

Banbury Guardian
Colin Sanders Innovation Centre,
Mewburn Road
Banbury OX16 9PA

David Smith
Oxfordshire Clinical Commissioning Group
Jubilee House, John Smith Drive
Oxford Business Park South, Oxford OX4 2LH

RESPONSE TO OXFORDSHIRE TRANSFORMATION PLAN PHASE ONE

Dear Mr Smith,

The Banbury Guardian has championed the Horton General Hospital since its establishment in 1872 and its expansion from then on. It will continue to do so in a bid to ensure patients in the growing Horton catchment, expected to rise to 283,000 by 2032, are able to access the core acute general services in a hospital local to home. We believe centralisation of these general specialities is not helpful to patients even though it may be easier for NHS planning. We believe an NHS, paid for by the public must give its patients reasonable access to care for routine, general specialist care. In spite of frequently-described issues for certain specialities, these six core functions must be maintained in order to allow the full support structure to continue.

The Oxfordshire Transformation Plan appears to offer greatly expanded day and clinic services in Banbury. This is welcome and should be provided in addition to maintenance of the core acute services. The two will be mutually and beneficially supportive on a financial and clinical basis.

The documents accompanying this email – with the contents of this covering letter – form the Banbury Guardian's considered opinion on the proposals of the OTP which we believe to be deeply flawed in many respects. We would like these points responding to the plan to be considered and taken into account in a meaningful way in the eventual decision over the future of health and hospital services in Oxfordshire.

Best wishes

Richard Howarth

Content Editor, Banbury Guardian

Banbury Guardian response to Part One of the consultation of the Oxfordshire Transformation Plan

In response to Phase One of your consultation on the proposed Oxfordshire Transformation Plan (OTP), the Banbury Guardian would like you to take the following points as our response in rejecting the proposals:

- 1 Splitting the consultation has rendered it invalid. Intelligent response to Phase One proposals is impossible without information to make a judgment, while Phase Two will depend on the successful rubber-stamping of all proposals in Phase One. The most glaring example of this is the consideration of Midwife-Only and Consultant-Led Units in separate consultations.

Another major case is GP provision and Primary Care which is the intended support framework to take the place of inpatient beds that have already been closed, and indeed the whole downgrading of the Horton. The proposal is to confirm these bed closures before the un-evidenced, un-proven new system is in place. OCCG January minutes suggest provision of this care may not prove possible. **This is unacceptable. The level of danger to patients and responsibility on health professionals is unreasonable.**

The OTP makes repeated references to staff being difficult, or impossible to recruit, e.g. that 800 domiciliary staff posts are vacant, without any ideas on how these might be filled.

There is nothing to confirm that 30,000-50,000-patient 'GP federation' surgeries mentioned could be safely run and managed.

The OTP plan is full of unreasoned statement. The 'ambulatory' model proposed for the Horton is consulted on in Phase One, with the all-important practical details in Phase Two. The proposed Hyper-Acute Stroke Unit model will also not be fleshed out with vital facts until Phase Two.

Statistics to justify losing Level 3 CCU (ventilation) are skewed in favour of the JR while the Horton medical service needs Level 3 support not only for very sick local patients but to enable A&E (Phase Two consultation) to continue, fully enabled. Almost all the proposals for service losses and downgrades in Phase One will have huge repercussions for Primary Care and Social Care services – again to be considered in Phase Two.

The increasingly cash-strapped Oxfordshire County Council – responsible for Social Care – has rejected the proposals' format because it cannot plan without information to judge what is possible in terms of ever-diminishing infrastructure, staffing and finance; possibly available in Phase Two. In addition, hospital staff, essential to moving hospital care to the community, have largely rejected entreaties to transfer to that visiting workforce.

- 2 The paper opposes absolutely the changes in Maternity and SCBU. Not only will permanent removal of these eventually render other 24-hour services such as Paediatrics, Anaesthetics and A&E unviable but they will also create potentially dangerous conditions for mothers giving birth in Banbury or travelling to Oxford, Warwick or Northampton.

As the Independent Reconfiguration Panel (IRP) stated in its 2008 recommendation for retention of Horton acute services, Oxford is too distant for expectant mothers to travel for obstetric delivery. The proposed midwife-only service (MLU) in Banbury for 200 – 500 births is an horrendous prospect since we know 40% of babies born during the 'temporary' Horton MLU have had to be transferred during delivery or because of post-delivery complications. This, as the IRP stated, is not a better service for the catchment of the Horton.

We reject the argument that Banbury's obstetric unit is unsustainable because of the loss of training accreditation. There is nothing in the plan to persuade us the JR can accommodate the extra deliveries. JR staffing has been supplemented by the Horton's obstetricians but

recruitment in Oxford is notoriously difficult because of its high cost of living and OCCG January minutes show there are unacceptable gaps. ***Professionals do however want to move to Banbury – providing it is without a downgrade hanging over the Horton – as the 50 applications for middle grade doctor posts indicate.***

It appears recruitment efforts for the Horton were undertaken many months after the gaps in rotas were anticipated and only when a direct threat to the future of the obstetric unit had been made public. This understandably triggered concerns a deliberate attempt was made to create a situation in which the unit would have to be closed for 'safety reasons'. It is a reasonable contention that recruitment of middle grades would have been successful if the Horton had been assured a future as a consultant-led unit.

A JR unit delivering up to 8,500 births, predicted in the plan, is of great concern. Reports of the current pressures at the JR birth unit describe intense pressures that cannot be sustained. For real improvement, the quota could and should be split to allow the Horton's training accreditation to be restored to allow full, safe, easily-filled obstetric staffing for Banburyshire's community - whose increase by a fifth in the coming decade will add crucial numbers to the quota rules.

