementia is the leading cause of death for women in Oxfordshire and diagnosis rates are increasing. In 2014/15 there were around 5,000 GP-registered patients in the Oxfordshire Clinical Commissioning Group area who had a diagnosis of dementia. Heart disease is the leading cause of death for men in Oxfordshire.

2.5 Likely Change in Demand for Services

A number of lifestyle factors impact on current and future health care needs. The people of Oxfordshire have relatively low levels of excess weight (though 60% of adults and 25% of Year 6 children are overweight), exercise more, smoke less and are less likely to be admitted to hospital for alcohol-related reasons compared to English averages.

In general, people are healthier and live longer than elsewhere in England. However, there is a rising incidence of obesity among children, rising hospital admissions for alcohol related conditions for men but especially women, around 14% of the population continue to smoke, and around 22% of adults say they take less than 30 minutes of physical activity a week.

Oxfordshire has a relatively high level of cancer incidence, increasing numbers of people with high blood pressure, higher rates of road accident serious injuries and deaths; and as the population on average grows older as people live longer, there is a rising demand for health care.
A particular concern is that people living in deprived areas are not living as long as others in more affluent areas, but also that they experience more years of disability. The life expectancy gap within Oxfordshire is as wide as nine years, and the disability-free life expectancy gap can be as wide as almost 12 years.

There is a growing burden of disease in Oxfordshire. In 2014/15 there were around 28,100 GP-registered patients aged 17 and over in the Oxfordshire CCG area with a diagnosis of diabetes, an increase of 1,000 (or 3.7%) since 2013/14. There are increasing numbers of people who have several long term conditions which increases the complexity of how they are cared for. In 2014/15 there were around 5,000 Oxfordshire GP-registered patients who had a diagnosis of dementia, an increase of 1,000 (or 25.3%) since 2013/14.

Over the period 2016 to 2021, forecast activity growth – driven by population growth and other factors - is summarised below:

<table>
<thead>
<tr>
<th>Activity</th>
<th>Growth 2016-21</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total non-elective admissions</td>
<td>10.21%</td>
</tr>
<tr>
<td>Total elective admissions</td>
<td>12.45%</td>
</tr>
<tr>
<td>Maternity admissions</td>
<td>2.21%</td>
</tr>
<tr>
<td>A&amp;E</td>
<td>7.37%</td>
</tr>
<tr>
<td>Outpatient appointments</td>
<td>7.81%</td>
</tr>
<tr>
<td>Community contacts</td>
<td>14.97%</td>
</tr>
<tr>
<td>Mental health contacts</td>
<td>4.43%</td>
</tr>
</tbody>
</table>

Figure 2.4: Forecast Activity Growth based (2016-2021)

### 2.6 National Policy Context

The NHS Five Year Forward View, 2014 set the agenda for improving health and wellbeing, redesigning care and strong financial management. The NHS England Business Plan 2016/17 asked every health and care system to come together to create its own ambitious local blueprint for accelerating its implementation of the Forward View.

The 20116/17 Planning Guidance saw the creation of 44 wider footprints for the development of Sustainability and Transformation plans (STP’s) and the 2016/17 -18/19 planning guidance is driving the development by the end of December 2016 of 2 year operational plans for the delivery of the new STP’s.

The Government Mandate to NHS England has set a number of measurable for 2020 Goals with clear year on year deliverables. The Government has also set planning requirements for delivery of the General Practice Forward View, Cancer services and Mental Health transformation.

The aim of this policy is to improve health and secure high quality healthcare for the people of England, now and for future generations by improving health by closing the health and wellbeing gap, transforming care by closing the care
and quality gap and controlling costs and enabling change by closing the
finance and efficiency gap.

2.7 Local Policy Context

The needs of patients are changing: new treatment options are emerging and
demand for services is increasing. At the same time, we know that quality of
care can vary, many illnesses are preventable and social deprivation can
significantly impact health outcomes. Coupled with ongoing financial
pressures, this means that we need to take positive action to ensure patients,
their families and carers are empowered to take more control over their own
care and treatment; services are offered in a range of ways yet provide
consistent high quality care and treatment and local budgets are spent wisely.

Oxfordshire’s Transformation Plans are intended to tackle these challenges
whilst supporting local delivery of the Five Year Forward View, which sets out
a vision of better health, better patient care and improved NHS efficiency.

Locally we have six strategic priorities:

<table>
<thead>
<tr>
<th>What</th>
<th>Enabling (How)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Operational Delivery</td>
<td>Empowering patients</td>
</tr>
<tr>
<td>Transforming Health and Care</td>
<td>Engaging Communities</td>
</tr>
<tr>
<td>Integration</td>
<td>System Leadership</td>
</tr>
</tbody>
</table>

Figure 2.5: Oxfordshire’s Six Strategic Priorities

We are refining the detailed deliverables for these over the next two years as
part of our operational planning process taking into account the outcome of
the planned consultation on our transformation plans.

2.7.1 BOB Sustainability and Transformation Plan (STP)

Local health and social care organisations have come together to form the
Buckinghamshire, Oxfordshire and Berkshire West (BOB) footprint to develop
and deliver a Sustainability and Transformation Plan (STP).

Delivery of the STP plan will take place at Local Health Economy (LHE) level
where relationships with provider trusts and local authorities are well
established and the transformation of primary care can best be supported.
CCG operating plans will provide substantial detail on how this will be
achieved.

In this context the BOB STP has three core functions:

- Delivery of BOB wide programmes that require the scale of the footprint to
  have maximum benefit.
- Establishment of an STP wide planning and commissioning function for services such as cancer, stroke, ambulance and 111, through a joint CCG Commissioning Executive.

- Identification, adoption and spread of innovative practice, mobilising the expertise and support of arm's length bodies.

For specialist health services, clinical networks extend beyond the boundaries of the BOB footprint and we are collaborating with other STPs using established clinical networks (such as those supported by the Oxford AHSN) and participating in national new care models (such as secure mental health) to coordinate national activities with neighboring health economies.

BOB aims to co-design and implement a new model of care to address the challenges facing our health and social care system and its priorities are:

- **Prevention of ill health**, with a particular focus on obesity to reduce demand for services over the medium to long term.

- **Standardising access to urgent care** so a range of well-informed clinicians can safely diagnose and prescribe treatment while minimising the number of duplicated consultations a patient receives. This will release GP time so they can work together at scale, become more integrated with community services operating out of community hubs and focus on people with more complex conditions. GPs will also be able to call on an increased number of home carers to enable more people to be cared for in their own homes rather than being sent to hospital. In the long term, this will avoid the cost of building and running additional hospital wards.

- **Centralising back office functions** to deliver savings by procuring at scale for example using the Shelford Group framework.

- ** Undertaking meaningful engagement and consultation activity** on services, such as those at the Horton General Hospital in Banbury, community hubs in Buckinghamshire and community hospital provision in Berkshire West, to help inform decisions on the commissioning of future services.

- **Increasing efficiency** by commissioning, where appropriate, at scale across the BOB geography. For example, there is significant variation in spend from £175 to £290 per patient for co-commissioning specialised services with NHS England. Benchmarking higher than the national average, we have an opportunity to work across the geography to manage demand and identify alternative pathways of care. We have already started to do this in specialised mental health secure services, with OHFT managing the budget. We are also reinvesting in local services and supplementing increases from CCG allocations to support delivery of the Mental Health Forward View.
- **Improving our workforce offer and increasing staff retention** by working with Trusts and Health Education England to improve recruitment, standardise terms and conditions and offer employees interesting rotational opportunities.

- **Providing digital solutions** for self-care, virtual consultations and interoperability to increase patients’ access to information and reduce duplication and travel.
Chapter 3: Governance and Programme Management

3.1 Our Partnership Approach

Oxfordshire CCG is the accountable body for the Transformation Programme. The CCG is, however, working closely with other commissioners, providers and patients to develop the proposals.

The list below summarises the organisations engaged in the programme and their role:

- Oxfordshire Clinical Commissioning Group (overall accountable body)
- NHS England (for specialised commissioning / formal assurance)
- Oxford Health NHS Foundation Trust (provider)
- Oxford University Hospitals NHS Foundation Trust (provider)
- GP federations (provider)
- South Central Ambulance Service (provider).
- Health and Wellbeing Board (oversight)
- Health and Overview Scrutiny Committee (oversight and scrutiny)
- Clinical Senate (assurance)

Oxfordshire County Council (OCC) is to be a consultee. Some OCC staff have been involved as specialist advisers. This does not imply OCC support.

Neighbouring CCGs, providers and HOSCs are also being engaged where there is a potential impact on patient flows or service provision. We are in the process of engaging with the CCGs, providers and HOSCs in Berkshire, Warwickshire and Northamptonshire. Engagement is also taking place through the Buckinghamshire, Oxfordshire, Berkshire (BOB) STP work.

3.2 Our Governance Structure

The work of the Transformation Programme is being overseen by a multi-agency Programme Board. This Board provides a co-ordination and advisory role but does not have any formal decision-making powers.

A number of sub-groups report into the Programme Board. These are show in the diagram over-page.
3.3 Formal Decision-Making

Formal decision making flow follows the process articulated in the diagram below. It seeks to develop robust proposals which are shared with the Transformation Board and, if approved, the formal Boards of the organisations participating in the programme. The ultimate decision, however, sits with the CCG.
The formal decisions made by the CCG are summarised in the table below and supporting evidence of this decision-making is included in Appendix 3.1.

<table>
<thead>
<tr>
<th>Date</th>
<th>Workshop</th>
<th>Meeting</th>
<th>What?</th>
</tr>
</thead>
<tbody>
<tr>
<td>29 January 2015</td>
<td>✔</td>
<td></td>
<td>Chief Executive’s report outlining establishment of Transformation Board.</td>
</tr>
<tr>
<td>10 February 2015</td>
<td>✔</td>
<td></td>
<td>Look at priorities for developing joint health and social care strategy</td>
</tr>
<tr>
<td>10 March 2015</td>
<td>✔</td>
<td></td>
<td>Vision for integration and community delivery of services (older people/urgent care)</td>
</tr>
<tr>
<td>26 March 2015</td>
<td>✔</td>
<td></td>
<td>Chief Executive’s report confirming first meeting of Transformation Board for 31 March 2015.</td>
</tr>
<tr>
<td>11 August 2015</td>
<td>✔</td>
<td></td>
<td>Update on Transformation including sharing of the storyboard v3.1</td>
</tr>
<tr>
<td>13 October 2015</td>
<td>✔</td>
<td></td>
<td>Transformation including v3.6 of storyboard</td>
</tr>
<tr>
<td>8 February 2016</td>
<td>✔</td>
<td></td>
<td>Role of Board in Transformation</td>
</tr>
<tr>
<td>31 March 2016</td>
<td>✔</td>
<td></td>
<td>Operational Plan incorporates key principles and emerging pathways from Transformation work.</td>
</tr>
<tr>
<td>26 May 2016</td>
<td>✔</td>
<td></td>
<td>Chief Executive’s report, agreement of OCCG priorities in context of Oxfordshire (Transformation Board) vision</td>
</tr>
<tr>
<td>14 June 2016</td>
<td>✔</td>
<td></td>
<td>Transformation plan – developing clinical models and locality plans</td>
</tr>
<tr>
<td>28 July 2016</td>
<td>✔</td>
<td></td>
<td>Paper on Transformation Programme setting out details of</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Process of going out to consultation</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Governance and decision making requirements of the Board</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Communication and engagement</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Highlight information available and in the public domain</td>
</tr>
<tr>
<td>9 August 2016</td>
<td>✔</td>
<td></td>
<td>Horton short and long term options; early sight of PCBC v2.1</td>
</tr>
<tr>
<td>13 September 2016 (all day)</td>
<td>✔</td>
<td></td>
<td>Transformation</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Leadership - Board role and decision making</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Feedback from Senate review</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Business cases – do we understand them, options etc (PCBC v3.2.1; Horton v31, community hospitals)</td>
</tr>
</tbody>
</table>
3.4 Programme Management

A formal programme management methodology has been adopted. The table below summarises the roles that have been assigned as part of this.

<table>
<thead>
<tr>
<th>Role</th>
<th>Purpose</th>
<th>Designated body/person</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sponsoring group</td>
<td>Responsible for defining the direction and ensuring overall alignment of the programme with the strategic direction.</td>
<td>Transformation Board</td>
</tr>
<tr>
<td>Accountable body</td>
<td>Responsible for determining the scope, shape, plans for and authorisation of service reconfiguration (including decisions on consultation) as a result of the Transformation Programme. Responsible for the investment decisions.</td>
<td>OCCG Board</td>
</tr>
<tr>
<td>Programme board</td>
<td>Responsible for defining the acceptable risk profile and thresholds for the programme, ensuring the programme delivers within its agreed boundaries, resolving strategic issues between projects, understanding and managing the impacts of change. Signing off key strategic documents and delivering assurance on the programme.</td>
<td>OTHP Programme Board</td>
</tr>
<tr>
<td>Senior responsible owner (SRO)</td>
<td>Accountable Officer for the successful delivery of the programme.</td>
<td>OCCG CEO</td>
</tr>
<tr>
<td>Deputy SRO</td>
<td>Deputises for SRO on key decisions and issues for the programme.</td>
<td>OCCG COO</td>
</tr>
<tr>
<td>Role</td>
<td>Purpose</td>
<td>Designated body/person</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------</td>
</tr>
<tr>
<td>Programme director</td>
<td>Creating and communicating the vision for the programme, providing clear leadership and direction throughout the life of the programme, securing investment needed, ensuring delivery of a coherent capability, establishing the governance arrangements, ensuring viability of the business case, maintaining communication and alignment with senior managers, ensuring assurance is in place, monitoring key strategic risks, chairing the programme board.</td>
<td>Programme Director (system appointment)</td>
</tr>
<tr>
<td>Programme manager</td>
<td>Day-to-day management of the programme. Planning and designing the programme and monitoring its progress. Developing and implementing the governance framework, coordinating projects and their interdependencies, managing the programme budget. Manages workload of the Programme Officer.</td>
<td>Strategy &amp; Transformation Manager (OCCG)</td>
</tr>
<tr>
<td>Programme officer</td>
<td>Day to day administration of the programme, maintaining up-to-date files, documents and records. Arranging and planning PMO meetings</td>
<td>Programme Support Officer</td>
</tr>
<tr>
<td>Strategic engagement lead</td>
<td>Managing and coordinating engagement plans with ALL stakeholders. Including maintaining an overview of engagement activity with; a) public and patients, MP’s, partner stakeholder organisations b) staff c) clinicians</td>
<td>Head of Communications (OCCG)/Head of Strategy &amp; Transformation (OCCG)</td>
</tr>
<tr>
<td>Patient, public and partner engagement lead</td>
<td>Managing, planning and coordinating consistent and effective communication and engagement with patients, the public, external stakeholder organisations and MPs for the programme</td>
<td>Head of Communications (OCCG)</td>
</tr>
<tr>
<td>Clinical engagement lead</td>
<td>Plans, coordinates and manages the engagement with clinicians</td>
<td>Head of Strategy &amp; Transformation (OCCG)</td>
</tr>
<tr>
<td>Document manager</td>
<td>Manage the drafting, editing, production and collation of key strategic documents including management of the programme’s ‘evidence library’.</td>
<td>Head of Strategy &amp; Transformation (OCCG)</td>
</tr>
<tr>
<td>Role</td>
<td>Purpose</td>
<td>Designated body/person</td>
</tr>
<tr>
<td>-------------------------------------------------------------</td>
<td>------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------</td>
</tr>
<tr>
<td>Programme business case</td>
<td>Manage the production of the full business case for consultation</td>
<td>Programme Director (system appointment)</td>
</tr>
<tr>
<td>Community Hospitals business case</td>
<td>Manage the production of any business cases required for estate on community hospitals</td>
<td>TBA</td>
</tr>
<tr>
<td>Horton General Hospital business case</td>
<td>Manage the production of the business case for recommendation to OCCG on the Horton General Hospital</td>
<td>Executive Director (Oxford University Hospitals)</td>
</tr>
<tr>
<td>Equality analysis</td>
<td>Lead the production of an Equality Analysis for the programme and guide EA production across each work stream</td>
<td>Programme Director (system appointment)</td>
</tr>
<tr>
<td>Analytic Support</td>
<td>Provide analytical support to clinical work streams and Locality Plans on financial modelling and travel flow analysis</td>
<td>Programme Director Transformation &amp; Consultancy (SCW CSU)</td>
</tr>
<tr>
<td>Scrutiny body</td>
<td>Responsible for reviewing and scrutinising the programme, including financial considerations. Responsible for ensuring that the needs and experiences of local people are considered in the development of the programme, including financial considerations.</td>
<td>Joint Health Overview and Scrutiny Committee (HOSC)</td>
</tr>
</tbody>
</table>

Table 3.2 – Current Programme Management Roles
Part Two:

CURRENT SERVICE PROVISION AND THE CASE FOR CHANGE
Chapter 4: The Case for Change

4.1 The overarching ‘case for change’

4.1.1 Context and Data Analysis

The population of Oxfordshire currently enjoys good overall health but access and outcomes are not consistent across the county. The health needs of the population are also changing, driven by increasing chronic disease and ageing, and significant increase in complexity of childbirths, due to a range of factors.

The Oxfordshire Transformation Programme began by examining demographic trends, health needs and performance data. This found relatively low mortality rates for preventable diseases and top quartile performance for many national health metrics. However, there were several outcome areas where the county should be performing better (for example, diabetes and mental health for children).

The data analysis showed that Oxfordshire has relatively low levels of hospitalisation compared to other CCG areas but outcomes are not uniform across the county. It also revealed that over 80% of the county’s hospital resources are used by around 10% of the population.

The overall picture was one of a health and social care system increasingly struggling to deliver good access for the population when they require it. This is exacerbated by workforce shortages and the financial challenges facing all public sector organisations.

The Transformation Programme also considered national targets and expectations alongside information about international best practice in healthcare. Together this information was used by partners from across the Oxfordshire health and care system to develop a shared vision for the future of healthcare in the area. This vision was presented in the form of a ‘storyboard’ and used to engage stakeholders in discussions about transformation (see Appendix 4.1).

4.1.2 The overarching ‘case for change’

The feedback from these stakeholders helped inform the development of the overarching ‘case for change’ which has seven elements.

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11 Graphs summarising this data are included in the Oxfordshire ‘Storyboard’ (see Appendix 4.1). An overview of this information is also included in the context section in Chapter 2.
4.1.3 Increasing Demand

Oxfordshire has a growing, ageing population (with the number of over 85s in the county expected to rise from around 15,000 to around 24,000 between 2011 and 2026). Increases in life expectancy mean that people are living with good health for longer and new treatments mean people are also living longer with long term chronic conditions. There is a growing prevalence of co-morbidities and patient needs are increasingly complex.

The ageing population will be increasingly ethnically diverse: this means that the pattern of disease will change. For example, people from parts of Asia and the Indian sub-continent are more prone to develop diabetes and its complications at lower levels of obesity.

While Oxfordshire’s population is ageing overall, there other changes in specific areas including growing populations across parts of the county, particularly Cherwell and Didcot.12

Demand for both children’s and adult’s social care is growing at a faster rate than would be expected by population growth, suggesting that previously unmet need is coming forward.

4.1.4 Workforce Shortages across the Healthcare System

Like most places in the country, Oxfordshire is facing workforce shortages across the healthcare system from challenges to replace GPs as they retire and a high turnover of residential care and social care staff, to difficulty in recruiting specialist acute doctors.

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12 22,000 new homes are due to be built in Didcot and 23,000 in Cherwell (including Bicester).
The situation is exacerbated by: the proximity to jobs with London weighting and the high cost of living in Oxfordshire; the limited availability of key worker housing schemes for essential staff groups; and competition with other businesses (given Oxfordshire’s high level of employment).

4.1.5 Quality and Safety

The overall quality of health services provided in Oxfordshire is good. However, there are some aspects of care that must be improved, especially where access and outcomes are not consistent across the county.

This will include tackling the workforce issues above, meeting relevant standards and performance targets, ensuring that buildings are fit for purpose to deliver high quality care, and redesigning pathways to improve patient outcomes.

Oxfordshire is committed to learning from best practice and making the changes needed to provide high quality 21st century services.

4.1.6 Financial Pressures

Oxfordshire CCG and local providers have a track record of good financial performance but there is a gap between the costs of anticipated future demand and funding. This gap needs to be addressed to ensure that the health and care system in the county is sustainable.

The CCG has modelled a ‘do nothing’ scenario over the next five years. This compares known allocations to commissioners (which will increase by £125 million over the next five years) with the expected costs of providing services, allowing for rising demand and inflation. This exercise demonstrates that by the end of 2020/21, if no action is taken, the local system will face a financial gap of £134 million.

4.1.7 Prevention

While the health of people in Oxfordshire is good compared with elsewhere, services are geared to detect disease and provide treatment rather than prevent ill-health. For example, the growing proportion of the population who are overweight or obese is reflected in the higher diagnosis rates for diabetes. Health services identify and treat those with diabetes but do little to stem the increase in obesity.

Some geographical areas and groups within the Oxfordshire population also suffer from health that is far worse than the county averages. For example, there are higher rates of early death from cardiovascular disease in more deprived communities and among those who continue to smoke, those who drink above recommended maximum limits of alcohol, or who are physically inactive.
4.1.8 Inequalities

There are many areas of inequalities explored in the Director of Public Health report.\textsuperscript{13}

A stark example used below is deaths from Cancer by District and wards. Looking at death rates gives us insight into how disadvantage plays out in the County. The chart below shows characteristic findings for Oxfordshire

![Oxfordshire wards with the highest cancer mortality rates (indirectly age-standardised ratios)](image)

Figure 4.2 – Wards with High Cancer Mortality Rates in Oxfordshire

The chart shows that:

- Disadvantage has very tangible results – in this case higher death rates from cancer in Oxford City than in the rest of the county.
- The bars on the chart show the death rates for the highest areas in the County. Death rates in the most disadvantaged wards are 50% higher than the County average.
- This pattern of the results of disadvantage is mirrored in many statistics about death and disease and underlines the reasons for tackling disadvantage head on.

The Health and Wellbeing Board has sponsored a more detailed review of disadvantage. This analysis should inform the Joint Health and Wellbeing Strategy, Local Authority plans, the Clinical Commissioning Group’s 5 year plan and the work of the NHS and County Council Systems Leadership Group and Transformation Board. The Health and Wellbeing Board has sponsored an independent Commission on Health Inequalities and the work is due to report in the Autumn. It has taken evidence from a wide range of sources and has had access to local data. The results of this work will further inform how we address inequalities.

\textsuperscript{13} Director of Public Health Annual Report for Oxfordshire Report IX, May 2016, Jonathan McWilliam
4.1.9 Estates and Infrastructure

The ward in the community Hospital in Wantage is closed because of the risk of Legionella. The size and nature of service in much of our community estate needs to be reviewed. We need to optimise care pathways ensuring an effective range of service, any benefits of scale and sustainable workforce skill mix. This work is under review and is likely to result in a further public consultation on Community services during 2017.

In regard to the Horton an independent assessment\(^{14}\) reported that the Horton General estate had many facilities that were in an “unacceptable” state. Making changes piecemeal to this estate is expensive. The replacement of the current CT scanner with modern equipment is anticipated to cost £3m, rather than £900k, because of the additional cost of addressing poor quality estate. Any new build at the Horton General would not only lead to a state of the art facility that increases and improves clinical care on this footprint, but could also realise the savings of scale from a planned and coordinated estate improvement plan, which will be required on any account.

There is a temporary closure of obstetrics which has required temporary estates reconfiguration in John Radcliffe. Additional temporary theatres for gynaecology surgery have also been rented to accommodate interim arrangements on obstetrics.

4.1.10 Summary

This overarching ‘case for change’ demonstrates that ‘doing nothing’ is not an option if the Oxfordshire population are to continue to enjoy good health. It is also crucial that access and quality issues are addressed to ensure that everyone in the area has access to high quality care when they need it.

4.2 The clinical ‘case for change’ for acute hospital services

The Transformation Programme’s overarching ‘case for change’ gives an overview of the challenges that the Oxfordshire health and care system faces.

4.2.1 Scope of the clinical ‘case for change’

A more detailed clinical ‘case for change’ has been developed to support the overarching ‘case for change’. This ‘case for change’ looks at the three of the areas that are the focus of Phase One of the acute sector changes.\(^{15}\)

- Three specific elements of Urgent and Emergency Care:
  - Critical Care facilities

\(^{14}\) Green and Kassab and AECOM reports (2016) to Oxford University Hospitals NHS Foundation Trust

\(^{15}\) Emergency Departments will be part of Phase Two but the ‘case for change’ for all aspects of urgent and emergency care have been included in order to provide context for the proposals around critical care.
4.3 Urgent and emergency care, including stroke care and critical care

4.3.1 Current Provision

4.3.2 Urgent, Emergency and Critical Care

Urgent and emergency care services provide life-saving care 24 hours a day 365 days a year. The Oxford (Headington) Hospitals also provide full acute services and tertiary support to the wider catchment of Wiltshire, Berkshire and Buckinghamshire.

In Oxfordshire urgent and emergency care is provided by two Emergency Departments (ED), two Emergency Multidisciplinary Units (EMU), three Minor Injury Units (MIUs), two First Aid Units (FAUs), One Emergency Care Practitioner Unit, One Rapid Access Care Unit (RACU) (scheduled to be launched in quarter four of 2016/17) and GP Out of Hours (OOH) operating in each of the six locality areas of the county.

Emergency and Urgent Care Services are also provided by NHS 999 and 111 services.\(^\text{16}\)

Oxfordshire’s two Emergency Departments are intended to deal with genuine life threatening emergencies such as:

- loss of consciousness
- acute confused state and fits that are not stopping
- persistent, severe chest pain
- breathing difficulties
- severe bleeding that cannot be stopped

\(^\text{16}\) Oxfordshire CCG commissions each of these services. ED is provided by Oxford University Hospitals Foundation Trust (OUHFT). EMU, MIU, FAU and OOH are provided by Oxford Health Foundation Trust (OHFT). NHS 999 and 111 services are provided by South Central Ambulance Service (SCAS).
- severe allergic reactions
- severe burns or scalds.\textsuperscript{17}

The \textbf{Minor Injury} facilities\textsuperscript{19} can treat any injuries that are less severe than those mentioned above.

The two \textbf{Emergency Multidisciplinary Units} (EMU) provide assessment and treatment for adults with sub-acute care needs as close to patients’ homes as possible. Providing medical, nursing and therapist assessments and treatments, the units are designed to offer patients a faster and more convenient alternative to admission to an acute hospital.\textsuperscript{19}

From 2017 the Townlands Hospital in Henley \textbf{Rapid Access Care Unit} will provide a next day service led by a consultant and a team of health and social care professionals including community nurses, physiotherapy and occupational therapy practitioners, social care staff, mental health staff and hospital clinicians. The RACU which will have lead Clinicians from Royal Berkshire Hospital NHS Foundation Trust will provide assessment and treatment of patients with a crisis or deterioration in their health or long term condition – including patients with complex medical, social and/or mental health needs. The service will offer a next day clinic so that patients can be assessed by a consultant and then, if needed can receive diagnostic tests or treatments such as blood transfusions and intravenous antibiotics all on the same day.\textsuperscript{20}

The \textbf{GP Out of Hours} service provides patients with the ability to speak with or see a GP if there have a medical condition that they would usually seek advice from their GP but cannot wait until their practice is next open.

Urgent and emergency care is supported in the community by the Hospital at Home service.

The Horton General has a 6-bedded \textbf{Critical Care Unit} (CCU). It is designated as a Level 3 critical care facility and is, therefore, expected to care for patients requiring advanced respiratory support alone or basic respiratory support together with support of at least two organ systems, including all complex patients requiring multi-organ failure.

The CCU has served a number of purposes in its history including coronary care, high-dependency care and intensive care. Over the last three to five years, however, the demand for critical care at the Horton General has reduced because:

\textsuperscript{17}\url{http://www.nhs.uk/NHSEngland/AboutNHSservices/Emergencyandurgentcareservices/Pages/AE.aspx}
\textsuperscript{18} The two Emergency Multidisciplinary Units (EMU), three Minor Injury Units (MIUs), two First Aid Units (FAUs), and one Emergency Care Practitioner Unit.
\textsuperscript{19}\url{http://www.oxfordhealth.nhs.uk/service_description/emergency-multiprofacial-unit/}
\textsuperscript{20}\url{http://www.oxfordshireccg.nhs.uk/news-and-media/news-articles/plans-for-townlands-rapid-access-care-unit-given-clinical-support-but-with-conditions/}
Patients with myocardial infarction are now taken directly to Oxford for primary percutaneous coronary intervention (PPCI);

Patients with major trauma are taken directly to the Major Trauma Centre at Oxford (since 2012);

Emergency surgery services were relocated to the John Radcliffe in 2013.

This has resulted in a reduction in the number of patients requiring Level 3 critical care at the Horton General. There were only 488 Level 2 and 3 critical care admissions in 2015/6, 41 of which were for Level 3 care.

Figure 4.3 - Urgent and Emergency Care in Oxfordshire

4.3.3 Delayed Transfers of Care (DTOC)

The Oxfordshire health and care system has a history of poor performance in terms of delayed transfers of care (DTOC). This is bad for patients and also creates budget pressures.

Data is published nationally once a month by the department of health. This breaks down all delays by hospital trust, local authority of the resident, reason for the delay and who was responsible for the delay (health, social care, both). The graphs below show performance in Oxfordshire to December 2015 when the ‘Rebalancing the System’ pilot project was introduced.
At any one time Oxfordshire had around 150 patients whose medical care had finished but who remained in hospital waiting to be discharged. A large number of these patients need some form of ongoing health and social care or rehabilitation in their own homes or nursing home care.

4.3.4 National Perspective (standards, guidance and best practice)

4.3.5 Urgent Care, Emergency and Critical Care

The NHS Five Year Forward View (5YFV) published in October 2014\(^\text{21}\) described the need to redesign urgent and emergency care services for people of all ages. The vision it presented is as follows:

- For adults and children with urgent care needs, we should provide a highly responsive service that delivers care as close to home as possible, minimising disruption and inconvenience for patients, carers and families.
- For those people with more serious or life-threatening emergency care needs, we should ensure they are treated in centres with the right expertise, processes and facilities to maximise the prospects of survival and a good recovery.

Related to this the Future Hospitals Commission (FHC)\(^\text{22}\) report considered how patients could in future receive 'safe, high-quality, sustainable care centred around their needs and delivered in an appropriate setting by respectful, compassionate, expert health professionals'.

The need for Integrated Care – improved quality through patient-centred coordination of complex care across traditional boundaries – led the FHC to conclude that the specialist resources available in hospital need to be deployed in a way that supports the whole community and the health and social care system. This means clinicians working both inside and outside hospitals, and more closely with community teams to provide a progressive, collaborative spectrum of support. This is illustrated in Figure x below.

\(^{21}\) NHS England, Five Year Forward View, October 2014
\(^{22}\) Future Hospitals Commission (2013) Future Hospital: Caring for Medical Patients A report from the Future Hospital Commission to the Royal College of Physicians
The FHC report advocates a model of 'hospital-based centres of acute care' supported by the extension of currently hospital-based services into or close to the patient's home, with staff linked to local hospitals working with primary and social care services. Preventing patient deterioration and crises in care at home should be a prime focus, but when a crisis does occur, the preferred option should be to provide integrated, patient-centred care at home or in a community setting close to home; if care in the hospital is required, access should be provided without delay and then services must support prompt return to the community.

The care of patients with complex needs, delivered across settings and by several teams, requires excellent coordination. The FHC describes a Clinical Coordination Centre (CCC), as a base for the hospital's clinical teams coordinating care for patients with active clinical needs in both hospital and community. Crucially, the CCC supports clinicians (GPs, nurses, ambulance practitioners and others) outside hospital with 'patients in crisis', with advice in determining the best immediate care and ongoing care pathway, and with the direct provision of care whenever appropriate.

Such a change to partnership working and collaboration has the potential to deliver the necessary quality and value improvements for the population and to overcome fragmentation in pathways and service delivery.

4.3.6 Stroke Care

Stroke commonly causes death or severe disability. In the first hours of a stroke, immediate access to advanced tests, treatments and teams results in better outcomes. These include Computerised Tomography (CT) and Magnetic Resonance Imaging (MRI) scanning, thrombolysis (clot-dissolving drugs) and increasingly thrombectomy (physical removal of clots from arteries supplying the brain), and the 24-hour presence of specialist stroke doctors.
and nurses, and complementary specialist teams such as neurosurgery and neuroradiology.

The clinical evidence is that the best outcomes for patients are delivered within units that have adopted these measures. These outcomes are seen when the initial care of all patients with acute stroke (other than rare exceptions such as end-of-life care) are assessed initially in a *Hyper-acute Stroke Unit (HASU)* with access to all the services that might help survival and recovery. As soon as the hyper-acute phase is over, care is then transferred to a specialist team providing rehabilitation in a stroke rehabilitation ward, or when possible at home (Early Supported Discharge). Research has found that patient satisfaction and outcomes are better for home rehabilitation than for rehabilitation in hospital.\(^{23,24}\)

**4.3.7 The ‘case for change’**

**4.3.8 Increasing Demand**

There are growing pressures on Oxfordshire’s urgent and emergency care services. Increased demand is being driven by an ageing population whose medical needs are becoming increasingly complex. Over 65s in Oxfordshire currently make up 17% of the population and this figure is predicted to rise to 23% in the next 10 years. The over 85 population is also predicted to rise by 30%. This will put an increasing strain on all services including primary care, dementia and community care. With older age comes increased likelihood of multiple complex physical and mental comorbidities. For example, in 2014, 42% of non-elective hospital admissions in Oxfordshire were for people aged 60 or over.

This is exacerbated by the lack of capacity in the health and care system. For instance, there is insufficient capacity within the primary care system to manage demand for appointments and offer all the preventative care GPs want to provide for their patients – particularly those with lots of complex conditions.

GP consultation rates increased by 11% between 2011 and 2014 but, despite this, patients often have to wait longer than they would want to with 29% of patients reporting that their length of wait for an appointment was unacceptable. The Royal College of Emergency Medicine found that 15 per cent of A&E presentations could have been treated in the community.\(^{25}\) This may be the case in Banbury and The City which both have much greater rates of attendance at A&E than the remainder of Oxfordshire.


A&E services in Oxfordshire have experienced year on year growth in attendance. In 2015/16, OUHFT saw an increase in attendances of 6,848 which is an increase of 5% or an extra 18.7 patients per day. In the four years between April 2012 and March 2016, activity in A&E increased by 16,771 patients: a rise of 13.1% or 46 additional patients per day. The continual growth and demand on services utilises a greater proportion of resources available to the emergency department resulting in longer waits to be seen, bigger queues and decreasing patient experience.

Local Delivery Boards and A&E departments must account for their performance, using targets such as “95% of patients must been seen within four hours of arrival”. In 2012/13 93% of patients were being seen within four hours but by 2015/16 this had fallen to 89%.

In June 2016, the position remained behind target and behind the England average:

<table>
<thead>
<tr>
<th></th>
<th>Target</th>
<th>England</th>
<th>Oxford University Hospitals NHS Foundation Trust</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>95.0%</td>
<td>90.5%</td>
<td>86.3%</td>
</tr>
</tbody>
</table>

Table 4.1 - OUHFT A&E four-hour performance, June 2016

4.3.9 Workforce Shortages

Urgent, Emergency and Critical Care

Staffing the Horton Critical Care Unit is becoming increasingly unviable. The CQC inspection in February 2014\(^{26}\) noted that there was a clear gap in the presence of appropriately trained staff to deliver the service in a consistent manner. There is a high vacancy rate for band 6 nurses and recruitment at any band is proving virtually impossible. This has led to a consistent failure to meet the Guidelines for the Provision of Intensive Care Services (GPICS) and has

\(^{26}\) Care Quality Commission, Horton General Hospital Report, May 2014
resulted in a current plan to transfer all intubated patients to Oxford in a planned manner.

4.3.10 Quality and Safety

Urgent, Emergency and Critical Care

Pathways of care for patients requiring urgent and emergency care often cross organisational boundaries, contributing to impaired patient experience and outcomes. Current arrangements contribute to inefficient and repetitive assessments, excessive delays, and overcrowded facilities.

Current arrangements for referral, for advice, for supporting transitions of care, and for supporting joined-up care for the most complex patients outside hospital are time-consuming, unreliable and variable in quality.

There are also specific issues in relation to the Critical Care Unit at the Horton. The current activity numbers are low and, therefore, impact on the ability of clinicians to maintain their skill set.

The Intensive Care National Audit and Research Centre (ICNARC) data for 2013/14 demonstrates that patients remain on the Horton General CCU relatively longer in relation to peer units in the Thames Valley and Wessex. Later ICNARC data demonstrates that the unit has the lowest number of ventilated patients in this region but that its mortality for ventilated patients is the highest amongst peers.

4.3.11 Stroke Care

There are a number of reasons for focusing specifically on stroke including increased demand, national perspective and performance particularly A&E and Delayed Transfers of Care

Oxfordshire currently has two ‘front doors’ for stroke services and this results in issues around timely entry to a specialist acute stroke unit, long lengths of stay in inpatient rehabilitation settings and difficulties with prompt discharge/onward referral. There is inconsistency in inpatient rehabilitation, a lack of psychological medicine (psychiatry and psychology) provision across the pathway outside of The Oxford Centre for Enablement. This pathway of care results in worse Sentinel Stroke National Audit Programme (SSNAP) scores at the Horton in particular and anecdotal reports of inappropriate use of tertiary referrals. In addition there is inequity in the provision of early supported discharge.

