



Response to the Oxfordshire Clinical Commissioning Group's 'Big Consultation' on Phase 1 of the Oxfordshire Transformation Programme

From Oxfordshire Keep Our NHS Public

Introduction

This split consultation, itself only one third of the BOB STP, is flawed from the outset.

The current consultation (Phase 1) is based on a 'Pre-consultation Business Case' which we discuss below and find unconvincing. We expose its assumptions, lack of clarity, lack of sound evidence, and absence of financial detail. Although it is entirely based on an interdependency of Health and Social Care, it does not include any evidence or future planning for Social Care, in the contents of either Phase 1 or Phase 2.

The glossy 'Big Health and Care Consultation' and the Business Case fail to pass the test of public accessibility through the use of plain language and simple evidence-based argument.. Terms such as 'ambulatory care', 'emergency multidisciplinary unit, or 'acute hospital at home' are not adequately explained in the consultation in our view, and nor is the difference between urgent and emergency treatment. These choices are hard in the consultation, but would be even more difficult for a family to grapple with in the heat of an emergency situation.

There is a telling phrase at 12.2 p. 217 in the Business Case: the consultation is to 'create understanding of the need for change and the case for developing new models of care'.

In other words - nothing more than a charm offensive.

The basis of our response: Examination of the Pre-consultation Business Case

We think that this Phase I document can only be properly understood and debated in the context of the 'whole system' STP footprint plan. We observe that it is one sixth of the plan for the full BOB footprint. We also note that though it is headed 'Health and Care', it does not contain the Care element, despite the proposals' high dependency on the success of the Care element.

The Consultation Document is based on a 235-page 'Pre-Consultation Business Case' agreed by NHS England prior to the launch of the consultation itself on January 16th 2017¹. We have therefore responded to that document which underlies the widely available document the public

1 See the arguments behind the CCG Phase1 proposals at www.oxonhealthcaretransformation.nhs.uk

have been sent, the 'Big Health and Care Consultation: Phase 1'.² All page numbers in this text refer to the Business Case document unless otherwise stated.

We note that the business case had to satisfy four tests before NHS England would accept it, and that the final draft and addenda had been to and from NHSE more than once. The four tests are:

Test One: Strong public and patient engagement

Test Two: Consistency with current and prospective need for patient choice

Test Three: A clear clinical evidence base; and

Test Four: Support for proposals from clinical commissioners.

We are not convinced that the OTP passes any of these.

We also note that the appendices are not in the online document. We have responded to this as the most complete description of the OTP available to us.

A phased approach falls at the first hurdle

Your chart on pp. 30-2 of the Business Case shows that a phased approach is not feasible. It shows the interdependency of every part of the patient's care and treatment, including self-care and social care, primary care and hospital care.

We agree that the patient needs to be at the centre of a whole picture including self care, decent housing and nutrition, social and primary care in the community, and appropriate access to the right level of specialist intervention.

Therefore, to agree to proposals of one element of this picture without knowing the rest of the picture is ludicrous – like agreeing to the roof of a building without knowing anything about the walls (or indeed if there were to be any money for walls)

Weaknesses in the argument for the need to change

The detailed discussion about the need to change the services at the Horton (stroke, maternity, diagnostics, elective work) is predicated on:

- a) *Travel time evidence.* The source of most of the adduced evidence is the Oxford university Hospitals Trust and the Clinical Commissioning group (CCG) (pp. 92-3, 134-7). We would have expected evidence that had been tested to destruction before the public could trust it. The ambulance service, the volunteer drivers who take villagers to hospital, or the Automobile Association might have been better places to begin if the purpose was to convince the public of the accuracy of the 40-minute 'blue light' travel time. (p. 93)
- b) *The desirability of separating elective from trauma work.* This is taken as a given in the proposals for rebranding the Horton as a diagnostic and elective care centre. There is no discussion by clinicians about the effectiveness or desirability of this separation for best practice. Yet specialists in the early days of Independent Sector Treatment Centre work argued coherently for the importance of i) giving surgeons a mix of every day and emergency work for better patient outcomes and ii) keeping them together so any quick escalation of treatment which might emerge could be done in the same setting – elective surgery which turns into an emergency, for instance. (pp. 76-90)
- c) *Declining need for services in the Horton.* Yet much of the evidence for stroke, heart, and maternity change comes from the fact that the OUHT has already been diverting patients by ambulance to Oxford over the past months, as is noted in the document. (pp. 57-8)
- d) *The lack of any negative impact on the John Radcliffe and Churchill hospital facilities.* In fact, the document suggests dropping the number of available beds by 194 through the

closure of the Horton and other facilities. With bed occupancy climbing again, when the existing measures for 'safety' suggest hospital bed occupancy should be no more than 85%³, we would assert that all the evidence points to growing waiting times, deaths, and disasters in trauma care if these proposals are implemented.

Lack of adequate clinical evidence

- Over the different sections, the interdependency of services is identified as a key issue; it is said that hospital beds cannot be closed without adequate care in the community. Simon Stevens himself has called for three tests to be met - "Demonstrate sufficient alternative provision, such as increased GP or community services, is being put in place alongside or ahead of bed closures, and that the new workforce will be there to deliver", and/or "Show that specific new treatments or therapies, such as new anti-coagulation drugs used to treat strokes, will reduce specific categories of admissions" and/or "Where a hospital has been using beds less efficiently than the national average, that it has a credible plan to improve performance without affecting patient care (for example in line with the Getting it Right First Time programme before accepting any more bed closures)⁴; Yet there are 800 vacancies in domiciliary care with no concrete plans as to how these will be filled. (p.157) Since Phase 1 appeared, several more care agencies in Oxfordshire have folded – to the point where even councilors are beginning to call for bringing the service back in house.⁵
- The chart at fig. 9.2 on p.158 should be full of information on community posts but much of the community post information is 'not available' (N/A).
- There is an arguably highly speculative chart of levers to encourage displaced staff to change their jobs at fig. 9.4 p.160 and, although staff housing is identified as a problem (pp. 53-4), no concrete solution is offered.
- Some of the evidence is extremely thin. In fig. 10.4 p.176, where did the need for less than 800 beds come from? In the whole OUH?
- Figure 1.1, p.10 shows Social Care is a key component but Social Care is not included in the documents.
- The growing contribution expected from carers in this 'pared to the bone' service is not mentioned.