- 3 The loss of 46 medical and trauma beds is alarming. Cutting beds does not reduce disease or trauma. Oxfordshire is desperately short of beds. Closing beds will not prevent health crises. It is the lack of Social Care funding at local authority level that has caused Delayed Transfers of Care (bed-blocking), not a failure of hospitals. The district hospital must not be disabled before the alternative has been fully established and proven.
- 4 Consultation and engagement: Before this plan was published, engagement was inadequate. The OCCG appears to have based this wholesale change from hospital to untested, potentially un-staffable community care on the Post It notes of 360 already-aware members of the public from a county of nearly 700,000 individuals. There was apparently a survey of 900 members of the trust itself, of whom only 200 replied. This cannot be said to be representative.
The majority of Horton staff appear dismayed at the attack on this successful, popular District General Hospital. If they had been truly consulted, there should be some direct evidence of it in the plan. Instead it appears Oxford medics have succumbed to fashionable centralization and the political pressure of the cost-cutting Sustainability and Transformation project.

Public consultation has been utterly inadequate. The style of public meeting has been rightly seen as skewed towards achieving the intended outcome. Those meetings and the response sheet have appeared one-sided to effect centralisation, limiting numbers of attendees to minimal representation and using meeting time with slanted videos. There is real concern vital information has been manipulated to diminish the work and accomplishment of the Horton in favour of the large numbers treated at the JR.

Some 27,000 Horton catchment residents in south Warwickshire have had little or no opportunity at all to find out and be consulted adequately on the plan. This was accepted at the March 24 meeting of Stratford on Avon District Council.

The Transformation website is difficult to navigate; anyone wanting information must navigate dislocated links, many hundreds of pages of unintelligible text and many appendices that are not published. Instead the visitor is immediately faced with a full page link to the response form, which appears to make it almost impossible to make a determined challenge to the plans, especially to those who are inexperienced in these 'public consultation' processes. We contend GP surgeries were not furnished with plan copies as promised. There has been no recognition anywhere of the majority of GPs' unequivocal opposition to

downgrading the Horton. Claims by the representative on the North Oxfordshire Locality Group do not represent the majority of GPs; no votes were taken. We believe the language used in the consultation paper/pre-consultation business case/appendices has been reviewed by NHS England to ensure it psychologically appeals to readers, leaving the reality of the changes unspoken.

5. There is no evidence of adequate, essential prior consultation between the CCG and the ambulance services of how this plan can work in practical terms. Swapping a fully operational district general hospital for a day centre with acute cases and emergencies transferred to Oxford cannot work without sufficient blue-light ambulance cover that clearly has not been shown as possible.

On Friday, April 7, the Nuffield Trust released a report saying: **“The number of times hospital A&E units in England have had to close their doors to ambulances has almost doubled this winter compared with the previous three, new research from the Nuffield Trust health think-tank reveals today.”** The authors say that the extra time paramedics are having to spend on the road as a result is a factor in the service’s inability to meet its targets for urgent requests for an ambulance.

The authors of the report, ‘Winter Insight 3: The Ambulance Service’, say the efficient performance and smooth running of the ambulance service are vital to the operation of every part of the health service, from care homes to general practice to hospital care.

The research finds that pressures facing the ambulance service are growing at an even faster rate than those facing hospitals. We believe this is more evidence that the OTP is simply not viable. The CCG would be wrong to enact or approve this plan to reduce Banbury’s acute services in these circumstances.

6. The CCG was, by NHS England’s rules, obliged to include patients and the public in the *planning* of any future reorganisation. This has not been done; the OTP has been produced in secrecy and this is not acceptable. Had inclusion of the public and patients been effected, this plan would not have been produced.

We ask the CCG to consider carefully all these points – enlarged upon with our supporting documents – and reject these proposals which will inevitably lead to a diminution in the quality and quantity of all NHS care in Oxfordshire and result in serious problems the CCG will be unable to deal with.

Banbury Guardian appendix 1 - Consultation/Engagement

The PR exercise by The Oxfordshire Clinical Commissioning Group (OCCG) has seen it seek to persuade the public and stakeholders of a downgrading exercise that the paper believes will never be accepted in Banbury.

The 84-page summary document was advertised in the Banbury Guardian to be available as from January 16th. By post it needed two days at least to reach anyone: leaving 8 days to digest it before the first planned meeting on January 26th.

The Big Consultation document insisted that if people wanted to know more than the summary, they must refer to the website. This directed people straight to a response page which guided the reader through questions that seemed likely to result in their acquiescence of downgrading. The actual 'Big Consultation' paper was on page 3 of the website, and within that a plethora of links to supporting information. This was not clear, easy reading. The Pre Consultation Business Case (PCBC) was 238 pages long, providing none of numerous important appendices (withheld until three weeks before the end of the consultation) including the 144-page Horton Strategic Report (alone released on February 23). Banbury was expected to discover and respond to all that and more in 8 days leading up to the first public meeting.

The meetings themselves gave people no sense of the reality of life after downgrading of the Horton; only a picture of how much better results would be for them. Probing questions were met with rehearsed avoidance and use of jargon that was difficult to argue with because most did not understand it.

Consultation meetings for all of the north Oxfordshire population (those most affected by the 'Phase 1') were originally planned as 'cabaret' style and limited on a first-come, first-served basis of 100 maximum. The 'cabaret' style was designed to move small groups of people around tables staffed by selected promoters of the changes, including clinicians. Angry public opinion forced a change to a more traditional audience-style public meeting which featured CCG-picked staff and dominated by videos, filmed at the John Radcliffe with no crowds, no lines of waiting patients; in quiet, peaceful offices or wards, belying the overstretched, crowded nature of that hospital.