Acute stroke services for Oxfordshire patients are provided by Oxford University Hospital NHS Foundation Trust (OUHFT). The majority of the

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27 Intensive Care National Audit and Research Centre (ICNARC) data, 2013/14. See Appendix 4.2: Reference Slide 1
28 See Appendix 4.2: Reference Slide 2 and 3
patients admitted to an acute stroke service will be sent to the John Radcliffe Hyper-Acute Stroke Unit (HASU). During 2014/15, the John Radcliffe HASU saw 88% of the stroke patients in the county. The Horton General also provides acute services for stroke patients through the Acute Stroke Unit that is located on their Oak Ward. During 2014/15, the Horton saw 12% of the stroke patients in Oxfordshire.

The two hospitals also host inpatient rehabilitation and therapy. This is available for patients for up to six weeks and includes: Speech and Language therapy, Occupational Therapy and Physical Therapy, among others.

Further stroke rehabilitation services are available in the form of Early Supported Discharge (ESD) services. These are provided by OUHFT in the city of Oxford and also Bicester. While ESD is a clinically appropriate and cost-effective rehabilitation solution for many stroke patients, it is not available across many Oxfordshire localities, and serves only half of the total population of the county.

4.4 Planned Care (Elective Care, Diagnostics and Outpatients)

4.4.1 Current Provision

Planned care is the care received along a predictable pathway, often starting with self-management and which may lead to patients presenting to their GP or another healthcare professional. The management of the condition and treatment, if required, may be carried out locally within primary care or the community or may result in referral to hospital for treatment, with a health care professional who is an expert in their condition. Often diagnostics such as X-ray, MRI and ultrasound are part of this pathway. If the condition is very specific or rare it can lead to a consultation in a more specialist service in secondary care. Planned care includes management of elective surgery, treatment of cancer and long term conditions such as osteoarthritis.

Much of planned care is carried out in a hospital setting as are the associated diagnostics. Planned care services are offered at both the Horton General Hospital and at the Oxford Hospitals and Churchill Nuffield Orthopaedic Centre.

4.4.2 National Perspective (standards, guidance and best practice)

A number of issues are driving changes in the way planned care is delivered:

- Advances in surgical techniques, drugs and equipment enabling more surgery to be done on a day case basis or, where a stay in hospital is needed, leading to reductions in the time spent in hospital;
- A move to greater specialisation in surgery;
- Pressures to optimise productivity to meet growing demand: there is evidence of a need for improved productivity in some areas with clear pathways for specific conditions.
The steady increase in day case surgery in this country from 417,000 (7%) in 1974 to 6,300,000 (35%) by 2013/14 has not only resulted in better quality care and patient experience, but an average saving of 1.4% per year in the NHS from 1998/99 to 2013/14.\(^{29}\) While it is imperative that a tertiary trust such as OUHFT provides urgent and emergency treatment for its immediate and wider catchment population, it is also important that such care does not interfere with the smooth planning and passage of planned or elective work. Failure to manage both effectively results in cancellations and postponements of elective work, which may lead occasionally to patient harm and usually leads to poor patient experience. The separation of urgent and emergency work from elective work, therefore, represents a clear benefit in terms of the quality of clinical care. Patients can plan their lives around procedures, pre-operative assessment and preparation can be organised, discharge plans can be put in place, and recovery and rehabilitation can be designed and delivered in a seamless fashion.

A Monitor study on elective orthopaedic and ophthalmic surgery explored opportunities for improving operational performance.\(^{30}\) The study involved eight NHS Trusts and identified nine opportunities for operational improvement. These included: preoperative assessment and risk-stratification; day-of-surgery admission; improved theatre scheduling; standardised postoperative care and enhanced recovery and an increased proportion of virtual follow-up.\(^{31}\) One centre which participated in this study, South West London Elective Orthopaedic Centre, reported not only improved operational performance but also a reduction of same-day cancellations to 1% and 0.5% for clinical and non-clinical reasons respectively, consistent delivery of 18-week targets, reductions in length of stay (LOS) and a reduction in infections to 0.02%.\(^{32}\)

Monitor also reviewed the international elective surgery experience in five centres. At Alfred Health in Melbourne, Australia, operational separation of elective surgery from emergency and specialist or tertiary surgery resulted in reduced hospital initiated postponements from 28% to 6%, reduced LOS from a mean of 4.8 days to 2.3 days, increased same-day discharge to 95% and 100% patient satisfaction with the pre-admission process\(^ {33,34}\).

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\(^{30}\) Monitor (2015) Helping NHS providers improve productivity in elective care

\(^{31}\) See Appendix 4.2: Reference Slide 4

\(^{32}\) See Appendix 4.2: Reference Slide 5

\(^{33}\) See Appendix 4.2: Reference Slide 6 and 7

4.4.3 The ‘case for change’

4.4.4 Increasing Demand

Hospital demand is increasing (forecast to grow by 15% over the next five years across all age groups) as a result of a growing and ageing population.

Although many routine outpatients and cancer services are delivered within the key national targets (NHS Constitution standards), there are long waits for appointments in some planned care areas in Oxfordshire particularly in the high volume specialities such as: ear nose and throat, orthopaedics, gynaecology and cardiology services. In addition to this, whilst cancer waiting times have improved considerably over the last year across a range of tumour sites, there are some areas still in need of further work to ensure people are seen as quickly as possible to get them onto treatment pathways.

The table below gives a ‘snapshot’ of OUHFT specialties not meeting the target of treating 95% of patients referred within 18 weeks of the referral.

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trauma &amp; orthopaedics</td>
<td>84%</td>
</tr>
<tr>
<td>Ear, nose, throat</td>
<td>85%</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>78%</td>
</tr>
<tr>
<td>Plastics</td>
<td>91%</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>90%</td>
</tr>
</tbody>
</table>

Table 4.2 - OUHFT waiting times (RTT 18 weeks) performance, June 2016

The ageing population means that the number of elderly patients being seen with long term conditions and frailty will continue to rise. This, in turn, increases the complexity of care and treatment. There is an increasing demand for elective services, particularly cataract surgery and hip and knee replacements.

Patients scheduled for planned surgery often have to wait when urgent and emergency care puts pressure on theatres, ITU and inpatient beds. This results in delays and cancellations. Hospital care is also under pressure due to:

- Lack of up to date information on patients, leading to patients not receiving appointments and then having to be rebooked.
- Complex pathways that are disjointed.
- Poor communication and information systems. IT is not keeping pace with technological advances and there is a lack of shared information across all parts of the local ‘system’.
4.4.5 Quality and Safety

Many patients from the catchment area of the Horton General Hospital are required to travel to Oxford for elective treatment as there is currently little scope to increase activity.

Patients from the catchment area also travel to the Oxford Hospitals for diagnostic work due to either the absence of diagnostic equipment or because they are tied into co-location with outpatient services in Oxford.

The Horton General has many diagnostic facilities but not all that would routinely be expected to be found in a large DGH or tertiary hospital. This is most obvious in its diagnostic imaging capacity, with no Magnetic Resonance Imaging (MRI) scanner available for use. There is an MRI scanner on the hospital estate within the Ramsay Horton Treatment Centre (HTC) but this is only suitable for outpatient imaging. Horton General inpatients have to be transported to Oxford for an MRI scan. There is a single Computerised Tomography (CT) scanner but this is more than 10 years old, and is single energy, compared to the new dual energy scanners in Oxford. The CT scanning suite at the Horton is old and does not conform to modern configurations. There are no DEXA (Dual-Energy X-ray Absorptiometry) scanners to measure bone mineral density, and inadequate facilities and inadequate capacity to meet the demand for exercise stress tests, transoesophageal echocardiography, lung function tests, urodynamics, sleep studies and ophthalmic investigations.

The imaging capacity available at the Horton General is underutilised: each X-ray machine only produces 8 images each day and the single CT scanner delivers 23 scans each day, with an average of < 5 inpatients, in comparison to the more than 40 scans per scanner and > 10 inpatients on the Oxford sites.

4.5 Maternity Services

4.5.1 Current Provision

The Oxford University Hospitals Trust (OUHFT) provides maternity services for women in Oxfordshire and for up to 1,000 women from surrounding counties. Services are delivered in two separate obstetric units (at the John Radcliffe Hospital and Horton General Hospital), one alongside maternity led unit (MLU) and three freestanding MLUs.

Obstetric care is currently provided by 5WTE Obstetrics and Gynaecology consultants and 8 resident Trust Grade/Clinical Research Fellows at the Horton General. At John Radcliffe there are 10 WTE Consultants.
In 2015/16 there were about 8,500 births (including home births) at the OUHFT as outlined below:

<table>
<thead>
<tr>
<th>Unit</th>
<th>Births</th>
</tr>
</thead>
<tbody>
<tr>
<td>John Radcliffe Obstetric Unit</td>
<td>5729</td>
</tr>
<tr>
<td>Spires alongside MLU</td>
<td>844</td>
</tr>
<tr>
<td>Wallingford MLU</td>
<td>216</td>
</tr>
<tr>
<td>Wantage MLU</td>
<td>93</td>
</tr>
<tr>
<td>Cotswold MLU</td>
<td>142</td>
</tr>
<tr>
<td>Horton Obstetric Unit</td>
<td>1466</td>
</tr>
<tr>
<td><strong>All</strong></td>
<td><strong>8490</strong></td>
</tr>
</tbody>
</table>

Table 4.3 - Births 2015/16

As the table shows, there is a marked difference in activity between the two obstetric units in Oxfordshire with noticeably less women giving birth at the Horton General Hospital. Indeed, the obstetric unit at the Horton General was the ninth smallest in the country (out of a total of 160) and, following further maternity services reconfigurations, is currently lower in the list of units by size.

The case mix between the two hospitals is also very different with the John Radcliffe Unit dealing with a larger proportion of women who have a high risk pregnancy, or who have been referred for tertiary care. In 2014/15, for example, approximately 400 woman giving birth at the Horton General required obstetric-led care while in the same year 5,800 obstetric cases were managed at the John Radcliffe Hospital. Despite this difference in risk profile, the outcomes reported by both units are similar.35

There is evidence that some women from the Horton catchment choose to travel to Oxford to give birth. In addition to those who received their care at John Radcliffe Hospital as a result of assessed risk, 200 women from north Oxfordshire chose to give birth at the alongside MLU. Overall, nearly one third of pregnant mothers from north Oxfordshire are currently travelling to the John Radcliffe in order to receive maternity care.

4.5.2 National Perspective (standards, guidance and best practice)

A good quality maternity service should always be able to provide women with options of care so they can make informed choices. Whilst recognising the need to support women’s choice, the Royal College of Obstetrics and Gynaecologists (RCOG) in 2011 also noted that “there is a need to be mindful that choice has to be delivered in a realistic manner, balancing wants and

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35 See Appendix 4.2: Reference Slide 8
needs with what is clinically safe and affordable and what resources can be made available without destabilising other services. 36

There are national standards that every Trust providing maternity services must adhere to. This includes metrics for clinical care and staffing numbers. 37 Based on these principles and national standards, the models for the provision of maternity services are underpinned by the following:

- Pregnancy and childbirth are a normal life stage, but pregnancy is not risk free;
- Consistent quality of service and assessment of individual risk will enable women to make genuine choices and receive effective personalised care;
- Women with a low risk pregnancy should be managed in a Midwifery Led Unit (MLU) where they will have better outcomes (i.e. reduced likelihood of interventions such as induction of labour and emergency caesarean section);
- Robust, evidence-based, national standards of care for women with more complex pregnancies and high-risk pregnancy (such as twin pregnancies, morbid obesity and diabetes) demonstrate that care is more effective when delivered by specialised and dedicated services;
- Clinical outcomes are improved with early targeted interventions (e.g. prophylactic Fragmin to reduce the likelihood of thrombosis, low dose aspirin, assessment of cervical length in pregnancy etc.). Equity of access to this specialist care must be improved for all women, to reduce morbidity and mortality.

The Birthplace study, conducted by the National Perinatal Epidemiology Unit (NPEU) at the University of Oxford, 38,39 examined the impact of intended place of birth on maternal and perinatal outcomes for low-risk mothers. It compared four birth settings: birth in hospital obstetric units; free standing (FMU); alongside (AMU) midwifery units; and home birth. The study looked at 65,000 births which included nearly 17,000 planned home births and 28,000 planned midwifery unit births from 2008–2010. It found that for women with no complications in pregnancy, childbirth is generally very safe. The outcome for mothers was good in all birth locations. In 250 births, however, the baby had a poor outcome (4.3 events per 1000 births) across the four birth locations.

Key findings from the study included that:

37 Royal College of Obstetricians and Gynaecologists (2008) Standards for Maternity Care: Standards Database
38 National Perinatal Epidemiology Unit (2011) The Birthplace Cohort Study, University of Oxford
- For first-time mothers planning to have a home birth, there was an increased risk of poor outcomes for the baby (9.3 per 1000 births at home compared with 5.3 per 1000 births in obstetric units). There was no increased risk for babies, delivered at home in women who were in their second or subsequent pregnancy.
- There was a 45% transfer rate to obstetric units for first-time mothers planning to deliver at home. The transfer rate for midwifery units was 36.3% (FMU) and 40.2% (AMU).
- The transfer rate for mothers who were in their second or subsequent pregnancy to obstetric units was 12% (home birth), 9.4% (FMU) and 12.5% (AMU).
- Lower intervention rates were reported in both types of midwifery units than in obstetric units.
- There are wide differences across the country in the availability of midwifery units, and in the way maternity services are organised and staffed, with 50% of trusts having no midwifery units in 2010.

The Birthplace study provides good evidence on the risks and benefits of each birth setting, which helps women and healthcare professionals make informed choices on locations for low-risk births. It supports the concept of configuring maternity services differently and with it the expansion of midwifery units, which deliver better outcomes for low-risk births.

With high-risk births, however, the Royal College of Obstetricians & Gynaecologists (RCOG) recognises that for maternity services to improve, obstetric care needs to be concentrated to deal with the expanding numbers of complex pregnancies and with women being transferred from other birth locations. These obstetric units should provide continuous senior medical staff presence on the labour ward. This is not the case for either of the obstetric units in Oxfordshire. This can only be achieved by expanding the numbers of consultants in Obstetrics and Gynaecology. Despite the number of women with complex pregnancies increasing both in Oxfordshire and nationally, the stillbirth and neonatal mortality rate has fallen by over 20% in the last ten years.

In February 2016, as part of the Five Year Forward view, the maternity review team published “Better Births: Improving outcomes of Maternity services in England”. This report called for all staff to be supported to deliver care which is women centred, working in high performance teams, in organisations

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41 www.rcog.org.uk/resources/Public/pdf/future_role_consultant.pdf
which are well led in cultures which promote innovation, continuous learning and break down organisational and professional boundaries’.

4.5.3 The ‘case for change’

4.5.4 Demand

The Thames Valley Strategic Clinic Network Review carried out detailed analysis on population and birth rate projections and projected an increase in births across Oxfordshire of 8% over the next 10 years. This equates to between 0.5 and 1.0% each year. This analysis included assumptions made about expected housing growth particularly in areas with big developments including Bicester and Didcot.

The review by the Thames Valley Strategic Clinical Network noted that all maternity units in the Thames Valley are close to capacity but Oxfordshire is up to capacity in delivering 6,000 women in its consultant led obstetric units and work is needed to increase this capacity. Oxfordshire needs to work as part of a wider local maternity system to ensure effective management of future capacity.

4.5.5 Workforce Shortages

There are rigorous national standards that any Trust which provides maternity services must adhere to. However, recruitment of obstetricians is a national challenge. At present OUHFT struggles to meet the minimum staffing levels on obstetric wards at the Horton and the recommended levels at the John Radcliffe site.

OUHFT can usually appoint to any emergent midwifery vacancies at both the John Radcliffe and Horton General. Maintaining sufficient medical staffing capacity within the Horton General Obstetric Unit, however, represents a significant and increasing challenge.

In 2013 the obstetric service at Horton General lost recognition as a RCOG approved training centre, predominantly due to the low number of deliveries, which diminished the obstetric training experience. The number of births at the Horton has continued to decline: currently approximately 4 per day. Even with significant growth in housing planned for the surrounding areas, and the growth predicted by the Thames Valley Strategic Clinic Network Review, it is unlikely that the number of births will return to 2011-12 levels. It is even more unlikely that the levels recommended by the Royal College of Obstetricians and Gynaecologists will be reached. Dr Michael Bannon (Dean Thames Valley Health Education England) quoted to the Community Partnership Network on 21st October 2016 a figure of 2,500 to 2050 as a minimum that could be secured for obstetrics in remote places such as Scotland.

Since 2014 the ‘middle grade’ medical obstetric cover at Horton General has been provided by Oxford University Clinical Research Fellows (CRFs).
However, it has become increasingly difficult to recruit and retain sufficient numbers of adequately qualified and trained CRFs and this academic programme has now been withdrawn.

The night obstetric service at the Horton General is currently carried out by a single resident middle-grade obstetrician and as such they require a high degree of operative and clinical skill to work alone. Such clinicians are in short supply throughout the NHS, in part because a number of units have lost recognition as a training centre and in part because of national shortages.

The John Radcliffe Hospital also faces recruitment challenges. The number of deliveries at the hospital means there should be 168 hours of consultant cover for the obstetric unit but, as of August 2016, there was 106 hours of cover.

<table>
<thead>
<tr>
<th>Category</th>
<th>Definition (Births/Year)</th>
<th>Consultant Presence (year of adoption)</th>
<th>Specialist Trainees (n)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>&lt;2500</td>
<td>60-Hour: Units to continually review staffing to ensure adequate based on local needs</td>
<td>1</td>
</tr>
<tr>
<td>B</td>
<td>2500-4000</td>
<td>98-Hour: 2009</td>
<td>2</td>
</tr>
<tr>
<td>C1</td>
<td>4000-5000</td>
<td>168-Hour: 2008, 2009</td>
<td>3</td>
</tr>
<tr>
<td>C2</td>
<td>5000-6000</td>
<td>Immediate: 2008, 2010 Immediate if possible</td>
<td></td>
</tr>
<tr>
<td>C3</td>
<td>&gt;6000</td>
<td>Immediate: 2008</td>
<td>-</td>
</tr>
</tbody>
</table>

Table 4.4: Obstetric Staffing Targets 2007-2010 (adapted from The Future Role of the Consultant)

In 2015/16, although the budget for obstetricians and gynaecology medical staff in the acute trust was 20WTE across the year, the actual staff in post level was between 12 and 14 WTE. There were 8 WTE specialist registrar unfilled University-funded posts and 3.4 WTE unfilled Trust-funded posts. With no training recognition and a significantly high vacancy rate across the Deanery for recognised training positions, the posts at the Horton General are required to be filled by middle grade doctors. There are currently nine required posts, of which only two will be filled from October 2016.

For The Horton the Trust has undertaken a focused recruitment campaign but has had limited success in recruiting sufficient Obstetricians with the necessary experience to deliver a safe obstetric service. Additional attempts
continue to recruit long-term Trust grade locum medical staff from national agencies.

The shortage of middle grade obstetric doctors forced the Trust to temporarily suspend obstetric services at the Horton General Hospital from 3 October 2016. A contingency plan was implemented with maternity services offered temporarily by a Midwifery-led Unit (MLU) at the Horton General Hospital, while efforts continue to fill vacant obstetric posts. Women requiring an obstetric-led birth will deliver their baby at the John Radcliffe Hospital or at neighbouring obstetric units. Other aspects of their care continue to be provided at the Horton.44

4.5.6 Quality and Safety

It is nationally recognised that there has been an increase in case complexity caused by changing demographic factors including women giving birth later in life, obesity, multiple pregnancies and existing co-morbidities. Research suggests that women with complex pregnancies have better outcomes if they are looked after and/or deliver in specialist (obstetric led) units.

Similarly research demonstrates that low-risk pregnancies can be delivered safely in midwifery units with reduced rates of intervention.

The low numbers of births at the Horton General makes it challenging for the general obstetrician to maintain their clinical skill set and this is a potential safety issue.

The maintenance of two obstetric units also impinges on the ability to maintain the RCOG standards for medical staffing (consultant and below).

It is important to note that neonatal (special care baby unit or SCBU) and maternity services are linked and cannot run independently of each other, because both services need a range of different consultants to be able to support mothers and babies. For example, an obstetric consultant may deliver a premature baby, but a paediatric consultant would also need to be available in case the new-born baby needed any treatment. Therefore, a SCBU must be located on the same site as an obstetric unit and should not be based on a site with midwife only led care. To do otherwise would present governance issues, has no precedence within the UK as a safe model of care, and is not compliant with the National guidelines and standards (NHS England Service Specification for Neonatal Intensive Care Services, 2015)

4.5.7 Finance

There is a need to review our balance of investment to improve Oxfordshire’s maternity services. Technology is under-utilised and there is a need to embrace community based diagnostics and electronic care records.

44 More information on these temporary changes can be found in Appendix 4.3
The current maternity estate (some of which is not fit for purpose, some under-utilised and some requiring more capacity) needs to be reviewed and employed to the greatest effect to ensure consistent and high quality care for women and their babies. There is much estate cost dedicated to the current four midwife led units but with some births occurring only every third day. There is a fixed tariff allowed for each birth - in one case, Chipping Norton, it appears the fixed overhead cost of housing the unit is considerably beyond any income achievable from tariff. The introduction of a fifth unit if we propose the Horton to become a permanent midwife led unit will further bring the need to review investment in overheads compared to the numbers of births supported. Any proposed configuration would still need to work to deliver reasonable access for all residents.

The CCG are currently funding the provision of two obstetric units. There is a premium (£2.147m covering obstetrics and paediatrics) being provided over tariff by the CCG to retain obstetric care in the Horton. Meanwhile we need to improve our medical risk assessment and improve breast feeding and other post-natal support.

4.5.8 Prevention

More could be done to improve the maternity pathway. For example, a clearer and more defined role is required for GPs to assess women early enough in pregnancy to achieve the best outcomes for both women and their babies. It is recognised that early targeted interventions such as reducing the incidence of anaemia, low dose aspirin, assessment of cervical length in pregnancy and venous thromboembolism prophylaxis significantly improves clinical outcomes but consistent access to this care has not yet been achieved. The pathway of care for low risk women should be reconsidered to ensure women are seeing the right professional at the right stages throughout their pregnancy, with appropriate guidelines for reassessing risk and escalating concerns should the risk change. High risk women should be identified early and supported by specialist services and teams.
Part Three:

THE CLINICAL MODEL
Chapter 5: The Development of the Proposals

5.1 Overview of the development process

Oxfordshire Clinical Commissioning Group (OCCG) has recognised that a number of local services require review and this may result in significant change. To provide a system-wide governance structure for this process the Oxfordshire Transformation Programme was established. As part of this Transformation Programme, Oxford University Hospitals Foundation Trust (OUHFT) undertook a strategic review of its hospital sites. This examined the distribution of clinical services with a particular focus on the Horton General Hospital. The scope included the nature of the emergency services which should be provided on a small general hospital site and the clinical safety issues in relation to obstetric and children’s services. The output from this clinical review process was captured in the form of a business case for the future of the Horton General Hospital.45

OCCG and its GP commissioning leads via the locality meetings reviewed the recommendations for clinical services set out in the business case on the future of the Horton General Hospital and has adopted relevant proposals for this Pre-Consultation Business Case.

The development of a clinical model for stroke services took place in parallel to the work on options for the Horton General Hospital, but is cross-referenced and consistent with the proposed models. A similar position applies to the development of ambulatory care and the reduction in acute inpatient beds.

Changes to Critical Care services are necessary, as a consequence of changes to clinical pathways and service standards.

OCCG has also included within its transformation programme the way primary and community care services are organised and changes to the care pathways for some patients with long term conditions. These changes have been signalled in OCCG’s formal commissioning intentions and will be crucial to support the implementation of the changes described in this Pre-Consultation Business Case.

The premise within Oxfordshire is that patients will be expected to follow an ambulatory pathway, unless there are overriding clinical or social reasons. This will result in a new model of providing acute bedded capacity. These proposals are fully consistent with those of the Horton Strategic Review.

45 This is available in Appendix 5.1
5.2 The OUHFT Strategic Review

The strategic review undertaken by OUHFT considered a wide range of services at the Horton General Hospital, and proposals were made across a range of clinical services. These proposals have been disaggregated to permit a staged approach to consultation.

- Changes to obstetric services, critical care and planned care services are included in this business case.
- Other proposals which have the potential to require significant change are currently being developed as part of Phase Two of the Transformation Programme.

5.2.1 The establishment of Clinical Workstreams for the OUHFT Strategic Review

Clinicians were the foundation of the OUHFT development process because they understand the issues from the clinical frontline and it was recognised that there had to be clinical ownership for the transformation to succeed. They worked together with managerial colleagues to identify viable clinical service models through four clinical workstreams. The objective is to improve the quality and safety of care provided for the people of north Oxfordshire and surrounding geography, while, at least, maintaining quality for other residents of the county. There was overlap between the clinicians involved in the CCG work streams and the specific Horton work and this enabled consistent clinical development of proposals within both contexts.

The four clinical workstreams are set out in the table below:

<table>
<thead>
<tr>
<th>Workstream</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent and Emergency Care</td>
</tr>
<tr>
<td>Planned Care, Diagnostics and Outpatients</td>
</tr>
<tr>
<td>Maternity Services</td>
</tr>
<tr>
<td>Children's Services</td>
</tr>
</tbody>
</table>

Table 5.1: the four Clinical Workstreams in OUHFT’s Strategic Review

The workstream for Children’s Services is not considered further here as any proposals developed in this area will be consulted upon in Phase 2 of the Transformation Programme.

The emerging thoughts with regards to the Oxfordshire Transformation Plan’s primary care workstream also informed the development of proposals for acute hospital services.
Oxford Health Foundation Trust (OHFT) is responsible for the delivery of mental health services in Oxfordshire, and the OUHFT Horton Strategic Review did not include a specific mental health workstream. Representation from OUHFT's Psychological Medicine Service, which integrates care for physical and mental health, was incorporated into each of the four workstreams in the table.

5.2.2 The long list of options and the criteria used to filter these

Over 50 clinicians from OUHFT including the Horton General site were enrolled in generating a range of options for clinical models. They were asked to identify issues within their working arenas that required attention. These groups of clinicians were then tasked with assessing a full spectrum of new models of care for the Horton General, which would be clinically viable; clinically effective and safe; and sustainable in the medium-term (5-20 years). Each clinical workstream developed its own models over several meetings, initially independently, and the Groups were then brought together to consider the interdependencies of their clinical models and their effect on clinical viability across the whole care pathway.

The scope covered by the option appraisal process for Urgent and Emergency care and Maternity care are shown in the two tables below. (The scope was also considered for children’s care at this time, but this is not considered further at this point, and will form an element of Phase 2 of the consultation process.)

Table 5.2: The scope for the options appraisal for Urgent and Emergency care
Table 5.3: The scope for the options appraisal for Maternity Services

These models were then assessed against a set of agreed criteria. Quality of care for all was assessed by the clinical workstreams on the basis of Clinical Effectiveness (including safety), and patient and carer experience. As shown in Table 5.4, clinicians evaluated the services against clinical and constitutional standards. They also assessed the access to and sustainability of skilled clinical staff and specialist facilities. Access was defined by three metrics: distance and the impact of the travel time to access services; service operating hours; and the availability of patient choice. Affordability and value for money took into account the revenue position of OUHFT in 5 years’ time, and the likely capital cost of options. The fourth criterion, Workforce, considered the estimated effect on the local workforce and the sustainability of the option. Finally, Deliverability took into account the ease of delivery and alignment with other strategies.

It was agreed that the issue of affordability for OCCG would be tested at a later date, after the initial filtering process had generated viable clinical options.
On the basis of these evaluations, some models were discarded.

Particular consideration at this stage was undertaken with regard to Maternity services, and subsequently OCGG considered and tested a wide range of options (section 5.3.1). The low volumes of births led to the rejection of the option of continuing with a functioning small obstetric unit at the Horton General. The expected low volumes related to the maintenance of clinical skills, and inability to provide consultant presence in line with RCOG standards for obstetric units. It is recognised good practice for the clear demarcation of obstetric risk into high and low risk only, rather than also including an unusual intermediate risk category. The clinical view was that a low volume obstetric unit might, over time, lead to risk-taking by practitioners, which would not be in the interests of mothers or neonates. It should also be noted, that it is recognised good practice that a SCBU is sited only where obstetric services are provided. This means, therefore, that the removal of obstetric services from the Horton General Hospital must be accompanied by the closure of the Horton SCBU and the transfer of all relevant admissions to the neonatal unit at the John Radcliffe Hospital.
With regard to access, a proposal for two equally sized obstetric-led maternity units (at the Horton and John Radcliffe) was rejected on the basis that mothers from within Oxford would have to travel to the Horton General for it to have an adequate catchment population.

### 5.2.3 Short List of Options

This process resulted in the emergence of options in relation to clinical services specifically located at the Horton General Hospital. The options relating to those areas in Phase 1 of the consultation process are shown in the table below. In some cases, there was agreement that only one clinical viable option should be considered further.

<table>
<thead>
<tr>
<th>Clinical area</th>
<th>Range of options considered</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternity</td>
<td>Obstetric and maternity services</td>
</tr>
<tr>
<td></td>
<td>Freestanding MLU</td>
</tr>
<tr>
<td>Stroke</td>
<td>Acute stroke rehabilitation</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation and Early Supported Discharge</td>
</tr>
<tr>
<td>Critical care</td>
<td>Level 3 ITU</td>
</tr>
<tr>
<td></td>
<td>No provision</td>
</tr>
<tr>
<td></td>
<td>HDU (Level 2) on site + e-ICU (24/7)</td>
</tr>
<tr>
<td>Planned care, diagnostics and out-patients</td>
<td>No elective inpatient surgery or short-stay inpatient surgery</td>
</tr>
<tr>
<td></td>
<td>Full day surgery or limited hours day surgery</td>
</tr>
<tr>
<td></td>
<td>5-day or 7-day diagnostics</td>
</tr>
<tr>
<td></td>
<td>Current range of outpatients or addition of “one-stop” clinics</td>
</tr>
</tbody>
</table>

Table 5.5: The Short List of Options arising from the Horton Strategic Review, for those services within Phase 1

The short-listed models are based on the premise that an ambulatory care system will be in operation within Oxfordshire, but there are a range of different expressions of such ambulatory care. All, however, are in alignment with the overall principles of providing care closer to home, while
concentrating specialist services in locations with adequate scale that ensures high quality and safe care, and provides real value to the health economy.

The rationale for moving from the short list of options, to the preferred option, is set out in the following section 5.3, considering individual service areas.

5.3 Moving to a preferred option

A range of processes were undertaken by OCCG, in conjunction with its partners, to take the outputs from the evaluation process of the Horton Strategic Review and refine these to a set of proposals for Phase 1 of the consultation. These are described by the various service areas.

5.3.1 The development of proposals for Maternity services

During the process leading to the construction of the Horton Strategic Business Case, OCCG considered the options for maternity services in the north of the county at two Board development workshops. GP commissioning leads via Locality meetings looked at these proposals. OCCG accepted the analysis that had been undertaken as part of the construction of the Horton Strategic Business Case by OUHFT, and understood the factors that had led OUHFT to prefer a single site for obstetric services and those leading to a temporary change of service provision. The Board, however, asked that all options should be considered for maintaining existing or partial obstetric services at the Horton General Hospital (in addition to the John Radcliffe Hospital). These options were:

- A full 24/7 middle-grade medical rota in Banbury;
- A full 24/7 consultant-provided service in Banbury and Oxford;
- A joint medical obstetric rota between John Radcliffe Hospital and Horton Hospital;
- A partial solution, with caesarean section deliveries for the whole of Oxfordshire taking place at the Horton site and low risk births for North Oxfordshire taking place at the current Chipping Norton MLU. (This option was proposed by a member of the public).

The table below sets out the considerations on each option made by OCCG with its partners, with a reference to the supporting evidence for this approach.

<table>
<thead>
<tr>
<th>Option considered</th>
<th>Rationale for discounting</th>
<th>Supporting evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>A full 24/7 middle-grade medical rota</td>
<td>Training approval for medical trainees in obstetrics has been withdrawn from the Horton site. The Deanery has confirmed that approval would not be considered for Units with less than 2000 births</td>
<td>Written confirmation from Deanery to OCCG Director of</td>
</tr>
<tr>
<td>Option</td>
<td>Description</td>
<td>Reference</td>
</tr>
<tr>
<td>--------------------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------</td>
</tr>
<tr>
<td>A full 24/7 consultant-provided service</td>
<td>In order to manage safely two obstetric units at RCOG staffing levels there would need to be an additional 22.1 wte Consultants appointed over current levels. In order to safely manage one obstetric unit with 24/7 Consultant cover on the ward would take an additional 6.1 wte Consultants.</td>
<td>Clinical senate submission Nov 2016 RCOG “Safer Childbirth” (2011)</td>
</tr>
<tr>
<td>A joint medical obstetric rota</td>
<td>The obstetric middle-grade trainees at JRH cannot be rotated to the Horton site and retain accreditation for their training. OUHFT is unable to recruit sufficient additional non-training medical staff to make this viable</td>
<td>Written confirmation for Deanery to OCCG Director of Quality OUHFT Board Paper regarding temporary closure and OUHFT Contingency Plan - 31 Aug 2016</td>
</tr>
<tr>
<td>A partial solution, with all caesarean sections at Horton</td>
<td>This was discounted on both safety and workforce grounds, and is not a model that has any national comparator. The safety issue related to confusion in the mind of the public about the function of the unit. Women presenting at Horton General Hospital with low or high risk labour would then have to transfer to another suitable unit.</td>
<td>Letter from Dame Fiona Caldicott, OUHFT Chair to Yvonne Constance, HOSC Chair</td>
</tr>
</tbody>
</table>

Table 5.6: Considerations on each option made by OCCG and Partners

These options were explored, but not considered to be clinically feasible, and therefore rejected. Some additional options were considered for the long list, but these were discounted on the grounds of safety. This included, for example, operating a limited-hours obstetric service (MLU at other times) which could lead to increased risk from transfers out as closing time approached, or a lack of suitably skilled staff available at key times. The common key issues that discounted options had were the need to manage clinical risk appropriately in and out of hours, ensuring clinicians with the right
skills were available at appropriate times and being clear with the public where to go so that they didn’t delay seeking help when necessary.

With regards to the workforce, a model with a high-risk obstetric-lead maternity unit and an additional small intermediate-risk obstetric-led maternity unit was perceived as undesirable because of difficulties with providing adequate medical staff to cover obstetric-led maternity care for the whole of Oxfordshire.

The Oxfordshire obstetric service, based at John Radcliffe Hospital, has an obligation to higher risk mothers from across a wider area, in addition to Oxfordshire, through its role as a centre for tertiary referrals. This includes up to 1,000 births per year. In terms of workforce it is probable that two obstetric units would both operate without the recommended obstetric staffing level whereas one unit could be staffed at RCOG standards of 24/7 consultant cover by 2020/21. The John Radcliffe’s important specialist function has been confirmed by the Thames Valley Clinical Network.

The experience of the recent past is that it is unlikely, whatever the financial cost, that OUHFT would be successful in recruiting sufficient middle-grade or consultant medical staff to provide a resilient rota for a second obstetric service at the Horton Hospital.

After consideration, the CCG concluded that a single obstetric unit at John Radcliffe Hospital is its preferred option, in that a second obstetric unit cannot be maintained with the predicted staffing resource, and to attempt to do risks undermining the ability of OUHFT to provide a high quality service on the JRH site.

The CCG then went on to consider whether it would propose a freestanding MLU at the Horton site, and has concluded that proposals for all 4 freestanding MLUS in Oxfordshire would be included in Phase Two of the process.

There are however necessary consequential changes which would arise from the consolidation of obstetric services at the John Radcliffe Hospital:

- Transfer of SCBU services from Horton Hospital to John Radcliffe Hospital
- Centralisation of emergency gynaecology services at John Radcliffe Hospital

5.3.2 The development of proposals for stroke services

The clinical evidence for the centralisation of Hyper Acute Stroke Services is thought to be 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 OCCG has previously signalled this direction of travel in its Commissioning Intentions. This also set out the principle that the best place for the patient to receive rehabilitation is in their own home. An option appraisal to achieve this objective was undertaken with the contrasting positions of:

- Maintaining an Early Supported Discharge Service in two localities in Oxfordshire;
- Extending the service to the whole county population

The preferred option is to extend the service on the grounds of equality of access; reduction in length of inpatient stay; fit with NICE best practice guidance; and improvement in rehabilitation outcomes.

The split of stroke patients between John Radcliffe Hospital and Horton Hospital is roughly 90:10. This means that there are less than 2 patients per week treated at the Horton Hospital. At this level, it is not possible to provide 24/7 rotas for stroke specialists, neurology and MRI. Continuing with an acute stroke service at the Horton Hospital was discounted by the CCG, as providing an equitable quality of service for residents of the North Oxfordshire.

The Transformation Programme is therefore proposing to secure an improvement in stroke mortality through direct conveyance of all appropriate Oxfordshire patients to a Hyper Acute Stroke Unit (HASU) at the John Radcliffe Hospital in Oxford. This would be supported by the roll out of countywide Early Supported Discharge (already available in two localities, extending to six localities) to improve rehabilitation and outcomes.

The OCCG has not come to a view yet on the model for rehabilitation for patients requiring an inpatient bed, and it will be considering this in the round with its options for the provision of community hospital inpatient services in Phase 2 of the consultation process. This option appraisal will also consider what function, if any, the Horton General Hospital site will play in stroke rehabilitation.

