

KTHG Formal Response to the OCCG “Big Consultation” on Oxfordshire Transformation Plan (OTP)

8 April 2017

General Comments

It is difficult to have confidence in a consultation process which, for Banbury residents opened with a public meeting at St Mary’s Church on 26th January 2017 during which David Smith, CEO of OCCG said, in effect that the OTP being presented was the best that could be done within the constraints of the budget, challenging the public to come up with something better within the budget or complain to the government for more funds. The consultation round, for Banbury, finished on 16th March, at the same venue, with the same Mr Smith informing the audience that the day of the District General Hospital had passed and they should get over it. What confidence can the North Oxon public have that the consultation can have any influence on the outcome with such declarations from the CEO of the consulting body? But more fundamental is the fact that the OTP has been produced in secret over some months, clearly against a template imposed upon OCCG and apparently directed by Management Consultants. KTHG recognises that OCCG has laboured under impossible constraints and has produced the plan which gives best value for money but does not provide the affected population with adequate health provision as is required under law. The OCCG has statutory duties under the Health & Social Care Act 2012 (HSCA), the first of which under clause 14P of the Act is a “Duty to promote NHS Constitution”, Article 4 of which states:

4. The patient will be at the heart of everything the NHS does

*It should support individuals to promote and manage their own health. NHS services must reflect, and should be coordinated around and tailored to, the needs and preferences of patients, their families and their carers. As part of this, the NHS will ensure that in line with the Armed Forces Covenant, those in the armed forces, reservists, their families and veterans **are not disadvantaged in accessing health services in the area they reside** [KTHG emphasis] .*

Patients, with their families and carers, where appropriate, will be involved in and consulted on all decisions about their care and treatment. The NHS will actively encourage feedback from the public, patients and staff, welcome it and use it to improve its services.

OCCG has fallen short in its duty to ensure the best health provision for the North Oxfordshire population “in the area [we] reside”.

Our objections to the OTP are both in process and conclusions.

1.0 Process

1.1. Two Stage Process

We believe that splitting the consultation into two phases was a serious mistake. In a District General Hospital, services are interdependent in a way which may not pertain to the same extent in a tertiary centre. They must be considered as a whole, for instance separating Obstetrics and Paediatrics is inexplicable. It has resulted in a lack of coherent vision for the future of health and care services in Oxfordshire. Rolling so many specific issues into the consultation has meant that it lacks clarity. The impact of the proposals on primary care will be significant but this is not discussed in this first phase of proposals and is a significant flaw.

1.2 Inappropriateness of Information

OCCG claims that its paper to HOSC (17 November 2016) and other documents provided for public consideration was sufficient information on which to make an assessment of the proposals. One of the documents that the public was supposed to read and understand was the Pre-consultation Business Case – an extensive management-speak document, accessible on the obscure Oxfordshire Transformation Programme website. The document is long, confusing and incomprehensible without access to the copious appendices which were made available only after the meeting at St Mary's church on the 16th March, a matter of days before the closing date for comments on the OTP.

1.3 Failure to involve affected groups in development of plans

Under the HSCA, the OCCG has a duty to involve (*note "involve"*) patients in the examination and preparation of alternative arrangements for their health provision thus:

Public involvement

14Z2 Public involvement and consultation by Clinical Commissioning Groups

... (2) *The Clinical Commissioning Group must make arrangements to secure that individuals to whom the services are being or may be provided are involved (whether by being consulted or provided with information or in other ways)—*

(a) in the planning of the commissioning arrangements by the group,

(b) in the development and consideration of proposals by the group for changes in the commissioning arrangements where the implementation of the proposals would have an impact on the manner in which the services are delivered to the individuals or the range of health services available to them, and

(c) in decisions of the group affecting the operation of the commissioning arrangements where the implementation of the decisions would (if made) have such an impact.

1.4 Lack of options

No options for alternative delivery options are presented in the consultation. It could be supposed that this implies a 'fait accompli' as no alternative future arrangements are presented for consideration.