Many residents in villages received no information whatsoever about the plan or the consultation. Indeed in rural public meetings held by the Banbury Guardian the overwhelming number of attendees knew nothing about it – even up to a fortnight before the end of consultation. The CCG has paid scant attention even to High Court (Mr Justice Mann) rulings as to adequacy of process in public consultation.

One member of the public wrote to the local media: "This is not proper consultation process. It rides roughshod over anything remotely definable as decent or even proper process. Many DOH requirements/advice are simply being ignored. CCG/Oxford University Hospitals Trust (OUHT) are plainly indifferent to any concept of formal standards. There is an unseemly rush to impose their model, regardless."

OCCG's consultation is being done in two phases, yet asking for views on phase 1 depends on what is proposed in Phase 2. It includes desired outcomes already put in place yet DOH consultation guidance forbids such 'done deals'.

The public believes the CCG and OUH are determined to get their way and impose the changes, believing consultation is 'a sham and a shambles'. At the public meeting the Trust said clearly the motivation was money but this has not been honestly discussed in the OTP.

The OTP suggests a considerable number of clinicians has been consulted but does not say what proportion is Horton staff, many of whom are dismayed at the way services have been removed. Many feel very pessimistic. It would appear those working at the Horton have been very happy here; some have chosen to move here from Oxford. However the plan paints a picture of the Horton being almost unstaffable because clinicians do not approve its limitations or want to live here.

Since rumour of the downgrading plans for the Horton have leaked out, some staff (midwives/ A&E staff and more) have understandably felt the need to seek employment elsewhere giving the hospital trust even more fuel for its plan to remove services. A secure future for the acute hospital would reverse staff shortages.

Overall, the Banbury Guardian believes the information has been skewed throughout to suggest a solution that does not benefit Banburyshire but achieves the goals of the OTP/STP.

The plan says issues 'most likely to excite local opinion' among Banburyshire public are money and transport (in their case for change and communications material). We contend the public is not concerned with finance (many would be willing to pay a local tax to retain Horton acute services) – therefore it appears fears for life and specialist help close to home have been left out of the consultation points for this crucial planning.

Claims 'patients and the public have been involved in shaping proposals to develop and improve local Healthcare and been given the opportunity to have their say in Our Big Health and Care Conversation' are contentious at best. We suggest there have been no 'conversations' in which local people have been warned about such major changes to their local NHS. From current interest, if they had known, there would have been a very different outcome to the 'proposal shaping'.

OCCG claims feedback from 'a wide range of people' during the Big Conversation in summer 2016. A tiny proportion of the general public was involved. Few had any idea what OCCG was tasked to do and how it might impact on the Horton/local services. They were being asked opinion without any context which is unacceptable.

Results show the 'distilled views' (collected via Post-It notes stuck on to general posters) of some 360 people, the vast majority of whom were already involved in Oxfordshire NHS matters, with only a miniscule number of members of the public, at a few events which advertised 'wanting to hear what you want from your future health services' rather than being open about the cuts in mind.

Survey results of the 900 Oxford University Hospitals Trust (OUHT) staff resulted, even in that 'interested' cohort in responses of 200, less than a quarter. Many do not live in the catchment and have every reason to dismiss the effects on the area with which they have no connection or loyalty. These cannot be deemed to constitute public consultation, neither can general reports to the Community Partnership Network (CPN) which was also not given clear information about the drastic consequences for the area.

Claims in the plan that 'You told us/you said/people who responded said' are not backed up by numbers. It is disingenuous to suggest the evidence on which aspects of this plan have been created

were demanded by the public. A few dozen people is not 'the public'. We suggest the public responses reported on by this newspaper and shown in photographs and through our letters pages reflect the broad public opinion, namely widespread opposition to the plans.

Staff engagement – Staff our reporter has spoken to are dismayed at what has faced them and are too frightened to speak out because of relentless relocation to the JR of staff who have objected. The current collective grievance brought against the OUHT for bullying in the run-up to removal of obstetrics is a good indication of this. The exodus of maternity staff in March endorses it.

A&E staff have also begged campaigners not to identify them for fear of threats – this team has been decimated by clinicians leaving in despair. All are 'gagged' by contracts and fear of practical consequences of speaking out. This newspaper would need to see consultation returns for Horton staff to believe claims of decent staff engagement.

CPN 'engagement' has also been poor – members have shown their opposition to the plan and the stealthy way services have been removed, by voting against the split consultation. Indeed the newspaper believes Horton consultants have voiced their total disapproval at how this has been done.

Claims about meetings with MPs, councillors and other stakeholders are not clear – MPs and councillors are all for improving care and ending bed blocking, but unanimously against downgrading the Horton, so any suggestion they have been positively engaged is potentially misleading.

More local services – Yet again, the plan disallows adequate or proper consultation by putting the future of community hospitals (which the 'engagement' suggest people are concerned about) – in phase 2. This simply is not a proper consultation when you disallow discussion continuity of planning for interlinking services. We suggest that renders this consultation invalid as does the entire split consultation.

Horton General Hospital – In the same way, discussion of A&E is delayed and consideration of this will be in Phase 2. It is impossible to have had proper engagement when talking about safety and ignoring the future of interdependent Horton services.

"Patient feedback about the Horton General Hospital included an emphasis on the need to keep services local and the problems associated with transport for those needing to travel to Oxford" Patients mean what they say, we believe they do not understand the possibility that to have some services local means removing acute services from the Horton, and their fears about transport are relevant, as the OUH has proved by providing a dedicated ambulance for maternity on removal of the consultant-led service.