5.3.3 The development of proposals for Critical Care services

The Horton General has a 6-bedded Critical Care Unit (CCU). It is designated as a Level 3 critical care facility, and is, therefore, expected to care for patients whom are requiring advanced respiratory support alone or basic respiratory support together with support of at least two organ systems, including all complex patients requiring multi-organ failure. CCU has served a number of purposes in its history including coronary care, high-dependency care and intensive care. Over the last 3-5 years, however, the demand for critical care at the Horton General has reduced because:

- Patients with myocardial infarction are now taken directly to Oxford for PPCI
- Patients with major trauma are taken directly to the Major Trauma Centre at Oxford (since 2012)
- Emergency surgery services were relocated to Oxford in 2013.

This has resulted in a reduction in the number of patients requiring Level 3 critical care at the Horton General and specifically in the numbers requiring intubation and ventilation. There were only 488 Level 2 and 3 critical care admissions in 2015/6, of which 41 were for Level 3 care. There is no provision for emergency surgery, and in its place, clear pathways exist for the assessment and transfer of patients requiring urgent intervention to Headington. Patients requiring certain specialist services, such as primary percutaneous coronary intervention (PPCI) or treatment of major trauma are directed directly to the tertiary centre at Oxford.

In addition to these quality issues, staffing the Horton CCU is becoming unviable. The CQC inspection in February 2014 noted that there was a clear gap in the presence of appropriately trained staff to deliver the service in a consistent manner. There is a high vacancy rate for band 6 nurses and recruitment at any band is proving virtually impossible, and results in failure to meet the Guidelines for the Provision of Intensive Care Services (GPICS). This has resulted in a current plan to transfer all intubated patients to Oxford in a planned manner.

The Intensive Care National Audit and Research Centre (ICNARC) data for 2013/14 demonstrates that patients remain on the Horton General CCU relatively longer in relation peer units in the Thames Valley and Wessex. Later ICNARC data demonstrates that the unit has the lowest number of ventilated patients in this region; but that its mortality for ventilated patients is the highest amongst peers.

OCCG concluded that the current configuration of CCU at the Horton was not sustainable and that change was required. The presence of a Level 2 was desirable due to the clinical interdependencies of Critical Care and Emergency Services, and will help to sustain emergency services at the Horton, if this is a preferred option in Phase 2 of the consultation process. Level 2 Critical Care will also provide a supporting service for the proposed increase in inpatient elective surgery in the North of the county.

Therefore, the option preferred is HDU services on the Horton site (Level 2). The Unit will be supported by enhanced electronic links to the Level 3 CCU at JRH, allowing collaborative decision-making across the sites. Level 3 patients will transfer from the north of the county to treatment at the JRH.

5.3.4 The development of proposals for Planned Care services

The Horton Strategic Review provides an opportunity to offer more planned care services at the Horton General and, therefore, provide care closer to home for patients for the North of the county.
The Planned Care workstream considered a long list of options, ranging from a status quo options through to a highly distributed model with planned care being provided across five sites in the county. Some of these options were not considered viable or were too costly.

A short-list of two options was generated for major planned care and diagnostics delivery:

- Two sites – Headington and Horton
- Three sites – Headington, Horton plus a further site in the West or South

Outpatients and appropriate diagnostic services will be provided in a wide range of physical settings across the county. In commissioning these services, the CCG will expect to see a good utilisation of workforce skills and other resources.

These options were appraised against the following criteria:

- Access and choice
- Quality and safety
- Clinical sustainability
- Financial sustainability
- Deliverability

After evaluation of the options, and consideration of the opportunities afforded by the Horton Strategic Review, increased provision of services at the Horton General Hospital was preferred, and further development work was undertaken to understand the proposed offer in the north of the county.

The proposal is to build a new modern facility on the Horton General Hospital that will act as a showcase for 21st century healthcare. It is a vision where significantly more clinical staff from OUHFT participate in the delivery of care at the Horton General site, including transferring current planned care services from the Oxford sites. The proposal will be subject to a robust process of consultation and subsequent decision making by OCG.

It is anticipated that the existing Horton General Hospital theatre infrastructure will be reconfigured to absorb the initial 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, where effective scheduling will reduce cancellations, unacceptable delays and breaches. Better scheduling and improved throughput will allow the health economy to achieve its Referral To Treatment (RTT) and cancer targets consistently for the benefit of the population of north Oxfordshire and surrounding geography.
Where numbers allow, existing Trust surgical services will open an elective day case surgical service for patients in north Oxfordshire and its surrounding geography, improving access and reducing travel times.

5.4 The endorsement of OUHFT proposals by OCCG

During the development process for the Horton Strategic Review, the CCG considered the emerging options at a number of its development workshops. The purpose was to inform CCG members, and to guide the Review process, so that its conclusions where integrated with others within the Transformation Programme. The CCG accepted the accuracy of the data in the published Horton Strategic Review and endorsed the direction of travel of the individual clinical workstreams in deriving sustainable options. (See Appendix 7.10 for more information on the involvement of the OCCG Board in the development of the specific proposals).

5.5 The development of proposals for ambulatory care services

In November 2015, Oxfordshire health and social care providers agreed to work together to develop a joint plan to enable patients who no longer needed acute medical care to move from the hospital setting into a nursing home. This enabled their needs to be met more appropriately while they waited either to be transferred home with community-based support or to a permanent care home placement.

The central aims of this initiative (entitled ‘Rebalancing the System) 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;
- Linked to this, reduce avoidable patient deterioration caused by delays in bed-based care;
- Reduce the number of patients delayed;
- 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 co-ordinate and manage the needs of the patients being transferred to nursing homes, a multi-agency Liaison Hub was established. The essential features of the rebalanced system are set out in the table below:

- Single point of access to medical review, specialist opinion and diagnostics.
- Reducing long waits for medical and ‘frailty’ patients in the Emergency Departments.
- Improved access to senior, expert decision makers seven days a week between 08:00 and 20:00hrs, in late 2016 this will be extended
to 08:00 - 22:00.

- Ambulatory care pathway managed by a single MDT and supported by psychological medicine.
- Patient and carer involvement in decision making.
- Prompt discharge planning within 24hrs unless hospital treatment is necessary.
- Post discharge support.
- Effective and appropriate rehabilitation and re-ablement after acute illness.

Table 5.6: Features of the rebalanced system

At this stage, the options in relation to this workstream comprise:

- Reopening acute hospital beds, and removing the Liaison Hub, Hospital at Home service, and ambulatory assessment units
- Make permanent the current pilot arrangements

Given the impact that delays in discharge has on individual patients, and the effective flow in the system and the recent improvements in ambulatory care, the CCG is proposing that the current arrangements should be made permanent.

All the partners in the Oxfordshire Health and Social Care environment have endorsed the partial and full changes to the rebalanced system. The Oxfordshire HOSC has requested that these changes should be included in any formal public consultation and they are, therefore, incorporated into Phase 1.

Associated with the ambulatory care model is the realignment of 194 acute beds (a reduction of 76 beds in phase one and then 118 beds in phase two of the changes). This would formalise the temporary changes made as part of the ‘Rebalancing the System’ delayed transfer project.

5.6 Selection of options for phasing of public consultation

Oxfordshire CCG, in conjunction with its partners, has considered which options it wishes to consult upon immediately, and which would make sense to combine with other anticipated changes to provide a more comprehensive picture for the public.

A number of factors were in play in driving a decision on early consultation (Phase 1):

- Urgent temporary changes to clinical services as a result of staff shortages or risks to maintaining skills;
- Where changes have already been piloted;
- Clear clinical consensus on the service model to be proposed;
- A request from Oxfordshire HOSC to include the proposals.
Conversely, some of the options being considered are more clearly described in the context of the Transformation Programme’s new models of care in community settings (Phase 2), which are expected to result in:

- More people being supported in their own homes and less reliance on inpatient beds in supporting rehabilitation after treatment;
- More consistent urgent care in local settings.

For some options it would therefore be more clinically coherent and explicable to the public to consult during the Phase Two process.
Chapter 6: The Proposed Clinical Models

6.1 Critical Care

The proposals for critical care is summarised in the table below:

<table>
<thead>
<tr>
<th>Critical Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>It is proposed that there would be a single Level 3 Critical Care Unit within Oxfordshire, located at the John Radcliffe Hospital in Oxford and that the CCU at the Horton General would function at Level 2, working in conjunction with the major centre.</td>
</tr>
</tbody>
</table>

6.1.1 The New Model of Care

The majority of Critical Care patients (greater than 90%) at the Horton General Hospital require single organ support or a period of intensive monitoring following emergency admission. These patients can be successfully managed in a Level 2 Unit, with support from the major Level 3 centre in Oxford.

Good co-ordination between the Units will be put in place, with a single clinical management structure, to allow the swift transfer of patients from Banbury to Oxford for Level 3 care, and to enable the step-down of north Oxfordshire patients.

6.1.2 Pathways

The development of services on the Horton site will include Level 2 Critical Care capacity as part of the medical pathway, perhaps located adjacent to the Emergency Assessment Unit (EAU). This would support a more flexible model of nurse staffing which would allow a variable number of HDU beds dependent on activity, with appropriately trained nursing staff being able to work across both HDU and EAU, as required.

Whilst primarily utilised for medical patients, these beds will not be ‘ring fenced’ for those patients only. Other services which may require access to Level 2 care include orthogeriatric patients, north Oxfordshire patients undergoing ‘step-down’ from Level 3 care at John Radcliffe Hospital to more local Level 2 care, and surgical patients whose clinical course unexpectedly requires a period of intensive monitoring or increased nurse-patient care ratio. Whilst these patients will be the exception, the HDU will facilitate the provision of enhanced supported care, when appropriate.

Clearly defined clinical parameters will be agreed on the level of patient care capability at the Horton General CCU, to ensure timely transfer to appropriate intensive care facilities at John Radcliffe Hospital using a retrieval service. An
e-Intensive Care Unit using telemedicine will allow the review, timely treatment and transfer of critically-ill patients requiring Level 3 care to John Radcliffe Hospital.

6.1.3 Interdependencies

There is a clinical interdependency with Accident and Emergency Services, and the clinical model for this service will be consulted upon in Phase 2 of the Programme.

The Critical Care Unit 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.

The presence of a Level 2 CCU at the Horton General Hospital will support the plan to undertake increased amounts of elective surgery in the north of the county.

6.2 Stroke Care

The proposal for stroke care is summarised in the table below:

<table>
<thead>
<tr>
<th>Stroke Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Transformation Programme is proposing to secure an improvement in stroke mortality through direct conveyance of all appropriate Oxfordshire patients to a Hyper Acute Stroke Unit (HASU) at the John Radcliffe Hospital in Oxford. This would be supported by the roll out of countywide Early Supported Discharge (already available in two localities) to improve rehabilitation and outcomes.</td>
</tr>
</tbody>
</table>

6.2.1 The New Model of Care

There are three elements to the proposed pathway to improve services for stroke patients:

- Admission
  All patients diagnosed with acute stroke will be transferred directly to the Hyper Acute Stroke Unit (HASU) at the John Radcliffe Hospital in Oxford for assessment and management.
  This will ensure compliance with the latest NICE guidance which suggests all stroke patients should attend a Hyper Acute Stroke Unit within one hour of a stroke. It will ensure all patients in Oxfordshire 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.
The travel time analysis undertaken by the Thames Valley Clinical Senate found that the majority of patients within Oxfordshire are within 40 minutes “Blue Light” travel time from the HASU at the John Radcliffe. The remaining patients would attend the Northamptonshire or Warwickshire HASUs.

- **Discharge**
  All patients will be assessed for suitability to receive discharge support from the Early Supported Discharge team. The Early Supported Discharge Service will be expanded 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.

6.2.2 **Pathways**

The new pathway is summarised in the diagram below:

![Proposed Stroke Pathway](image)

6.2.3 **Interdependencies**

The development and implementation of the changes to the stroke pathway have several interdependencies, these include:

- The outcome of the Transformation Programme’s review of community hospitals as this project is considering the options for bed based rehabilitation for stroke patients.
• **The availability of beds in the Hyper Acute Stroke Unit** at the John Radcliffe. This is linked to the Delayed Transfer of Care initiative described below. If this is unsuccessful, it will become difficult to move patients through the pathway as the community rehabilitation beds become over-subscribed.

This risk will be considered during the development work on the future of Community Hospitals in Phase Two.

### 6.3 Changes to Acute Bed Numbers

The proposals for the ambulatory model of care are summarised in the table below:

<table>
<thead>
<tr>
<th>Changes to bed numbers in order to move to an ambulatory model of care</th>
</tr>
</thead>
<tbody>
<tr>
<td>To make permanent the current realignment of 194 acute beds (a reduction of 76 beds in phase one and then 118 beds in phase two of the changes). This would formalise the temporary changes made as part of the 'Rebalancing the System' delayed transfer project that has been running since November 2015. 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.</td>
</tr>
</tbody>
</table>

### 6.3.1 The New Model of Care

Oxfordshire is moving towards an ambulatory model of care.

In November 2015 Oxfordshire health and social care providers agreed to work together to develop a joint plan to enable patients who no longer needed acute medical care to move from the hospital setting into a nursing home. This enabled their needs to be met more appropriately while they waited either to be transferred home with community-based support or to a permanent care home placement.

The central aims of this initiative (entitled 'Rebalancing the System) 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 patients delayed.
• 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 Oxford University Hospitals Foundation Trust (OUHFT). This included staff from the three provider organisations (OUHFT, Oxford Health NHS Foundation Trust and Oxfordshire County Council).

During Quarter three of 2015/16, OUHFT realigned 76 beds which included 23 beds in the Post-Acute Unit (PAU). A number of staff from the PAU with experience in complex discharge planning moved to the Liaison Hub.

During September 2016 is was proposed that a further 118 beds in General Medicine, Orthopaedics, Trauma and the West Wing be released by OUHFT as a result of the ongoing success of the Liaison Hub.

As part of the acute hospital changes outlined in this business case, it is proposed that these temporary changes made as part of the ‘Rebalancing the System’ project are formalised. This would make permanent the current realignment of 194 acute beds (a reduction of 76 beds in phase one and then 118 beds in phase two of the changes).
6.3.2 Pathways

An example of an ambulatory care pathway for medical patients in Oxford is shown below:

- **Proposed Ambulatory Pathway**

6.3.3 Interdependencies

There is an interdependency between the movement and reconfiguration of the acute hospital beds and the ability of OUHFT to reorganise its services for improvements to the stroke pathway.

6.4 Maternity Services

The Transformation Programme has a vision to 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 real 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 services.
The proposed changes to hospital maternity services are summarised in the table below:

| The Transformation Programme is proposing to create a single specialist obstetric unit for Oxfordshire at the John Radcliffe Hospital, supported by Midwife Led Units in both the North and the South of the county. |

6.4.1 The New Model of Care

Under the proposed model of care all obstetric care for Oxfordshire’s population will be provided by one Obstetric Unit at the John Radcliffe. This will also provide tertiary and complex care for the wider Thames Valley region and neonatal intensive care cots for the sickest neonates. This 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 also manage the high risk unborn children in the wider area. The model will move Oxfordshire to having a 24 hour presence on the labour ward by 2021, which will meet RCOG standards for over 5,000 births.

For women in north Oxfordshire and outside of the county boundaries there are two additional obstetric units. The obstetric unit at South Warwickshire NHS Foundation Trust Hospital 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.

Low risk women who do not require obstetric care, will receive care from one of ten Community Midwifery Teams and will receive personalised care from a team of 4-6 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) as agreed with the local medical committee (LMC). 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.

The maternity service will continue to offer all four choices for place of birth. In order to be effective this choice will need to be made as part of a wider discussion about the best option and a woman can change her mind at any time in her pregnancy.

Each community midwifery team will be able to support a woman with home birth. In addition there will be freestanding MLUs in both the North and South
of the County to be reviewed as part of the community hospital reconfiguration in Phase Two of the Transformation Programme.

The community midwives will also coordinate the 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 with access to the specialist perinatal mental health team. Midwives will 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 hearing screening. Information on support groups and other local information will be available electronically if preferred.

6.4.2 Key Pathways

The proposed service delivery model is summarised in the diagram below:

- **Pre-conceptual care**: There is clear evidence that the health and wellbeing of a woman before she is pregnant has a significant impact on pregnancy outcomes for both her and her baby. Therefore the proposed model will be underpinned by a clear pre-conceptual programme. Some women will require targeted or specialist support (discussed later), but in
this model universal pre-conceptual care will focus on the top three preventable factors: smoking, maintaining a healthy weight and alcohol.

- **Low risk pregnancy:** By combining the outcome of the GP’s medical assessment and the midwife’s health and social assessment, the woman’s overall level of risk can be ascertained and the correct pathway of care identified. By taking these early, but crucial steps of assessment women will receive the right care, by the right person in the right place with the continuity of care, delivered to NICE standards. Women with a low risk pregnancy will be cared for by a small team of midwives and care will be delivered from community hubs and/or local primary care centres. The antenatal pathway will be delivered in line with NICE standards.

- **High risk pregnancy:** The new model is focused on centralising these specialist services to meet the increased demand whilst maintaining high standards of safety and quality within the context of current workforce pressures. Oxfordshire provides tertiary and complex care to the most high risk women across a much wider region whilst also providing regional neonatal intensive care. The new model will provide sustainability for both local women and those women in need of the most specialist care from outside the county.

- **Intrapartum/birth:** As recommended in the NICE guidance\(^{46}\), Oxfordshire offers women all four choices for place of birth including a home birth; birth in a freestanding MLU; an MLU alongside the obstetric unit in Oxford or in an obstetric unit.

- **Perinatal mental health:** There will be a multidisciplinary specialist Perinatal Mental Health Service developed and clinically led by a dedicated psychiatrist with specialist knowledge of Perinatal Mental Health. The Clinical Lead will oversee and support the pathway to deliver a NICE compliant\(^{47}\) service across a number of service areas. The team will ensure all women can access timely evidence-based specialist perinatal mental health care locally throughout the ante and postnatal period. The service will act as a facilitator to other services including Psychological Services, Infant Perinatal Service (IPPS) and Adult Mental Health Teams (AMHT) to support mental health needs of the perinatal population to ensure good planning, treatment and support.

- **Postnatal pathway:** By utilising personalised care plans, the midwife will ensure the effective provision of postnatal care, supported by Maternity Support Workers (MSWs) and closely linked with voluntary sector services. Increased support will be provided in the community, including

\(^{46}\) NICE guidance Intrapartum Care QS 105 (2014)

\(^{47}\) NICE CG192 Antenatal and Postnatal Mental Health (2015)
drop in sessions in the MLUs and new local Children and Family Centres. MSW support for breast feeding women will be key and staffing numbers will need to be appropriate to provide this service.

6.4.3 Interdependencies

A number of clinical interdependencies have been identified for implementing the new model of care:

- **IT systems interoperability (EMIS and EPR):** The ability to link GP systems with the hospital system is important to improve assessment of risk and ensure each woman is assessed onto the right pathway.

- **The split of work between obstetrics and gynaecology surgery:** Additional theatre capacity is needed at the JR site in order to deliver planned and emergency gynaecology surgery as well as additional planned and emergency caesarean sections.

- **The requirement for special care and NICU cots at an obstetric unit:** Each obstetric unit requires SCBU cots as a minimum requirement. Conversely a unit without obstetrics should not have SCBU cots.

- **Paediatric cover required for obstetric unit 24/7:** Each obstetric unit requires paediatric cover 24/7 at each site.

- **Anaesthetic cover:** Each obstetric unit requires an anaesthetic rota 24/7.

6.4.4 Consistency with Commissioning Intentions and other local Plans

Commissioning Intentions

The Commissioning intentions for both OCCG and the Strategic Clinical Network are aligned around the need to deliver the recommendations of the national review Better Births. The new maternity model and the work to develop it addresses the most pressing commissioning intentions around:

- Providing the additional capacity required to care for women throughout the maternity pathway
- Providing so women are risk assessed appropriately and cared for by the appropriate teams
- Reviewing of home birth provision and the introduction of labour assessments at home in order to support more home births in Oxfordshire
- Developing MLUs and community hubs across the local maternity system
- Commissioning the highest quality model of care for women at highest risk and ensuring we commission the correct number of obstetric and high dependency beds in the relevant units.
Local Authority Plans

The Health and Wellbeing Strategy for Oxfordshire identifies “A healthy start in life” as one of its key priorities. Promoting breastfeeding, reducing smoking in pregnancy, addressing obesity and improving uptake of immunisations are key initiatives that are delivered through the new model of maternity services and therefore support the Health and Wellbeing Boards direction of travel for the Oxfordshire population.

6.5 Planned Care

The Oxfordshire Transformation Programme has a vision to provide planned care services – including elective care, diagnostics and outpatients – closer to patient’s homes. This supports the specific proposals to transfer the location of current hospital planned care services.

6.5.1 These Planned Care proposals are summarised in the table below:

<table>
<thead>
<tr>
<th>Summary of Planned Care Proposals</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Separation of elective from emergency interventions.</td>
</tr>
<tr>
<td>• Development of a new 21st century Diagnostic Facility at the Horton General Hospital to deliver high quality diagnostic procedures (MRI, CT scanners and ultrasound etc.), rapid assessment and reduced travel to Oxford for routine diagnostic imaging.</td>
</tr>
<tr>
<td>• Introduction of a new Outpatient Facility at the Horton General Hospital with capacity for significant transfer of outpatient activity from Oxford in order to make local services more accessible to North Oxfordshire’s population. This includes ‘one stop clinics’ which should also reduce multiple journeys.</td>
</tr>
<tr>
<td>• Introduction of an Advanced Pre-operative Assessment Unit at the Horton General Hospital to enable smooth running of elective interventional services.</td>
</tr>
<tr>
<td>• Development of a Coordinated Theatre Complex at the Horton General Hospital to improve surgical throughput and complement an enhanced Elective Care Centre.</td>
</tr>
</tbody>
</table>

6.5.2 The New Model of Care

The previous section describes proposals to centralise specialist services for urgent, emergency and critical care at the John Radcliffe Hospital in Oxford. This provides an opportunity to offer more planned care services at the Horton
General and, therefore, provide more care closer for patients for the north Oxfordshire population.

The proposal is to build a new modern facility on the Horton General Hospital that will act as a showcase for 21st century healthcare. It is a vision where significantly more consultants from the Headington sites in Oxford participate in the delivery of care at the Horton General site, by transferring current activity out of the Oxford sites.

It is anticipated that the existing theatre infrastructure 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, where proper scheduling will reduce cancellations, unacceptable delays and breaches.

Where numbers allow, existing Headington surgical services will open an elective day case surgical service for patients in north Oxfordshire and its surrounding geography, removing the need for them and their families to travel to Oxford.

Incorporating the advantages of focusing purely on elective activity, there will not only be benefits to patient experience of the certainty of procedure, but also of better clinical outcomes and safer care, such as reduced infections and quicker rehabilitation. Patient experience will be enhanced, therefore, not only by avoiding cancellation. Better scheduling and improved throughput will allow Oxford University Hospital NHS Foundation Trust (OUHFT) achieve its Referral To Treatment (RTT) and cancer targets consistently for the benefit of the population of north Oxfordshire and surrounding geography.

The same will be true for medical interventions. Some medical interventions are already delivered at the Horton General but more interventions currently delivered at Headington will be transferred and delivered at the Horton General.

There is an ever-increasing demand for diagnostic capacity that facilitates the early assessment and management of patients and supports the preventative attributes of screening. It is not good policy for OUHFT to concentrate most of its diagnostic capacity on its Headington sites in Oxford, where congestion and urgent activity impede access. The catchment population of the Horton General is of a size that offers OUHFT an opportunity to disseminate some of this diagnostic capacity in north Oxfordshire. The diagnostics estate at the Horton General is in an unacceptable state of repair. It is the vision of this Clinical Review Group to build a brand new Diagnostic Facility at the Horton General with MRI and CT scanners, ultrasound and other equipment that would allow the rapid assessment necessary for delivery of high quality ambulatory urgent care and dispel the need for the north Oxfordshire population to travel to Headington for routine diagnostic imaging.
As specialist services have developed over the last 30 years, more and more of the Horton General's catchment population has had to travel to Oxford for outpatient services. The proposal is to develop a new Outpatient Facility on the Horton General site with capacity to absorb the thousands of appointments for the north Oxfordshire population currently delivered at Headington. Nearly all the clinical services have committed to transfer, where appropriate, their relevant outpatient activity to the Horton General, with the travelling 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. Not only will this Unit address the needs of the patients undergoing elective surgery at the Horton General, but offer comprehensive preoperative assessment for those north Oxfordshire 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 Horton General sites. The Preoperative Assessment Unit will also be able to offer fitness regimes before operation that will reduce the perioperative risk of surgical intervention.

6.5.3 Key Pathways

Some services are already developing more detailed plans for expanding their services on the Horton General site. As an example, Cardiology is developing its outpatient and day case proposals. The service will serve the patients of north Oxfordshire and surrounding geography. Such a strategy has the potential to generate new tertiary work by serving Warwickshire and Northamptonshire populations.

Outpatient and day case services (clinics and diagnostics) will be provided by Cardiologists, in particular those with an imaging or heart failure background. Specialist clinics will also be transferred from Oxford, including those for cardiac electrophysiology, adult congenital heart disease, cardiac surgery, heart failure and pre-procedural assessment.

This service for local people will be located within the new Diagnostics and Outpatients Facilities and be linked to the Elective Care Centre. For Cardiology it is proposed that they are:

- Increased outpatient clinic rooms: numbers to be specified.
- In line with best practice guidance, Cardiac CT as a first line test for atypical and typical chest pain in outpatients. The provision of 1 or 2 CT
scanner(s) at the Horton General will facilitate rapid assessment of these patients as part of the ambulatory care model.

- Treadmill testing room for low risk patients requiring ischaemia testing.
- Echocardiography including Transoesophageal Echocardiography, Dobutamine Stress Echocardiography (2-4 equipped rooms).
- CPET (Cardiopulmonary Exercise Testing) machine, which could be used in conjunction with the Preoperative Assessment Unit in the assessment of high risk patients for surgery.
- Cardioversion (DC) room, and facilities for day case intravenous diuretics for ambulatory heart failure patients.
- Floor space to introduce Implantable Loop Recorders to analyse heart rhythm disorders.
- ECG rooms, which can be used to fit monitors etc.
- Telemedicine as an essential part of these developments, whereby community physician/nurses could then also have easy access to specialist opinions and therefore re-direct patients away from EAU.

The cardiology service at the Horton General has already established networked care between the Horton General and sites hospital sites in Oxford. For the last two years all patients with emergency heart block have been ‘blue lighted’ to the Oxford Heart Centre for temporary/permanent pacemakers. No mortalities have been reported. Stable heart block patients are admitted to the Horton General CCU and then transferred for the next available daytime pacemaker slot at Headington (without major complications reported).

6.5.4 Interdependencies

The development and implementation of the changes to the way Planned Care is delivered has several interdependencies, these include:

- Development of primary care skills and capacity in managing patients with long term conditions (Phase 2 consultation)
- Presence of Level 2 Critical Care services at Horton General Hospital.
Part Four:

MEETING THE NHS ‘FOUR TESTS’ AND THE BEST PRACTICE TESTS
Chapter 7: Meeting the Four Tests

7.1 Introduction to the ‘Four Tests’

NHS England has issued guidance on how commissioners should manage major service change and the criteria that should be met. One of the key requirements is to ensure that the ‘four tests’ are embedded within the reconfiguration planning process.

All proposed service changes should be able to demonstrate evidence of:

- **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.**

The ‘Four Tests’ form part of the Government’s Mandate to NHS England. The tests are designed to demonstrate that there has been a consistent approach to both managing change and liaising with patients and the public. Meeting the ‘four tests’ should, therefore, build confidence with the service proposals.

Figure 7.1 – The NHS Four Tests
7.2 Test One: Strong Patient and Public Engagement

7.2.1 Oxfordshire has a strong history of public interest and involvement in health services and the local population are generally well-informed, engaged and involved in how local services are developed.

From the outset, the Transformation Programme has been committed to ensuring that there is strong patient and public engagement and that the proposals for change are developed in partnership with the local community and stakeholders. The section below provides a high level summary of this work.

7.2.2 Our Approach

Our engagement adheres to the following principles:

- To be accessible and inclusive to all sections of our community;
- To be honest and transparent;
- To be flexible - ensuring we use a range of different formats to communicate which reflect the diverse needs of our stakeholders;
- To be open and clear from the start what our plans are, what is and what is not possible and why;
- To be informative, ensuring people taking part in activities and consultations have the right information at the right time to make informed comment / decisions;
- To be timely by informing and involving stakeholders as early as possible in the process of communications or engagement;
- To have two way communications, wants to talk to you and listen to your views;
- To communicate in plain language which people understand, avoiding the use of jargon.

7.2.3 Raising Awareness of the Case or Change

From the beginning of June 2016, OCCG have used various methods to engage with patients and the public to raise awareness of the case for change and to get them involved in the development of proposals to help transform the way health is delivered in the county. This work began in June 2016 and detailed reports on the engagement undertaken between June and October are available in the Appendices to this business case.48

48 In particular, see the Appendix 7.1 - Report on the Transformation Stakeholder Event held on Monday 6th June 2016; Appendix 7.2 - The ‘Big Health and Care Conversation’ Engagement Report (August 2016); and Appendix 7.3 - The ‘Big Health and Care Conversation’ Phase 2 Engagement Report (November 2016)
Highlights of activity include:

- 6th June 2016 stakeholder event - official launch of the public engagement (over 100 people attended);
- Big Health and Care Conversation Roadshows held in Banbury, Oxford city, Wallingford, Bicester, Witney and Wantage, Abingdon, Henley (over 400 people attended);
- Smaller displays in Thame, Farringdon and Didcot;
- Online and hard copy survey for the Transformation Programme (over 200 responses);
- Online survey undertaken with OUHFT foundation trust members in the north of the county, South Northamptonshire and South Warwickshire. specifically around services at the Horton General Hospital (233 responses);
- Presentations and feedback at stakeholder meetings including Age UK, Carers Oxfordshire, 6 x Public Locality Forums, Community Groups, and Strategic Partnership Boards across Oxfordshire;
- Scrutiny and development of engagement with Healthwatch and HOSC;
- MP, County and District Councillor briefings / feedback sessions;
- On-going media programme to promote the case for change including proactive briefings and advertising of events.

7.2.4 Focused Public and Patient Engagement Events

In addition to this awareness raising activity, the Transformation Programme has sought to engage public and patients in the development of the individual models of care. This includes:

- 3 x focus groups on maternity
- 4 x focus groups with students to explore prevention / self-care / primary and urgent care
- 1 x session with the CCGs primary care patient advisory group
- On-going meetings / briefing and feedback sessions with community and patient groups
- On-going outreach to hard to reach groups (see below).

7.2.5 Engagement with Hard to Reach Group

The OCCG Equality and Access team undertook outreach engagement with seldom heard groups across Oxfordshire during August 2016. Various ‘seldom heard’ groups have been visited and feedback has been captured at both group and individual level. The feedback has been documented according to protected characteristic(s) rather than actual community group name. It has not been possible to interact face to face with all groups listed in the engagement plan for a variety of reasons as it was not possible to make contact with some groups and some groups did not meet during the summer.
break. Where meetings with groups of vulnerable people did take place they did not always wish to make comments or disclose information.

Members of the CCG’s Equality Reference Group, which has representation from each of the nine protected characteristics as defined in the Equalities Act 2010, were also engaged. However, individuals from within some of the vulnerable groups were reluctant to express their views particularly where they felt they did not have a rapport with the person helping them with the questionnaire.

7.2.6 Drawing on Existing Engagement Activity

In order to avoid consultation overload, the Transformation Programme has also drawn on the feedback received as a result of other related engagement and consultation activities. This includes the views expressed in relation to the development of the following strategies:

- Developing primary care in Oxfordshire
- Older Peoples Strategy
- Health & Wellbeing Strategy
- OCCG Strategy
- Townlands Hospital Redevelopment (introducing ambulatory care)
- Outcomes based contracting for mental health
- Outcomes based contracting for maternity
- The Big Plan (Learning Disabilities)

7.2.7 Feedback Received To Date

7.2.8 What the public and patients have said

The feedback from patients and the public to date has been collated into key themes:

- 75% respondents said they understood why change was needed and listed the following top reasons for change:
  - Lack of resources / money / efficiency
    - Ageing population
    - Increased pressure on services – growing population & delayed transfers of care
    - Staffing problems – number, specialists and quality
    - Technology / new medical techniques
    - Transport & accessibility to services
    - More funding required
  - Patient safety, patient experience and patient outcomes are important
  - A focus on prevention and education on leading a healthy lifestyle is needed
• The need to retain community hospital services
• Emphasis on staff and recruitment
• Difficulties in accessing GP services
• More integration of health and social care
• A need for public attitudes to change—moving to an understanding that people are responsible for their own health
• Use of technology
• Better communications

7.2.9 What people from hard to reach groups said

Overall there was praise for many of services, including community paediatrics and maternity services at the John Radcliffe and maternity services at the Horton hospital. Respondents also commented on experiences of local NHS services as being friendly, helpful, kind, caring, a good service, clean and quick.

However negative feedback was received in relation to:

• **Aftercare by midwives in Banbury** following delivery and discharge.

• **General Practice**: A long wait or inability to get an appointment with a GP, the receptionist being a barrier and a long wait in the surgery to be seen, ineffective call back systems, GPs not reading patients’ notes, not fully knowing the patient and understanding any specific issues relating to their disability. There were also comments about language barrier difficulties experienced by some patients and a perceived negative attitude towards patients from Black and Minority Ethnic communities.

• **Mental Health Services**: Key issues were not receiving sufficient support, even when feeling suicidal, lack of continuity of service and lack of available beds for older mental health patients in Banbury.

• **Horton General Hospital**: Long waits for triage in A&E, patients being referred to the JR if there are no ENT appointments available locally.

• **Physiotherapy**: long wait for referrals.

More generally there were concerns about appointments for referrals into secondary care being changed several times and the distance from Banbury to Oxford (JR) for services such as paediatrics and the distance from home to the JR if a child needs to be admitted in the future.

7.2.10 How feedback from patients and the public has been used

The public feedback and input has been shared with all those involved in the Oxfordshire Transformation Programme and has been considered to help further develop the models of care and future service as well as helping to develop the evaluation criteria to review the proposals.

Feedback from patients and the public has also been used to identify the potential challenges that the programme may face and to allow the
Transformation Programme to make plans to address this. (More information on the current and potential challenges that have been identified are included in Appendix 7.4).

7.2.11 Involvement of stakeholders in the development of the Strategic Review of the Horton General Hospital

The Strategic Review of the Horton General Hospital sought to attain clinical consensus about the best models of care and their viability. Over fifty clinicians from all OUHFT sites worked with managerial colleagues to develop clinically viable and sustainable options for new models of care.

During this early phase, OUHFT held several meetings with public representatives, including the North Oxfordshire Community Partnership Network to keep all parties well informed of the process, until public consultation. Public meetings with the North Oxfordshire Locality Forum, meetings with local MPs and Council have taken place between March and August 2016 and a public meeting at St Marys Church 25th August. For full communications and engagement activities to date, please see Appendix 7.5.

A survey has been conducted with OUHFT members on services at the Horton General Hospital with 233 responses received. The survey was open until 22 September and findings are in the process of being collated. These will inform developments as the Review progresses.

Engagement sessions have also taken place, throughout the development of proposals, with North Oxfordshire Locality Group GPs, South Warwickshire NHS Foundation Trust and Northampton General Hospital.

The Royal College of Paediatric and Child Health (RCPCH) has visited the Horton General to provide an independent opinion on the two Clinical Decision Unit (CDU options for Paediatrics in September 2016. The final report is awaited.
7.3 Test Two: Patient Choice

“You have the right to make choices about your NHS care and to information to support these choices. The options available to you will develop over time and depend on your individual needs.”

NHS Constitution 2014

7.3.1 Introduction

In line with the NHS Constitution, Oxfordshire CCG is committed to offering patients choice. Greater Choice and Control, published by the Department of Health in October 2010, identified increased choice as being good for patients because:

- Choice promotes better outcomes for patients;
- Choice promotes confidence and recovery;
- Choice has an important role in promoting equality and reducing inequalities;
- Choice encourages providers to tailor their services to what people want.

A central principle of the Transformation Programme is, therefore, that patients should have access to the right treatment, at the right place, at the right time. This includes providing services locally wherever possible.

However, there is a balance between offering patient choice and the delivery of high quality services. In some cases centralisation will be necessary to ensure that clinical standards are met and patients have the best outcomes.

7.3.2 Implications of Proposals for Patient Choice

An assessment has been undertaken to consider the impact of the proposed changes on the competition landscape and, specifically, on patient choice. Each of the workstream leads have summarised the implications of their proposals for patient choice:

7.3.3 Critical Care

Patient Choice for critical care will be no different to that which is currently available. This is because the vast majority of critical care patients arrive at hospital via ambulance. It is the ambulance crew who make the decision as to where best to take the patient based on where the most appropriate care can be delivered. The changes proposed for Critical Care have been designed to increase the quality of care delivered.
7.3.4 Stroke

Patient choice within stroke will be impacted as the removal of the Acute Stroke Unit at the Horton will mean patients who have a stroke will no longer have a choice between the Horton and the John Radcliffe. The Hyper Acute Stroke Unit will be the only option for these patients. As outlined elsewhere in this document, this reduction in patient choice should be outweighed by an improvement in outcomes.

Regarding discharge, patients will continue to have the same level of choice as is available at the moment. Depending on the patient’s needs, they may be eligible for Early Supported Discharge which will have an increased geographical footprint. Patients who are not eligible for Early Supported Discharge will continue to have a bed based rehabilitation service available.