1.5 Inadequate Time Horizon

For such a profound reconfiguration of health provision, not only in Oxfordshire, but the length and breadth of the country, a time purview of only five years is inadequate. Both Cherwell DC and Oxfordshire CC have prepared development plans over the period to 2031. Health provision plans for the affected population should be congruent with this time horizon. In that period, major capital investments across all the OHHFT estates will be required. A five-year period is inappropriate for these purposes and any development in the next five years must be consistent with a longer period if irreversible, inappropriate capital investments are to be committed in the first five years.

2. Objections to OCCG Conclusions

2.1 Stroke

There is no dispute that all cases should be seen initially in Oxford but it is important that those from the Banbury area are repatriated quickly, either for home or hospital care and undoubtedly some will need the latter. In this context, it is disturbing to learn that the previous stroke rehabilitation team at the Horton has been disbanded.

However, one must question whether, in a more reasonable planning horizon to 2031, rather than the immediate five-year period chosen, techniques and technology for clot capturing might not have developed to become a procedure appropriate for application in a District General Hospital such as the Horton. All things being equal, for strokes surely the shorter the period between diagnosis and treatment the better. There is no circumstance in which an ambulance journey of (an optimistic) 45 minutes can enhance outcome.

2.2 Maternity

The proposed closure of a Consultant Led Maternity Unit is premature; there are several units with fewer deliveries per annum than the Horton which provide a satisfactory training for young doctors with rotations to larger units. No evidence has been produced to demonstrate the CCG's will to implement this idea. The loss of Consultant Led Maternity Units will impact (due to the loss of anaesthetic training) on other departments at the Horton making the Horton unsafe for the provision of A & E and medical emergencies.

Furthermore, it ignores the recommendations made less than 10 years ago, by the Independent Reconfiguration Panel after a very detailed investigation. Organisations, both professional and lay, concerned with childbirth stress the importance of women having the choice of place of birth. As published by the National Maternity Review, birth at a stand-alone MLU is the least popular option, being favoured by only 6% of women. The dramatic drop in births at the Horton since the temporary downgrading bear this out and of course those who might have considered and been judged

suitable for home birth will think again if there is no easily accessible medical help available. Already, OHUFT estimate that almost four in ten births commenced at the Horton are transferred as emergencies to the JR or other hospitals. It seems likely that a stand-alone MLU in Banbury would wither on the vine and close as have a number of others where such a downgrade has taken place. This would further damage the rights of women in the Banbury area.

We are told that staffing is the only barrier to continuing a full service although the history of the determined attempt to downgrade in 2006 gives reason to doubt this. One of the other IRP recommendations was that there should be better integration across the hospital sites. There is no reason why this should not apply to the senior staff and even with the middle grade trainees there is now confirmation from the GMC that they CAN spend a small part of their time at a smaller unit which does not have accreditation. The Trust has never acknowledged this and always insisted it is forbidden. It must now be taken into account and the various staffing options given serious appraisal

2.3 A&E – Trauma& Orthopaedics

There is no mention of Trauma and Orthopaedics provision at the Horton. Whilst it is accepted that major trauma should go to a tertiary centre it is vital that general trauma, fractures of the common types, dislocations etc. continue to be dealt with locally and this requires, as does A & E, trauma surgeons and anaesthetists 24/7. Currently the Horton T & O surgeons do their trauma work at the Horton and their elective orthopaedics at the Ramsay Centre. KTHG have been unable to get any clear picture of what will happen at the Ramsay when the building returns to the NHS but unless Horton surgeons are going to be able to do their major elective work, hip and knee replacements etc. in Banbury it is unlikely that they would wish to stay doing trauma only.

2.4 Travel times

In 2008, the Independent Reconfiguration Panel was convinced that the travel time between the Horton catchment area and the Oxford hospitals was too long to permit a safe, equitable service. In 2017, the distance is no less and the travel no easier, particularly for those North of Banbury, and for those who must rely on public transport. Victoria Prentis, MP for North Oxfordshire, has recently issued a press release detailing the results of her long-running survey into travel times between the Banbury area and the JR. Victoria received 377 individual completed surveys. The data shows it takes, on average, 1 hour and 20 minutes to travel from the Banbury area to an Oxford hospital, and a further 20 minutes to park. The average patient travelling from the Banbury area will therefore enter a hospital in Oxford approximately 1 hour and 40 minutes after leaving their point of departure.