Consultation in S Northants and S Warwickshire - areas covered by this newspaper - has been dire, considering these patients form one third of the Horton catchment. These patients stand to have to make equally unacceptable journeys to their county town hospitals, destroying the traditional Banbury-facing community this area has enjoyed for many generations – passing the 'savings' over to the public as travel and health access expenses. This is a regrettable outcome of the break-up of the NHS into footprints.

S Northants patients have been given no real confidence that the cross border issues that will inevitably affect them have been adequately dealt with. In S Warwickshire a leaflet has been delivered to 'an unspecified area' and direction to the website but no public consultation meetings.

27,000 Horton catchment patients there have been effectively left without adequate information or a voice.

Banbury Guardian appendix 2 - General points on Horton downgrade:

A&E – The Horton's A&E department is dealing with just under half the numbers seen by the major A&E unit at the JR. Recent figures show in December 2016 the Horton saw 3175 patients and the JR 7,638. The Horton A&E saw 2,810 patients vs the JR's 4,848 in the three weeks between Jan 9 – Jan 21, 2017.

The OUH has told the local press there is no mechanism for counting how many patients were transferred to Oxford from the Horton and counted again, or not counted at the Horton, in spite of presenting here first - therefore we cannot say whether the Horton took more cases than stated.

Loss of acute services at the Horton would have to include A&E if the downgrade of clinical care level 3 - the ability to ventilate seriously ill patients (Phase 1 consultation) - goes ahead. We believe downgrade of full A&E is proposed in phase 2 possibly to a more GP centred urgent care unit.

OUH is meeting only 86% of the 95% target (for seeing patients within four hours) against a national 90% in four hours. How will this A&E target be manageable if more Horton A&E cases go to Oxford? It is clear the JR does not have the capacity – or for other acute services lost to Banbury. Claims that up to half patients would go to Northampton or Warwick are un-evidenced. Also the trust/CCG have not been clear about what charges will be made to hospitals for care across the 'footprint' boundary (whether S Northants and S Warks patients will be charged 'tariffs' by Oxfordshire and vice versa). This information is necessary but excluded.

Ambulance Service – The South Central Ambulance Service (SCAS) has confirmed there has been no documented discussion between it and the CCG – no assurance that it can manage the huge increase in activity that Horton downgrading would entail. Last August a SCAS paramedic told the Banbury Guardian downgrading the Horton would cause 'danger, delays and risk to life'; that SCAS was 250 paramedics short and only four ambulances cover all of Oxfordshire at night instead of the necessary 12. SCAS is desperately trying to recruit in an empty market. There is apparently no way SCAS can deal with downgrading the Horton.

OCCG plans a large midwife-only unit at the Horton delivering 200 – 500 babies a year. During the 'temporary' removal of obstetrics 40% of mothers/babies were transferred to the JR in labour or with complications after delivery in a dedicated ambulance, at a cost of c£1m a year. It is suggested the OUHT will not fund a dedicated ambulance in Banbury post-downgrade, which we contend would be placing mothers at unacceptable risk.

SCAS and OCCG say it would not be 'appropriate' for SCAS to make calculations on 'mere proposals'. However public consultation must contain assurances of patient safety. We believe transfer of complicated births will become more risky than ever without assurances. These plans should have risk assessments but cannot without detailed service delivery assurances from SCAS.

Loss of beds/care at home - The OTP depends on closing beds to reduce admissions and preventing 'bed blocking'. Patients will be treated in a 'hospital at home' or in nursing homes **for which there is insufficient and diminishing funding**. Extreme assumptions are made about savings from exchanging acute unit care for visiting health professionals in the community. This has several notable flaws:

- i) The National Audit Office report of Jan 2017 says Care at Home does not cost less but more, and hospital admissions did not decline, they increased in the first year. The projected figures in the Pre Consultation Business Case will not materialise. See press release extract in italics below
- ii) The assumed crossover of staff from acute hospitals to perform this visiting care/treatment has not materialised. Staff do not want to take on visiting nursing work.
- iii) The Consultation Document repeats universal agreement on how difficult it is to find care staff in all sectors, nationwide. Trial schemes have recruited from the retail sector; untrained and without proven commitment or loyalty to the care sector. P157 of the document says there is a lack of 800 care staff.
- iv) One Banbury GP has said GPs are under such stress their mental health is suffering. This plan depends on a primary care system headed by GPs who clearly will not be able to cope with it. Their views are being ignored.

National Audit Office Press Release: *“Nationally, the Better Care Fund did not achieve its principal financial or service targets over 2015-16, its first year. The principal financial goal for 2015-16 was that the Fund would achieve savings of £511 million, based on local plans. The principal service measure was the reduction of demand for hospital services as a clear indicator of the effectiveness of integrated local health and social care services. Local areas planned to reduce emergency admissions by 106,000, saving £171 million. However, in 2015-16 the number of emergency admissions increased by 87,000 compared with 2014-15, costing a total of £311 million more than planned. Furthermore, local areas planned to reduce delayed transfers of care by 293,000 days in total, saving £90 million. However, the number of delayed days increased by 185,000 compared with 2014-15, costing a total of £146 million more than planned. In our November 2014 report Planning for the Better Care Fund, we cautioned that the Fund made bold assumptions about the financial savings expected **based on optimism rather than evidence.**”*

It appears only internal (to OCCG and OUHFT) costs are considered. No illumination is given on the massive additional costs of community provision such as

- capital expenditure in GP surgeries
- capital expenditure on transport
- ambulances
- community resources cars
- medical equipment
- district nurses, physiotherapists etc.
- Nor does it mention (at first glance) current costs of additional salaries for additional community workers.