7.3.5 Changes to Bed Numbers

Patient Choice regarding the proposed bed realignment will be no different to that which is currently available. This is because the first opportunity that the patient has to make a choice will remain the same – at the point at which they are ready to be discharged from the acute environment. The pilot has demonstrated that the proposed changes will result in few Delayed Transfers in Care, therefore this choice will come at an earlier point than with the current model. The distributed model of intermediate care beds mean there are a greater number of localities of care. Maximising flow of patients to keep the Urgent Care pathway flow for new very sick patients will by necessity override an individual patient choice decision. The ambulatory approach however maximises the ability of patients to return to their own bed.

7.3.6 Maternity Services

For maternity services, the Department of Health paper *Maternity Matters: Choice, access and continuity of care in a safe service*, lists four guarantees:

1. Choice of how to access maternity care – directly through a midwife or through their GP;
2. Choice of type of antenatal care provided by midwives, or a team of midwives and obstetricians;
3. Choice of place of birth – depending on their circumstances, women and their partners should be able to choose between three different options:
   - Birth in a local facility, including a hospital, under the care of a midwife
   - Birth in a hospital supported by a local maternity care team including midwives, anaesthetists and consultant obstetricians. For some women this will be the safest option.
4. Choice of place of postnatal care either at home or in a community setting.
In Oxfordshire women will have access to the full choice of services including home birth, birth in a freestanding MLU, in an alongside MLU and in an obstetric unit. Midwives, GPs and Obstetricians will work with mothers during their pregnancy to ensure women have all the information they need to make an informed choice about what is best for them and their baby. The full choice menu is available to any woman who lives in Oxfordshire or who is registered with an Oxfordshire GP. Oxfordshire Hospitals provide tertiary and complex care to the most high risk women, unborn children and sick neonates across a much wider region. Women in surrounding counties will have the choice of access to these specialist services.

7.3.7 Planned Care

The new model of Planned Care being consulted on in Phase One will enhance choice. For example someone who currently goes to the John Radcliffe Hospital for a clinic but lives in Banbury will now have the choice of going to the Oxford sites or the Horton General Hospital in Banbury. If a patient requires a service, such as diabetes, cardiology or ENT that is planned to be offered in each locality there would be more choice.

7.3.8 Compliance with public, procurement and competition law

External legal advice will be sought to ensure the proposals are complaint with public, procurement and competition law.
7.4 Test Three: A Clear Clinical Evidence Base

7.4.1 Clinical Evidence Base

All of our proposals have a clear clinical evidence base. At the outset of the programme, when developing our detailed 'case for change', we considered clinical standards, guidance and best practice. See Chapter Four for a summary of these for each of the areas within the scope of Phase One.

Additional summary tables of the clinical evidence and links to best practice for the maternity proposals are included in Appendix 7.6.

7.4.2 Patient and Quality Benefits

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

7.4.3 Critical Care

<table>
<thead>
<tr>
<th>Because we know...</th>
<th>We will...</th>
<th>And the benefit will be...</th>
</tr>
</thead>
</table>
| More patients want the best quality of care delivered across the Urgent and Emergency care system within Oxfordshire | - 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) | - 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. |
### 7.4.4 Stroke

<table>
<thead>
<tr>
<th>Because we know...</th>
<th>We will....</th>
<th>And the Benefits will be...</th>
</tr>
</thead>
</table>
| Patients need access services quickly and receive the best possible care for them | - 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 | - 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 |
| Patients want to know what will happen throughout, while their health needs are cared for. | - 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 | - 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. |
| Patients don’t want to have to travel backwards and forwards to the Acute hospital sites for routine appointments following a non-elective spell. | - Increase the skills, coverage and capacity within our Early Supported Discharge Service | - 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. |
| More patients are experiencing mental health problems | - 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. | - 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.
- 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.
- 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
- Ensuring Stroke Services and Pathways are NICE guidance compliant
- Redesigning pathways to incorporate more integrated ways of working by centralised centre for excellence approaches
- 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

### 7.4.5 Changes to Bed Numbers

<table>
<thead>
<tr>
<th>Because we know...</th>
<th>We will...</th>
<th>And the benefit will be...</th>
</tr>
</thead>
</table>
| More patients are becoming unwell while waiting for packages of care or other services while awaiting discharge from an Acute or Community Hospital Bed. | - 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. | - 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 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 |
Because we know… | We will… | And the benefit will be…
---|---|---
Community Hospital Bed. | support the discharge of patients across the County - Consolidate progress on DTOC - Formalise and expand the Liaison Hub | 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 earlier. - More effective and efficient use of intermediate care beds.

#### 7.4.6 Maternity Services

| Because we know… | We will… | And the benefit will be…
---|---|---
Insufficient resource is directed at pre-conceptual care⁴⁹ | - 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 | - 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 health⁵⁰ | - 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 | - An integrated team working closely with all health professionals involved in the maternity pathway will improve early identification and better management of

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⁵⁰ Five Year Forward View DH London 2016
Because we know… | We will… | And the benefit will be…
---|---|---
| 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

| - Continue to provide all four choices for place of birth to women in Oxfordshire as per NICE guidance |
| - 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 |
| - Women will receive the right care, by the right person in the right place for them |
| - 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

| - 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 |
| - 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 |

<table>
<thead>
<tr>
<th>Because we know…</th>
<th>We will…</th>
<th>And the benefit will be…</th>
</tr>
</thead>
<tbody>
<tr>
<td>women postnataally including breastfeeding support</td>
<td>- A clinically safe and sustainably model of care</td>
<td></td>
</tr>
<tr>
<td>There is no clearly defined role for primary care</td>
<td>- 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</td>
<td>- GPs, who have insight and knowledge of a woman, and her family, are best placed to carry out the initial medical risk assessment</td>
</tr>
<tr>
<td></td>
<td>- Ensure all women are consistently and effectively screened and medically risk-assessed by their GP as early as possible in pregnancy</td>
<td>- GP’s skills and knowledge are utilised in the most appropriate manner</td>
</tr>
<tr>
<td></td>
<td>- GPs will maintain responsibility for the management of long term conditions and ensuring medication prescribed is safe for a pregnant or breastfeeding woman</td>
<td>- The initial risk assessment is with a professional a woman is familiar with and so she is more likely to disclose important information that may be relevant to her pregnancy</td>
</tr>
<tr>
<td>Inconsistent medical risk assessment</td>
<td>- Ensure all women are screened and medically risk assessed by their GP (as above) as soon as possible in pregnancy</td>
<td>- Consistent medical risk assessment resulting in early identification of problems and better outcomes for mother and baby</td>
</tr>
<tr>
<td></td>
<td>- Ensure robust policies and procedures for midwives to identify and escalate women when there is a perceived change in risk (antenatal, intrapartum and postnatal)</td>
<td>- Clear and effective risk assessment underpins informed choice and the decisions women will make about their care</td>
</tr>
<tr>
<td>Some estate remains unfit for purpose</td>
<td>- Reconfigure services to meet the needs of the population</td>
<td>- Improved patient experience throughout the birth and postnatal period.</td>
</tr>
<tr>
<td>We under-utilise technology</td>
<td>- Seek to develop existing IT systems to enable a</td>
<td>- Fast and easy access to a woman’s care</td>
</tr>
</tbody>
</table>

52 NICE QS22 Sep-12
<table>
<thead>
<tr>
<th>Because we know...</th>
<th>We will...</th>
<th>And the benefit will be...</th>
</tr>
</thead>
<tbody>
<tr>
<td>woman’s notes to be held electronically and accessed by all professionals involved in her care</td>
<td>records including risk assessments and birth preferences</td>
<td></td>
</tr>
<tr>
<td>- Look to the use of apps and other solutions to support women</td>
<td>- Women and healthcare professionals will not be reliant on women physically carrying their notes with them to every appointment</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Community diagnostics will enable more antenatal care to be delivered closer to home</td>
<td></td>
</tr>
<tr>
<td>Midwife-led care delivers the best outcomes for low risk women</td>
<td>Make sure MLUs are in areas of greatest demand now and in the future</td>
<td>Better outcomes for low risk women and their babies including less medical intervention during birth</td>
</tr>
<tr>
<td>- Expand capacity in the alongside MLU</td>
<td>- Promote MLUs as the preferred place of birth for low risk women</td>
<td></td>
</tr>
<tr>
<td>High risk women achieve better outcomes when cared for by specialist teams</td>
<td>Identify high risk women early on in pregnancy and direct them to ensure the right person/team to deliver their care</td>
<td>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.</td>
</tr>
<tr>
<td>- Deliver outpatient care more locally where possible</td>
<td>- Deliver a single obstetric unit with consultant staffing 24/7 as per RCOG standards.</td>
<td>- A sustainable consultant workforce, leading the number and complexity of births required to enable them to maintain and develop their specialist knowledge.</td>
</tr>
<tr>
<td>Women tell us we should improve our postnatal support and particularly access to specialist breastfeeding</td>
<td>Develop a postnatal offer that matches women’s expressed needs with support including</td>
<td>Improved infant mother attachment</td>
</tr>
<tr>
<td></td>
<td>- Improved breastfeeding</td>
<td></td>
</tr>
</tbody>
</table>

Because we know… | We will… | And the benefit will be…
---|---|---
support | specialist support where required | continuation rates

### 7.4.7 Planned Care

<table>
<thead>
<tr>
<th>Benefit</th>
<th>How will it be assessed?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care would be delivered closer to home with access to traditionally ‘acute’ services delivered in a local setting.</td>
<td>Number of patients seen within their locality or place of choice</td>
</tr>
<tr>
<td>Increased access to real time consultant advice from GP practices to support management in primary care to reduce referrals.</td>
<td>Introduction of telephone advice system for high volume specialities. Monitor usage of system including pick up by secondary care Reduction in outpatients</td>
</tr>
<tr>
<td>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.</td>
<td>Improved patient experience. Fewer follow ups Better self-management and ownership of care plans by patients reflected in a specific questionnaire</td>
</tr>
<tr>
<td>More patients being treated and managed by their GPs where appropriate</td>
<td>Less referrals to outpatients Improved patient experience</td>
</tr>
<tr>
<td>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</td>
<td>Achievement of RTT and cancer waits Audit of pathways Referrer satisfaction Patient experience</td>
</tr>
<tr>
<td>Early care planning for patients to take over their care where appropriate</td>
<td>Improved patient experience Fewer follow ups Better self-management and ownership of care plans by patients reflected in a specific questionnaire</td>
</tr>
<tr>
<td>Earlier identification of cancer through better access to diagnostics and advice at primary care level and quicker access to cancer services when needed</td>
<td>GP and health care professional’s education attended. Appropriate use of new pathways demonstrated through audit</td>
</tr>
<tr>
<td>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.</td>
<td>Increased uptake of community diagnostics Audit of usage and appropriateness Introduce point of care testing where possible and monitor usage</td>
</tr>
<tr>
<td>Requirement</td>
<td>Methodology</td>
</tr>
<tr>
<td>-----------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Less need to travel to hospital sites for outpatient appointments</td>
<td>Travel times</td>
</tr>
<tr>
<td></td>
<td>Number of patients seen within their locality or place of choice</td>
</tr>
<tr>
<td>Joined up care using shared care records across all providers so improving communication and reducing duplication.</td>
<td>Availability of shared records for all professionals and patients</td>
</tr>
<tr>
<td>Better co-ordination of care with patients being clear about the clinical pathway at the outset and clear agreed management plans</td>
<td>Number of patients with an agreed care/treatment plan</td>
</tr>
<tr>
<td></td>
<td>Patient experience</td>
</tr>
<tr>
<td></td>
<td>Monitoring system for pathways</td>
</tr>
<tr>
<td></td>
<td>Availability of shared records</td>
</tr>
<tr>
<td>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.</td>
<td>Number of patients with an agreed care/treatment plan</td>
</tr>
<tr>
<td></td>
<td>Decision making process in place</td>
</tr>
<tr>
<td></td>
<td>Patient experience</td>
</tr>
<tr>
<td></td>
<td>Referrer experience</td>
</tr>
<tr>
<td></td>
<td>Availability of shared records for all professionals and patients</td>
</tr>
<tr>
<td>Reduction in preventable diseases through earlier intervention</td>
<td>Use of programmes such as NDPP</td>
</tr>
<tr>
<td></td>
<td>Uptake of weight management by practice and speciality</td>
</tr>
<tr>
<td></td>
<td>Uptake of smoking cessation</td>
</tr>
<tr>
<td></td>
<td>Uptake of exercise offers</td>
</tr>
<tr>
<td>Better local management of chronic diseases enabling people to live well at home with good education and self-management</td>
<td>Number of people requiring secondary care for their LTC</td>
</tr>
<tr>
<td></td>
<td>Admissions to hospital for a LTC related condition</td>
</tr>
<tr>
<td></td>
<td>Uptake of education for LTCs</td>
</tr>
<tr>
<td></td>
<td>Number of patients with agreed care/treatment plan</td>
</tr>
<tr>
<td>Quicker access to acute services when needed</td>
<td>Use of pathways audit</td>
</tr>
<tr>
<td></td>
<td>Use of communication systems email, telephone etc.</td>
</tr>
<tr>
<td>Reduction in unplanned admissions</td>
<td>Admissions to hospital audit</td>
</tr>
<tr>
<td>Increased patient satisfaction and improved experience</td>
<td>Patient satisfaction/experience surveys</td>
</tr>
<tr>
<td></td>
<td>Focus groups for specific areas</td>
</tr>
<tr>
<td>Less complications and hospital acquired infections</td>
<td>Complication rate</td>
</tr>
<tr>
<td></td>
<td>Infection rates</td>
</tr>
</tbody>
</table>

55 CQC patient satisfaction survey 2001
| 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\(^{56}\) 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 |

### 7.4.8 A Clinically-led Review

The Transformation Programme has been clinically-led. This section explains the approaches taken to ensure effective clinical leadership and to engage clinicians in the programme.

### 7.4.9 Clinical Leadership of the Transformation Programme

Clinical leaders have been fully integrated across all elements and stages of the Programme. Across the scope of the Programme, clinicians have been involved in the following functions:

- Developing the case for change
- Understanding best practice
- Developing a vision
- Gaining clinical consensus on a range of options

\(^{56}\) 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.
Clinicians have been organised around their specialities to maximise the input of their knowledge and skills. The diagram on the next page illustrates how the clinical-leadership of the Transformation Programme has been organised:

7.4.10 CCG work streams

In April 2016, a series of clinical work streams were established to develop the case for change in their specific areas (termed the 'gaps' in health and wellbeing, finance and quality), develop a future vision for those areas based on best practice and consider options that would deliver on the vision. The work streams were tasked with considering the implications of delivering the vision for patients, staff, estates and finance.

Appendix 7.7 articulates the initial Terms of Reference for these clinical working groups and Appendix 7.8 provides the names of both the managerial and clinical leads for those work streams. A Locality Clinical Director from the CCG was included in each of the clinical work streams.

The clinical work streams have met frequently since March 2016 to develop thinking, consensus and to develop the proposals that are contained within this document.
7.4.11 Horton Strategic Review pathway groups

For the development of proposals around the Horton General Hospital, OUH clinicians were drawn together throughout April, May and June 2016 to:

- Review current service provision
- Develop a vision for the pathways
- Gain clinical consensus on a range of options
- Develop a case for change for each pathway
- Develop evaluation criteria for the strategic options for the Horton General Hospital
- Develop strategic options for the Horton site
- Establish the estates, technology and work force requirements for the different options
- Assess the options against the criteria developed.

Appendix 7.9 sets out on slide 1 how this work was organised and on slide 5, it provides the names of the clinicians involved in the work. McKinsey Consultants led this work and they made the following observations about the effectiveness of the clinical leadership in those pathway groups:57

"Clinicians willing to have open, friendly and frank conversations with regarding current challenges and vision for the future.

Clinicians have strong grasp of the key issues and pain points and often substantiate key points with facts and figures.

Acknowledgement of “imperative to act” and general excitement about the potential future”

There was overlap between the clinicians involved in the CCG work streams and the specific Horton work and this enabled consistent clinical development of proposals within both contexts.

7.4.12 System-wide workshops

Throughout April, May and June 2016, the work from the CCG clinical work streams and the Horton clinical review was brought into a system-wide forum to draw in clinicians and professionals, including GP Federations from across Oxfordshire, into the development of thinking, discussions and proposals.

The system-wide workshops covered the following ground:

- Discuss emerging case for change, focusing on trends & challenges in current health care provisions along the pathways
- Review best practices and case examples on models of care and discuss potential implications for Oxfordshire

57 These observations were included in the slide pack in the discussion document presented to the Strategic Redesign Overview Group on 13 April 2016
• Discuss and input into emerging views on the best practice care pathways
• Review and input into emerging models of care
• Review refined models of care
• Discuss high level requirements from different care settings, including out of hospital care, to make the models of care sustainable in the long term
• Discuss key enablers for the new models of care:
  - Settings for care provision
  - Workforce
  - Ways of working
  - Technology.

In addition to the series of workshops outlined here, the CCG held two events for clinicians on the 19th of July 2016 (one in the afternoon and one in the evening). Both were learning and development events to showcase successful healthcare transformation using an example from New Zealand and combined an opportunity to relate it to Oxfordshire’s plans. This engaged both primary and secondary clinicians in discussions around transformation.

7.4.13 CCG Clinicians

Board Meetings and Workshops

Over the last twelve months, the CCG Board (with its Locality Clinical Directors) has been involved in the development of all aspects of the Programme. This has given CCG clinicians the chance to shape, direct and decide upon the proposals and options. See section 7.5.2 for more information on the involvement of the CCG Board.

Locality Meetings

Since April 2016, Oxfordshire’s Transformation Plans have been on the monthly agendas of all six of Oxfordshire’s Locality meetings. This has given GP’s (and Practice Managers) from across the county the opportunity to hear about the Programme and feed in their views on the shape of proposals. From April to August, the discussions with Localities were general and these became more focused as the programme has developed in September and October.

Throughout September 2016, Locality meetings focused specifically on the potential implication of transformation options in their areas. Initial meetings were held with each Locality Clinical Director ahead of their September meetings and then further discussion was held at the Locality meetings themselves.

Throughout October 2016, the CCG Board led a Transformation Programme session at each of the six Locality meetings, whereby a non-executive Director and Executive Director and a Locality Clinical Director from another area went to a Locality meeting and explored the Transformation Programme
in detail. An example of a slide set used at these meetings can be found in Appendix 7.10.

### 7.4.14 Medical Director Support

In addition to these ongoing arrangements for the clinical leadership of the Programme, the Medical Director of Oxford University Hospitals and Oxford Health, alongside the CCG Clinical Chair formally added their support to the clinical models (see Appendices 7.11 and 7.12).

### 7.4.15 Engagement of wider clinicians across the provider organisations

In addition to the active participation of clinicians in all aspects of the programme, both provider trusts in Oxfordshire have taken pro-active steps to disseminate information about developments to staff. This has ensured that clinicians in both organisations are aware of the proposals and able to raise concerns, ask questions or make suggestions.

- **Oxford University Hospitals NHS Foundation Trust (OUHFT)**
  
  OUHFT has undertaken extensive staff engagement base on the following three themes:
  
  - OUHFT Strategic Review – initiated by the trusts new Chief Executive in October 2015
  - Horton Strategic Review
  - BOB STP, Oxfordshire Transformation Plans and Oxfordshire Transformation Board

  The CEO provides updates every six weeks to his senior team on all aspects of the strategic reviews and BOB and local transformation. These issues are a standing item on the trusts. All Staff Briefing and ‘drop in’ sessions are available for staff to raise and discuss any issues that they are concerned about.

  Information about the strategic reviews and transformation are featured in a staff and public facing newsletter and there is an internal e-newsletter that updates staff on any issues and development s in relation to the strategic reviews and/or transformation.

  A copy of OUHFT Communication and Engagement log is included as Appendix 7.13.

- **Oxford Health NHS Foundation Trust (OHFT)**

  OHFT has undertaken a series of workshops in all of the Community Hospitals and with senior clinicians and operational lead Directors. All staff in the community hospitals have met had the chance of a face to face meeting with the OHFT Directors leading on engagement and the trust is
just completing a second round of staff engagements in the community hospitals.

A site has been set up on the trusts intranet where staff can ask questions and receive information and a reply to their query.

The Integrated Locality leads are running workshops with integrated locality team and GPs to develop effective multidisciplinary team working and address the issues of working in a new way.

7.4.16 Independent Clinical Assurance

Any changes to healthcare services must comply with, and where possible improve, clinical standards. The Thames Valley Clinical Senate was, therefore, commissioned to establish an independent clinical review panel to assure both the clinical case for change and the emerging proposals for service change.

The Clinical Senate held a formal assurance meeting to examine the proposals in Phase One (those described in this business case) on 7th November 2016. The final report following the Thames Valley Clinical Senate meeting, 29th November 2016, was provided to NHS England for its Gateway 2 Assurance of Oxfordshire Transformation Programme - Phase One transformation plans.
7.5 Test Four: Support for Proposals from Clinical Commissioners

7.5.1 Clinical Commissioners have been involved in the Oxfordshire Transformation Programme throughout, from shaping the overarching vision to active involvement in the development of the detailed clinical proposals. This section provides a brief overview of this.

7.5.2 CCG Board

The CCG Board is the accountable body for the Oxfordshire Transformation Programme (see Chapter 3 on the Governance of the Programme). They have been kept informed of all developments and are fully supportive of the programme’s objectives.

The table in Appendix 7.15, in particular, demonstrates how the CCG Board has been informed of, and involved in, the development of the specific proposals with the scope of this business case.

This business case was approved by Oxfordshire CCG Board on the 29th November 2016 in a Part II session of its Board Meeting.

7.5.3 GP Member Practices

Oxfordshire CCG is a membership organisation and all GPs in Oxfordshire are members of the CCG. The Clinical Chair is a practicing GP and each of the six localities has a Locality Clinical Director (LCD) and a deputy who are working GPs.

The Clinical Chair and the LCD’s are all actively involved in the development of the transformation plans and in the new pathways of care, looking at the potential implications for primary care. As members of the CCG Executive and the Board they have also received and discussed papers relating to the transformation plans and have participated in Board workshops, including one to prepare them for their role in the consultation with the public on our plans.

The Chair and a number of GPs involved with our local Federations also sit on the Oxfordshire Transformation Board along with the CEO’s of the two larger Federations and the Chair of the LMC.

Transformation has been a standing item on the six primary care Locality Meeting agendas.

The CCG attempted to organise a series of evening meetings for GP practices and their staff during September but poor take up meant that only the meeting in the South West in Didcot took place. 14 staff from local practices attended and engaged in discussion of the development of the options and what the transformation plans would mean for their locality.
To support the engagement with GPs, Board-led discussions with localities were held during October and November. These used their scheduled meetings which are attended by a member of each practice in that locality. These meetings were opened to the wider primary care workforce to enable them to understand, comment and contribute to the plans that are being developed. The presentation used at these meetings was made available to those who attended and they are being encouraged to share and discuss it with the staff and colleagues in their own practices. The North and North East Localities where there is the greatest impact from Phase One changes have had a specific focus in their discussions on obstetric, critical care and stroke. In all cases the need for safe patient care in all areas and workforce constraints in obstetrics were acknowledged and whilst any loss of services is to be regretted the rationale for the public consultation was supported.

In November 2016 the CCG Board approved this PCBC and supported the move to public consultation on the proposals.

7.5.4 Commissioners in Surrounding Areas

The Transformation Programme has maintained close links with health commissioners and providers in neighbouring areas to ensure that key organisations and individuals are aware of proposals as they are developed and have been able to highlight any potential implications for their area.

7.5.5 Engaging with the Local Maternity System (LMS)

Oxfordshire is a Local Maternity System within itself but also provides services for wider geographic population. Specific engagement has, therefore, taken place with the commissioners and providers within the maternity system to ensure they are aware, and willing to support, the proposals.

South Central Ambulance Service (SCAS) has also been part of discussions about plans for maternity services, in particular around plans to improve transfer times between MLUs and the obstetric units. For the temporary closure at the Horton General Hospital, SCAS is providing a standby ambulance.

GPs have been essential to discussion about the new model of care, recognising where GP skills are best deployed through the Maternity Medical Risk Assessment.

Other commissioners on the borders of Oxfordshire have been engaged, in particular Nene CCG and South Warwickshire CCG. Discussions are ongoing

58 The OUHFT is also the tertiary provider of maternity services (with the next nearest tertiary centre in Southampton) and a tertiary provider of NICU cots. There is a bespoke ambulance transfer service between the maternity units in Thames Valley and the NICU cots at the John Radcliffe Hospital.
with CCGs to the south of the county as part of the wider Strategic Clinical Network and the work on capacity planning for the future. There are parallel processes in place for engaging users of services and local women/partners.

In the future the Oxfordshire Maternity System (OMS) will be responsible for the strategic oversight and delivery of the local transformation plan. The OMS will focus of measuring outcomes for women and babies and ensuring safe and accessible service wherever women live. This includes working with cross boundary CCGs to manage capacity issues going forward. The OMS is responsible for driving up the number of births in community settings in line with the recommendations of the national review. The OMS will maintain oversight of the workforce across maternity services including the wider system members.

7.5.6 Commissioners of Specialised Services

The Transformation Programme will be working in close partnership with commissioners of specialised services whenever there is a potential for the services they commission to be impacted either directly or indirectly.

In Phase One, the Clinical Development Lead for the Programme has checked and confirmed that the proposals do not directly impact on any specialised services.

Some planned care is designated as a specialised service e.g. scoliosis surgery, and the plan is to continue providing these services in Oxfordshire, but to make them more accessible to patients in the North of the county.

Oxfordshire does have specialised services related to maternity (e.g. tertiary obstetric services, mother and baby mental health inpatient beds) at the John Radcliffe Hospital but these will not be negatively affected. In fact, the proposed move to having a 24 hour presence on the labour ward has the potential to strengthen these specialised commissioning services.
Chapter 8: The ‘Best Practice’ Checks

In addition to the formal NHS ‘Four Tests’ the CCG has considered a number of other ‘best practice checks’.

8.1  Access and Travel Analysis

8.1.1  Baseline

The CSU on behalf of the OCGC have undertaken baseline analysis of the current travel times across the county. This is included in Appendix 8.

8.1.2  Implications of proposed changes

Additional work was also undertaken by OUHFT to look at the implications of the proposed changes on travel times. This focuses on the north of the county.

Access to the Horton General and to the Headington sites were assessed for different locations in north Oxfordshire and beyond. Travel times were calculated for three scenarios: by blue light, by private car at peak time, by public transport at inter-peak time using detailed modelling. An assumption was made that activity would shift between sites depending on travel time. On this basis no longer providing a service at the Horton General would result in approximately half this activity shifting to non-Headington sites such as Northampton General Hospital or Warwick Hospital.

8.1.3  Findings

8.1.4  Blue light or private car at night

When blue light or private car at night transport is modelled, 75% and 99% of the north Oxfordshire population is within 20 or 30 minutes respectively of the Horton General, the Headington centres, Northampton General Hospital or Warwick Hospital. If services are not delivered at the Horton General, this will result in longer travel times, with 14% and 85% of patients taking 20 or 30 minutes respectively to reach a hospital with suitable emergency care (Reference slide 61). The maximum time for all the population to reach a suitable hospital by blue light is 31 minutes.

8.1.5  Peak time with private car

In peak time when using a private car, currently 55% and 97% of the population of Oxfordshire are within 20 and 30 minutes respectively of a hospital (either the Horton General or the Headington sites) (Reference slide 62). If only the Headington sites provide services then 0% and 39% of north Oxfordshire population will be within 20 and 30 minutes respectively of the Headington sites. In peak time using a private car the maximum time for a person in north Oxfordshire to reach a suitable hospital facility is 40 minutes.
with the current configuration and 48 minutes, if there are no services at the Horton.

8.1.6 Inter-peak time with public transport

When using public transport in inter-peak time, 44% and 70% of north Oxfordshire population are within 30 and 60 minutes respectively of a hospital (either the Horton General or the Headington sites) but 0% and 39% of the north Oxfordshire population are 30 and 60 minutes respectively from a hospital for services that are only provided at Headington (Reference slide 63). The maximum time for all the north Oxfordshire population to reach a hospital is 99 minutes for current provision and 113 minutes for services only provided at Headington.

8.1.7 Alternative forms of transport

Because of sensitivities about travel times, the feasibility of helicopter transfer for maternity patients between the Horton General and the John Radcliffe sites has been discussed with South Central Ambulance Service (SCAS). The following initial broad concerns have been raised:

- Potential difficulty with obtaining Civil Aviation Authority approval to build a helipad on the Horton General site
- Transfer times by helicopter, which probably would not shorten, and may even lengthen, journey times between the two hospitals
- The suitability of helicopter transport for a woman in labour

Such concerns suggest that there are no real alternatives to blue-light transfer, but it is intention of this Review to explore this option further.

8.1.8 Summary

Relocating services will impact on individual travel time. Broadly, the weighted average travel time increases from 13 to 25 minutes for blue light transport, 17 to 33 minutes for private car travel at peak time and from 40 to 61 minutes for public transport at inter-peak time for the population of north Oxfordshire and surrounding geography, if services are not available at the Horton General.59

These longer travel times for the above services are reversed for journeys for elective services that have been transferred from the Headington sites to the Horton General.60 In the current configuration using non-blue light transport, 0% and 39% of the north Oxfordshire population are within 20 and 30 minutes respectively of the Headington sites for these services. But if these elective services are transferred to the Horton General, 55% and 97% of the population will be within 20 and 30 minutes respectively of the Horton General. The maximum time for all the north Oxfordshire population to reach

59 See Appendix 8.2: Travel Analysis Supporting Evidence Slides
60 See Reference Slide 4 in Appendix 8.2.
the Headington sites for these services is 46 minutes and 40 minutes if these services are transferred to the Horton General.

A similar travel time analysis performed by the Advisory Committee on Resource Allocation (ACRA)\(^6\) in 2015 reported that for the Horton General Hospital, 33.1% of its catchment population was within 30 minutes of the next nearest hospital by private transport, 94.5% were within 45 minutes and 100% outside 60 minutes. The definition of remoteness used by ACRA was a population who were more than 60 minutes from the next nearest hospital. If all the population could travel to the next nearest hospital within 60 minutes, the population and in this case according to ACRA the population of north Oxfordshire and surrounding geography is not remote.

### 8.1.9 Access to obstetric units

The Clinical working Group for Maternity Services also looked specifically at travel access to the obstetric units in order to consider the potential implications of closing the Horton Unit. Their findings are summarised in the tables and figures below. They found that under the proposal all journeys would be 45 minutes by blue light transport and 421 women become more then 60 minutes away from their closest obstetric unit with no service provided by the Horton General.

<table>
<thead>
<tr>
<th>Time</th>
<th>Private Vehicle Peak</th>
<th>Private Vehicle Off Peak</th>
<th>Blue Light*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>%</td>
<td>Number</td>
</tr>
<tr>
<td>0-15 mins</td>
<td>55,419</td>
<td>34.9</td>
<td>70,742</td>
</tr>
<tr>
<td>0-30 mins</td>
<td>95,250</td>
<td>61.7</td>
<td>146,963</td>
</tr>
<tr>
<td>0-45 mins</td>
<td>147,564</td>
<td>95.5</td>
<td>154,456</td>
</tr>
<tr>
<td>0-60 mins</td>
<td>154,456</td>
<td>100</td>
<td></td>
</tr>
</tbody>
</table>

*plus average 19 minute wait after calling

<table>
<thead>
<tr>
<th>Time</th>
<th>Private Vehicle Peak Time</th>
<th>Private Vehicle Off Peak</th>
<th>Blue Light*</th>
</tr>
</thead>
</table>

Table 8.1– Current Obstetric Unit Access (to JR Horton and surrounding)

Note: Table 1 destinations include the John Radcliffe Hospital, Horton Hospital, Stoke Mandeville Hospital, Royal Berkshire Hospital, Milton Keynes General Hospital, Northampton General Hospital, Warwick Hospital and The Great Western Hospital

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\(^6\) ACRA (2015) Unavoidable smallness due to remoteness – identifying remote hospitals
Table 8.2 – Access to Obstetric Units
(JR and out of county hospitals not including the Horton General)

Note: Table 2 destinations include: The John Radcliffe Hospital, Stoke Mandeville Hospital, Royal Berkshire Hospital, Milton Keynes General Hospital, Northampton General Hospital, Warwick Hospital and The Great Western Hospital

<table>
<thead>
<tr>
<th>Time</th>
<th>Number</th>
<th>%</th>
<th>Number</th>
<th>%</th>
<th>Number</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-15 mins</td>
<td>41,126</td>
<td>26.6</td>
<td>54,865</td>
<td>35.5</td>
<td>54,929</td>
<td>35.6</td>
</tr>
<tr>
<td>0-30 mins</td>
<td>76,026</td>
<td>49.2</td>
<td>137,116</td>
<td>88.8</td>
<td>134,463</td>
<td>88.4</td>
</tr>
<tr>
<td>0-45 mins</td>
<td>137,913</td>
<td>89.3</td>
<td>154,456</td>
<td>100</td>
<td>154,456</td>
<td>100</td>
</tr>
<tr>
<td>0-60 mins</td>
<td>154,035</td>
<td>99.7</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Over 60 mins</td>
<td>421</td>
<td>0.3</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*plus average 19 minute wait after calling

Figure 8.1 – Current Access to Obstetric Units
Figure 8.2 – Access to Obstetric Units (without Horton General Hospital)

8.1.10 Mitigations

These two pieces of work together provide data on the potential travel and transport implications of the proposed changes. This is being supplemented by patient views which will be gathered through the Integrated Impact Assessment (see Chapter 11) and an independent travel analysis by Healthwatch. Once this additional information is available, the CCG will draw up a set of proposed mitigations which they will share with the public.
8.2 Meeting the Public Sector Equality Duty

8.2.1 The approach to equality and inequality has been a consistent theme throughout the development of the options and in the system’s engagement with the public, patient and carers. This section sets out the approach and analysis in terms of equality and inequality and the conclusions that have been reached.

8.2.2 Equality Assessment of the 9 Protected Characteristics

Much of the work in this business case draws on the Strategic Review of the Horton General Hospital. This gave careful consideration to the potential impact of the proposed changes on patients and the public, including the implications for equality and inequality.

The involvement of stakeholders in the Strategic Review is described in Chapter 7. It included extensive work with clinicians, OUHFT members, public and patient representatives and staff from surrounding providers.

This consultation activity informed the assessment of the impact on patients who meet the 9 protected characteristics.

8.2.3 Disability

In England 17.6% of people have a limiting long-term illness or disability. The proportion of people limited in their daily activities amongst people living in the catchment area for Horton General Hospital is below the England average, with the exception of the small cohort of people from the Warwickshire counties.

The proportion of people limited in their daily activities is broadly similar across the county (14.5% in West Oxfordshire and 14.1% in Cherwell compared to 12.4% in Oxford and 13.8% in South Oxfordshire).

The key aspect of the proposed changes for disabled people with physical, sensory or cognitive disabilities is the potential impact on their travel times. This applies to service users, their carers and staff with disabilities.

Emergency care

The aim of an ambulatory approach is to improve the provision of support to patients with complex needs (including disabilities) in their own homes and communities, avoiding hospitalisation where possible and improving patient experience. The Future Hospitals Commission (FHC) report advocates that care of patients with complex needs, delivered across settings, and by several teams, requires excellent co-ordination.

The proposal for experienced teams of ‘specialist generalists’, to support and address the active physical, social and psychological care needs of older people and those with complex needs is aimed at improving the care of those
with physical disabilities and bring care closer to home with the ‘acute hospital at home’, ‘early transfer to home’ and ‘rehabilitation at home’ services. The proposed Clinical Coordination Centre at the Horton General would act as a base for hospital’s clinical teams to coordinate this care for patients, supported by GPs, nurses, ambulance practitioners and others outside hospital.

**Maternity**

Research shows that disabled women and their partners are often anxious about pregnancy and concerns are highly specific to women’s individual circumstances and impairments. Some disabled women will be more likely to have high risk pregnancies and so will require the care of specialist obstetric services.

Central to the provision of changes to maternity services is that the right women (including low risk pregnant women) are cared for by the right specialist teams. All women will have a bespoke plan for their pregnancy that includes individual choice. To ensure the best outcomes, the choices for women with more complex pregnancies are likely to be different to the choices for women with low risk pregnancies.

Care plans to support disabled pregnant women who will be required to travel to the John Radcliffe will take into consideration their individual needs. The provision of pre-natal and ante-natal care in dedicated and accessible facilities in Banbury aims to provide responsive and accessible care for patients.

It has been recent practice for any woman with a BMI of $\geq 40$ to be advised to deliver at the John Radcliffe where care should be reviewed by an appropriate manual handling facilitator. Moving and handling aids are supplied as required. Level 5 and Level 6 family rooms at the John Radcliffe have larger doors and bathrooms with adaptations for people with physical disabilities.

**Planned care**

Providing significant numbers of diagnostic and outpatient appointments in Banbury (as opposed to the Headington sites in Oxford) will improve access for those who live in North Oxfordshire and will also impact on the congestion and parking issues that are currently problematic on the Headington sites. Development plans will give careful consideration to parking, including ease of access for disabled people at the Horton General Hospital.

**Other considerations / mitigations**

It is OUHFT policy that patients at the Horton General Hospital or John Radcliffe with a hearing loss should be offered a British Sign Language Interpreter via language line.
Suitable transport options should also be provided, including parking for women and their partners with disabilities who need to travel further to access services.

8.2.4 Learning Disability and Cognitive impairment

It is estimated that by 2030 the number of people identified as having a learning disability will have doubled. Having a learning disability can increase anxiety and distress, particularly in emergency situations. OUHFT’s Learning Disability policy outlines that training is provided for staff on communication techniques for working with people with learning disabilities.