In sharp contrast, the Oxfordshire Clinical Commissioning Group (OCCG) maintains that the average journey time from Banbury to Oxford is just 45 minutes. This is perhaps possible on a good day outside rush-hours but is atypical, not average.

2.5 GP Support

Despite claims to the contrary, GPs in the Banbury area do not support the plans. In the summer of 2016, local GPs from Bloxham and Hook Norton Surgeries, Chipping Norton Surgery, Cropredy Surgery, Deddington Surgery, Fenny Compton & Shenington Surgeries, Hightown Surgery, Horsefair and Middleton Cheney Surgeries, Shipston Medical Centre, Sibford Surgery, West Bar Surgery, Windrush Surgery, Woodlands Surgery and Wychwood Surgery joined together in writing a letter of strong opposition to the OUHFT's proposals. In their letter they state that they are "opposed to the proposals on the grounds of safety, sustainability and the reduction in access to basic health care and choice for our patients, which will affect especially the most vulnerable."

2.6 Local Authority Opposition

Councillors from across the whole political spectrum are united in their opposition. This is demonstrated in the partnership of Keep the Horton General with Cherwell District Council, South Northamptonshire, Stratford-on-Avon District and Banbury Town Councils in mounting a legal challenge against the proposals. Furthermore, in February 2017, the influential Health Overview & Scrutiny Committee voted to refer the temporary closure of Consultant Led Maternity at the Horton to the Secretary of State for Health, Jeremy Hunt.

2.7 Recruitment

The trust claims to have worked hard to recruit within the UK and internationally for the obstetric vacancies at Banbury. However, job adverts were found to have been placed in a small number of inappropriate journals and websites, at a lower level of remuneration than would normally be expected. No evidence has been presented publicly that the Trust has actively attempted to recruit from the Indian subcontinent despite the fact that the majority of foreign doctors working in the UK hail from India. More than one recruitment agency has indicated that it could source such specialists "from the Indian Subcontinent" trained to UK standards.

2.8 Doubt on extent of SCAS involvement in OTP development

The South Central Ambulance Service (SCAS) has confirmed that there has been no written confirmation with OTP planners – no assurance that it can manage the huge increase in activity that Horton downgrading would entail. At the CPN meeting of 21st March, Richard McDonald of SCAS admitted that no detailed costings had been done to corroborate the viability and cost effectiveness of the OTP proposals.

2.9 The Robustness of the Financial Analysis

KTHG has grave doubts regarding the cost analysis of the OTP; having received the copious appendices with little time for detailed examination, it is difficult to calculate if the economic benefits claimed for the new arrangements proposed under the OTP are robust. However a cursory examination of the financial data provided seems to indicate a serious underestimation of both the capital and current costs of any "at-home /community" have been grossly underestimated or ignored. This has led KTHG to be concerned that these services will be provided under private contract as is proposed in the arrangement in Manchester.

The National Audit Office, in a recent report stated:

“Integrating the health and social care sectors is a significant challenge in normal times, let alone times when both sectors are under such severe pressure. So far, benefits have fallen far short of plans, despite much effort. It will be important to learn from the over-optimism of such plans when implementing the much larger NHS sustainability and transformation plans. The Departments do not yet have the evidence to show that they can deliver their commitment to integrated services by 2020, at the same time as meeting existing pressures on the health and social care systems.” [Amyas Morse, head of the National Audit Office, 8 February 2017]

3.0 **KTHG Recommendations**

- 3.1 Suspend immediately the implementation of phase one of the consultation.
- 3.2 Engage with the affected population (The whole of Oxfordshire and parts of contiguous counties) in the development of alternative models of health provision to 2031, with corresponding budgets.
- 3.3 Immediately implement a viable and sustainable staff rota for the whole of the OUHFT including teaching consultants.
- 3.4 Enter into meaningful discussions with the professional colleges and the accrediting bodies to define a modern, sustainable education scheme across all OUHFT sites.
- 3.5 Develop a rational protocol for hospital catchment areas to optimise the capital and human resources of all OUHFT establishments.
- 3.6 Commit to working with all stakeholders to develop, agree and implement a plan that ensures the retention of all the services of a District General Hospital at the Horton General Hospital.

For and on behalf of the Keep the Horton General Group

Keith Strangwood – Chairman

8th April 2017