The public has to bear the total net costs.

Travel aspects - are still in development by the OCCG. David Smith, at the Brackley consultation meeting (February 27) said South Coast Ambulance Service was providing new data to be posted on the Transformation website. It has still not been seen. This should all have been confirmed and

proven as 'safe' before the OTP was published. Visiting in-patients can treble the traffic involved. It may save specialists travelling to Banbury but the visitors and vehicles for patients in acute wards will be unmanageable. The City Council refuses to add parking spaces as it imposes a burden on residents.

Population growth - "Forecasts show that the 85-plus population may increase by around 48% in the period 2014 to 2026. This growth is forecast to be higher in the more rural parts of the county than in Oxford City." – OTP. Therefore need is greater in the north of the county at the time OCCG is proposing removing core acute services. Figures from Oxfordshire County Council also show substantial growth in the population of 0-14s, reinforcing the need for the Banbury children's service which will be compromised if obstetrics is removed permanently.

The Rural Services Network said in February that people in rural areas are suffering disproportionately from lack of GPs and other services. We say this applies to Banburyshire which will certainly be badly hit from a downgrade of the Horton. The answer to the problem of elderly people needing care in the community is to increase funding for social care, not disable hospitals.

OCCG minutes for January 27, 2017 talk about "across Oxfordshire there are areas of huge housing growth which will also put increased pressures" on GP premises for whom "many practices are working at capacity" and "working a fine line of just being able to cope with the demand" with sustainability requiring patients being "empowered further to self-care".

"In 2015/16, an extra 6,848 people attended A&E compared to the previous year; an increase of 5% or an extra 18.7 patients per day. In the four years between April 2012 to March 2016, the number of people who attended A&E increased by 16,771 patients; a rise of 13.1% or 46 additional patients per day." OTP.

Overstretched GPs admit some people attend A&E because primary care is in crisis; how then can primary care take the burden of patients denied inpatient beds? The population increase should be reflected in the amount paid to health trusts, increases offset by money to expand services.

"50-60% of stroke patients have been unable to access the Early Supported Discharge Service to help their recovery." OTP

More funds should put into rehabilitation and social care which is being starved. Rehabilitation must be provided **on the Horton site** for easy access and adequate facilities for recovery, unavailable at home.

Funding – The OTP says it needs to save £134m from a £1.2bn budget. This is just over two per cent. Funding for the NHS has been running at 2.8% below the mean average to cover advances in science, technology, diagnostics and population.

The PFI (private finance initiative) repayments for Oxford hospital buildings are £53m a year – more than the total cuts necessary in the OTP scheme which will obliterate the Horton's services, Oxfordshire's midwife birth units, all the community hospitals and hundreds of hospital beds.

Pressure should be applied to achieve refinancing to remove this burden of debt so money can be put into frontline patient care.

The entire scheme flows on paper but transfers responsibility to successive agencies over which the CCG and Trust will not have full control, depending on such as County Council provision, ambulance service decisions, social care agencies and responsibilities, GPs and friends, relatives and neighbours of patients. There is no indication at all of how guaranteed the fluency of these provisions would be - no mention of how many hours of care visiting would be required for example in cases cited in the documents such as return home 72 hours after an acute stroke. There was no indication of what would happen if any of these elements failed and yet all are currently under maximum stress and near breakdown. Nor is it easy to determine if the net overall cost to taxpayers would reduce NHS costs or just Trust/OCCG budgets.

“Population growth for Cherwell will go up 13.9% between 2014 – 2026 and only 7.3% in Oxford.” The case for *increased* services at the Horton is advanced in the light of this, not access removed 26+ miles away. Oxfordshire is reckoned to be the most rural county in the south east and proportionately more over 65s live in towns or villages under 10,000. Parts of Banbury have significantly lower income than the local average. This plan seeks to remove acute care from the area of Oxfordshire, S Northants and S Warks where need is greatest - by its own admission.

“A national shortage of a wide range of staff including people working in emergency care, intensive and critical care, stroke care, radiography, obstetrics and paediatrics” We have always had doctors and staff willing to locate to Banbury and settle. The problems have only come since the merger between the Horton and Oxford, the Dean’s refusal to allow training accreditation for the trust, rather than the site, and the recruitment problems the JR has suffered causing it to borrow Horton staff. Witness all the obstetric/gynae specialists have been moved to the JR, and recruited middle grades – ostensibly engaged to work in Banbury – are filling vacant posts at the JR, which finds it extremely difficult to recruit and retain staff. Had the Horton not had the uncertainty hanging over it, we again contend there would have been no problem replacing obstetric middle grades.

“Primary care is under tremendous pressure in terms of capacity, confidence and skills. 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.”

Another expression that there is not enough money being paid to the social care and mental health services Increasing capacity, early intervention and support demands more money, not cuts.

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 – evidence for keeping Horton services as the JR is already overcrowded and is likely to be increasingly devoting facilities to private patients; as a foundation trust it may raise 49% of its income by private patients.

Planned Care - OCCG claims 60,000-90,000 appointments will be available in Banbury, arguing less travel to Oxford. The Horton to survive, stripped of maternity, A&E and specialist treatment is said to be 'visionary'. Yet any treatments needed would be referred to one of the removed in-house Horton specialists to the JR.

Banbury Guardian appendix 3 - GP/Primary Care.

The key to the OTP is hugely reinforced primary care (GPs, surgery nurses, visiting carers, physiotherapists/occupational therapists etc) taking responsibility for those who might otherwise have been treated in hospital.