In 2015/16 the estimated number of people aged 65 and over in the Oxfordshire CCG area who have dementia is 7,641 with nearly 3,000 of these as yet undiagnosed. In 2014/15 there were around 5,000 GP-registered patients in the area who had a diagnosis of dementia. This number has increased by around 1,000 (or 25.3%) since 2013/14.

Emergency care

Under the proposals if stroke or critical care services are required patients will need to travel to the John Radcliffe. As with any change, this would need to be carefully managed to ensure that it does not result in additional disadvantage, stress and anxiety for people with a learning disability.

Maternity services

There is no additional impact on women with learning difficulties. If a woman has any learning difficulties an advocate should be in attendance. Pictorial explanations should be given when providing and explanation about care.

There are single rooms on level 5 of the John Radcliffe hospital that have been specifically designed for women with mental health issues, so that a member of staff, support worker or family member can stay with the woman. At the John Radcliffe individual care plans are agreed and some of these women are able to choose to give birth at the MLU (Spires) and then transfer to the level 5 rooms. This enhanced service is available at the John Radcliffe because of the availability of obstetricians and the psychological medicine service.

Other considerations / mitigations

The following considerations were also noted during the Strategic Review of the Horton General Hospital:

- The Trust employs a Lead Nurse for Learning Disabilities who oversees the care of patients with a learning disability. The nurse is a point of

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contact for people with learning disabilities, families, carers and healthcare professionals and is available to support both children and adults.

- A ‘hospital passport’ has been developed and recently updated in response to feedback from carers, people with learning disabilities and healthcare professionals.

- The Psychological Medicine service provides seven day support either directly or via interface of the Clinical Coordination Centre (CCC).

- Ensuring that adequate and suitable transport options are available, along with accommodation options, would also support patients and minimise stress for them and their families.

- In-line with the Trust’s Learning Disability policy, the views of people with learning disabilities on the proposed options will be sought during consultation within user groups and other relevant forums.

8.2.5 Sex

In 2014 an estimated 49.6% of Oxfordshire’s population was male and 50.4% was female. These are similar to England overall (49.3% male; 50.7% female).64

Emergency care

There is no additional impact on either sex.

Maternity

All options aim to provide high quality care for all women, offering enhanced clinical assessment with earlier interventions in pregnancy, informed choice and promotion of midwife led care for low risk women.

Planned care

There is no additional impact on either sex.

8.2.6 Age

The proportion of older people (65 and above) is 17.08% of the total catchment population: that was 27,933 in 2012.65 Most age groups will see increases in their population size over the next 10 years. The largest increase in numbers by 2026 will be in adults aged over 65, whose share of the population will increase to 23%.

Emergency Care

This strategic review outlined quality and staffing issues at Horton critical care unit and stroke services. Stroke and cardiac conditions are common

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64 Oxfordshire County Council (2016) Joint Strategic Needs Assessment Annual Report 2016 p.21
65 Source: Oxon projections for Oxon wards; ONS District projections for non-Oxon wards, assumed same % increase as District level for these wards
conditions in older people and thus this group are likely to benefit from improved services with all patients transferred to the Hyperacute Stroke Unit (HASU) at Headington and improved Diagnostics and Outpatients at the Elective Care Centre for cardiology patients. Given that there are high densities of older people north of Banbury, they are likely to be affected by the proposals, in terms of longer travel times to visit partners whilst in HASU or other specialist care in Headington. Whilst this group may feel a negative impact on travel the known clinical outcome benefits from a HASU or safe Critical Care outweigh any travel disadvantage.

Maternity

Certain risk factors for high risk pregnancies may be age-related (i.e. young or older maternal age, multi-parity, pre-existing health conditions such as high blood pressure or diabetes which are associated with age). Central to the provision of changes to maternity services is that the right women (including low risk pregnant women) are cared for by the right specialist teams. This would mean that certain age-related factors may determine whether a woman can access any low-risk, closer to home, maternity unit or whether they need to travel to Oxford.

For women under 19 years of age, the teenage pregnancy lead should be informed for support. Early referral is advocated by Public Health England national guidance ‘Getting maternity services right for pregnant teenagers and young fathers’ (2015)⁶⁶.

Planned Care

A ‘one-stop clinic’ model at Horton General Hospital will reduce travel burden for all ages by enabling coordination where multiple different visits are required. For many patients who live in North Oxfordshire, there will be less distance to travel. The greater availability of diagnostics at Horton General Hospital is also likely to have a positive impact on all ages.

Enhanced elective day care is supported by the Royal College of Paediatric and Child Health and is likely to have a positive impact reducing travel by children and families, enabling accessible rapid assessment. Currently, 10,000 outpatient children’s appointments per year occur at the Children’s Hospital in Headington for children north of the county. Enhanced outpatient facilities will benefit these children as their specialist appointments can be delivered closer to home at the Horton General Hospital.

8.2.7 Race

Black and Minority Ethnic (BME) communities’ access to healthcare is often restricted by language, communication and cultural barriers. In Oxfordshire, the majority of the population is from White British or Irish background. People from groups born outside the UK tend to settle in urban, inner city areas where poverty, deprivation, health and social risks are already present.

Compared to the rest of England, Cherwell is less ethnically diverse with 7.83% from a Black and Minority Ethnic (BME) population compared to 14% in England in 2011. A third of people who identify as White non-British in the county (living in Cherwell) are born in Poland.

However, in Banbury figures are higher than the national average. People from BME groups living in predominantly white British areas can face particular challenges in terms of accessing culturally appropriate services. BME populations are more likely than the general population to suffer strokes and obstetric complications.

Emergency Care

The business case proposes that all cases of acute stroke are transferred to the specialist HASU in Headington where they will benefit from receiving high quality care as recommended by national guidance. As there are a number of people from BME communities resident in Banbury, there is the potential for these patients (and their carers) to experience a disproportionate impact with the relocation of stroke services further away in Headington and the resulting increase in travel times.

Maternity

Women from BME communities statistically have more complications in pregnancy, and infant mortality rates are higher (in babies of mothers born in Pakistan and the Caribbean mortality rates are twice the national average). They are, therefore, more likely to need to give birth in the specialist obstetric unit.

Planned Care

There is no additional impact on patients from BME communities.

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70 Knight M. (2000) Inequalities in maternal health; national cohort study of ethnic variation in severe maternal morbidities BMJ 338 doi: http://dx.doi.org/10.1136/bmj.b542
**Other considerations and mitigations**

All patients regardless of race can expect to receive the same excellent standard of care without discrimination and that particular needs are met. The OUHFT Equality Delivery System 2 assessment has identified how well the Trust is supporting staff and patients who have one or more characteristic protected by the Equality Act 2010.

**8.2.8 Sexual Orientation**

It is difficult to obtain reliable estimates of the number of people who identify themselves as heterosexual/straight, gay/lesbian, bisexual or of another sexual orientation. Data at local level is not currently available.

There is no additional impact relating to sexual orientation. Consideration is already given to women within a same sex partnership. Partners are entitled to the same access as heterosexual couples.

**8.2.9 Pregnancy and maternity**

In 2012, the fertile population was 30,398 or 37% of the total female population. Whilst this is lower than regional and national comparators, the general fertility rate is higher (66.9 live births per 1000 fertile population).

This Strategic Review considered a number of options in relation to pregnancy and maternity. The table below shows the number of births per OUHFT unit in 2015/16.

<table>
<thead>
<tr>
<th>Year</th>
<th>Births JRH</th>
<th>Births Spires</th>
<th>Births South MLU’s Wallingford / Wantage</th>
<th>Births HGH</th>
<th>Births North MLU’s</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015/16</td>
<td>5,729</td>
<td>844</td>
<td>216/93 = 309</td>
<td>1,466</td>
<td>142</td>
<td>8490</td>
</tr>
<tr>
<td>Year to date</td>
<td>1,774</td>
<td>262</td>
<td>73/23 = 96</td>
<td>444</td>
<td>51</td>
<td>2627</td>
</tr>
</tbody>
</table>

Table 8.3 – **Births per OUHFT Unit 2015/16**

Since 3 October 2016, there has been a temporary relocation of obstetric services to the John Radcliffe. During this temporary relocation, women planning to deliver from the north of the county are supported, if they wish, to book for care at the John Radcliffe. However, women from other areas beyond Oxfordshire who are not referred for specialist care are asked to book for care in their local Trust. A contingency plan has been put in place to care for 1,000 extra births at the John Radcliffe.
Under the proposed changes it is anticipated that (compared to before October 2016) an additional 700-1000 women per year will give birth at the John Radcliffe at either in the Obstetric Unit or Spires MLU. The current proposal also includes options for Midwife Led Units in the north of the county. There is no evidence, regionally or nationally, that midwifery led units are any less safe than a consultant led service. This is supported by the Birthplace study, conducted by the National Perinatal Epidemiology Unit (NPEU), which found no difference in outcomes between midwifery units and obstetric units\textsuperscript{72}.

Expectant mothers would continue to receive their ante-natal and postnatal care at the Horton General Hospital, with opportunities to access midwife led care, support to go home quickly after giving birth and services such as breastfeeding clinics closer to home.

The proposals will impact on travel times for pregnant women in north Oxfordshire who have to travel to Oxford. Women who are eligible for help with travel costs to the John Radcliffe can apply for financial support to the Healthcare Travel Costs Scheme.\textsuperscript{73}

At present, there is a 45% transfer rate to obstetric units for first-time mothers planning to deliver at home (reduced to 12% for those who have delivered previously). This group of women may be negatively impacted by the proposals as the journey time to Headington, modelled for the north Oxfordshire population, shows 75% are within 20 minutes when blue light or private car at night and 55% when private car in peak time.

Under the proposals special care for neonates would be relocated to the John Radcliffe: this will result in increased travel and distance from parents, carers and siblings and has the potential to impact parents and families in terms of cost and time.

\textbf{Other considerations / mitigations}

Transfer to the John Radcliffe in an emergency was raised during public meetings. If the Horton General Hospital is a designated MLU, in order to minimise transfer times to the John Radcliffe Maternity Unit the Trust has discussed with South Central Ambulance Service, the potential to station a 24/7 ambulance at the Horton solely for transferring women. These arrangements have been put in place during the temporary relocation. Robust criteria, policies and procedures for transfer have been implemented to ensure the highest quality of care and safety is achieved.

Because of sensitivities about travel times, the feasibility of helicopter transfer for maternity patients between the Horton General Hospital and the John

\textsuperscript{72} National Perinatal Epidemiology Unit (2011) \textit{The Birthplace Cohort Study} University of Oxford

\textsuperscript{73} Details available at \url{http://www.nhs.uk/nhsengland/Healthcosts/pages/Travelcosts.aspx}
Radcliffe sites has been discussed with South Central Ambulance Service (SCAS). The following initial broad concerns have been raised:

- Potential difficulty with obtaining Civil Aviation Authority approval to build a helipad on the Horton General site;
- Transfer times by helicopter, which probably would not shorten, and may even lengthen, journey times between the two hospitals;
- The suitability of helicopter transport for a woman in labour.

Such concerns suggest that there are no real alternatives to ‘blue-light’ transfer, but it is the intention of the review to explore this option further.

8.2.10 Religion or belief

In the 2011 census, 60% of Oxfordshire residents said they were Christian, 27.9% reported no religion, 2.4% Muslim, 0.6% Hindu, 0.5% Buddhist, 0.3% Jewish and 7.5% did not state their religion. No specific issues have been identified in respect of religion or belief.

Maternity services

There is no change in the criteria for women who decline blood products on the basis of religion or for any other reason. These women continue to be advised to deliver at the John Radcliffe since senior anaesthetic and intensive input relating to complications of haemorrhage including possible use of cell salvage are only available at the John Radcliffe. Interventional radiology is also available at John Radcliffe – meaning women having an elective lower segment caesarean section with predicted high blood loss can have access to this imaging prior to surgery.

Other considerations / mitigations

A multi-faith prayer room is available for patients on level 2 John Radcliffe main building. There is a quiet prayer room on the neonatal unit which technically can be used by any faith but is used predominantly for the followers of Islam.

Dietary provision as per religious requirements is available on all OUHFT sites.

8.2.11 Gender re-assignment

It is difficult to obtain data about gender reassignment, with no data available locally.

74 Oxfordshire County Council (2016) Joint Strategic Needs Assessment Annual Report 2016 p.27
Emergency care

Patients who have stigmatising conditions can end up in urgent and emergency departments partly because of limited access to other health care services. The Trust provides guidance to staff on how best to support transgender and transsexual patients when they stay in hospital.

Other considerations / mitigation

There is no additional impact envisaged in respect of sexual orientation.

The Trust is committed to understanding and recognising the needs of patients who are undergoing, or have gone through, gender reassignment. The Trust continues to give consideration within policy of appropriate accommodation for trans-people.

Given poor quality data available, qualitative information gathered through the public consultation will help inform the equality assessment further and shape options.

8.2.12 Marriage or civil partnerships

The same consideration is given to patients who are married or in a civil partnership, and partners are entitled to the same access.

There is no additional impact relating to marriage or civil partnership.

8.2.13 Other considerations within the Strategic Review of the Horton General Hospital

The following section considers other areas of impact, which whilst not directly aligned with consideration of the nine protected characteristics, are considered important in terms of a wider analysis of equality and inequality.

8.2.14 Carers

At the time of the 2011 Census, 9.9% of the population in West Oxfordshire were carers and 9.4% in Cherwell. This is similar to South Oxfordshire. Carers are less likely to be in employment than the general population and therefore have less income.

Emergency Care

The Strategic Review sets out options for a hospital that envisages urgent care to be delivered as close to home as possible. This aims to avoid hospitalisation which would have a positive benefit on carers in terms of travel and parking. Further work is needed to understand the potential implications for carers in moving towards an ambulatory model of care and in ensuring that patients have adequate provision of home care when they require it (as well as re-ablement etc.).
Maternity

There are single stay rooms at John Radcliffe so that partners have the option to stay with the woman in privacy.

If any woman has learning difficulties or mental health issues, a carer may be present. Their opinion will be sought for the best way to communicate to the woman.

Other considerations / mitigations

An Outreach Support Worker from Carers Oxfordshire is employed within the Trust who can provide support and advice to informal carers.

In-line with the Trust’s Carers Policy, during consultation the Trust will work closely with carer’s forums and networks to ensure their views and opinions are considered.

8.2.15 Safeguarding people who are vulnerable

OUHFT fully recognises the importance of working together to ensure that vulnerable children continue to have joined up services which protects and safeguards them.

For people whom English is not their first language, older people or those with disabilities, they can be particularly vulnerable in times of reconfiguration due to the inherent trust they already have in existing services. The impacts on these groups have been discussed under the relevant protected characteristic groups.

8.2.16 Socioeconomic deprivation

There are pockets of deprivation within the north Oxfordshire catchment population. In parts of Banbury, Bicester and Chipping Norton, 15-24% of low income families are on means tested benefits compared to a national average of 14.7%.

Emergency Care

The use of urgent and emergency healthcare services is inextricably linked to socioeconomic factors and particularly to deprivation. Increased travel time for some urgent care services will impact on costs to the family, impacting relatively more in families who are deprived. Whilst this group may feel a negative impact on travel the known clinical outcome benefits from a HASU or safe Critical Care outweigh any travel disadvantage.

Maternity

Certain risk factors for high risk pregnancies may be associated with deprivation status e.g. teenage pregnancy, multiparity, pre-existing health conditions, smoking, higher alcohol use. This would mean that certain
deprivation-associated factors may determine whether a woman can access any low-risk maternity unit. The proposals seek to improve risk assessment. This would seek to mitigate any other negative impacts and be reflected in the personal birth plan.

**Planned Care**

Increased outpatient services and improved long term condition management may mitigate the impact of some of the proposed changes to emergency care as elective day care surgery and diagnostics will become more accessible for patients in north Oxfordshire and its surrounding geography.

**Other considerations / mitigations**

Healthy start vouchers are available for pregnant women or those with children under the age of 4 years.

Those patients eligible for help with travel costs to the John Radcliffe can apply for financial support through the Healthcare Travel Costs Scheme. Details will be made available through displayed notices and discussed at appointments.

To support parents on low incomes parents with babies on the John Radcliffe unit can apply for support for travel by submitting an application via the charity SSNAP (Support for Sick Newborns and their Parents). This is awarded by the charity on basis of need and is only given to those in difficult circumstances. The charity currently helps 8-12 families a week in this way.

**8.2.17 Homelessness**

In 2014/15 there were estimated 14 people in Cherwell and 3 in West Oxfordshire rough sleeping. A greater number (43 people) are thought to sleep rough in Oxford.

No additional impact from these proposals is envisaged for people homeless people. However, information is limited so consultation should involve social housing providers and homelessness organisations as part of an integrated approach to better understand the experiences of the homeless population.

**8.2.18 Equality Impact Assessments by the Transformation Workstreams**

Equality Impact Assessments have also been undertaken by the Transformation Programme workstreams. These are included in Appendix 8.3.

**82.19 Integrated Impact Assessment**

Whilst significant work has been undertaken, understanding the implications of equality and inequality on the development of the proposals, it is also an area which can be further strengthened. In recognition of this, and in support of the equality work that has been undertaken previously within the
Programme, an Integrated Impact Assessment (IIA) is being commissioned by OCCG, and will be completed alongside the public consultation.

The scope of the IIA is summarised in the diagram on the next page.

8.2.20 Use of the formal consultation to inform equalities work

Further work will be undertaken as part of the public consultation to understand the impact that any potential changes might have and any adverse effects on particular groups of the local population. The consultation itself will include further public meetings, focus groups and other outreach work with individuals and groups affected by these proposals.

The OUHFT Patient Experience Team and OCCG Communications Team are in contact with approximately 50 voluntary and community organisations
within Oxfordshire which campaign and/or represent individuals and communities (many with protected characteristics). The consultation documents will be sent directly to these groups with the offer of translating materials into other languages and easy read. Groups that may be particularly affected will be offered a visit to discuss the proposals.

8.2.21 Developing the Mitigations

Prior to a decision by OCCG, the Programme will consider the conclusions from both the Consultation and the Integrated Impact Assessment Report. These will be incorporated into the Post-Consultation Report.

Through engagement with stakeholders, the Transformation Programme will support OCCG to consider two areas:

1. Further development of the Clinical Model, to mitigate potential findings;
2. To consider other developments that might mitigate the impact of the proposed clinical model.

The Programme will work with the stakeholder groups to define and confirm the nature of these proposals. Once these proposals have been finalised they will be brought back to the OCCG Board to agree.
8.3 Public Sector and Commissioner Duties

In addition to the public sector equality duty, Oxfordshire CCG is aware of the importance of ensuring compliance with its other public sector and commissioner duties. This includes consideration of the NHS Constitution. The CCG has, therefore, taken steps to verify that all the proposals outlined in this PCBC are consistent with these duties.

The commissioner duties that have been considered are summarised in the table below:

<table>
<thead>
<tr>
<th>Duty to promote the NHS Constitution (13C and 14P)</th>
<th>Duty to promote education and training (13M and 14Z)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality (sections 13E and 14R)</td>
<td>Duty to have regard to impact in certain areas (13O)</td>
</tr>
<tr>
<td>Inequality (sections 13G and 14T),</td>
<td>Duty as respects variations in provision of health services (13P)</td>
</tr>
<tr>
<td>Promotion of patient choice (sections 13I and 14V)</td>
<td>Expenditure on integration of health and social care (Better Care Fund) (223B and 223GA)</td>
</tr>
<tr>
<td>Promotion of integration (sections 13N and 14Z1)</td>
<td>And the Health &amp; Social Care (Quality &amp; Safety) Act 2015:</td>
</tr>
<tr>
<td>Public involvement (sections 13Q and 14Z2)</td>
<td>▪ Consistent identifiers (251A)</td>
</tr>
<tr>
<td>Innovation (sections 13K and 14X)</td>
<td>▪ Duty to share information (251B)</td>
</tr>
<tr>
<td>Research (sections 13L and 14Y)</td>
<td>Commissioners should also ensure they are familiar with Section 244 of the NHS Act 2006 regarding the duty to consult the relevant local authority in its health scrutiny capacity.</td>
</tr>
<tr>
<td>Obtaining advice (sections 13J and 14W)</td>
<td></td>
</tr>
<tr>
<td>Effectiveness and efficiency (sections 13D and 14Q)</td>
<td></td>
</tr>
<tr>
<td>Promotion of the involvement of each patient (sections 13H and 14U)</td>
<td></td>
</tr>
</tbody>
</table>

Figure 8.3 – Commissioner Duties (Health and Social Care Act – 2014)

8.4 External Scrutiny (HOSC and the Health and Wellbeing Board)

8.4.1 Formal Scrutiny Roles

The Oxfordshire Transformation Programme is subject to scrutiny by the Health Overview and Scrutiny Committee (HOSC) and oversight by the local Health and Wellbeing Board (HWB).

- **Health Overview and Scrutiny Committee (HOSC)**

Health scrutiny regulations say NHS commissioners must consult local authorities where there is a ‘substantial development of the health service’. The programme is therefore subject to scrutiny and challenge by the
Oxfordshire Health Overview and Scrutiny Committee (HOSC) which is a committee of Oxfordshire County Council.

- **Health and Wellbeing Board (HWB)**

  The local Health and Wellbeing Board also has a role in overseeing any changes along with its formal responsibilities to:
  
  o Prepare a Health and Wellbeing Strategy for the whole population of Oxfordshire to drive the development and delivery of services to meet agreed priorities;
  
  o Oversee the joint commissioning arrangements for health and social care across the county
  
  o Maintain oversight of the commissioning intentions of both the Oxfordshire Clinical Commissioning Group and the Council.

### 8.4.2 Engagement with the Health and Wellbeing Board and Health Overview and Scrutiny Committee

Throughout the development of Oxfordshire’s Transformation Plans the CCG and system leaders have provided regular reports and presentations to Oxfordshire’s Health and Wellbeing Board and the County Council’s Health Overview and Scrutiny Committee.

In the last twelve months, from November 2015, six updates have been provided to HOSC. In March and July 2016 details of the emerging transformation plans were shared, discussed and noted.

HOSC understand the need for Oxfordshire’s Transformation Programme but have asked to receive regular progress reports, receive assurances of good public engagement, and have requested more information regarding what will be delivered locally in relation to home and bed-based care.

They have also advised of the need to conduct an open and transparent consultation highlighting the importance of good quality information, providing maximum access for the public to attend meetings, and easy routes for the public to provide feedback.

HOSC have advised the CCG to listen to what people say and respond openly to public opinion, particularly where there is a groundswell of opinion on a particular issue. HOSC advised on the importance of being clear about the constraints and potential consequences of keeping the status quo. They emphasised the need to bring about cultural change by working with people to empower them to live healthier lifestyles that would prevent illnesses such as diabetes.

HOSC requested that information is also provided on changes that have or are taking place and that, where appropriate, they are included in consultation material to provide a full picture of local developments.
8.5 Legal Advice
Oxfordshire CCG has engaged Capsticks to provide legal advice to the programme.

8.6 Other ‘Best Practice’ Checks
Oxfordshire CCG is also planning to undertake a number of other ‘best practice’ checks. This will include:

- An assessment of the impact of the proposed changes on the resilience of local health economy to plan and respond to a major incident; and
- A privacy impact assessment.
Part Five:

THE PRACTICALITIES
Chapter 9: Workforce and Estates

9.1 Workforce

9.1.1 Context

It is recognised that a fulfilled workforce with high morale is a significant factor in the quality of care experienced by patients and carers and affects both performance and outcomes. There are however a number of challenges relating to workforce that are both similar and different from those experienced elsewhere.

However to provide truly world-class care we know we must focus on enabling and supporting our staff to work “at the top of their licence”. The most precious commodity to staff is that of time; and in simple terms achieving this is about having sufficient staff with the right expertise working in evidence-based pathways of care with the right tools to provide care at the right time.

One of the greatest challenges for Oxfordshire’s healthcare system is our ability to attract, recruit and retain skilled and motivated staff in the numbers we need. The key issues are outlined below:

- A Primary Care vacancy rate of up to 30% (due to an aging workforce and recruitment challenges in replacing GP’s seeking to retire)

- A high staff turnover rate in direct care, domiciliary care and residential care (28%) and an estimated 800 vacancies in direct domiciliary care provision set in a context of very low unemployment in Oxfordshire.

- A requirement to employ substantially more staff within adult social care by 2020, in order to meet the needs of an ageing population with increasingly complex co-morbidities.

- The national challenge associated with the recruitment of experienced social workers, and physicians in emergency and frailty care.

- Recruitment hotspots in a number of specialist areas, including: paediatric intensive care; radiography; community and mental health; community nursing; middle-grade obstetric, paediatric and urgent care medical staff.

- The need to recruit, develop and retain autonomous practitioners in frailty and urgent care.

There are also three other major issues we need to overcome to be able to establish a resilient and sustainable workforce:

- The proximity to London weighting and the high cost of living in Oxfordshire

- The availability of key worker housing schemes for essential staff groups

- Competition with other businesses, given Oxfordshire’s high level of employment
9.1.2 The National Picture

Nationally, the NHS is facing a huge growth in activity: Between 2004/05 and 2014/15 Emergency Department attendances increased by 22%, admissions by 31% and GP consultations by 35%. In parallel, the NHS clinical workforce grew by only 14%.

There are national challenges in attracting, recruiting and retaining clinical staff that plays through into Oxfordshire. Nationally, the shortfall across all nursing, midwifery and health visiting posts is 7.2%. This is due to:

<table>
<thead>
<tr>
<th>Reason</th>
<th>Percentage Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Education England (HEE) commissioning 3,100 fewer adult nurse training places in 2014/15 compared to 2004/5 (a reduction of 19%)</td>
<td>19%</td>
</tr>
<tr>
<td>3,000 fewer trained nurses entering the NHS workforce compared to 2004/5</td>
<td>1%</td>
</tr>
<tr>
<td>An 1.1% increase in the proportion of nurses leaving the NHS (rising from 7.9% in 2010/11 to 9.0% in 2014/15)</td>
<td>1.1%</td>
</tr>
</tbody>
</table>

Table 9.1 – Reasons for workforce shortages in nursing

9.1.3 The Local Picture

The healthcare workforce establishment across Oxfordshire constitutes c.31,000 full time equivalent (FTE) staff with a vacancy rate of 7%. Details of the gaps between budgeted establishments and actual staff in post, across all healthcare settings and for all main staff groups are shown below:

Figure 9.1 – Oxfordshire healthcare workforce – gaps between establishment and staff in post
9.2 **Workforce Plan (Proposed) Overview**

The table below maps the changes in the service models, by healthcare setting, to summarise the main impact on activity and highlight the most significant implications for our healthcare workforce.

<table>
<thead>
<tr>
<th>Impact on activity across settings of care</th>
<th>Acute</th>
<th>Mental health</th>
<th>Community</th>
<th>Primary Care</th>
<th>Social Care</th>
<th>Ambulance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary care</td>
<td></td>
<td>N/A</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urgent and emergency care</td>
<td></td>
<td>N/A</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Planned, diagnostics and specialist care</td>
<td></td>
<td>N/A</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maternity care</td>
<td></td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Children’s care</td>
<td></td>
<td>N/A</td>
<td>N/A</td>
<td>See outpatient</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Mental health, learning disabilities and autism care</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Figure 9.2 – Impact of proposed changes in service model on activity and workforce

The Horton Strategic Review (pages 69-83 of Appendix 5.1), provides greater detail of the workforce implications of the proposed changes to the provision of acute care across Oxfordshire.

9.2.1 **Workforce Modelling**

Detailed work has been undertaken to quantify the main workforce implications associated with the proposed changes in service delivery and changes or shifts in activity within the Transformation Plan. Workforce modelling has centred on a top-down assessment of how the workforce type and size will need to change as a consequence. However the modelling work completed to date is not a comprehensive assessment of every workforce change needed to support the proposed service changes and this detailed work is being undertaken for those clinical services which are included in the Phase One consultation. The outputs from the modelling will then be sense checked with the individual clinical workstreams.
Based on an assessment of the proposed activity, the associated workforce modelling has been undertaken to understand the:

- Non-bed related activity increases in primary and community care;
- Workforce implications of changes in the number and type of beds and bed equivalents;
- Workforce (number and type) that will be released due to moving outpatient and A&E activity into primary care.

To date the workforce analysis based on the Transformation Plan's financial modelling suggests that, assuming no changes in productivity, but assuming that everyone who is ‘released’ across the system (e.g. due to reductions in activity in acute settings) is redeployed elsewhere, an additional c.80 FTE will be needed. This is against the backdrop of a prevailing 7% gap to establishment. This is illustrated in the bridge analysis above.
The health community has identified four ‘levers’ which could assist in reducing this gap. These are:

<table>
<thead>
<tr>
<th>Lever</th>
<th>What</th>
<th>How</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reducing in the level of new or existing activity</td>
<td>By identifying opportunities to eliminate duplicative or unnecessary activity</td>
<td>Ensuring the model of care is right and the activity appropriate</td>
</tr>
<tr>
<td>Change what people spend time doing (shifting tasks and/or roles)</td>
<td>Move workforce from one role to another or relieve them of existing work that others could do</td>
<td>Move workforce around the system, filling new roles in the community with appropriately skilled staff currently in the acute sector</td>
</tr>
<tr>
<td>Enabling people to be more efficient</td>
<td>Facilitate more activity to be delivered by the workforce in the same number of hours</td>
<td>Identify new and more efficient ways of working (including digital) to enable staff to manage more activity without raising hours worked</td>
</tr>
<tr>
<td>Employing more people</td>
<td>Fill any remaining gaps by recruiting new workforce to take on remaining activity</td>
<td>Consolidate the remaining gaps that exist and hire new workforce</td>
</tr>
</tbody>
</table>

Table 9.2– Potential workforce ‘levers’

The workforce analysis completed to date has not focused on reducing activity as this is being addressed within the new clinical pathways. However there are opportunities to move tasks and staff from acute settings to support primary and community-based care models.

In addition, there are opportunities to deliver productivity improvements in both primary and community care settings by adopting new ways of working (such as greater utilisation of digital solutions and telemedicine). Although this would require supporting investment, it could lead to a substantial improvement in productivity which, if combined with effective re-training and redeployment of staff within the system, would impact on the need for an additional 80 FTEs.

9.3 Recruitment and Retention

To address the local workforce challenges Oxfordshire healthcare system needs to focus on three interlinked areas of activity including:

- Strategic Workforce planning: so that the right level and type of workforce is available to deliver transformed services and meet demand, supported by robust plans for training and re-skilling of staff
- Transformational changes in the way healthcare staff work together and where and how care is delivered
• Development of a strategy to address the challenges in Oxfordshire associated with the cost of living, the pull of the London market and local competition.

We will be working with partners across the STP footprint on a strategy for recruitment, retaining and developing the workforce, establishing a joint workforce across all organisations as well as identifying new combined roles across sectors underpinned by integrated education and training. At STP level we will be exploring the feasibility and opportunities for sharing a flexible workforce via a joint staff bank.

9.4 Working Practices and Culture

Workforce planning to deliver Oxfordshire’s Transformation Plans is set in the context of the Systems Leadership and OD capability planning that is taking place within the wider Buckinghamshire, Oxfordshire, Berkshire Strategy and Transformation Plan (BOB STP) footprint.

The BOB STP workforce planning focuses on leadership and OD priorities which will enable ‘systems’ thinking, collaboration and behaviour change to support new ways of working, integration and innovation to deliver significant transformational change. Oxfordshire is a partner in the BOB Workforce Action Group and will identify best practice for system leadership behaviours.

We will also be working closely with Health Education England’s Local Workforce Action Board (LAWB) on a workforce strategy to address the workforce implications of our transformation plans, including workforce type, numbers, skills and leadership development, both at a BOB and Oxfordshire level.

9.5 Staff Engagement/transition

Acute and Community Staff Engagement

Both OUHFT and OHFT have undertaken extensive staff engagement around the Transformation Programme and the specific proposals. More information on this is available in Section 7.4.15.

Primary Care Staff Engagement

Locality meetings discuss the Transformation Programme monthly. The Integrated Locality leads are running workshops with integrated locality team and GP’s to develop effective multidisciplinary team working and address the issues of working in a new way. More information on this is available in Section 7.5.3.
9.6 Estates

9.6.1 Current Position

The Horton General Hospital

The Horton General Hospital occupies over 27,500m² set in 27 Hectares. There has been very little development in the last 30 years.

The condition of the Horton General Estate is mixed, as shown in map 9.1 below. Some of the estate has been assessed as being in good and acceptable condition. Other services however, are set in a multitude of inappropriate and dilapidated buildings, some of which have been assessed as being unsuitable for the provision of high quality healthcare. Nearly 20% of the hospital buildings are over 50 years old and 64% were constructed over 30 years ago.

Many of these buildings were designed only for short term use post war and are now in poor physical condition with, high statutory compliance risks, fire safety issues and lack of Disability Discrimination Act provision. Further moderate risks attributed to the estate condition include old and failing mechanical and electrical engineering infrastructure. The lifts regularly break down, water services are old and lighting and environmental controls are out of date and not up to the standards needed to deliver modern healthcare.

Those buildings that are over 30 years old also have an additional challenge of having extensively used asbestos. Asbestos removal makes remodelling and refurbishment of these existing buildings costly and unsuitable. A further issue is that hospital services are located in buildings far apart from one another, and key services such as diagnostics, imaging, theatres, emergency department and maternity are not connected.

Estate refurbishment and new build options need to be developed in line with clinical plans for the Horton General Hospital.
9.6.2 Overview of implications for service changes on the Horton General Hospital

The following table provides an overview of the initial and key considerations of changes to the estate.

<table>
<thead>
<tr>
<th>Clinical Service Area</th>
<th>Key Planning and Estates changes by option</th>
</tr>
</thead>
<tbody>
<tr>
<td>Critical Care</td>
<td><strong>Preferred Option</strong></td>
</tr>
<tr>
<td></td>
<td>- Changes in high dependency capacity to incorporate additional patients at Headington</td>
</tr>
<tr>
<td>Acute Stroke Care (not including rehabilitation beds)</td>
<td>Option 1: no changes</td>
</tr>
<tr>
<td></td>
<td>Option 2: additional capacity at JR, but minimal estates implications.</td>
</tr>
<tr>
<td>Option 3: additional capacity at JR, but minimal estates implications</td>
<td></td>
</tr>
<tr>
<td>---</td>
<td></td>
</tr>
<tr>
<td>Bed realignment and development of an ambulatory model of care</td>
<td></td>
</tr>
<tr>
<td>Option 1: no changes</td>
<td></td>
</tr>
<tr>
<td>Option 2:</td>
<td></td>
</tr>
<tr>
<td>• Development of provision to support ambulatory care including AAU and Clinical Coordination Centre.</td>
<td></td>
</tr>
<tr>
<td>Option 3: as option 2 above.</td>
<td></td>
</tr>
<tr>
<td>Maternity Service</td>
<td></td>
</tr>
<tr>
<td>Option 1: no changes. Considerations relating to adequacy of estate for continued obstetric provision.</td>
<td></td>
</tr>
<tr>
<td>Option 2: Formalise increase in obstetric capacity at JR, including theatre capacity for elective caesarean</td>
<td></td>
</tr>
<tr>
<td>New build for MLU at HGH</td>
<td></td>
</tr>
<tr>
<td>Planned Care (including elective care, diagnostics, and outpatients)</td>
<td></td>
</tr>
<tr>
<td>Option 1: no changes</td>
<td></td>
</tr>
<tr>
<td>Option 2 – building new outpatient and diagnostic centre, reconfiguration of theatres with pre-operative assessment and adjacent day case facility.</td>
<td></td>
</tr>
<tr>
<td>Option 3: building new outpatient and diagnostic centre, reconfiguration of theatres with pre-operative assessment and adjacent day case facility.</td>
<td></td>
</tr>
</tbody>
</table>

Table 9.1: **Key estates considerations – Phase One**

In relation to Phase One of the consultation, there are minimal implications for estates changes and buildings, although changes will need to be made to accommodate additional critical care patients in Headington. The John Radcliffe Hospital (JR) also hosts the Hyperacute stroke unit for stroke...
services. There would be minimal implications for ensuring provision for additional stroke patients.

While the outpatient facility at the Horton General Hospital is acceptable, if there is a projected increase in virtual outpatient appointments, then outpatient capacity would be sufficient. The condition of the radiology estate, however, is unacceptable according to an independent assessment in January 2016 and will require improvement. For both, Option 2 and 3, the development of a new Outpatients and Diagnostics Facility is proposed. Under options 2 and 3, there will also be a need to increase the theatre capacity to absorb the added transferred work (from Headington), even with the potential re-acquisition of the Ramsey HTC theatres.

Under emergency temporary arrangements, obstetric patients from the Horton General Hospital area are currently being transferred to the John Radcliffe to access maternity services. These arrangements have included refurbishments required to accommodate additional numbers of women giving birth at the John Radcliffe Hospital and the temporary move of the Special Care Baby Unit.

If maternity provision was to convert to a standalone MLU or Birth Centre it is estimated that this would require two - three delivery suites for an estimated 500 births. A new MLU would be provisioned under this option.

9.6.3 Further work to address changes required under the proposals

Work is ongoing to identify the long-term estates developments that will be required as a result of the proposals in this business case. Further detail of key considerations are outlined in the chapter on implementation – see Section 11.4.2 of Chapter 11.
Chapter 10: Activity and Finance

10.1 Summary & Purpose of this section

10.1.1 Purpose

This chapter describes the activity and financial implications of the identified preferred option for change. It provides a relative comparison of the financial impact of the proposed option. The chapter sets out:

- The scale of financial challenge to Oxfordshire;
- The current financial position of the CCG and OUHFT;
- The financial scope of the PCBC;
- The approach to modelling;
- The impact of proposed consultation options linked to:
  - Changes to services currently based at the Horton General Hospital;
  - The OUH’s delayed transfers of care (DTOC) programme.

