**General points on Horton downgrade**: (“We are committed to: putting patients’ needs first” - OCCG)

**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 3,175 patients and the JR 7,638.

The Horton A&E saw 2810 patients vs the JR’s 4848 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 there 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 – more dangerous assumptions to get this plan pushed through. Also the trust/CCG have not been clear about what charges will be made to hospitals for care across the ‘footprint’ boundary (S Northants and S Warks patients will be charged ‘tarrifs’ by Oxfordshire and vice versa).

**Ambulance Service –** The South Central Ambulance Service (SCAS) has confirmed 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. 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. Ambulance staff are under terrible stress and pressure and delays and it takes up to five hours to attend incidents in busy periods. 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. The OUHT will not fund a dedicated ambulance in Banbury post-downgrade, placing mothers at unacceptable risk. Already one ‘low risk’ delivery resulted in a baby left with limited life and major disabilities because of complications in the midwife-only unit.

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 or consultees are offering views on entirely false proposals. 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.

Mr Justice Mann in the High Court ruled for public service consultation to be legal it required “***adequate and sufficient information to enable intelligent considered response***” and those consulted should see something of what they contributed in eventual decisions. CCG behaviour demonstrates it will bother with little other than its plans which flow smoothly on paper show no evidence of being workable*.*

Lord Woolf later extended the definition of adequacy beyond formal consultation saying ***it applied as much to informal****.*  High Court decisions reflect proper process, evaluate rationality and reasonableness. The ambulance element is not only breach of proper process but also an unreasonable situation to put out to consultation.

**Loss of beds/care at home - failure will be repeated –**

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 fatal flaws:

1. 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
2. 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.
3. 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.
4. 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 which is irrational since they wish to institute a system of 100% acute patients going 25 miles for care. 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. This should all have been confirmed and proven as ‘safe’ before the OTP was published. It is astonishing that such basic essentials are being devised and calculated only half way through the public consultation. 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. As urban pollution is associated with later diabetes and dementia, this must considered rationally. 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. It also shows 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. 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.

The irony is that 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. F

**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. That people are living longer and recovering from previously fatal conditions comes at a price which must be paid. Reinstating NHS necessary increases, restricted to 1.1% since 2010 would address this, as would the abolition of the internal market which services competitive privatisation and costs £4.5bn - £10bn a year.

The PFI (private finance initiative) mortgage 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.

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 25+ miles away. The PCBC says Oxfordshire is 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 a death sentence hanging over it, 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 confession that there is not enough money being paid to the social care and mental health services, the latter being the terrible, hidden chasm of distress among the young. 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 will 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. The figures appear exaggerated for persuasion. Where is the evidence? This is demanding the Horton’s lifeblood in exchange for something that should have already been there in the requirements of previous inquiries.