However the National Audit Office report of January 2017 says the proposed Care at Home Plan does not cost less but more and hospital admissions did not decline, they increased.

The Pre Consultation Business Case says savings to the OUHFT of ending 'bed blocking by closing beds' is £1.7m but at a cost of £2.5m to the private sector for care beds. So the NHS incurs a cost of £800,000, patients lose hospital care and acute nursing/medical jobs are lost.

CCG's own minutes (January 2017) describes concern that the primary care infrastructure needed to enable this move away from hospital care is in doubt.

It appears only internal (to OCCG and OUHFT) costs are considered. There appears no reference to the additional costs of community provision e.g. capital expenditure in GP federated surgeries, transport; ambulances, community resources, cars, medical equipment etc; district nurses, physiotherapists etc. The public would have to bear the total net costs.

The Pre Consultation Business Case (PCBC) repeatedly states General Practice and Primary Care is badly staffed. There is "a high turnover rate of support workers who look after people in their own homes and in care homes, with a very large number of vacancies at any one time" and "Primary care is under tremendous pressure in terms of capacity, confidence and skills" (RCPCH - Royal College of Paediatrics and Child Health). Indeed the PCBC notes that there are 800 vacancies in domiciliary care with no concrete plans as to how these will be filled (p157).

As well as taking responsibility for those who would have been inpatients, with no declared extra funding, the document demands of Primary Care:

- "Develop paediatric skills and knowledge within Primary Care, with improved access, to enable minor illnesses and injuries to be managed in the community"
- Primary Care support for 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 ability to manage long term conditions and their use of the urgent care system; likely to be needed among people with needs around deprivation and/or isolation (especially high in some Banbury wards)
- Primary care services to address the 4% a year rise in demand and the sustainability issues. "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' this should be consulted upon as part of Phase Two. This would be too late as major changes will have been confirmed, ensuring downgrade of the Horton and confirming new demands of Primary Care.

- P74 Pre-Consultation Business Case (PCBC) – maternity. “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”.

GP consultation rates increased by 11% between 2011 - 2014 but, despite this, patients often have to wait longer than they would want to with 29% of patients reporting length of wait for an appointment was unacceptable.

The changes proposed for Primary Care are immense but are now not being accepted as being a ‘substantial change’ and therefore not subject to consultation.

The PCBC makes assumptions about Primary Care being the ‘lynchpin of the newly transformed health and care service’ with GP surgeries conjoined with 30,000 – 50,000 patients. Many patients will be expected to measure their conditions at home using new technology. There is no evidence the ageing population will be able to manage this.

The ‘new thinking required and new models of care’ – have not been evidenced or proven possible, let alone that it will ‘improve the health and care of the population’ as claimed.

Key principles include influencing lifestyle and nutrition, language and literacy, housing, transport and social care, and education work and training through CABs and councils. None of these goals are within its capability put responsibility for health outcomes on public services that are under massive financial stress and may not be capable.

The PCBC suggests 25% of people need on-going care at any time with 1%, of Oxon’s 750,000 population in a health crisis (stroke victims, end of life or major trauma victims).

Closing Horton beds – and removing the infrastructure (staff, equipment, porters, facilities) so beds cannot be reopened - must not be permitted before this experimental system is proven workable and preferable.

Evidence given to Oxfordshire HOSC in September 2016 by OUH (while talking about closing Oak Ward’s 36 beds and ten trauma beds) said they had managed to recruit 40 care workers ‘mainly from the retail sector’ – a fraction of the number needed, untrained and with no experience in or dedication to the care/nursing sector.

General Practice is already under considerable pressure. This newspaper has reported how two surgeries closed in Banbury in 2016 and Bicester has lost at least one surgery. A private company has been brought in to manage the 17,500 patients of Horsefair Surgery. GPs warn the domino effect (where practices take patients from closed surgeries) will endanger their practices. Nationally, the outlook for general practice is dire with a many GPs due to retire within five years. Those remaining are at breaking point through increased business administration and no increase in the £136-£147 per year patient, unchanged for a decade (source Dr Paul Roblin, Bucks Local Medical Council; see below). HOSC has not apparently considered vital opinion from Banburyshire GPs opposing department and bed closures in October 2016. They wholeheartedly oppose downgrading of the Horton.

Despite these issues in GP provision, it is being made the bedrock of this plan with ‘acute hospital at home’ limited to a maximum of two weeks with care being handed to primary care at that point. But

yet again the consideration of this will be in Phase Two. We contend, again, that renders this OTP consultation invalid, as does the entire split consultation.

The OTP makes what we suggest are optimistic assumptions about public health education (PHE) tackling major issues of obesity and diabetes and easing NHS pressures. Budgets for PHE have been slashed and even if funding had been maintained, we contend it could take decades to achieve significant change.

We note the words from Dr Paul Roblin, taken from an email to national newspapers and Theresa May on January 15 this year: "A year of GP care in England costs the government on average £142/year (about the same as one hospital out-patient appointment) and each patient now consults their GP 6 times a year on average. This represents phenomenal value for money but is delivered at a cost. The role of being a GP is now so stressful that no one wants to do the job. There exists the very real prospect that the whole GP system will collapse in the near future and with this the NHS."

Banbury Guardian supplementary 4 - Maternity

The plan intends to make removal of HGH consultant led maternity to the JR in Oxford, permanent. The temporary closure was introduced for want of five middle grade obstetric doctors to replace five clinical research fellows whose posts' training recognition was removed from the Horton by the Post Graduate Dean in 2012.