The scope of the financial modelling is set out below and is related to the changes list above and their impact on commissioners and providers within and beyond Oxfordshire.

10.1.2 Summary

Revenue position

The Oxfordshire Transformation Plan (OTP) is a key component of the Buckinghamshire, Oxfordshire and Berkshire (BOB) STP, which aims to deliver the system to financial balance by 2020/21 whilst ensuring delivery on key national priorities for improving the quality of services and health outcomes. The STP identifies an overall “do nothing” financial gap of £479m by 20/21.

The STP sets out that this financial gap will be closed by specified solutions and the contribution by solution is set out in the table below.
This has been subject to NHS England review which confirms the STP is in line with national financial assumptions contained within the Business as Usual / Do Nothing scenario.

The OTP will have its main impact on Oxford University Hospitals Foundation Trust (OUH).

The STP “do nothing” scenario implies a system wide gap of £479m for the STP by 2020/21. The STP identifies £8m of the closure of this gap as being attributable to the Oxfordshire Transformation Programme. Local schemes underpinning this figure include the reconfiguration of Ambulatory Care and Outpatients across OUH, Primary Care and Community Care.

The PCBC models two scenarios using a common set of activity assumptions; A “do nothing” scenario (Option 1). In this scenario there is no reconfiguration of services other than minor changes to the model of care in outpatients. The basis of this scenario is the projected deficit for OUH and the STP up to 2020/21 based upon the planning and activity assumptions used in the development of the STP.

In this scenario:

- The projected deficit for the Trust is £27.3m in 2020/21
- There is no capital investment other than which would necessarily be incurred to service demand growth with no service model reconfiguration. This totals £106.2m
A “do something” scenario (Option 2). In this scenario the impact of the Oxfordshire phase 1 reconfiguration is modelled, and the projected deficit position is presented.

In this scenario:

- The projected deficit for the Trust is reduced by £11.1m to £16.2m in 2020/21.
- Incremental capital development to achieve the required changes is £20.8m, to reflect additional diagnostic capacity and reconfiguration of Outpatient facilities at the Horton site for the most part.
- £6.3m of the £20.8m is sourced by transferring equipment from other sites or growth funding.
- This leaves £14.5m as the incremental capital ask, of an overall £127.0m, for the PCBC changes such that option 2 can be implemented.

The preferred reconfiguration option (Option 2) requires additional capital investment of £14.5m with a net benefit to I&E of £11.1m per annum.

Return on the Capital Investment

This £11.1m improvement in the 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. The table summarises the impact of the two options.
The additional costs of purchasing nursing home beds are included in the 2016/17 financial position, as are the financial implications of all changes relating to the DTOC and bed realignment programmes. There is not expected to be any further incremental investment above this going forward.

Detailed position (OUH view) below.

Liaison Hub oversees the nursing home beds.

<table>
<thead>
<tr>
<th>Service</th>
<th>Pay</th>
<th>Non Pay</th>
<th>Total cost</th>
<th>2016/17 Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Liaison Hub</td>
<td>1,103</td>
<td>24.9</td>
<td>1,127.9</td>
<td>1,127.9</td>
</tr>
<tr>
<td>Acute Ambulatory Unit</td>
<td>1,650</td>
<td></td>
<td>1,650</td>
<td>825</td>
</tr>
<tr>
<td>Supported Hospital Discharge</td>
<td>1,250</td>
<td></td>
<td>1,250</td>
<td>830</td>
</tr>
<tr>
<td>Trust Discharge Team Expansion</td>
<td>100</td>
<td></td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>Totals</td>
<td>4,103</td>
<td>24.9</td>
<td>4,127.9</td>
<td>2,882.9</td>
</tr>
</tbody>
</table>

Table 10.14 – Investments in OUHT (£000’s)

<table>
<thead>
<tr>
<th></th>
<th>2016/17</th>
<th>2017/18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bed reconfigurations</td>
<td>2,791</td>
<td>4,910</td>
</tr>
<tr>
<td>Service Investments</td>
<td>(2,882.9)</td>
<td>(4,127.9)</td>
</tr>
<tr>
<td>Commissioner Investment - Hub</td>
<td>900</td>
<td>900</td>
</tr>
<tr>
<td>Non Direct Savings</td>
<td>Tbc</td>
<td>tbc</td>
</tr>
<tr>
<td>Maternity Saving</td>
<td>25</td>
<td>50</td>
</tr>
<tr>
<td>Total saving</td>
<td>833.1</td>
<td>1,732.1</td>
</tr>
</tbody>
</table>
£3.3m of this difference relates to changes in models of care and will materialise as a commissioner benefit under current contractual mechanisms.

The remaining £7.8m is derived from the ability to more effectively and efficiently use estate due to the movement of clinical services between sites. This will materialise as a provider benefit under current mechanisms.

Detailed modelling assumptions have been made available to NHS England. They are the basis for the modelling underpinning the Trust’s input into the BOB STP. The genuine “do nothing” option has been discounted as an option for consideration as this “base case” scenario excludes the revenue impact of required capital investment to support growth in patient numbers.

**Capital Investment Funding**

The Trust has assumed for financial modelling purposes that it will have access to external finance for capital expenditure at rates comparable with PDC (3.5% pa). These proposed changes to models of care in Oxfordshire require a capital investment of £14.5m of newly sourced capital on the Horton site. This, alongside the transfer of equipment valued at £6.3m relates to the incremental change specific to enabling new models of care.

This does not address the full 2021 financial gap. It is anticipated that a second phase consultation will propose further changes to move activity away from an acute hospital setting and so address the need for additional acute hospital capacity and thus the capital costs of providing additional inpatient beds which would otherwise be required to service demand under a “do nothing” scenario.

The Trust assumes that as a minimum there would be access to Public Dividend Capital (PDC) to cover the incremental £14.5m. If PDC funding were not available, and as part of overall capital investment required to provide modelled capacity, alternative options might include internal, alternative-NHS or commercial sources of finance. The Trust has an expected capital programme of £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, achieved through a more effective use of existing estate on the same site.

**Financial case - Summary and conclusions**

The case presented is based on assumptions which have been tested with NHSE. Further and fuller diligence would be undertaken prior to any decision to authorise the commitment of capital in line with NHSI’s agreed protocols.
The key points are:

- An incremental capital investment of £14.5m of new capital is required to move from option 1 to the preferred option 2.
- The Trust has calculated the likely revenue benefit of this investment at c. £11.1m per annum. This calculation appears to be based on sound assumptions.
- The incremental investment has been subjected to sensitivity analysis. Sensitivities modelled include:
  - Capital costs being 30% higher than planned;
  - Transition costs being double that assumed;
  - A discount rate of 5.0% rather than 3.5%;
  - Demand being 1% higher and 1% lower than forecast.
- None of these sensitivities resulted in option 1 having the higher NPV of the two options.

While work remains to be undertaken on moving from PCBC to FBC and on sourcing of capital, it is not believed that there is an insurmountable financial obstacle to the proposal to continue to consultation at the current time.

10.2 The financial challenge facing Oxfordshire

The Oxfordshire system is already comparatively efficient given its upper quartile performance against key indicators such as non-elective admission rates (85.5 per 1,000 population in 2015/16), elective inpatient admissions (23 per 1,000 population) and day case admissions (95 per 1,000 population) against a backdrop of lower than national average funding allocation. Our CCG and local providers have a track record of good financial performance, but we recognise that if we are to be sustainable we must continue to focus on getting maximum efficiency.

The Oxfordshire health, public health and adult social care system receives and spends approximately £1.3bn of taxpayer funds each year. These funds are spent on a wide variety of health and adult social care services commissioned on behalf of local residents by the CCG (almost £0.8bn of spend), Oxfordshire County Council (£0.2bn) and NHS England (over £0.3bn). Private resources are also spent on health care - as financial resources or as personal time and effort.

The external context within which we commission and provide health and social care services is changing rapidly and these changes combine to mean that the current pattern of provision and the associated commissioning and
contracting processes need to change. We need to ensure that we continue to provide safe effective and efficient services. The key reasons we must change the way we do things are:

- Fragmented provision can also mean that people receive duplicate services such as multiple overlapping assessments from different health and care teams. Duplication not only wastes money, but can result in the individual being given conflicting care plans; error has obvious costs to the individual receiving care as well as the taxpayer;
- Commissioning responsibilities are also fragmented being divided between statutory bodies. This can result in commissioning strategies not being aligned which risks divergence of aims, service duplication and individual organisations making decisions that are in their own interests but not in the best interests of patients, carers and the taxpayer;
- The fragmentation of commissioning risks hindering the implementation of our new models because commissioning intentions are not always aligned and associated risks that individual commissioning bodies make decisions that are not necessarily in the overall interests of the taxpayer;
- Demand for health and social care services has been increasing as the population grows and ages, and our ability to meet people’s needs has grown with medical and technological advances;
- The need, as set out in the Five Year Forward View, for the NHS in England to make £22bn in efficiency savings by 2020 to bridge the gap between the costs of anticipated future demand and funding, and the expectation that social care budgets will come under renewed pressure post-the spending review, combine to mean we must find more efficient ways of delivering care. Social care services have been cut in recent years and we expect funding to reduce further in coming years;
- The scale of efficiency improvements necessary to stay within our funding levels will not be met without a fundamental shift in both how care is delivered and also how care is paid for. Current payment mechanisms based on payments for activity (e.g. hospital admissions) in acute secondary care and fixed payments for activity (e.g. GP contract) in primary care create perverse incentives within the system; we need to move to an outcomes based payments mechanism which focuses all providers on providing the right care at the right time and right place for the individual;
- The health care workforce can be relatively inflexible, with strong demarcation of roles and a working model often centred on single episodes of treatment. Alongside this, there are shortages of particular types of staff, leading to use of higher cost agency staff.

**10.2.1 The Oxfordshire system’s ‘do nothing’ financial gap**

In early 2016/17 we modelled a ‘place-based whole health and care’ do nothing activity and financial scenario for Oxfordshire covering the five years
from 2016/17 to 2020/21. The model’s scope was all healthcare and adult social care commissioned for people living in Oxfordshire. The purpose of the modelling was to set out the financial challenge facing the Oxfordshire health and care system and to provide a baseline against which we can assess our change options. It also formed the basis of Oxfordshire’s input to the BOB Sustainability and Transformation Plan (STP).

The do nothing model compares known allocations to commissioners (which increase by £125m over the next five years) with the expected costs of providing services after allowing for rising demand and inflation. This exercise demonstrates that by the end of 2020/21, if no action is taken, including in 2016/17 the local system will face a financial gap of £209m (equivalent to 15.2% of total taxpayer funding) due to costs rising to £1,582m set against allocations of £1,373m.

![Figure 10.1 – The ‘do nothing’ financial forecast](image)

The chart below illustrates how the gap grows over time and how it is split between commissioners (the CCG, NHSE and Oxfordshire County Council), providers and the taxpayer (the ‘taxpayer’ gap is the total system gap).
The largest element of the financial gap falls to providers. The cause of this is a combination of increasing costs due to inflation assumptions and increasing demand-led activity; the offsetting of financial contribution from assumed increases to tariff and contract funding; and undertaking more paid activity attracting full tariff at marginal cost.

The key assumptions driving the overall ‘do nothing’ financial gap are that:

- Activity grows as a result of demographic change. We have modelled demographic led growth at HRG level for acute hospital activity and at service line level for other activity. Our modelling excludes the potential impact of new housing because we would expect any population growth due to housing to be reflected in annual adjustments to the CCG’s allocation;
- Growth for all services continues to rise at 1.5% per annum over and above increases caused by population change. The 1.5% figure is an estimate based on historic trends;
- Cost inflation is incurred by all providers in line with published NHSE guidance;
- CCG and NHSE allocations reflect those published recently. Local authority plans are based on up to date published financial forecasts. NHS commissioners are assumed to benefit from ‘tariff efficiencies’ in line with NHSE guidance - a benefit to commissioners in terms of tariff changes represents a loss of income to providers.

The relative impact of these assumptions varies by service as illustrated in the graph below which shows the rate of increase in costs by major service line.
Although acute service costs are the largest individual element of spend, costs rise at a faster rate over the five years, for specialised (+27%) and primary care (+25%) reflecting demographic mix, non-demographic growth factors and higher predicted cost inflation experienced by these services.

Demographic change (the ageing and rising population) and other growth factors will lead to a rise in demand for all services. As an example the table below illustrates the predicted rise for non-elective patients (excluding maternity patients).

<table>
<thead>
<tr>
<th>Non-elective patients</th>
<th>16/17</th>
<th>17/18</th>
<th>18/19</th>
<th>19/20</th>
<th>20/21</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admissions</td>
<td>52,458</td>
<td>54,033</td>
<td>54,675</td>
<td>56,302</td>
<td>57,816</td>
<td>10%</td>
</tr>
<tr>
<td>Occupied bed days</td>
<td>227,533</td>
<td>236,709</td>
<td>241,400</td>
<td>251,837</td>
<td>260,619</td>
<td>15%</td>
</tr>
</tbody>
</table>

Table 10.1 – Predicted rise of non-elective patients to 2021

Our modelling indicates that under the ‘do nothing’ scenario non-elective admissions will rise by 10% and bed days by 15% reflecting changes in case mix towards more complex admissions with an associated longer length of stay.

Rising demand translating into rising activity means that under the ‘do nothing’ scenario we will need significantly more capacity (clinics, theatres, beds, staff), all of which creates significant delivery risk e.g. recruitment risk. By the end of 2020/21 OUHFT alone would need to open 116 more inpatient beds for Oxfordshire residents (or 203 additional beds for their entire catchment area). The graph below shows the increase in acute inpatient beds that would be required across all providers to meet demand for Oxfordshire.
Figure 10.4 – Required Bed Growth, do nothing

Our modelling suggests that ‘business as usual’ commissioner and provider efficiencies will not be sufficient to bridge the £209m gap. If we assume all providers make 2% efficiency savings each year and that commissioners deliver a 1% activity reduction across all services (as per NHSE/NHSI guidance and considered ‘business as usual’), the gap would reduce from £209m to £34m. However, this scenario is a ‘best case’ in that it assumes providers can continue to deliver efficiencies at historic levels and that efficiencies can be made across all services - including primary care and other areas not previously subject to tariff efficiency requirements. We believe that there is a high risk that this approach will not deliver the financial efficiencies needed, so we must adopt a more transformational approach.

The modelling described above was undertaken in early 2016/17. Since completing this detailed exercise, both commissioners and providers have continued to deliver against the 2016/17 efficiency targets within the overall base case scenario. If we assume 100% delivery of these 2016/17 cost improvement plans (CIPs) and quality, innovation, productivity and prevention) QIPPs, and if we exclude the element of the £208m gap which relates to adult social care (which is out of scope for this consultation), the residual financial gap forecast by the end of 2020/21 is £134m – the movement from £208m to £134m is shown below.
### Table 10.2 – Do nothing gap 2017/2018 to 2020/21

<table>
<thead>
<tr>
<th></th>
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<tr>
<td><strong>Financial gap cumulative build up</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Opening gap</td>
<td>36,361</td>
<td>36,361</td>
<td>36,361</td>
<td>36,361</td>
<td>36,361</td>
</tr>
<tr>
<td>Add cost of rising activity</td>
<td>0</td>
<td>42,114</td>
<td>81,283</td>
<td>124,037</td>
<td>169,111</td>
</tr>
<tr>
<td>Add inflation</td>
<td>0</td>
<td>20,953</td>
<td>47,248</td>
<td>75,054</td>
<td>128,140</td>
</tr>
<tr>
<td>Add allocation increases</td>
<td>0</td>
<td>-25,753</td>
<td>-51,900</td>
<td>-80,007</td>
<td>-124,628</td>
</tr>
<tr>
<td>(Surplus)/deficit</td>
<td>36,361</td>
<td>73,675</td>
<td>112,992</td>
<td>155,445</td>
<td>208,984</td>
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<tr>
<td><strong>Adjust to assume 16/17 is delivered to plan</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Opening position</td>
<td>-36,361</td>
<td>-36,361</td>
<td>-36,361</td>
<td>-36,361</td>
<td>-36,361</td>
</tr>
<tr>
<td>Add cost of rising activity</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Add inflation</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Allocations</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>(Surplus)/deficit</td>
<td>-36,361</td>
<td>-36,361</td>
<td>-36,361</td>
<td>-36,361</td>
<td>-36,361</td>
</tr>
<tr>
<td><strong>Adjust to remove Adult Social Care gap</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Opening position</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Add cost of rising activity</td>
<td>0</td>
<td>-5,015</td>
<td>-10,209</td>
<td>-15,091</td>
<td>-20,289</td>
</tr>
<tr>
<td>Add inflation</td>
<td>0</td>
<td>-3,076</td>
<td>-7,394</td>
<td>-12,074</td>
<td>-18,757</td>
</tr>
<tr>
<td>Allocations</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>(Surplus)/deficit</td>
<td>0</td>
<td>-8,091</td>
<td>-17,602</td>
<td>-27,165</td>
<td>-39,046</td>
</tr>
<tr>
<td><strong>Revised financial gap</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Opening position</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Add cost of rising activity</td>
<td>0</td>
<td>37,099</td>
<td>71,074</td>
<td>108,946</td>
<td>148,822</td>
</tr>
<tr>
<td>Add inflation</td>
<td>0</td>
<td>17,877</td>
<td>39,854</td>
<td>62,980</td>
<td>109,383</td>
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<tr>
<td>Allocations</td>
<td>0</td>
<td>-25,753</td>
<td>-51,900</td>
<td>-80,007</td>
<td>-124,628</td>
</tr>
<tr>
<td>(Surplus)/deficit</td>
<td>0</td>
<td>29,223</td>
<td>59,029</td>
<td>91,919</td>
<td>133,577</td>
</tr>
</tbody>
</table>

#### 10.2.2 The Berkshire, Oxfordshire and Buckinghamshire Sustainability and Transformation Plan

Our Oxfordshire activity and financial model forms the basis for our input into the Berkshire, Oxfordshire and Buckinghamshire STP. The STP’s financial modelling differs from our earlier work because:

- The scope of the STP is 100% of NHS commissioner spend for Oxfordshire residents and 100% of OUHFT and OHFT’s financials. By contrast our modelling is 100% of NHS and adult social care commissioner spend and the proportion of providers’ financials relating to Oxfordshire residents for all providers serving Oxfordshire residents;

- The STP assumes all ‘in scope’ organisations achieve plan for 2016/17 recurrently, whilst our local model includes the CIP and QIPP needed to achieve 2016/17 plans in the do nothing gap.

As a result of the two differences described above, the STP ‘do nothing’ gap is not £209m by the end of 2020/21. It is £233m divided as follows:
• £49m deficit for the CCG;
• £38m deficit for NHSE (split £6m primary care and £32m specialised services);
• £27m deficit for OHFT (including services to non-Oxfordshire residents);
• £119m deficit OUHFT (including services to non-Oxfordshire residents).

The delivery of the preferred option (Option 2) supports the requirement within the BOB STP to deliver an £8m local scheme improvement. These local schemes include the reconfiguration of Ambulatory Care and Outpatients across OUH, Primary Care and Community Care. There is, however, a small difference relating to the modelled capital expenditure requirement to support this change.

The capital requirement underpinning the STP was £115m with an I&E cost (relating to the Horton business case) of £5.8m, the capital requirement underpinning the preferred option is higher at £127m with a commensurate impact on I&E cost.

10.2.3 Oxford University Hospitals NHS Foundation Trust financial position

OUHFT has agreed a financial plan for 2016/17 with NHS Improvement (NHSI) that delivers an underlying income and expenditure position of a zero-retained surplus, or ‘break even’ in 2016/17. Applying activity and financial planning assumptions for the period 2017/18 to 2020.21 results in a potential ‘do nothing’ financial gap for the trust of £94.6m. If we then assume delivery of ‘business as usual’ CIP efficiencies of 2% per annum, the financial gap is closed by £82.9m by then end of 2020/21 (this CIP would form part of the Oxfordshire system business as usual solution described above) leaving the trust with a 2020/21 gap of £11.7m, before including any costs of capital investment.

This £11.7m ‘do nothing’ or ‘base case’ scenario has been used as consistent start point for modelling of all options as it accounts for the general financial impact of activity, price and inflation changes across the modelled period, which applies to all options, and shown in figure 10.5.

This ‘base case’ scenario is not in of itself an option for consideration as it excludes the revenue impact of required capital investment to support growth in patient numbers, amongst others, which vary between each option and have been modelled separately. These are shown below and in figure 10.11:

• New models of care;
• Activity shifts between sites;
• Further productivity improvements made possible through reconfiguration; and
• Changes in fixed costs resulting from investment in capacity.
All financial modelling and assumptions exclude any local cost increases to support quality improvements, investments in cost above marginal rate assumptions and any other local pressures. They do include an £11.2m investment to cover the costs of moving to new, as yet unknown, service standards.

The diagram below summarises the high level changes between 2016/17 and 2020/21 before applying consultation option changes.

Figure 10.5 – Financial ‘base case’ movements 2016/17 to 2020/21

By the end of 2020/21 the trust will be in underlying deficit of £11.7m unless further efficiencies can be made. As in previous years ‘business as usual’ CIPs of circa 2%, plus tariff inflation and activity increases should offset inflationary cost pressures, but the trust is also anticipating an additional £11.2m cost pressure resulting introducing new service standards such as 7-day working.

The diagram below provides further detail about how OUHFT’s income and expenditure (I&E) position is forecast to change between 2016/17 and 2020/21 if we ‘do nothing’.
10.2.4 Summary of the Oxfordshire financial challenge

The combination of rising demand, cost inflation and national strategic priorities is expected to cause the Oxfordshire system a significant financial challenge over the next four years which will only be partly mitigated through the planned increase in commissioner allocations. The residual financial gap will need to be closed through a more transformational approach to service redesign and CIP delivery.

The proposed changes to the configuration of services at the Horton provides a foundation for the transformation of services by, for example, providing additional capacity needed to meet rising demand and fit for purpose accommodation to deliver services closer to where people live. The financial implications of our proposals are discussed in more detail below.

10.3 The financial scope of the consultation

There have been a number of significant changes to the scope of the proposed public consultation which led to the need to rework the financials relating to this PCBC. The table in appendix 1.1 sets out which service changes form part of this phase one consultation and which services will expect to form part of a future phase two consultation. Our activity and financial modelling, and this chapter cover phase one only – further work will follow on phase two and we anticipate a further set of proposals to emerge as a result of our Oxfordshire-wide service redesign.

Table 10.3 – Do nothing I&E bridge
10.4 The approach to activity and financial modelling

10.4.1 Option numbering

The activity and financial modelling has been undertaken on the basis of modelling two options:

1. A “do nothing” scenario. In this scenario there is no reconfiguration of services other than a minor change to the model of care in outpatients. The basis of this scenario is the projected deficit for OUHFT up to 2020/21 based upon the growth and activity assumptions (to increase bed and diagnostic capacity to balance capacity with expected demand). This is described as Option 1.

2. A “do something” scenario. This scenario assumes all of the proposed phase one consultation service reconfiguration changes are implemented as well as model of care changes related to outpatients and non-elective ambulatory care. The impact of the Oxfordshire Phase 1 reconfiguration is modelled, and the projected deficit position is presented. This is described as Option 2.

10.4.2 Activity modelling

The following assumptions underpin the activity modelling:

- The introduction at the Horton General of an ‘ambulatory care by default’ model will reduce hospital non-elective (NEL) activity by 20%;
- 5% of follow-up appointments will be delivered using mobile technology;
- Up to one third (33%) of births will be delivered at the standalone MLU at the Horton General.

10.4.3 Financial modelling

The financial model is driven by the activity model and financial planning assumptions published by NHS England and NHS Improvement for 2016/17 to 2020/21. The key underlying assumption is that both OCCG and OUHFT delivers their agreed financial plans for 2016/17 on a recurrent basis.

The objective of the financial analysis is to provide an assessment of the relative value of the potential reconfiguration options compared against each other. The focus of the modelling is on those factors which differentiate between the options rather than to attempt to account for all potential drivers of the future financial position of commissioners and providers or the affordability of the preferred option.

The latter two items would be required to accurately forecast future income and expenditure at a level required to produce a Long Term Financial Model (LTFM) that would meet requirements for any investment in capital. Subsequent business cases will be required to support investments both with OUHFT and as part of wider sector transformation and reconfiguration.
A key item to be identified following phase one of the consultation is the further productivity gains needed both within OUHFT and the wider Oxfordshire system in order make the capital investment requirements affordable. This will be a focus of phase two of the consultation.

The initial phase of modelling developed an income and expenditure forecast pre-reconfiguration, the ‘do nothing’. This is based on:

- OUHFTs 2016/17 operational, activity and financial plan as agreed with NHSI, adjusted for known and agreed non-recurrent items;
- Activity and income changes due to local and national planning assumptions, and assumptions on tariff changes, as at 2016/17. Prices have not been updated to reflect 2017-2019 planning guidance;
- Cost changes due to changes in activity, cost inflation and provider productivity (informed by national planning efficiency requirements), as per 2016/17 guidance, reproduced below.

### Economic modelling assumptions

<table>
<thead>
<tr>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Pay and pensions (including drift and mix effects)</td>
<td>3.30%</td>
<td>2.00%</td>
<td>1.60%</td>
<td>1.60%</td>
<td>2.90%</td>
</tr>
<tr>
<td>Drugs</td>
<td>4.50%</td>
<td>4.60%</td>
<td>3.60%</td>
<td>4.10%</td>
<td>4.10%</td>
</tr>
<tr>
<td>Capital costs</td>
<td>3.10%</td>
<td>3.20%</td>
<td>3.20%</td>
<td>3.10%</td>
<td>3.10%</td>
</tr>
<tr>
<td>Other operating costs</td>
<td>1.70%</td>
<td>1.80%</td>
<td>2.10%</td>
<td>1.90%</td>
<td>2.00%</td>
</tr>
<tr>
<td>Overall</td>
<td>3.10%</td>
<td>2.30%</td>
<td>2.00%</td>
<td>2.00%</td>
<td>2.90%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Tariff efficiency factor</td>
<td>-2%</td>
<td>-2.00%</td>
<td>-2.00%</td>
<td>-2.00%</td>
<td>-2.00%</td>
</tr>
<tr>
<td>Cost inflation adjusted price change</td>
<td>1.10%</td>
<td>0.30%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.90%</td>
</tr>
</tbody>
</table>

**Table 10.4 – Economic Modelling assumptions**

The supporting datasets used are:

- Activity baseline – 2016/17 OUH Service Level Agreement contracts;
- Income and Expenditure – 2016/17 Financial Plan, as submitted to NHSI;

The second phase modelled the changes due to reconfiguration options:

- Activity movements in line with the assumptions for how patient flows will change, developed and agreed by Clinical Review Groups (see activity modelling assumptions set out above);
- Capacity changes due to activity and bed movements;
- Capital requirements to build new capacity based on the proposed clinical models and activity flows between sites;
• Cost changes due to changes in activity, consolidation savings and changes in fixed costs.

The figure below summarises the approach to costing activity shifts between sites.

**Figure 10.6 – Approach to costing activity shift between sites**

Each of the options was assessed for how much capital investment would be incurred as a result of their implementation. The components of potential capital cost included adding new capacity for beds, theatres, diagnostics and outpatient rooms. Capital costing has not included an allowance for backlog maintenance, except where specifically stated, or any costs or receipts relating to land acquisition/disposal.

Capital costs have been calculated on a modular basis, with an estimated cost per unit of capacity (e.g. a bed or a theatre), derived from estimated activity per unit of capacity (e.g. elective cases per theatre). They have not been estimated on the cost of a specified building or set of buildings, or changes to existing estates infrastructure to support overall volumes of activity and capacity movements. The capital expenditure estimates used in the option evaluations are focused on those investments that would be directly related to the reconfiguration options, and that will differentiate the options from each other; these estimates include capital required to:
• Add capacity to accommodate the changes in activity and service models;
• Move services between sites.

The estimates exclude capital that does not directly relate to the reconfiguration options e.g. capital required to:

• Continue making ongoing replacement of assets;
• Make changes to the estate to support or enable the delivery of the CIP programmes;
• Make other changes to improve the quality of estate.

I&E forecasts for each option include the current annual depreciation charge. Each reconfiguration option is presented in terms of a comparative financial assessment of the options and its relative ‘value for money’, with criteria being:

• ‘End state’ financial impact on I&E as at 2020/21;
• Total required capital investment;
• Net present value (NPV);
• Transition costs.

Key elements of what is not included in the financial modelling are:

• Any changes not in phase one of the consultation scope;
• Financial impact of changes not noted in the assumptions, i.e. other costs or developments not linked to this case;
• Exceptional transitional or implementation costs, other than an allowance for c£4m year-on-year cost of meeting service standards and costs equivalent to three months double running of semi-variable costs moving between sites;
• Impact of wider activity changes under development in the STP within Oxfordshire and across the Buckinghamshire, Oxfordshire and Berkshire West (BOB) STP footprint;
• Detailed capital estimates on actual build costs;
• Detailed staffing costs, e.g. staffing rotas; and
• Further work required to complete a ‘Generic Economic Model’ (GEM), or economic appraisal.

10.5 The activity and financial impact of consultation options

The sections below take each of the two key elements of change (the Horton and DTOC) and for each describes the activity and financial impact of the options we propose to consult upon on:

• Oxfordshire CCG;
• Other commissioners (NHS England and neighbouring CCGs);
• Oxfordshire-based providers;
• Out of area providers.
10.6 Potential changes to services based at Horton General Hospital

10.6.1 Impact on OUHFT

This section summarises the results of our modelling on OUHFT split between activity implications; impact on the trust’s I&E and the requirement for capital. The services covered by the modelling are; non-elective medical inpatient (including stroke) and day cases; critical care (for adults and babies); maternity, planned care admissions (inpatient and day case, medical and surgical) and ambulatory care (outpatients, diagnostics, chemotherapy and renal dialysis).

The modelling considers the two core options (options one and two), but due to financial materiality, does not consider in detail the financial impact of the sub-options around the number of midwifery-led birth centres in the north of the county.

Activity implications

The starting point for both options is 2016/17 contracted activity. This baseline has been adjusted for forecast growth as per the table below.

<table>
<thead>
<tr>
<th>POD</th>
<th>2017/18</th>
<th>2018/19</th>
<th>2019/20</th>
<th>2020/21</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elective inpatient</td>
<td>104.5%</td>
<td>104.1%</td>
<td>103.8%</td>
<td>103.7%</td>
</tr>
<tr>
<td>Elective daycase</td>
<td>105.0%</td>
<td>104.4%</td>
<td>104.1%</td>
<td>103.9%</td>
</tr>
<tr>
<td>Non-elective inpatient (excluding maternity)</td>
<td>104.0%</td>
<td>103.2%</td>
<td>103.1%</td>
<td>102.7%</td>
</tr>
<tr>
<td>Maternity</td>
<td>101.9%</td>
<td>101.4%</td>
<td>101.3%</td>
<td>100.8%</td>
</tr>
<tr>
<td>Critical care</td>
<td>101.8%</td>
<td>101.4%</td>
<td>101.0%</td>
<td>100.9%</td>
</tr>
<tr>
<td>Outpatient</td>
<td>104.5%</td>
<td>103.9%</td>
<td>103.5%</td>
<td>103.4%</td>
</tr>
<tr>
<td>A&amp;E</td>
<td>105.7%</td>
<td>105.3%</td>
<td>105.0%</td>
<td>104.9%</td>
</tr>
<tr>
<td>Paediatrics</td>
<td>104.5%</td>
<td>103.9%</td>
<td>103.8%</td>
<td>103.9%</td>
</tr>
<tr>
<td>Other</td>
<td>101.8%</td>
<td>101.4%</td>
<td>101.0%</td>
<td>100.9%</td>
</tr>
<tr>
<td>Diagnostics</td>
<td>104.5%</td>
<td>103.9%</td>
<td>103.5%</td>
<td>103.4%</td>
</tr>
</tbody>
</table>

Table 10.5 – Activity growth assumptions (demographic plus non-demographic growth)

The resulting OUHFT-wide activity estimates by service line and for the four years to 2020/21 are shown in the following table together with a column showing the current percentage of total activity undertaken at the Horton.
The trust’s baseline financial position is driven, in part, by the activity forecasts shown above. Against this baseline two types of adjustment are made:

1. Minor adjustments are made to reflect model of care changes common to both options;
2. Option specific changes are made reflecting different service reconfiguration options. Most of these changes do not result in a material change to activity undertaken by OUHFT (the exceptions being some loss of activity to neighbouring providers resulting from longer travel times), instead differences relate to the OUHFT location at which activity is delivered. Our modelling assumes activity shifts between sites occurs from 2020/21 i.e. the final year in the activity and financial modelling.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>A&amp;E major</td>
<td>25,193</td>
<td>26,636</td>
<td>28,049</td>
<td>29,443</td>
<td>30,878</td>
<td>25%</td>
</tr>
<tr>
<td>A&amp;E minor</td>
<td>52,803</td>
<td>55,827</td>
<td>58,789</td>
<td>61,710</td>
<td>64,719</td>
<td>23%</td>
</tr>
<tr>
<td>A&amp;E standard</td>
<td>65,244</td>
<td>68,982</td>
<td>72,641</td>
<td>76,250</td>
<td>79,968</td>
<td>33%</td>
</tr>
<tr>
<td>Critical care - adult level 2</td>
<td>9,955</td>
<td>10,137</td>
<td>10,277</td>
<td>10,381</td>
<td>10,476</td>
<td>14%</td>
</tr>
<tr>
<td>Critical care - adult level 3</td>
<td>16,947</td>
<td>17,257</td>
<td>17,495</td>
<td>17,672</td>
<td>17,834</td>
<td>1%</td>
</tr>
<tr>
<td>Critical care - neonatal</td>
<td>19,558</td>
<td>19,917</td>
<td>20,191</td>
<td>20,396</td>
<td>20,583</td>
<td>9%</td>
</tr>
<tr>
<td>Critical care - paediatric</td>
<td>4,553</td>
<td>4,637</td>
<td>4,701</td>
<td>4,748</td>
<td>4,792</td>
<td>1%</td>
</tr>
<tr>
<td>Diagnostics - CT</td>
<td>30,038</td>
<td>31,380</td>
<td>32,617</td>
<td>33,774</td>
<td>34,917</td>
<td>13%</td>
</tr>
<tr>
<td>Diagnostics - MRI</td>
<td>30,702</td>
<td>32,074</td>
<td>33,338</td>
<td>34,521</td>
<td>35,690</td>
<td>3%</td>
</tr>
<tr>
<td>Diagnostics - other</td>
<td>29,760</td>
<td>31,091</td>
<td>32,316</td>
<td>33,462</td>
<td>34,595</td>
<td>6%</td>
</tr>
<tr>
<td>Diagnostics - ultrasound</td>
<td>65,395</td>
<td>68,318</td>
<td>71,010</td>
<td>73,529</td>
<td>76,019</td>
<td>17%</td>
</tr>
<tr>
<td>Diagnostics - X-ray</td>
<td>34,221</td>
<td>35,751</td>
<td>37,160</td>
<td>38,477</td>
<td>39,780</td>
<td>36%</td>
</tr>
<tr>
<td>Medicine - ELDC</td>
<td>41,656</td>
<td>43,733</td>
<td>45,672</td>
<td>47,526</td>
<td>49,373</td>
<td>11%</td>
</tr>
<tr>
<td>Medicine - ELIP</td>
<td>5,930</td>
<td>6,199</td>
<td>6,453</td>
<td>6,697</td>
<td>6,944</td>
<td>1%</td>
</tr>
<tr>
<td>Medicine - NEL</td>
<td>38,328</td>
<td>39,859</td>
<td>41,145</td>
<td>42,429</td>
<td>43,554</td>
<td>23%</td>
</tr>
<tr>
<td>Medicine - OP</td>
<td>438,826</td>
<td>458,439</td>
<td>476,503</td>
<td>493,404</td>
<td>510,113</td>
<td>11%</td>
</tr>
<tr>
<td>Neonatal (except well babies)</td>
<td>4,284</td>
<td>4,477</td>
<td>4,654</td>
<td>4,830</td>
<td>5,018</td>
<td>7%</td>
</tr>
<tr>
<td>Obstetrics - births</td>
<td>8,555</td>
<td>8,716</td>
<td>8,834</td>
<td>8,947</td>
<td>9,016</td>
<td>18%</td>
</tr>
<tr>
<td>Obstetrics - other</td>
<td>16,605</td>
<td>16,917</td>
<td>17,147</td>
<td>17,366</td>
<td>17,498</td>
<td>8%</td>
</tr>
<tr>
<td>Oncology - day case chemo</td>
<td>38,791</td>
<td>39,502</td>
<td>40,046</td>
<td>40,451</td>
<td>40,822</td>
<td>9%</td>
</tr>
<tr>
<td>Paediatrics - DC</td>
<td>7,337</td>
<td>7,668</td>
<td>7,970</td>
<td>8,272</td>
<td>8,593</td>
<td>3%</td>
</tr>
<tr>
<td>Paediatrics - IP</td>
<td>3,507</td>
<td>3,665</td>
<td>3,810</td>
<td>3,954</td>
<td>4,107</td>
<td>0%</td>
</tr>
<tr>
<td>Paediatrics - NEL</td>
<td>11,825</td>
<td>12,359</td>
<td>12,847</td>
<td>13,333</td>
<td>13,851</td>
<td>22%</td>
</tr>
<tr>
<td>Paediatrics - OP</td>
<td>83,104</td>
<td>86,857</td>
<td>90,284</td>
<td>93,700</td>
<td>97,340</td>
<td>12%</td>
</tr>
<tr>
<td>Surgery - ELDC</td>
<td>32,557</td>
<td>34,180</td>
<td>35,695</td>
<td>37,144</td>
<td>38,587</td>
<td>13%</td>
</tr>
<tr>
<td>Surgery - ELIP</td>
<td>16,545</td>
<td>17,294</td>
<td>18,002</td>
<td>18,683</td>
<td>19,373</td>
<td>2%</td>
</tr>
<tr>
<td>Surgery - NEL</td>
<td>19,319</td>
<td>20,091</td>
<td>20,739</td>
<td>21,386</td>
<td>21,953</td>
<td>8%</td>
</tr>
<tr>
<td>Surgery - OP</td>
<td>383,877</td>
<td>401,084</td>
<td>416,836</td>
<td>431,621</td>
<td>446,237</td>
<td>9%</td>
</tr>
</tbody>
</table>

Table 10.6 – OUHFT total activity forecasts – do nothing baseline
As a result of assumptions about site reconfiguration, the share of OUHFT's activity undertaken at the Horton changes in option two as per the table below (activity does not shift location under option one) – the shading denotes those Horton-based services affected by proposed phase one service reconfiguration changes (non-elective admissions will also be impacted by the move to ambulatory pathways).