Problems of geography

Where does the calculation come from which claims that it is safe to have 30,000-50,000 population per GP practice? It cannot possibly have included problems of a scattered rural population. Looking at the map of Oxfordshire, and hearing stories of rural isolation, would lead one to conclude that primary care facilities in the county are already inadequate..

Over reliance on self help

There are many assumptions about the population improving its own health with timely support from community staff. Nothing about the increased numbers of staff necessary to make this work, and the costs and supervision needed.

Staff recruitment and retention key problems

There are suggestions for new levels of staff in primary care – physicians assistants, nurse practitioners. However, the evidence is that these can increase costs and reduce timely accessibility – also that there are additional costs attached to recruitment, training, housing, and developing new systems. In fact, a report published on 1st of March 2017 by the Nuffield Trust,

³Dr Foster, the healthcare intelligence firm formerly part-owned by the government, has said that when occupancy rates rise above 85% "it can start to affect the quality of care provided to patients and the orderly running of the hospital". A 1999 paper published in the BMJ argued that any occupancy rate over 85% risked bed shortages and periodic bed crises. (*Guardian*, 27 March 2015)

⁴ HSJ NHS England chief reveals new restrictions on bed closures

March 3 2017

⁵ tbc Oxfordshire County Council meeting March 21 2017

(Shifting the Balance of Care) points to the mixed evidence for overall cost reduction where the following services are used :Intermediate care: rapid response services • Intermediate care: bed-based services • Hospital at Home - and yet all of these are in the CCGs overall plan to cut costs) (p14 of the report)⁶

A 2016 study published by the BMJ and mentioned by HSJ shows that diluting the nursing skill mix increases the risk of patient death. The study found that for every 25 patients, substituting one registered nurse with a non-nurse increased the possibility of the patient dying by 21 per cent on an average ward. The research was published in the BMJ Quality and Safety Journal.⁷

The impact of imminent changes to the historical doctor-patient relationship which is at the heart of the NHS

The impact on all parts of the NHS system, including those in Phase 1 of the consultation, of the imminent and inevitable changes to primary care, brought on by the extraordinary blindness of the government to the need for workforce planning and training in this area which is likely to lead to total loss of the historical doctor-patient relationship, the corner stone of the whole NHS: it looks set to lead to 'GP Federations' (no evidence for this working), as well as ensuring that the only front door left to the unsuspecting public will be through 'physicians assistants' and the revamped '111' service.

Other issues

The proposals seem unimaginative. No thought seems to have been given to sharing estate with schools, or bold housing solutions.

The suggestion that volunteers and pharmacists could play a crucial part in implementing the proposals (fig.1.4, p.12) would only work if the CCG could provide funds for support. Support has recently been withdrawn from a number of pharmacists, so evidence suggests that many will struggle to survive in the next few years.

In view of the cuts to public transport and the withdrawal of subsidies to bus services, and the as yet unknown distribution of car ownership (unknown but strongly suspected to be patchy, disproportionately hitting the poor, the elderly, and the isolated) the access to specialist care under these proposal seem unlikely to be adequate

Where is the evidence that the proposed technologies will work (no evaluation given p.14)? Yet they are presented as a crucial part of the success of the proposals.

Funding is inadequate for these proposals

It is acknowledged that some of the problems identified with the current system are about inadequate equipment and unsuitable buildings. Much of the argument about proposals for the Horton is based on this. Yet the documents are reticent about how the necessary changes would be funded.

One concrete figure produced on pp.162-5 concerns changes to the Horton Hospital. The figure of £14.5million is produced with no indication of where this money will come from. On p.196 the CCG says it will put £3.5 million aside: hardly enough to cover the costs of these changes.

On February 21st this year, the House of Commons Committee of Public Accounts published their damning report on 'the financial sustainability of the NHS' which has thrown even more doubt on the possibility of any of the 44 footprints developing a viable transformation plan at this time . The report shows that capital budgets earmarked for long-term capital funding have already been

⁶ nuffieldtrust.org.uk 'Shifting the balance of care: Great expectations.'

⁷ HSJ 16 Nov 2016 The research mentioned was first published in the BMJ Quality and Safety Journal.

raided, severely compromising any major capital changes such as that envisaged for the Horton.

The report goes on to develop the point that all the changes are predicated on well-funded social care and it challenges the government as follows: 'The Department and NHS England should assess the impact that financial pressure in social care is having on the NHS, so that it can better understand the nature of the problem and how it can be managed. It should publish the findings of its analysis by July 2017.'

We offer the same challenge to the Oxfordshire CCG. The CCG should assess the impact of financial pressures on Social Care in Oxfordshire. Meanwhile, the Phase 1 consultation should be halted until such time as an assessment has been carried out and published and the holes in the programme referred to above have been filled in.

Phase 1 of the Oxfordshire Transformation Programme fails on all four counts demanded by NHS England and will deliver only cuts and confusion for the people of Oxfordshire. We deserve better.

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