It is difficult for the OUHFT to recruit to Oxford because of the extremely high cost of living in and around the city. The Oxford University Hospitals Foundation Trust (OUHFT) has since benefited from five Horton Obs-Gynae consultants and the middle grades recruited thus far for when the Horton CLU reopens (5 as of March). The JR clearly benefits from the Horton's staff but we believe it is safer for this population to have the benefit of those specialists designated for this hospital in this hospital and for greater ease for expectant mothers both at the Horton and at the JR.

The OUHFT claims to have worked hard to recruit internationally for the obstetric vacancies at Banbury. Offers by a cohort of experienced Ugandan specialists to take up vacant positions – effected through Horton staff and Keep the Horton General – in a bid to avert the October crisis, were rejected by the trust. Recruitment since then has received significant interest but no 'takers' because of the downgrading cloud hanging over the Horton. Those appointed to 'Horton' positions have been adopted by the JR team.

The document claims that "irrespective of the numbers of births, OUHFT would not have enough doctors to staff the [Horton's obstetric] unit. This makes it unsafe for current and future demand and an unviable option for the future." This is absolutely unproven and is totally counter to the claim that the Trust has made, since July 2016, that it is committed to retaining a consultant-led unit (CLU) at the Horton. What the c50 applications received for the advertised nine posts (now deemed necessary to run the CLU safely) does demonstrate is that doctors really do want to live and work in Banbury - even during the threat of downgrade to the hospital.

The Thames Valley Strategic Clinical Network Review's analysis said there will be an 8% increase in births in the next decade. (p72) This includes assumptions about housing growth but omits Banbury as one of the rapidly growing housing areas in the PCBC appraisal of major development, mentioning only Bicester and Didcot. The review said Oxfordshire is 'at capacity' in delivering 6,000 women in its CLUs and 'work is needed to increase capacity'. The PCBC calculates Oxfordshire's expected births at c8,500. While Midwife only units (MLUs) are to be considered in Phase 2 of the OTP, it is clear this number cannot be managed at the JR which is bursting at the seams with its current c6,000 births.

Sharing the 8,500 between the JR and the Horton makes absolute sense as it would allow the Banbury hospital to regain training accreditation- and thus have no problem staffing the unit - and ease pressure at the JR. Many of the 2,500 births needed to satisfy that training

recognition, if not all, would come from the Banburyshire/W Oxon catchment. That capacity should be created at the Horton General Hospital to provide equitable access to consultant-supervised births for women from three counties.

With the clear intention of closing the Chipping Norton midwife-only unit (MLU), the Horton is in more need than ever of its obstetrics to ensure choice and safe provision of maternity care for a rapidly growing population.

The PCBC professes there are 'more complex pregnancies' needing specialist care. This reinforces the case for retention of the Horton obstetric unit still further.

The Oxfordshire Transformation Plan highlights bringing more patients to the Horton and saving travel to Oxford. It makes equal sense for the few specialist doctors to be based in an obstetric unit in Banbury than many hundreds of mothers going to the JR. An increase in complex pregnancies highlights the need for more obstetric units, not fewer, giant ones.

Obstetrics (the largest Horton department) allows other services including anaesthetics, paediatrics and A&E to be maintained. This is one of the reasons it is impossible to run public consultation in two parts as all the Horton's core, acute services are interdependent.

The Horton has always acted as a safety valve for the JR for maternity, paediatrics, trauma and A&E. Frequently, when the JR has had no capacity patients/expectant mums have been diverted to Banbury. Other hospitals have also had the security of knowing they could transfer patients to the Horton. Without Banbury's CLU, expectant mothers (and other patients) could have to travel as far as Warwick, Northampton, Milton Keynes for obstetric care. Our investigation make us aware of the JR's CLU being at capacity on numerous occasions, with women labouring in waiting areas and delivering in side rooms because there was no space for them in birthing suites or on delivery wards.

Banbury contains three of the most deprived wards in Europe. This fact means that a significant proportion of pregnancies are higher risk.

The Independent Reconfiguration Panel (IRP) in 2008 decreed that Banbury (26+m from the JR) was too far to humanely or safely transfer sick patients, adult and children or mothers in labour. The only thing that has changed since is the population/catchment has increased markedly, is planned to grow rapidly and traffic/congestion has got much worse, as evidenced by Oxfordshire County Council's entreaties. Oxford City Council has said it will not countenance changes to allow more traffic because of the effect on residents, making centralisation appear an impossible exercise.

The OTP, by design part of the Sustainability and Transformation Plan for Bucks, Oxon and Berks West (BOB), ignores the needs of one third of the catchment of the Horton – those

living in south Northants and south Warks whose communities have always relied on Banbury and its services.

According to recent figures the MLU in Banbury has delivered 60 babies. 40% of deliveries were transferred to Oxford, as births in progress or with complications after delivery. To attain agreement for the temporary removal of obstetrics, the OUHFT paid for a dedicated, private ambulance which is supposed to be parked outside the unit 24/7. The OUHFT has intimated this will not continue after consent is given for a permanent MLU. That leaves expectant mothers no confidence in giving birth so far from specialist. Claims in the PCBC that women have better outcomes in MLUs contradicts the fact that only 6% of women (nationally) choose to give birth in an MLU and even then we know transfer rates are 40%. And we know that Banburyshire GPs are wholeheartedly against removal of the CLU.

We have to ask how the JR will cope if it experiences many more births than anticipated, if fewer births take place at the MLU at the Horton than predicted, as is happening?

We are aware of the JR birth unit having to transfer premature babies to other regional hospitals throughout this last winter because of a lack of capacity.