<table>
<thead>
<tr>
<th>Service line</th>
<th>Current activity %</th>
<th>Future activity %</th>
<th>Year start</th>
</tr>
</thead>
<tbody>
<tr>
<td>A&amp;E major</td>
<td>25%</td>
<td>25%</td>
<td>4</td>
</tr>
<tr>
<td>A&amp;E minor</td>
<td>23%</td>
<td>23%</td>
<td>4</td>
</tr>
<tr>
<td>A&amp;E standard</td>
<td>33%</td>
<td>33%</td>
<td>4</td>
</tr>
<tr>
<td>Critical care - adult level 2</td>
<td>14%</td>
<td>14%</td>
<td>4</td>
</tr>
<tr>
<td>Critical care - adult level 3</td>
<td>1%</td>
<td>0%</td>
<td>4</td>
</tr>
<tr>
<td>Critical care - neonatal</td>
<td>9%</td>
<td>0%</td>
<td>4</td>
</tr>
<tr>
<td>Critical care - paediatric</td>
<td>1%</td>
<td>1%</td>
<td>4</td>
</tr>
<tr>
<td>Diagnostics - CT</td>
<td>13%</td>
<td>20%</td>
<td>4</td>
</tr>
<tr>
<td>Diagnostics - MRI</td>
<td>3%</td>
<td>20%</td>
<td>4</td>
</tr>
<tr>
<td>Diagnostics - other</td>
<td>6%</td>
<td>20%</td>
<td>4</td>
</tr>
<tr>
<td>Diagnostics - ultrasound</td>
<td>17%</td>
<td>20%</td>
<td>4</td>
</tr>
<tr>
<td>Diagnostics - X-ray</td>
<td>36%</td>
<td>36%</td>
<td>4</td>
</tr>
<tr>
<td>Medicine - ELDC</td>
<td>11%</td>
<td>19%</td>
<td>4</td>
</tr>
<tr>
<td>Medicine - ELIP</td>
<td>1%</td>
<td>0%</td>
<td>4</td>
</tr>
<tr>
<td>Medicine - NEL</td>
<td>23%</td>
<td>23%</td>
<td>4</td>
</tr>
<tr>
<td>Medicine - OP</td>
<td>11%</td>
<td>19%</td>
<td>4</td>
</tr>
<tr>
<td>Neonatal (except well babies)</td>
<td>7%</td>
<td>0%</td>
<td>4</td>
</tr>
<tr>
<td>Obstetrics - births</td>
<td>18%</td>
<td>6%</td>
<td>4</td>
</tr>
<tr>
<td>Obstetrics - other</td>
<td>8%</td>
<td>18%</td>
<td>4</td>
</tr>
<tr>
<td>Oncology - day case chemo</td>
<td>9%</td>
<td>23%</td>
<td>4</td>
</tr>
<tr>
<td>Paediatrics - DC</td>
<td>3%</td>
<td>3%</td>
<td>4</td>
</tr>
<tr>
<td>Paediatrics - IP</td>
<td>0%</td>
<td>0%</td>
<td>4</td>
</tr>
<tr>
<td>Paediatrics - NEL</td>
<td>22%</td>
<td>22%</td>
<td>4</td>
</tr>
<tr>
<td>Paediatrics - OP</td>
<td>12%</td>
<td>12%</td>
<td>4</td>
</tr>
<tr>
<td>Surgery - ELDC</td>
<td>13%</td>
<td>14%</td>
<td>4</td>
</tr>
<tr>
<td>Surgery - ELIP</td>
<td>2%</td>
<td>0%</td>
<td>4</td>
</tr>
<tr>
<td>Surgery - NEL</td>
<td>8%</td>
<td>8%</td>
<td>4</td>
</tr>
<tr>
<td>Surgery - OP</td>
<td>9%</td>
<td>27%</td>
<td>4</td>
</tr>
<tr>
<td>Other</td>
<td>2%</td>
<td>2%</td>
<td>4</td>
</tr>
</tbody>
</table>

Table 10.7 – Option two - activity location and year of change

The table illustrates material increases in the volume of activity at the Horton under option two for ambulatory care (diagnostics, day cases and outpatients) and decreases in the proportion of OUHFT elective inpatient and maternity activity. The proposed phase two consultation changes, which are not
included in this business case, would cause further changes to volumes of activity at the Horton (principally for A&E and paediatrics).

The table below summarises urgent and emergency care activity under each of the two options using 2016/17 contracted activity as the baseline.

![Change in urgent and emergency care](image)

**Figure 10.7 – Urgent and emergency activity by option**

Under option two, the new ambulatory care model will result in 2,596 inpatient medical NELs being substituted with a zero day attendance. Under option two there is also a reduction in non-elective medical inpatient admissions as a result of changes to the stroke pathway (HRGs AA22 and AA23 will move to the John Radcliffe Hospital).

The volume of other urgent and emergency care activity at the Horton is not expected to change under phase one proposed changes.

The table below summarises paediatric and admitted planed care activity under each option:
Key points to note are:

- Elective day case activity across medical and surgical specialties will increase under option two with the proposed increase in day case work undertaken at the Horton due to work being repatriated from other OUHFT sites – the key change is the assumption that the Horton will provide 19% of OUHFT’s day case medical activity up from the current 11% post-reconfiguration.
- All elective inpatient surgery would move away from the Horton under option two.
- Under option two, 1,272 inpatient spells would move from the Ramsay treatment centre at the Horton to the John Radcliffe.
- No changes have been assumed for paediatric services in phase one.

The phase one consultation proposals would result in more substantial changes to ambulatory planned care – these are summarised below.
It is important to note that we have assumed changes to models of outpatient care will result in a small reduction in outpatient numbers (from the 2016/17 base) under both options one and two due to demand management and changes in delivery models e.g. a move to virtual appointments. The key differences between the two options are:

- **Substantial higher outpatient numbers at the Horton under option two for a range of medical and surgical specialties.** As with day case activity, the underlying assumption is that the Horton would provide a considerably larger share of OUHFT’s total outpatient activity under this option.

- **Under option two activity for the full range of diagnostic modalities also increases.** The increase is driven by the change in the location of outpatient clinics and increased diagnostic capacity at the Horton.

- **Similar assumptions about reconfiguration under option two would lead to an increase in day attenders for chemotherapy and renal dialysis – neither change has been included in the financial modelling at this stage.**

The table below summarises maternity services activity under each option:

---

**Figure 10.9 – Ambulatory planned care changes**

---

1. Outpatient activity under new models of care and as a hospital service assumed a 5% demand management i.e. dosing 5% of follow up appointments to non delivered models (e.g., telephone).
2. Diagnostic includes plan endoscopy, not diagnostic per se as part of outpatient visits.
3. On万吨one or more inpatient services in addition to outpatient visits.
4. Assessing activity can be calculated according to travel times, service now not included in financial modelling.
Changes to maternity services are a key feature of option two under which most births would move away from the Horton site to either the John Radcliffe or, based on travel times, to alternate acute hospitals (most likely those in Northampton and Warwick). The OUHFT would lose £1.31m worth of maternity income relating to the births that move to other acute trusts. The Horton would move from providing 18% of OUH’s births to 6% under this option with the remaining 6% (496 births) being in the on-site midwifery led unit (MLU). The transfer of obstetric led births away from the Horton under option two would also result in the closure of the Horton’s special care baby unit (SCBU).

Due to the relative financial materiality of the change, detailed activity and financial modelling has not been undertaken on the two sub-options relating to the number of midwifery-led units in northern Oxfordshire. The sub-option that would result in the closure of the MLU at Chipping Norton would result in this activity being displaced elsewhere. Between July 2013 and July 2016 there were 374 births at Chipping Norton (an average of 122 per year). Travel analysis indicates that about 100 of these mothers would probably choose the Horton or John Radcliffe as an alternative setting for their delivery, but that about 20 from outside of the county, may choose to access non-OUH services.
Option two includes a material increase in the delivery of ante and postnatal pathway activity at the Horton. The activity increase is subject to further confirmation, but reflects the trend of repatriating activity from other OUH sites where it relates to local patients.

**Income and expenditure impact**

If the trust does nothing except deliver the required level of CIP for the next four years, the trust’s financial position will worsen from the current break-even (2016/17 plan) to a deficit of £11.7m at the end of 2020/21, before the costs of required capital investment and transition costs required to meet rising demand – see discussion above. The trust would then need to invest in additional capacity to meet rising demand – there are two options to achieve this; options one (do nothing) and two (do something- the changes set out above). The diagram below illustrates the relative impact of each option compared to this do nothing scenario using the £11.7m 2020/21 deficit starting point highlighted above.

**Reconfiguration of services and productivity improvement under option 2 help close deficit but not entirely**

<table>
<thead>
<tr>
<th>Net financial position for OUH, £m</th>
<th>Excluding transition costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Starting position FY 20/21</td>
<td>New models of care¹</td>
</tr>
<tr>
<td>Option 1</td>
<td>-11.7</td>
</tr>
<tr>
<td>Option 2</td>
<td>-11.7</td>
</tr>
</tbody>
</table>

1. New care models include reductions in non-elective medical admissions due to mandatory care model at level one and 21% length of stay reduction for non-elective patients in non-EU/EEA countries. In addition, there will be a 1% increase in overnight stays in the next four years.
2. Reduced length of stay and improved activity as stated above.
3. Based on the modelled impact of option 2 (2.8%) applied to non-elective care of OUH (£12.5m)
4. The figure includes the savings from a 1% increase in non-elective activity.
5. The finalised modelled deficit will be lower as the modelled deficit is based on a 21% reduction in overnight stays in the next four years.
6. The modelled deficit is based on the assumption of achieving the specified reduction in overnight stays.

**Figure 10.11 – Impact on I&E by option**

The revenue impact of capital investment under option one) would be a deficit of £27.3m. Option two is better as it results in a smaller deficit (£16.2m) because the associated increase in fixed cost is lower (driven by better utilisation of the two main OUHFT sites, for example fewer inpatient
beds being required) and new models of care deliver a saving (of £2m) versus an increase (of £1.4m) under option one.

The table below shows the bridge between the 2020/21 do nothing (£11.7m deficit) and option one.

<table>
<thead>
<tr>
<th>I&amp;E bridge output</th>
<th>2020/21 “do nothing”</th>
<th>Move to new model of care</th>
<th>Activity shift between sites</th>
<th>Productivity improvements</th>
<th>Change in fixed costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income</td>
<td>1,100.49</td>
<td>3.16</td>
<td>1,097.34</td>
<td>-</td>
<td>1,097.34</td>
</tr>
<tr>
<td>Expenditure</td>
<td>-1,112.17</td>
<td>1.77</td>
<td>1,110.39</td>
<td>-</td>
<td>1,110.39</td>
</tr>
<tr>
<td><strong>Horton I&amp;E</strong></td>
<td>-3.00</td>
<td>0.13</td>
<td>-3.13</td>
<td>-</td>
<td>-3.13</td>
</tr>
<tr>
<td>Income</td>
<td>77.52</td>
<td>0.34</td>
<td>77.19</td>
<td>-</td>
<td>77.19</td>
</tr>
<tr>
<td>Expenditure</td>
<td>-80.52</td>
<td>0.20</td>
<td>-80.32</td>
<td>-</td>
<td>-80.32</td>
</tr>
<tr>
<td>Income</td>
<td>1,009.81</td>
<td>3.90</td>
<td>1,006.31</td>
<td>-</td>
<td>1,006.31</td>
</tr>
<tr>
<td>Expenditure</td>
<td>-1,019.52</td>
<td>2.12</td>
<td>-1,017.40</td>
<td>-</td>
<td>-1,017.40</td>
</tr>
<tr>
<td><strong>Rest of OLH &amp; I&amp;E</strong></td>
<td>1.03</td>
<td>0.14</td>
<td>1.17</td>
<td>-</td>
<td>1.17</td>
</tr>
<tr>
<td>Income</td>
<td>13.16</td>
<td>0.68</td>
<td>13.84</td>
<td>-</td>
<td>13.84</td>
</tr>
<tr>
<td>Expenditure</td>
<td>-12.13</td>
<td>0.51</td>
<td>-12.68</td>
<td>-</td>
<td>-12.68</td>
</tr>
</tbody>
</table>

**Table 10.8 – Option one I&E bridge**

Model of care changes are discussed below. The main change under option one is the £14m increase in fixed costs. This is based on an additional 203 beds being needed, each costing £460k in capital investment and an assumption that fixed costs equate to 15% of the capital sum invested. As suggested in the table above most of the additional beds (154 would be at the John Radcliffe).

The option two I&E bridge is as follows:

<table>
<thead>
<tr>
<th>I&amp;E bridge output</th>
<th>2020/21 “do nothing”</th>
<th>Move to new model of care</th>
<th>Activity shift between sites</th>
<th>Productivity improvements</th>
<th>Change in fixed costs</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Oxford Trustwide &amp; I&amp;E</strong></td>
<td>-11.7</td>
<td>2.0</td>
<td>-9.7</td>
<td>0.0</td>
<td>8.7</td>
</tr>
<tr>
<td>Income</td>
<td>1,100.5</td>
<td>3.2</td>
<td>1,097.3</td>
<td>2.87</td>
<td>1,094.5</td>
</tr>
<tr>
<td>Expenditure</td>
<td>-1,112.2</td>
<td>5.1</td>
<td>-1,107.1</td>
<td>2.91</td>
<td>-1,104.2</td>
</tr>
<tr>
<td><strong>Horton I&amp;E</strong></td>
<td>-3.0</td>
<td>3.2</td>
<td>0.2</td>
<td>8.7</td>
<td>8.9</td>
</tr>
<tr>
<td>Income</td>
<td>77.5</td>
<td>0.3</td>
<td>77.2</td>
<td>21.6</td>
<td>98.8</td>
</tr>
<tr>
<td>Expenditure</td>
<td>-80.5</td>
<td>3.5</td>
<td>-77.0</td>
<td>12.9</td>
<td>-89.9</td>
</tr>
<tr>
<td><strong>Headington I&amp;E</strong></td>
<td>-9.7</td>
<td>1.4</td>
<td>-11.1</td>
<td>8.6</td>
<td>19.7</td>
</tr>
<tr>
<td>Income</td>
<td>1,009.8</td>
<td>3.5</td>
<td>1,006.3</td>
<td>24.4</td>
<td>981.9</td>
</tr>
<tr>
<td>Expenditure</td>
<td>-1,019.5</td>
<td>2.1</td>
<td>-1,017.4</td>
<td>15.8</td>
<td>-1,001.6</td>
</tr>
<tr>
<td><strong>Rest of OLH &amp; I&amp;E</strong></td>
<td>1.0</td>
<td>0.1</td>
<td>1.2</td>
<td>-</td>
<td>1.2</td>
</tr>
<tr>
<td>Income</td>
<td>13.2</td>
<td>0.7</td>
<td>13.8</td>
<td>-</td>
<td>13.8</td>
</tr>
<tr>
<td>Expenditure</td>
<td>-12.1</td>
<td>0.5</td>
<td>-12.7</td>
<td>-</td>
<td>-12.7</td>
</tr>
<tr>
<td><strong>Outside OLH</strong></td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

**Table 10.9 – Option two I&E bridge**

The key difference from option one is the impact of moving activity between sites which has the impact of improving the notional I&E for the Horton from £3m deficit under the do nothing to £8.9m surplus (before fixed cost changes),
but of worsening the position at Headington (the John Radcliffe plus other Oxford City sites). It should be noted that the site split for the I&E is notional and is based on a large number of assumptions.

The reconfiguration of services across the OUHFT estate is net neutral in financial terms. The reconfiguration between hospital sites will lead to a loss of some activity to neighbouring trusts which has been valued at £2.9m of which £1.3m relates to maternity, however, this loss in income is offset by cost savings resulting from the consolidation of inpatient elective activity.

The increase in fixed costs under option two is £6.5m. Although 210 additional beds are required leading to an increase in fixed costs of £10.8m, this increase is offset by a reduction of 16 in the number of theatres needed across the trust; this results in a fixed cost saving for theatres of £6.4m. Changes to diagnostics and outpatients (the increase in activity at the Horton) result in further capital investment in clinic rooms and diagnostic equipment, which taken together have an annual fixed cost of £2m. In summary the £6.5m increase in fixed costs under option two is the net of increases in beds (+£10.8m), clinics and diagnostic equipment (+£2m) less savings relating to a reduction in the number of theatres required (-£6.4m).

The relative benefits of new models of care under each option are summarised below.
Changes to the model of care will impact I&E before any activity is shifted between sites

Under both options there is a loss of tariff income linked to reductions in face to face outpatient appointments which outweighs the associated cost saving resulting in a net worsening of the deficit by £1.4m taking the total deficit to £13.1m.

Under option two only the trust's deficit position would recover by £3.3m as a result of the introduction of ambulatory care pathways for non-elective activity at the Horton. The result would be a deficit of £9.7m for option two.

As noted earlier we have not modelled the impact of sub-options relating to the number of MLUs operated by OUH across the north of Oxfordshire – the numbers above assume that both existing locations continue to operate (Horton and Chipping Norton). As noted in the section on activity changes, if the Chipping Norton MLU were to close we would expect over 80% of activity to shift to other OUH maternity units, with approximately 20 mothers choosing alternate out of county providers. Any loss of activity to other providers would result in a loss of income, but this would be relatively small (less than £50k). The closure of the MLU would not lead to staff savings because the Chipping Norton unit is operated by the local community midwifery team, which would remain in-situ providing ante and post-natal care to local women – this team is

**Figure 10.12 – Impact on I&E of new models of care by option**

Under both options there is a loss of tariff income linked to reductions in face to face outpatient appointments which outweighs the associated cost saving resulting in a net worsening of the deficit by £1.4m taking the total deficit to £13.1m.

Under option two only the trust’s deficit position would recover by £3.3m as a result of the introduction of ambulatory care pathways for non-elective activity at the Horton. The result would be deficit of £9.7m for option two.

As noted earlier we have not modelled the impact of sub-options relating to the number of MLUs operated by OUH across the north of Oxfordshire – the numbers above assume that both existing locations continue to operate (Horton and Chipping Norton). As noted in the section on activity changes, if the Chipping Norton MLU were to close we would expect over 80% of activity to shift to other OUH maternity units, with approximately 20 mothers choosing alternate out of county providers. Any loss of activity to other providers would result in a loss of income, but this would be relatively small (less than £50k). The closure of the MLU would not lead to staff savings because the Chipping Norton unit is operated by the local community midwifery team, which would remain in-situ providing ante and post-natal care to local women – this team is
based at the MLU. The unit itself is rented by OUHFT from NHS Property Services at an annual cost of £405k, so OUHFT would save this amount on closure of the unit, less any new rental needed for new accommodation for the community midwives. In the event of a tenant vacating a NHSPS property the resulting void cost has in the past elsewhere, been charged to the local CCG – if this were to be the case at Chipping Norton there would be no saving to the Oxfordshire system from vacating the premises unless an alternate use for the property, that freed-up space elsewhere, could be identified.

Further analysis of income and expenditure, including detailed timings of cashflows, will be required in the post-consultation business case and to complete a ‘Generic Economic Model’ (GEM).

**Transition costs**

It will not be possible for the reconfiguration of services to happen across OUHFT sites at a single point in time. Services will need to be moved in a staged approach to ensure safe working and to minimise disruption for patients.

Cost estimates for the transition between the current configuration and future states have not yet been calculated in detail due to the further work required for detailed plans on implementation and phasing, however, we have allowed £3.5m at this stage in the development of the PCBC.

**Capital investment requirements**

In order to support the reconfiguration options, including shifts of activity between sites and increase bed numbers across the trust to meet rising demand, there will be a requirement to invest in new capacity. The figure below shows the estimated capital cost of each option.
Both options require additional capital investment. In Option one the requirement is £106m to meet the increase in demand for services, with Option two being the highest at £127m due primarily to the additional cost of expanding outpatient and diagnostic capacity at the Horton – option two requires two additional CT scanners, three more MRIs, five more x-ray machines and two additional consulting rooms costing a total of £28.4m. By contrast option one requires investment of £7.9m to purchase one additional CT, one new MRI and five more x-ray machines: no additional outpatient rooms are needed. The considerable capital investment requirement is primarily new inpatient bed capacity (203 beds in option one costing £93m and 210 beds in option two at a cost of £97m).

There are no assumed costs or receipts relating to land in the estimated capital costs.

The assumed source of capital financing is public dividend capital (PDC), with a cost of 3.5% pa. The cost of alternative non-PDC financing has been modelled in the sensitivities, with a higher cost of 5.0% pa. Further financing and procurement options will be considered post consultation.
Net Present Value

As with the income and expenditure implications of proposed reconfiguration options, several factors are important in calculating the economic impact of these options through a net present value (NPV) figure. This allows the consideration of different payment profiles over time, and in particular the relative impact of upfront capital costs and on-going income and expenditure profiles. The relative NPVs of each option are shown below.

![Net present value of reconfiguration options](image)

**Figure 10.14 – Net present values**

Option two provides the highest NPVs (lowest negative value), and so the most favourable option using this criteria. Neither of the options repay the costs of the initial investment over the evaluated timeframe due to the deficit position of the ‘do nothing’ scenario start point, impacted by the cost of moving to new service standards, and the fixed costs of additional capacity being greater than the modelled beneficial impact of activity shifts and new models of care.

The key difference between each option’s NPV is the deficit position being worse for option one – the assumed ongoing deficit of £27.3m (before reversing out depreciation) versus £16.2m results in an undiscounted additional ‘cost’ of £216.8m over the 20 year evaluation period.
Further development will be required in the post-consultation business case to increase efficiencies to make the preferred option affordable. This does not impact on the relative position of the options.

Summary of financial evaluation - OUHFT

The evaluation of the two options using a comparison of an ‘end state’ financial impact on I&E as at 2020/21, total required capital investment and net present value (NPV), to provide a comparative financial assessment of the options, shows that despite option one having lowest overall capital investment requirement, option two is better overall. A ranking of options by their comparable ‘Value for Money’ measures has been summarised below.

10.6.2 Impact on other providers

Horton General Hospital’s catchment area consists of 37 electoral wards of which 30 are in Oxfordshire and the remaining seven are in Northamptonshire or Warwickshire. Option two assumes a modest transfer of activity from the Horton to providers in Warwickshire and Northamptonshire. The tables below summarises the activity and income that we would expect to shift to other providers under option two.
We would expect the activity to be divided between Northampton and Warwick hospitals, with Warwick gaining most (approximately 95% of the displaced activity). The largest volume of activity shifting relates to maternity services with an estimated 500 births moving. Whilst all activity would be funded at national or local tariffs, we will need to liaise with both trusts to ensure that each has sufficient capacity to absorb the potential increase.

We have assumed that the additional community-based activity associated with the introduction of ambulatory pathways will be absorbed by existing OUHFT hospital at home services rather than requiring additional investment in OHFT community health teams.

### 10.6.3 Impact on Oxfordshire and neighbouring CCGs

All CCGs commissioning care at the Horton would benefit from reduced outpatient attendance costs associated with new models of care. OUHFT has assumed a loss in income of £3.1m linked to these changes. This reduction in commissioner costs would accrue to Oxfordshire and neighbouring CCGs in proportion to their share of Horton’s activity.

The quantum of activity commissioned by the CCG for its residents is the same under both options with the exception of a reduction in occupied bed days resulting from new models of care driving down length of stay. CCGs will only benefit financially from this reduction if the reduction is associated with spells incurring an excess bed day fee. The financial modelling assumes no excess bed day payment reductions.

Oxfordshire CCG currently pays a premium of £2.147m to OUHFT to cover diseconomies of sale associated with the provision of paediatric and obstetric services at the Horton: £0.7m of this sum relates to obstetrics. This premium is assumed to be paid in all options and would support the continuation of these services and investment in delivery of recommended hours of consultant cover at the John Radcliffe under option two.

### 10.6.4 Impact on the system

The combined financial impact of each option on the system is summarised below.

<table>
<thead>
<tr>
<th>Service line</th>
<th>Income loss (£)</th>
<th>Lost activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Critical care - adult level 3 spells</td>
<td>0.27</td>
<td>20</td>
</tr>
<tr>
<td>Critical care - neonatal spells</td>
<td>0.65</td>
<td>124</td>
</tr>
<tr>
<td>Medicine - ELIP spells</td>
<td>0.03</td>
<td>36</td>
</tr>
<tr>
<td>Medicine - NEL spells</td>
<td>0.08</td>
<td>52</td>
</tr>
<tr>
<td>Obstetrics - births</td>
<td>1.31</td>
<td>500</td>
</tr>
<tr>
<td>Surgery - ELIP spells</td>
<td>0.52</td>
<td>249</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>2.87</strong></td>
<td></td>
</tr>
</tbody>
</table>

Table 10.9 – Activity transferring to non-Oxfordshire acute providers – option 2
Table 10.10 – Financial impact on the system (£m)

Note: no allowance has been made for the potential benefit to providers in Northampton and Warwick of providing displaced activity funded at tariff, at marginal cost.

Both options worsen the revenue position OUH, but this worsening is mitigated to some extent by CCG savings of £3.1m.

10.7 Impact of the DTOC programme

The DTOC programme aimed to reduce the number of inpatient beds across OUHFT by introducing:

- Ambulatory care in-reaching into patient’s homes delivering acute care for a defined time period;
- An extended Supported Hospital Discharge Service (SHDS);
- 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’

In addition the system has commissioned 134 intermediate care beds in local nursing homes.

10.7.1 Impact on OUHFT

The table below shows the impact of the programme on bed numbers at the trust.

<table>
<thead>
<tr>
<th>Ward</th>
<th>Present bed numbers</th>
<th>Beds Realigned</th>
<th>Beds left</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oak (ground floor)</td>
<td>36</td>
<td>0</td>
<td>36 based on 18 designed for Trauma and emergency Gynaecology and 18 acute medical short stay aligned with</td>
</tr>
<tr>
<td>Ward</td>
<td>Present bed numbers</td>
<td>Beds Realigned</td>
<td>Beds left</td>
</tr>
<tr>
<td>-------------------------------------</td>
<td>---------------------</td>
<td>----------------</td>
<td>----------------------------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td>medical assessment.</td>
<td></td>
</tr>
<tr>
<td>Laburnum (1st floor)</td>
<td>28</td>
<td>0</td>
<td>28 Female patients</td>
</tr>
<tr>
<td>Juniper (1st floor)</td>
<td>30</td>
<td>0</td>
<td>30 Male patients, bay in between can flex between either gender</td>
</tr>
<tr>
<td>JWW</td>
<td>20</td>
<td>20</td>
<td>0 ID will occupy 11 of the existing beds on Bedford ward</td>
</tr>
<tr>
<td>5B converting to ambulatory</td>
<td>18</td>
<td>10</td>
<td>8 inpatient for those who need to stay overnight</td>
</tr>
<tr>
<td>Stroke 5B will relocate to ward 6B</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Level 7A, B, C, and D if refurbished will have a reduced bed stock to meet present day requirements: dependant on capital program or charitable funds for older people, whilst works are completed move into 6A or 7F realigning 20 beds throughout the refurbishment which will take a year to complete.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Combine 7C and 7D</td>
<td>42</td>
<td>12</td>
<td>30</td>
</tr>
<tr>
<td>Combine 7A and 7B</td>
<td>44</td>
<td>14</td>
<td>30</td>
</tr>
<tr>
<td><strong>Total MRC</strong></td>
<td><strong>218</strong></td>
<td><strong>56</strong></td>
<td><strong>162</strong></td>
</tr>
<tr>
<td>F ward HGH</td>
<td>28</td>
<td>28</td>
<td>0 See above linked to Oak Ward</td>
</tr>
<tr>
<td>Orthopaedic (NOC)</td>
<td>102</td>
<td>12</td>
<td>90 Close 12 beds on C Ward but keeping 12 day beds on A Ward open 24/7 that currently close at 6pm</td>
</tr>
<tr>
<td>Neuroscience</td>
<td>75</td>
<td>0</td>
<td>75 Reduce by 12 in Green Ward and 12 in Neuro Day Surgery/TDA then relocate Vascular Ward 6A</td>
</tr>
<tr>
<td>Vascular Wards 6A and 5C</td>
<td>22</td>
<td>22(26)</td>
<td>0 Relocate to Neuroscience as above at 24 beds but absorb Business Case growth onto 5C</td>
</tr>
<tr>
<td><strong>Total NOTSS</strong></td>
<td><strong>227</strong></td>
<td><strong>62</strong></td>
<td><strong>165</strong></td>
</tr>
<tr>
<td><strong>Total Trust</strong></td>
<td></td>
<td></td>
<td><strong>118 (+4 on 5C)</strong></td>
</tr>
</tbody>
</table>

Table 10.11 – OUHFT Bed reconfiguration

The programme results in a reduction of 118 beds. The financial consequences for OUHFT of the DTOC changes are summarised in the tables below.
<table>
<thead>
<tr>
<th>Ward</th>
<th>Effective From</th>
<th>Saving 2016/17 £000s</th>
<th>Saving 2017/18 £000s</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>F ward HGH</td>
<td>01/10/16</td>
<td>644</td>
<td>1,288</td>
<td>All costs lost</td>
</tr>
<tr>
<td>JWW</td>
<td>01/10/16</td>
<td>332</td>
<td>663</td>
<td>9 beds pro rata</td>
</tr>
<tr>
<td>5B converting to ambulatory</td>
<td>18 for ambulatory day time</td>
<td>252</td>
<td>336</td>
<td>Half of overnight pay costs saved</td>
</tr>
<tr>
<td>Combine 7C and 7D into one ward</td>
<td>01/09/16 (decant); 01/04/17 (end state)</td>
<td>718</td>
<td>1,231</td>
<td>Assume 20 beds realigned in decant on 01/09/16</td>
</tr>
<tr>
<td>Combine 7A and 7B</td>
<td>01/09/18 (end state)</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>C Ward</td>
<td>1/7/16</td>
<td>147</td>
<td>195</td>
<td></td>
</tr>
<tr>
<td>6A/5C to WW</td>
<td>1/9/16</td>
<td>698</td>
<td>1,197</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>2,791</strong></td>
<td><strong>4,910</strong></td>
<td></td>
</tr>
</tbody>
</table>

Table 10.12 – DTOC financial savings to OUHFT

To support the move away from bed based care it is proposed to retain and develop the Liaison Hub by fully integrating and embedding acute, social care and therapy functions to oversee the 134 beds contracted with the Nursing Home Sector (49 OCC Intermediate Care, 31 OCG new Intermediate Care, 24 OUH new Intermediate Care, 18 OCC new Interim Care and 12 OCG new CHC), implement the Acute Ambulatory Unit, establish a trust-wide Discharge Team, and increase the SHDS staffing establishment by 50 wte. The costs associated with these developments are set out below.

<table>
<thead>
<tr>
<th>Service</th>
<th>Pay</th>
<th>Non Pay</th>
<th>Total cost</th>
<th>2016/17 Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Liaison Hub</td>
<td>1,103</td>
<td>24.9</td>
<td>1,127.9</td>
<td>1,127.9</td>
</tr>
<tr>
<td>Acute Ambulatory Unit</td>
<td>1,650</td>
<td>1,650</td>
<td>825</td>
<td></td>
</tr>
<tr>
<td>Supported Hospital Discharge</td>
<td>1,250</td>
<td>1,250</td>
<td>830</td>
<td></td>
</tr>
<tr>
<td>Trust Discharge Team Expansion</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td></td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td>4,103</td>
<td>24.9</td>
<td>4,127.9</td>
<td>2,882.9</td>
</tr>
</tbody>
</table>

Table 10.13 – Investments in OUHT (£000’s)

The impact on OUHFT’s financial position is summarised below.
OUHFT expects to generate savings of £4.9m in 2017/18 as a result of bed reductions. £4.1m will be invested in OUHFT service developments - £0.9m funded by the CCG and £3.2m funded by the trust from bed reduction savings. A small additional saving of 350k per annum will be made from maternity service changes which when added to the net position described above, will result in a net financial benefit of £1.7m to OUHFT. This saving is a key element of the trust’s CIP for 2016/17 and 2017/18.

10.7.2 Impact on Oxfordshire CCG

The CCG has committed to invest £0.9m in the Liaison Hub (see above) and £2.5m to purchase 134 intermediate care beds from the private sector.

10.7.3 Impact on the system

The DTOC programme results in savings of £1.7m per year to OUHFT, but at a cost of £2.5m in payments to the private sector. There is therefore, an overall net cost of £0.8m to the NHS.

10.8 Sensitivity analysis

As a final step in the evaluation, we conducted further analysis on the options being considered for consultation to check their sensitivity to changes in the assessment. The financial evaluation was based on a number of key assumptions that we wanted to test to understand the potential effect of variation in each. Using this approach, we can assess the likelihood that the options being considered for consultation would withstand the pressures of expected fluctuations and change.

The sensitivities modelled were:

- Capital costs being 30% higher than planned;
- Transition costs being double that assumed;
- A discount rate of 5.0% rather than 3.5%;
- Demand being 1% higher and 1% lower than forecast.

<table>
<thead>
<tr>
<th></th>
<th>2016/17</th>
<th>2017/18</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Bed reconfigurations</strong></td>
<td>2,791</td>
<td>4,910</td>
</tr>
<tr>
<td><strong>Service Investments</strong></td>
<td>(2,882.9)</td>
<td>(4,127.9)</td>
</tr>
<tr>
<td><strong>Commissioner Investment - Hub</strong></td>
<td>900</td>
<td>900</td>
</tr>
<tr>
<td><strong>Non Direct Savings</strong></td>
<td>Tbc</td>
<td>tbc</td>
</tr>
<tr>
<td><strong>Maternity Saving</strong></td>
<td>25</td>
<td>50</td>
</tr>
<tr>
<td><strong>Total saving</strong></td>
<td>833.1</td>
<td>1,732.1</td>
</tr>
</tbody>
</table>

Table 10.14 – OUHT financial summary (£000's)
Higher capital costs to add new capacity have the effect of increasing the financial cost of capital expenditure and ongoing costs to operate and replace assets.

Higher transition costs will give a higher revenue cost of the impact of reconfiguration.

A higher cost of capital will decrease the relative value of long term benefits compared with short terms costs when evaluating the net present value (NPV) of the option. This would reflect the increased cost of upfront capital and the risk of future returns.

A change in demand growth will affect the income, activity and running costs of each option, as well as the capital spend required to provide the needed physical capacity (beds, diagnostics etc).

The table below illustrates the impact of each sensitivity on key financial metrics in comparison to the baseline described above.

---

**Summary Outputs of Sensitivity Analysis on Options**

Financial position of reconfiguration options for OUH, £m

<table>
<thead>
<tr>
<th>Capital Investment</th>
<th>Transition Costs</th>
<th>Projected End Position FY20/21 (Excl Transition Costs)</th>
<th>Net present value</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Base Options:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Option 1</td>
<td>-101.2</td>
<td>0.0</td>
<td>-375.4</td>
</tr>
<tr>
<td>Option 2</td>
<td>-127.0</td>
<td>-3.6</td>
<td>-247.5</td>
</tr>
<tr>
<td><strong>Capital Costs:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20% higher than plan</td>
<td>-131.6</td>
<td>0.0</td>
<td>-346.9</td>
</tr>
<tr>
<td>100% higher than plan</td>
<td>-151.1</td>
<td>-3.6</td>
<td>-384.3</td>
</tr>
<tr>
<td><strong>Transition Costs:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>100% higher than plan</td>
<td>-101.2</td>
<td>0.0</td>
<td>-375.4</td>
</tr>
<tr>
<td>100% higher than plan</td>
<td>-127.0</td>
<td>-3.6</td>
<td>-250.8</td>
</tr>
<tr>
<td><strong>Cost of Capital:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5% discount instead of 3.5%</td>
<td>-101.2</td>
<td>0.0</td>
<td>-362.4</td>
</tr>
<tr>
<td>5% discount instead of 3.5%</td>
<td>-127.0</td>
<td>-3.6</td>
<td>-235.8</td>
</tr>
<tr>
<td><strong>Demand Growth:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1% higher than plan</td>
<td>-123.8</td>
<td>0.0</td>
<td>-417.9</td>
</tr>
<tr>
<td>1% higher than plan</td>
<td>-149.6</td>
<td>-3.7</td>
<td>-291.0</td>
</tr>
<tr>
<td><strong>Demand Growth:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1% higher than plan</td>
<td>-79.6</td>
<td>0.0</td>
<td>-266.7</td>
</tr>
<tr>
<td>1% higher than plan</td>
<td>-105.8</td>
<td>-3.6</td>
<td>-296.0</td>
</tr>
</tbody>
</table>

**Table 10.15 – Sensitivity Testing**

None of the sensitivities modelled result in option one becoming the preference, as measured by NPV and the only sensitivity which caused the gap between options to narrow was changing the discount rate to 5%.
10.9 Conclusion

The Oxfordshire system is facing a substantial financial challenge driven, in part, by rising activity. This proposal is an important element in beginning to address the challenge by providing some of the new capacity needed to meet demand and providing a foundation upon which additional service changes can be made.