OUHFT claims that CLUs experiencing fewer than 2500 births a year are unsafe because training doctors do not see a sufficient number or variety of complex cases to maintain their skill and experience. This attitude isn't shared on the continent: eg In Germany most obstetric units experience far fewer than 2500 births per year – the threshold for training accreditation at a British unit. The average number of births in German hospitals is 900 a year; 2500 births+ is a very large unit and 6000 births would be considered folly. Many training doctors prefer smaller units because they allow more one to one time with patients.

Prior to 2015, birth figures for the Horton were higher than the 1,466 that year- over 1,700 in 2014. OUHFT claims "number of births at the Horton has continued to decline". This appears to have happened because OUHFT altered the rules eg expectant mums with high BMI, are diabetic or expecting twins (that previously delivered at the Horton) were compelled to go to the JR. It is worth noting that the RCOG itself concedes "the number of births in a unit does not necessarily reflect the number of complex cases requiring consultant input".

OUHFT acknowledges "the outcomes reported by both units (Horton/JR) are similar". So there was absolutely nothing wrong in terms of safety with the Horton's birth outcomes as a smaller obstetric unit.

Training status at the CLU was withdrawn in 2013. The RCOG raised the threshold from 1500 to 2500 births which had a direct effect on HGH. This discretionary threshold shows a

disconnect between the healthcare needs of tens of thousands of people and the decisions of those with the power to confer training status. Depending on the Deanery, policy and procedure on training status can vary. This inconsistency is borne out when one considers that there is a number of hospitals with fewer births than the Horton which have retained training status in spite of this, e.g. Barnstaple, Aberystwyth, Dumfries.

The Postgraduate Dean has said that training status for the Horton could be re-conferred if the unit reached 2000 births per year. This is less than 400 more births a year than were taking place before the Trust changed the protocols and removed almost all complicated births to the JR, and would be achievable within the next few years, given the development and population increase expected.

OUHFT has demonstrated it is not difficult to allocate significant numbers of expectant mothers to a particular hospital where there is a will, so one obvious solution is for this arrangement to work in reverse. This would a) increase the numbers of births at the Horton resulting in it regaining eligibility for training status, b) ease the burden on the JR which will otherwise be the sole enormous obstetric centre for the whole of Oxfordshire, if the OTP is approved.

Banbury Guardian appendix 5 - Split Consultation

OCCG has split consultation on proposed changes in Oxfordshire health services into two sections, giving the public no opportunity to see how decisions taken now on the Horton General Hospital might be affected by matters (some still not finalised) that will not be consulted on until November at the earliest (according to January CCG minutes). We contend this leaves the current consultation lacking in essential information, imperfect, unbalanced, un-evidenced, unsupported and unfair.

The split consultation can be seen on almost all pages of the OTP. Readers will see references to 'we will be considering this in Phase 2'.

Phase 1 (current consultation) includes:

- 1) CCU (critical care unit) to exclude ventilation for very ill patients
- 2) Stroke care – new protocols
- 3) Consultant-led maternity and emergency gynaecology permanent removal
- 4) Special Care Baby Unit permanent removal
- 5) Adult medicine (36 beds closed)
- 6) Trauma (loss of 10 of 28 beds)

2) Phase 2 includes

- 1) 24-hour consultant-led Horton Children's Ward to become 'ambulatory'
- 2) Horton General Hospital's Accident and Emergency Department to be downgraded
- 3) Access to GPs
- 4) Joining up Health and Social Care services (a major element since most social care is in the private sector, not the NHS)
- 5) Use of technology – in which patients will be consulted via tablets/smart technology instead of in person
- 6) Mental Health services which are worryingly inadequate
- 7) Primary care – the cornerstone for the entire plan to move care out of hospitals to home or care homes
- 8) Replacement of consultant-led maternity units for midwife-only units (home birth in hospital);
- 9) Future of midwife-only maternity units
- 10) The future of community hospitals
- 11) 'Other ideas' being developed.

The Bucks, Oxon and Berks STP (BOB STP), of which the Oxfordshire Transformation Plan is a major part, was designed with a single consultation on all of the Horton's acute services (See p89 of the BOB STP). This was changed some time between October - January, seemingly because the OUHT/OCCG felt this would cause an intense outcry, calls for re-involvement of the Independent Reconfiguration Panel that rejected Horton downgrading in 2008 and a long delay to the nationwide STP project. Deputy CEO of the CCG, Diane Hedges, told CPN this intervention would cause a year's delay which could not be afforded by the deadlines. There is widespread concern in the Banbury

Guardian area, shared by the newspaper, that division of the consultation is designed to make it easier to achieve downgrading of the Horton.

The paper describes A&E and paediatric services still being 'worked up'. Splitting consultations about consultant-led and midwife-only maternity units is extraordinary and impractical. Mothers, residents, GPs and other stakeholders must know what service will be in place before they can give an informed opinion about consultant-led units.

Patients and the public have not been offered any knowledge, information or discussion about future service provision which is directly affected by the services in consultation now that directly and indirectly affect 'phase 2' proposals. Details of proposals in phase 2 are essential to inform any meaningful consideration or response to this document. We contend lack of this information renders this consultation unworkable and say it must be considered invalid.

The PCBC (p90) demonstrates the two phase consultation is inadequate when it admits the ambulatory model will be 'more coherent' when people see the proposals in Phase 2.

More evidence: p92 - There is a clinical interdependency (for CCU) with Accident and Emergency Services, and the clinical model for this service will be consulted upon in Phase 2 of the Programme.

p 94 - Availability of beds in the Hyper Acute Stroke Unit at the John Radcliffe... is linked to the Delayed Transfer of Care initiative described... 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. The Transformation documents admit that much of the theory cannot be considered properly without access to information from Phase 2 which is now being touted as impossible before November 2017 (OCCG minutes January 27, 2017).