Option two, the more radical reconfiguration option is the preferred option from a financial perspective. Although both options result in a small worsening of the trust’s I&E position they deliver the additional capacity needed to meet rising demand. Option two would deliver a significantly improved environment for a large number of patients and deliver a beneficial reconfiguration of clinical services. Option two is also the best from a financial perspective – it has the better NPV and results in the better I&E impact. Option one requires less capital investment, but this reflects the absence of large scale ambulatory care activity repatriation to the Horton site. Option one also has a comparably higher increase in fixed costs as it makes a less effective use of existing infrastructure when supporting planned activity growth.
Chapter 11: Implementation Plan

11.1 Background

The chapter describes the plans for implementation of the changes within the acute sector that are described in this pre consultation business case (Phase 1 of the Oxfordshire Transformation Programme). A phased approach allows for such development and where these contingencies exist, they have been highlighted.

11.2 Timing and Preparation

Implementation will only begin once a formal decision has been made by Oxfordshire CCG (see Chapter 13 which describes the processes after the formal public consultation). Exception being services currently under emergency closure (Horton obstetrics, Wantage inpatient – the latter subject to Phase Two consultation).

Formal implementation will begin once the formal consultation process has been concluded and relevant decisions have been made regarding the required governance processes. In terms of this implementation plan, this is assumed to be the summer 2017 for Phase One.

The first stage will be planning preparation to agree the following:

- The proposed workstreams for this phase.
- Clarity on who will be responsible for which pieces of work
- Key milestones for the planning phase.
- How the plans will be agreed and approved.

A critical success factor for implementation will be the clear allocation of accountability during this phase, which will be set out in a detailed Programme Implementation Plan which will provide further details of activities and sequencing to deliver changes. Details of the key aspects of the project planning stage are outlined below.

11.3 Governance Arrangements

Given the scale of transformation involved in this work, formal governance arrangements are required to steer and govern the process of service redesign and development. It is proposed that:

- An implementation programme board will be established that will meet monthly to provide direction, ensure effective co-ordination, resolve issues and manage risks and interdependencies;

- The programme board will include Executive Directors from OUHFT and leads for each of the workstreams as well as representatives from OCCG, OHFT and primary care;
- An implementation senior responsible officer will be appointed to take on overall accountability for the implementation relating to acute provision. They will be responsible for ensuring effective working relationships with the wider sector in planning and implementing changes;

- Performance metrics to track and manage progress against key milestones will be developed and used by the programme board to monitor progress.

A number of workstreams will be established (as illustrated below) to lead on both the planning and development required to support changes to service provision as well as the transactional processes of change. Governance arrangements need to have clear links with the CCG governance arrangements to ensure that implementation plans across sectors are aligned.

![Governance framework to progress (acute) implementation](image)

A robust risk management framework will continue to be implemented which will ensure that the principles of measuring, managing and reporting risk are maintained. This will provide a framework for the management of risk through rigorous governance arrangements and regular review by the Programme Board.
11.3 Service and pathway redesign: Clinical workstreams

It is envisaged that there will be a number of clinical workstreams to focus on the service changes needed. These will be agreed when the detailed implementation plan is prepared and are currently identified as:

- Urgent care with the focus in Phase One on bed realignment, ambulatory provision, critical care and stroke
- Planned care: diagnostics, outpatients and elective care
- Maternity and Obstetric services.

Each workstream will be responsible for planning the service transformation and reconfiguration programme and will report to the Horton Development Programme Board. There will also be a workstream dedicated to clarifying and developing working arrangements with primary care colleagues to ensure effective implementation across all sectors and for all patients. These workstreams will focus initially on:

- finalisation of clinical pathways;
- how service redesign would be phased, where would there be dual running and when transition and implementation would occur for aspects consulted on in Phase One;
- management structures, workforce considerations and governance including policies and protocols.

The key considerations for each of the services which constitute Phase One of implementation are described in Table 11.1 below.

<table>
<thead>
<tr>
<th>Clinical Service Area</th>
<th>Key Pathway and Service Changes by Option</th>
</tr>
</thead>
<tbody>
<tr>
<td>Critical Care</td>
<td>Do Nothing: no changes</td>
</tr>
</tbody>
</table>

Do Something:

- Agree clinical pathways within OUHFT and with colleagues in community, ambulance, primary care.
- Move critical care capacity/beds from HGH to JR.
- Implement processes to ensure the safe and smooth transfer of patients to Headington.
- Creation of an HDU at HGH (to enable joint management, ideally located within the Acute Care Hub of the HGH in close proximity to ED, EAU and the Short Stay ward and key diagnostics)
- Review staffing and model of care for Level 2 provision.
- Implement retrieval team to ensure safe and well
managed transfer of Level 3 patients.

<table>
<thead>
<tr>
<th>Service Area</th>
<th>Do Nothing: no changes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stroke care (not including rehabilitation beds)</td>
<td>Do Something:</td>
</tr>
<tr>
<td></td>
<td>- Continued development of early supported discharge stroke service.</td>
</tr>
<tr>
<td></td>
<td>- Creation of a single Hyper-acute stroke unit at JR hospitals to be made to incorporate additional capacity.</td>
</tr>
<tr>
<td></td>
<td>- Pathways developed for the direct transfer of patients to Headington.</td>
</tr>
<tr>
<td>Bed realignment and development of an ambulatory model of care</td>
<td>Do Nothing: no changes</td>
</tr>
<tr>
<td></td>
<td>Do Something:</td>
</tr>
<tr>
<td></td>
<td>- Move of bed capacity from HGH to JR</td>
</tr>
<tr>
<td></td>
<td>- Continue to establish ambulatory assessment unit at the Horton.</td>
</tr>
<tr>
<td></td>
<td>- Creation of clinical coordination centre.</td>
</tr>
<tr>
<td></td>
<td>- Other developments/provision to support ambulatory care including:</td>
</tr>
<tr>
<td></td>
<td>- Acute Hospital at Home and ‘Early Transfer to Home’ service.</td>
</tr>
<tr>
<td></td>
<td>- Rehabilitation at Home service.</td>
</tr>
<tr>
<td></td>
<td>- County-wide generic Rehabilitation at home and Enablement Service.</td>
</tr>
<tr>
<td></td>
<td>- County-wide Stroke Early Supported Discharge Service.</td>
</tr>
<tr>
<td>Maternity services</td>
<td>Do Nothing: Continue with current position, including fully staffed services.</td>
</tr>
<tr>
<td></td>
<td>Do Something:</td>
</tr>
<tr>
<td></td>
<td>- Changes to pathways based on current MLU provision.</td>
</tr>
<tr>
<td></td>
<td>- Corresponding increase to provision at JR.</td>
</tr>
<tr>
<td></td>
<td>- Increase in maternity clinics (antenatal, postnatal and breastfeeding) at HGH.</td>
</tr>
<tr>
<td></td>
<td>- All obstetric deliveries at Headington</td>
</tr>
<tr>
<td>Planned Care (including elective care, diagnostics and outpatients)</td>
<td>Do Nothing: Current (limited) provision of diagnostic and outpatients.</td>
</tr>
</tbody>
</table>
Do Something:

- Finalise demand and capacity model for relocating significant numbers of:
  - Surgical procedures
  - Medical interventions
  - Diagnostics
  - Outpatients
  - Pre-operative assessment unit

- Confirmation of functional content e.g.: equipment etc.
- See estates summary below for details of process of developing new build.
- Reconfiguration of existing theatre infrastructure.
- Identify what diagnostics could be put in place in advance of new building?
- Procurement of additional equipment.

Table 11.1: Key considerations for service change by option (Phase One)

11.3.1 Timings of Phase One implementation

The chart on the next page provides key milestones for Phase One of the acute services changes proposed in options 2 and 3. Each phase of changes includes the following (as provided in further detail below in Figure 11.2):

- process of design of changes and pathways (D). Some of this work has, by necessity needed to be completed as part of the development of options, analysis and understanding of the context. It does not, however pre-suppose the outcome of the consultation and if any changes made require reversal, this will be undertaken.
- implementation planning phase prior to change (IP)
- implementation phase (IMPL) and
- handover to business as usual (H BAU).
Critical care will require changes to configuration and provision in Headington to accommodate additional patients (under options 2 and 3). The change above incorporates HGH changes for provision of level 2 patients at HGH.

Diagram 11.2: Acute sector implementation for Phase 1

The implementation of each phase will include:[75:

<table>
<thead>
<tr>
<th>Design</th>
<th>Implementation Planning</th>
<th>Implementation</th>
<th>Handover and review</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Pathways, policies and protocols</td>
<td>• Pathways, policies and protocols</td>
<td>• Implementation of continuity plans</td>
<td>• Evaluation and lessons to inform next phases</td>
</tr>
<tr>
<td>• Commissioning, contracting and finance</td>
<td>• Implementation of continuity plans</td>
<td>• Go live</td>
<td>• Handover to Business as Usual</td>
</tr>
<tr>
<td>• HR and Workforce</td>
<td>• Monitoring and evaluation of impact and standards</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Communications</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Estates and IT</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Assurance and outcomes measures/KPIs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Support Services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Transport</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Notes: Critical care will require changes to configuration and provision in Headington to accommodate additional patients (under options 2 and 3). The change above incorporates HGH changes for provision of level 2 patients at HGH.

Diagram amended from Healthier Together Pre Consultation Business Case A review of health and care in Greater Manchester p185
11.4 Four non-clinical workstreams

These are currently identified to support the clinical workstreams and, as shown in diagram 1, are:

- Workforce
- Capital planning and estates
- IM&T
- Communication and stakeholder engagement

11.4.1 Workforce

As outlined in the ‘Case for Change’ in Chapter 4, and the in analysis of workforce in Chapter 9, reshaping service provision to meet future needs will not only pose some workforce challenges, but also provide some opportunities to pioneer certain models of new ways of working for its clinical workforce.

In the first instance, however, further workforce analysis will be conducted to underpin the proposed new models of care. In its development, consideration will be given to the following:

- Further analysis of the required staffing capacity to be identified in terms of skills, training, seniority, etc.
- Scoping the requirement of staff to move to different sites and greater number of roles requiring transfer or rotation between acute and community settings.
- Consideration of the scope for the development of new roles in delivering new services and changes in the overall mix of skills / grades required across different settings of care.
- Identification of the requirement for training / recruitment to develop these new skills.
- Identification of further and more detailed plans to mitigate anticipated recruitment/retention risks.
- Improved integrated working across organisational boundaries, including closer working between health and social care.

11.4.2 Capital Planning and Estates

The proposed changes have varying implications for the Horton General Hospital estate. Section 9.6 of Chapter 9 outlines the key considerations for estates for services that fall within the scope of Phase 1. High level estimates of capital expenditure requirements for configuration options have been developed. However, the extent of rebuilding and use of current premises requires further analysis and consideration that will include:

- Further work of the current condition of relevant parts of the Horton General Hospital estate (state of the existing premises and development of options.
• Specifying what is required for each service line to deliver new models of care which will be planned in detail prior to the implementation phase so that lead-in times for changes to configurations are understood, and the full scope of activities are built into the implementation plan.

• For each of the service areas, confirmation of the following is required:
  • demand and capacity modelling and functional content
  • development of site options
  • relevant planning permission sought and received
  • implementation of short term measures (e.g. purchase of near patient testing equipment)
  • design, planning, defining and awarding contracts
  • oversight of delivery
  • commissioning the new/ refurbished buildings
  • implementation.

The planning for this workstream will include planning for the management of transition (when facilities may be temporarily re-used) as well as investment/disinvestment of existing premises to reach the desired end state.

Facilities Management planning will be considered as part of changes in service configuration will have implications for the facilities needed in the hospitals including cleaning, catering, ICT etc.

11.4.3 IM&T

This workstream will focus on the informatics infrastructure and resources needed in the health and social care community to improve current systems and support the new models of care.

11.4.4 Communications and stakeholder engagement

The detailed Implementation Plan will need to explain the approach to how staff changes during implementation will be managed as the impact on staffing numbers and structures is potentially one of the most complex areas for transition.

Preparatory activities will include collecting complete data about existing staff in the areas likely to be affected, including their current terms and conditions, lengths of service. Periods of staff consultation will be built into the planning as required. Policies for staff transition will need to be developed and communicated effectively.

Stakeholder engagement will continue to play an important role during implementation. This includes with:

• Patients and public: ensuring that patients are well informed about changes that are proposed, have a say in how they are to be delivered and, ultimately are well informed about which services will be delivered from which locations in the future.
• Other providers: linking with others who will be planning and implementing service change, where the desire is to create seamless pathways of care for patients

• Staff: clinical leadership will continue to play a key role in planning and implementation of service change (including ensuring patient safety is maintained in transitions). Actively engage with staff to build awareness of the reconfiguration proposals and promote their central role in making these changes happen

• Local Authority: work together with partners in social care in the delivery of ambulatory provision and care outside of hospital.

Communications and media handling activities will be critical during implementation to maintain staff engagement throughout the change process.
Part Six:

NEXT STEPS
Chapter 12: Consultation Plans

12.1 Introduction

The Transformation Programme is committed to engaging with all relevant stakeholders. Specific proposals will also be submitted for formal public consultation. This chapter outlines the CCG’s consultation plan. It sets out the approach to be taken by Oxfordshire Clinical Commissioning Group (OCCG) in consulting with the public and stakeholders about changes to health services proposed in the Oxfordshire Transformation Plan.

A detailed action plan and identification of stakeholders and key audiences underpins this plan. This is available in Appendix 12.1.

12.2 Purpose of the formal Consultation

NHS organisations have a duty to involve patients and the public in:

- Planning the provision of services.
- The development and consideration of proposals for changes in the way those services are provided.
- Decisions to be made by the NHS organisation affecting the operation of services.

Involving patients and the public early on in options development will also help to demonstrate point four of the Secretary of State’s four key tests for service reconfiguration set out in the revised Operating Framework for 2010/11: strengthened public and patient engagement.

Notwithstanding statutory obligations, involving and engaging will help to:

- Create understanding of the need for change and the case for developing new models of care to transform health and social care services in Oxfordshire.
- Better inform the development of new models of care.
- Enable the Transformation Programme to work in partnership with the public to ensure the successful implementation of any service change projects.

76 The Programme’s approach to public and patient engagement is summarised in section 7.2 while the engagement of clinicians and commissioners is explained in sections 7.4.8-7.4.11 and 7.5 respectively. The Transformation Programme is also in regular contact with key Boards and organisations such as the HOSC and Health and Well Being Board (see section 8.4).

77 It should be noted that this action plan is a live document and further details including dates and specific stakeholder meeting opportunities will be added in the lead up to, and during, the consultation.
Alongside this, the following aims will apply to the consultation itself:

- Ensure the process, scope and scale of the consultation is of a sufficient level to demonstrate all Clinical Commissioning Group (CCG), NHS England (NHSE), legal and statutory assurance tests have been met.
- Achieve and provide evidence of deep engagement using a range of methods to do this with communities and diverse groups across Oxfordshire and providing a comprehensive log of engagement.
- Meet equality assessments and ensure materials are accessible on request. Ensure that the final decision is developed through genuine engagement and involvement.

12.3 Phasing of Consultation

The public consultation on a set of proposals for changes to health services in Oxfordshire is planned to start at the beginning of January 2017. The consultation will be in two parts.

The first, which we anticipate will start on the 16th January, 2017 will look at options for the future delivery of the hospital services covered in this business case.

The second, which is hoped will take place after later in 2017, will focus on the provision of emergency departments in Oxfordshire and the proposed options for the reconfiguration of other services provided from our community hospital sites including MLU’s and the development of more local models of urgent care integrated with primary care in the county. This means care will be provided on an outpatient or day basis including diagnosis, observation, consultation, treatment / intervention and rehabilitation services and support; unless treatment in hospital is the best place for a patient at the time. The premise being that ‘the best bed is your own bed’.

Further work and engagement with Oxfordshire GP Practices to develop options has been undertaken over the past few months and it has become clear that proposals for community based care will benefit from continued development with a wide range of stakeholders prior to launching a public consultation on any service change. Over the coming months more engagement with local groups across the county will be undertaken as well as further options development work with public and patients.

The population affected by these proposals are largely in Oxfordshire but for services based at the Horton General Hospital, this plan recognises the need to engage with the communities living in south Northamptonshire and south Warwickshire.
12.4 Consultation Principles

Our consultation will meet the following principles, which are based on previous consultations across Oxfordshire and on NHS England guidelines. They are:

1. We are committed to engaging as widely and deeply as possible, and will encourage those who have attended our events to continue to be engaged in our work. We will listen to them and take account of their views.

2. Our leaders will always talk to communities at an early stage to explain our proposals for change as deeply, openly and frankly as they can. They will accommodate local views and contributions, where they will contribute to a better service.

3. We will carry out a full assessment of the likely impact of any changes on communities from a health inequalities point of view, using evidence-based analysis and anecdotal feedback. Any gaps in engagement identified through this process will be filled by means of targeted engagement, such as through focus groups or similar.

4. Engagement events will be held in a variety of areas chosen for their contrasting geography and demography, as well as supplemented by other work to ensure the full geographic and demographic diversity of Oxfordshire (and any neighbouring areas it impacts on) is covered by representative events.

5. We will be open and transparent and will continue to hold meetings in public venues wherever practicable and with an open invitation to the public to attend (recognising that on occasion some management of numbers may be necessary for health and safety reasons).

6. We will make documents public and respond promptly and openly to requests for information. We will make our public-facing documents and presentations accessible, in different formats as required and present them in clear, simple language with proposed changes clearly explained, including what opportunity people have to influence those changes.

7. Our consultation will ask clear questions and provide an opportunity for involvement in the design of new services, so that patient views and experience can be considered alongside clinical input.

8. The programme will make a careful note of specific, individual concerns raised and either follow up with individuals or groups directly, or report back on action taken to resolve them at future events and in future reporting, before key decisions are made.
12.5 Stakeholders

OCCG has many stakeholders; in order to ensure consultation activities are tailored around individual stakeholder needs, we will analyse the various audiences. We will do this by identifying groups and/or individuals for each stakeholder as appropriate, undertaking analysis of the stakeholder's needs so we can understand who we need to communicate with and how.

12.5.1 Below shows the categories for our stakeholders:

- Public (e.g. patients, carers, community and minority groups)
- Internal stakeholders (Oxfordshire CCG member practices and staff)
- Commissioners (e.g. Oxfordshire County Council, NHS England)
- Local Providers (e.g. Oxford Health Foundation Trust, Oxford University Hospitals Foundation Trust, GP federations, pharmacists, independent and voluntary providers such as Age UK and MIND).
- Public Sector Partners (e.g. Oxfordshire County Council, district councils)
- Voluntary & Community Organisations (e.g. Oxfordshire Community and Voluntary Action, Oxfordshire Rural Community Council)
- Professional (e.g. Local Medical Committee, Local Pharmaceutical Committee)
- Political Partners (e.g. MPs, Councillors from parish, district and county councils)
- Scrutiny (e.g. Healthwatch, Oxfordshire Joint Health Overview and Scrutiny Committee)
- Overview (e.g. Health and Wellbeing Board)
- Media as a conduit to the public (e.g. Oxford Mail, BBC, Banbury Guardian)

12.6 Governance and Transparency

12.6.1 In line with our principle to be ‘open and transparent’, we will:

- Offer the same level of information to people attending our events and/or who ask to be given updates.
- Put as much information as we can on the website showing the clinical and demographic evidence behind the need for change and for the planned proposals.
- Put meeting papers and other key decision documents on the website.
• Provide regular updates to everyone in the local health and social care system about progress and next steps in the programme.

• Enable our clinicians and other key programme decision-makers to have a wide-ranging discussion in suitable forums which enable challenge and debate.

12.6.2 The consultation and communications for the programme will be run by the communications team in the CCG with support from advisers, and will:

• Fit within the overall governance arrangements of the programme, providing regular updates to the appropriate meetings of the programme, the CCG and its partner organisations.

• Meet regularly with communications colleagues from across Oxfordshire and cross-border health and social care systems, including the relevant local authorities and provider organisations (including hospitals) and update them on progress.

• Work with Healthwatch and the Locality Forums and wider community representatives to ensure that the patient’s voice is heard in discussions and decisions.

• Be accountable to the Transformation Programme Board and provide regular updates to it, as well as to NHS England and other key stakeholders such as government ministers and MPs.

• Be staffed by the programme team, including support and attendance at consultation events but draw on advice, support and some resource from local Trust teams.

• Draw on and manage outsourced resources e.g. for focus groups, design, print and distribution.

• Ensure that consultation responses are thoroughly considered and are included as a formal part of the decision-making process.

12.7 Materials

12.7.1 The materials to be developed to support the consultation are:

• Core consultation document (see draft in Appendix 12.2)
• Easy Read summary of the consultation document
• Frequently asked questions (FAQs) and answers
• Poster advertising the consultation
• Website
• Survey for use online and hard copy.
12.7.2 The core product will be the Consultation Document which will be developed to encourage maximum participation in the process, as follows:

- A core narrative, associated messages, with FAQs, will be developed with input from clinicians, Healthwatch, Patient representatives and other advisers as appropriate and used to generate key content for the consultation, including the main document.

- The document, and all other materials, will be written as clearly, simply and in as compelling a way as possible, avoiding jargon and ensuring stakeholder readability.

- All core materials will be tested for accessibility with lay members of the Transformation Board (chief executive of Healthwatch and the nominated representative Chair of Locality Forums) and there will be a summary version available.

- Copies of the full document will be distributed to community settings and stakeholder groups across Oxfordshire and cross-border areas as appropriate.

- There will be hard copies of the main document and/or summary posted out to areas defined as relevant to the programme, in recognition that not everyone wanting to respond will be able to do so online.

- There will be special versions – such as audio, translated, large print or braille versions – made available on request.

- Graphics and video material may be used to make the concepts and information more accessible to audiences.

- The branding from the ‘Big Health and Care Conversation’ will be developed for the consultation to demonstrate the connection and will be used to clearly identify the consultation materials.

12.8 Means of Communication

A number of different communication methods will be used to target all relevant stakeholders as well as patients and voluntary organisations as required. This can include but is not limited to:

12.8.1 Website:

The consultation document and associated materials will be published on a dedicated section of the CCG website.
This will be branded and will host:

- General information about the programme including context, background, maps and charts
- Meeting papers including actions and minutes of key meetings.
- Clinical evidence and data used to inform proposals.
- Previous relevant documents and data relating to the programme.
- The consultation document and easy-read summary document.
- The consultation questionnaire available to print out and via link to Talking Health.
- Web links will be provided to partner organisations to publicise the consultation on their websites.

12.8.2 News Media:

- News media will be kept informed with press releases and interviews provided as appropriate.
- Media enquiries will be handles as swiftly and accurately as possible, with inaccuracies challenged and rebutted, based on a set of agreed and updates FAQs.
- Local newspaper adverts may be considered as a way of providing information about events.

12.8.3 Social Media:

- Facebook and Twitter will be used to reinforce and bolster other channels as appropriate and monitored for relevant feedback.

12.8.4 Other:

- Regular information will be shared with members of Talking Health and Locality Forums (for onward distribution to PPGs).
- Partner and key stakeholder newsletters will publish information about the consultation.
- Information will be sent directly to members of:
  - Oxford Health Foundation Trust, Oxford University Hospitals NHS Foundation Trust and Healthwatch
  - Voluntary and Community Sector Organisations
  - Relevant advocacy groups

12.9 Key Messages

Oxfordshire CCG has already agreed and set out its corporate vision and objectives and its core values in Oxfordshire Clinical Commissioning Groups’
Strategy for 2014/15 -2018/9. These have been developed into key messages which underpin all of its communications and engagement activities.

12.9.1 The high level key messages for OCCG are as follows:

- Oxfordshire Clinical Commissioning Group plans and buys health services on behalf of everyone living in Oxfordshire. To do this successfully we need to work with local people, Oxfordshire GPs, hospital clinicians and other partners (including local government and the voluntary sector).

- We are committed to:
  - putting patients’ needs first
  - working with the people of Oxfordshire to develop quality health services fit for the future
  - working with GPs, hospital clinicians and other partners to tackle health inequalities
  - giving you a chance to have your say on the health priorities which matter to you.

- We believe you can make a difference to the way in which our health services are delivered.

12.9.2 The above messages are supplemented by the following for the Transformation Programme:

- Although most patients currently receive good care in Oxfordshire, achieving the best standards of care for everyone is becoming increasingly difficult.

- Pressure on services is increasing, particularly where demand is more highly concentrated among older people – our plans for health services are being driven by clinicians who see patients every day and see how services could be improved.

- Fundamentally it’s about improving quality and reducing inequality of health and care services – there is currently too much variation in the care that is provided across Oxfordshire.

- We need to help prevent people getting avoidable diseases by supporting healthier lifestyles – the people in Oxfordshire need to be a partner in this or we will not succeed.

- We want to work with local people to shape the future of health and social care and develop local solutions in response to local needs.
• The challenges we face will inevitably mean difficult choices will need to be made – we encourage people to share their views and comment on the options during the consultation.

• No decisions have been made and will not be taken until the public consultations have been completed and final proposals are put to Oxfordshire Clinical Commissioning Group’s Board.

12.10 Response Handling

The CCG will handle all queries and responses swiftly, efficiently and in a coordinated way so that people know their views are being heard and are being handled appropriately.

• We will establish systems to ensure questions and responses are logged.

• We will publicise the freepost address and generic email address for responses.

• As well as all formal responses to the consultation, we will bring together any questions that are directed through the Freedom of Information route in the CCG.

• We will maintain the stakeholder database ensuring it is updated regularly and can be relied upon to be accurate.

• We will not be overly proscriptive about when responses are made and will make clear to anyone enquiring of us or wanting to respond, where reasonable, we will always seek to accommodate wherever practicable responses or questions outside formal channels set up by us.

12.11 Feedback

We will commission independent support to thoroughly and comprehensively analyse all responses to the consultation, explain our analysis, and explain how we have taken into account all views given to us as part of the on-going future development of the programme.

• We will commission an independent analysis of the responses and writing of the report of the consultation.

• We will publish our consultation report which will include the analysis.

• We will make clear how the consultation feedback has been used to inform our decision making.

• We will regularly report back to those who have expressed an interest in the consultation to keep them informed about activity and progress.
12.12 Equalities and Impact

The consultation will take account of equality legislation around protected characteristics. The protected characteristics set out in the Equality Act 2010 are age; disability; gender reassignment; marriage and civil partnership; pregnancy and maternity; race; religion and belief; sex; sexual orientation.

We will therefore:

- Undertake an Integrated Impact Assessment, with the objective of ensuring the potential impact of any plans on protected groups has been assessed.

- Use the Integrated Impact Assessment to identify any groups such as those who do not have English as their first language who have not been fully engaged with and commission focus groups to proactively ensure any such groups do in fact provide feedback to the programme, even if this is not in the form of formal consultation responses.

- Employ similar methods to ensure the voices of other groups that may be seldom heard are included.

Similarly the programme will identify those impacted by the proposed changes and ensure they are supported to have their voice heard.

12.13 Staff Engagement

It will be important to reach out to health and care staff across Oxfordshire so they are aware of, and can get involved in, the consultation. A commitment has been made by NHS provider organisation to undertake engagement with their staff, however the programme will provide briefing materials on the consultation and information to local trust and other partner organisation communications teams so they can then lead the staff engagement process from within their individual organisations. This could (if appropriate for the organisation) include template materials and content which trusts can easily use to encourage participation by, for example, placing on websites, sending out via email and using at staff events.

We will also ensure hard copy materials are available at relevant staff sites and digitally on appropriate websites and intranets.

12.14 Spokespeople

The programme and consultation will depend for its effectiveness on dedicated, articulate, well briefed spokespeople/presenters who will:

- Be predominantly clinicians, drawn from across the health economy, with an emphasis on primary care;

- Be supported where possible by lay personnel;
• Be drawn from across Oxfordshire, with the proviso that if the emphasis is on consultation in one part of the county, where possible they will be drawn predominantly from that locality;
• Lead on responding to key stakeholders, both individually and in groups;
• Lead on media interviews and related media activities;
• Be supported by the communications team in terms of materials, briefings, media advice and presentation training where needed, to ensure their explanations and presentations are clear, easy to follow, and understood.

12.15 Engagement and events during the consultation

A number of events will be held to ensure that
• There has been pre-consultation on the proposals, in addition to earlier consultation and engagement, so that any plans then consulted on have been informed by engagement with the public, patients, and key stakeholder groups.
• The consultation itself can be shaped by early feedback, for example on format and language.
• During consultation, as many responses as possible are encouraged from the communities and populations potentially most affected by the plans.
• The wider context of any specific local proposals is considered.

These events will comprise:
• Large, system-wide events in key locations before, during and after consultation.
• Smaller mobile events – or ‘drop-ins’ – in each locality affected most directly by the local proposals relevant to them.

12.16 Consultation Events

A full programme of events and activity will be published at the start of the consultation along with the consultation document and questionnaire. Table 12.1 on over page gives a summary of the methods of consultation to be used.
<table>
<thead>
<tr>
<th>Consultation Method</th>
<th>Implementation assumptions</th>
</tr>
</thead>
</table>
| **General publicity** – advertising in local media, posters and postcards, support on social media, as well as via NHS organisations and established stakeholder channels such as Healthwatch and local voluntary group networks | • Information about consultation and public events available in GP and hospital waiting rooms and receptions, libraries, town hall and other civic and community centres.  
• Publicity in local papers to promote specific local events.  
• Website, questionnaire and freepost address advertised widely to drive responses. |
| **Public meetings** – an effective way of engaging with wide range of interested parties in the local health economy as well as patients and the general public. Also clear demonstration of public accountability. | • Any invitation received to attend a public meeting (whether campaign group or community group) to be considered and, wherever possible, accepted. Scope and reach of the anticipated audience will be a factor in our ability to accept all invitations as would clashing events. |
| **Drop in sessions** – to provide an opportunity for detailed conversations with the public, local commissioners and the acute trusts about their specific priorities and interests. | • Drop-in events held in areas most affected by proposals.  
• Include static and interactive elements including the ability to fill in the consultation questionnaire.  
• Events will take place at a variety of times, during the day, evening and weekends. |
| **Focus groups** will be held to target identified seldom heard groups in conjunction with the Equalities Impact Assessment work. | • Focus groups during consultation, with numbers and frequency to be confirmed, in part depending on the Equality Impact Assessment. |
| **Online** – Information about the Transformation Programme, the pre-consultation engagement and the business case together with the consultation document and questionnaire will be available online. | • Advertised directly to members of Talking Health.  
• Included in all publicity to encourage participation even if not attending a meeting or event. |
12.17 Risks and Mitigations

The main communications risks have been identified as follows:

<table>
<thead>
<tr>
<th>Communications risk</th>
<th>Mitigation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical engagement, leading to incorrect information about the impact of changes at the Horton</td>
<td>Local clinicians have been involved and informed of challenges and options for change.</td>
</tr>
<tr>
<td></td>
<td>Oxford University Hospitals Foundation Trust staff engagement at the Horton General Hospital.</td>
</tr>
<tr>
<td></td>
<td>The case for permanent relocation will be described in terms of patient and clinician benefits.</td>
</tr>
<tr>
<td></td>
<td>Clinical leaders to provide support.</td>
</tr>
<tr>
<td>Inadequate information causes undue concern among patients/public/stakeholders</td>
<td>Patient representatives involvement in developing supporting materials to ensure they are clear, consistent and comprehensive.</td>
</tr>
<tr>
<td></td>
<td>Ensure the issues most likely to excite local opinion – money and transport are adequately covered within the case for change and the communications material.</td>
</tr>
</tbody>
</table>
Chapter 13: Processes after the Public Consultation

13.1 Overall Timeline

This business case will be considered by NHS England in December 2016 and, subject to approval, the Transformation Programme is planning to adopt the following timescale for the consultation and post-consultation decision-making.

13.2 Post-consultation Actions and Decisions

13.2.1 Analysis of Consultation Responses

The responses to the consultation will be analysed and consolidated into a formal report. This feedback from the consultation will also be used to inform the final stage of the Integrated Impact Assessment (IIA) – the validation of the pre-consultation findings. The IIA will then be updated to provide final conclusions and recommendations, advice on monitoring / evaluation, and any next steps.

13.2.2 Review of the Consultation Feedback and Revision of Proposals

The report on the consultation feedback will be submitted to the CCG Board along with the post-consultation IIA. The Board will consider the contents of the two reports and the implications of these on the proposed changes.

The Board will determine how amendments are made. For example, it may be necessary to reconvene clinical working groups to review or amend the clinical model or more work may be needed to consider transport or other mitigations. Any changes to the clinical model or updating of the business case will be considered by the CCG Board.
13.2.3 These two post-consultation reports will also be shared with key stakeholder groups including:

- Oxfordshire Transformation Board
- Oxfordshire Health Overview and Scrutiny Committee
- The Health and Well-Being Board
- OUHFT Board

A summary of the key themes emerging in the consultation will be shared via newsletters and press releases with the relevant stakeholder groups, including staff who are likely to be affected.

13.3 Formal Decision Making

Oxfordshire CCG Board who will consider the Phase One business case and make any formal decision.

As a commissioner-led programme, OUHFT will not be required to make a formal decision. However, it is anticipated that any recommendation will be submitted to the OUHFT Board to note and endorse prior to CCG decision.

13.4 Timeline

A detailed timeline for this process is included in the figure below.

Figure 13.1 – Detailed Timeline for Phase One
Conclusion

Together the information in this business case should give a clear picture of the problems that Oxfordshire is facing in relation to critical care, stroke care, maternity services, and planned care along with the Transformation Programme’s proposed solution.

It demonstrates that the proposals are based on a strong clinical evidence base and that the CCG has a plan for how the changes can be successfully implemented within existing resources.
Appendices

PART ONE – VISION, SCOPE, CONTEXT AND GOVERNANCE

1. Scope

   No appendices

2. Strategic Context

   Appendix 2.1: Oxfordshire 2016 JSNA Executive Summary
   Appendix 2.2: The Buckinghamshire, Oxfordshire, Berkshire (BOB) Plan on a Page
   Appendix 2.3: Oxfordshire CCG Priorities Table
   Appendix 2.4: Oxfordshire CCG 2017-19 Commissioning Intentions

3. Governance and Programme Management

   Appendix 3.1: Supporting Evidence of Decision-Making

PART TWO – THE CASE FOR CHANGE

4. Current Service Provision, Best Practice and the Case for Change

   Appendix 4.1: The Oxfordshire ‘Storyboard’
   Appendix 4.2: Case for Change Supporting Evidence Slides
   Appendix 4.3: Temporary Changes to Maternity Services at the Horton General Hospital

PART THREE - THE CLINICAL MODEL

5. The Development of the Proposals

   Appendix 5.1: The Strategic Review of the Horton General Hospital

6. The Detailed Clinical Models

   No appendices

PART FOUR – MEETING THE NHS ‘FOUR TESTS’ AND THE BEST PRACTICE TESTS

7. Meeting the Four Tests

Appendix 7.2: The ‘Big Health and Care Conversation’ Engagement Report (August 2016)

Appendix 7.3: The ‘Big Health and Care Conversation’ Phase 2 Engagement Report (November 2016)

Appendix 7.4: Current and Potential Challenges Identified by Engagement Work

Appendix 7.5: Summary of the Communications and Engagement Activities undertaken to support the Strategic Review of the Horton General Hospital

Appendix 7.6: Clinical evidence and links to best practice for the maternity proposals

Appendix 7.7: Initial Terms of Reference for the clinical working groups

Appendix 7.8: Names of the managerial and clinical leads for the workstreams

Appendix 7.9: Initial Workplan for the Clinical Review

Appendix 7.10: Example Slide Set Used at Locality Meetings

Appendix 7.11: Letter of Support from Medical Director OUHFT

Appendix 7.12: Letter of Support from Medical Director Oxford Health FT

Appendix 7.13: OUHFT Communication and Engagement log

Appendix 7.14: Advisory Report from the Thames Valley Clinical Senate

Appendix 7.15: Involvement of the CCG Governing Body in the development of the specific proposals with the scope of this business case

8. The ‘Best Practice’ Checks

Appendix 8.1: Baseline Travel Analysis

Appendix 8.2: Travel Analysis Supporting Evidence Slides

Appendix 8.3: Equality Impact Assessments undertaken by the Transformation Programme workstreams

Appendix 8.4: Minutes of Meetings with the Health Overview and Scrutiny Committee and the Health and Wellbeing Board in relation to the Transformation Programme.

PART FIVE – THE PRACTICALITIES

9. Workforce and Estates

No appendices
10. Activity and Finances
   No appendices

11. Implementation Plans
   No appendices

PART SIX – NEXT STEPS

12. Consultation Plans
   Appendix 12.1: The Detailed Consultation Action Plan
   Appendix 12.2: The Draft Consultation Plan

13. Processes after Public Consultation
   No appendices