Appendix 1

A Joint Cherwell District Council and South Northamptonshire Council Response to the Oxfordshire Clinical Commission Group's Big Consultation Stage 1 Process

Introduction

Thank you for the opportunity to present the views of Cherwell District Council (CDC) and South Northamptonshire Council (SNC) of the Oxfordshire Clinical Commissioning Group's (OCCG) Big Consultation stage 1 process. This is a joint response as both Councils have the same points to raise. We are happy to support any follow up enquiries the OCCG have regarding the comments and the range of proposals contained herein.

As the OCCG will be well aware, CDC and SNC have a number of very real issues underpinned by the huge and widespread concern of local people from North Oxfordshire, South Northamptonshire and South Warwickshire about the two stage consultation process and the proposals for service change at the Horton General Hospital (HGH).

The Councils acknowledge the challenges faced by the NHS and as a consequence the need for change. Some of the stage 1 proposals are sound in principle, eg acute stroke services and planned care, but the benefits of these are somewhat lost in a flawed consultation process. Whilst the Councils welcome the opportunity to contribute, they believe that the split consultation process is flawed sufficiently for it to be halted. This is due to a confused and unclear two stage process, incomplete information, inconsistency with the pre-consultation engagement process and inadequate service implications and options analysis. That is why both Councils, along with Stratford-on-Avon District and Banbury Town Councils as co-claimants, have filed for a Judicial Review.

Our response to your formal consultation follows the following structure:

Section 1 - Concerns about the inadequacy of the consultation process
Section 2 - Concerns about the problematic two phase consultation process
Section 3 - General concerns
Section 4 - Commentary on each of the consultation proposals
Section 5 - The Obstetrics Service Proposals and Alternative Service Models
Section 6 – A Vision for the HGH

Section 1 - Concerns About The Inadequacy Of The Consultation Process

Late availability of all relevant consultation documents

The pre-consultation Business Case is a substantial 235 page document which has 30 appendices listed to support its content. CDC wrote to OCCG on 3 February 2017 requesting copies of these. Having not had a response, a reminder email was sent on 7 February 2017. The Council was informed that collectively they were too large to email and doing so would probably cause computed capacity difficulties. On 9 February 2017 the OCCG was asked why these were not made available with the other consultation documents on the OCCG website. On 10 February 2017, the Council received five of the appendices requested. The availability of all 30 appendices did not occur until 17 March 2017, approximately 75% into the consultation period along with approximately 65 other documents in a list of 90 appendices!

This sequence of events and the release of so much more information so late in the consultation process with no notice or announcement appear to be an attempt to restrict the availability of relevant consultation information. At the very least it limits the ability of consultees to make informed responses.

Cross boundary issues and unclear effects for patients in South Northamptonshire and South Warwickshire

At the Oxfordshire Joint HOSC meeting held in November 2016, the Committee stated that the geographical detail should be easily identifiable so that the public can be clear about proposed changes to services in their locality. This has not occurred with the degree of clarity which is required for informed consultation responses to be made.

There has been an inadequate consideration of a whole system approach to cross boundary issues. Banbury is less than two miles from both Northamptonshire and Warwickshire which means that a very significant proportion of the 165,000 users of the HGH come from outside Oxfordshire (in excess of 30%). This is known as the traditional ‘Banburyshire’ catchment and is very relevant to the patient flow to and from the HGH. Whilst there appears to have been dialogue between the acute service providers of the three county areas, only well into the consultation process has there been dialogue at the commissioning, STP, primary care and social care levels. This is too little and too late, and should have been undertaken before the consultation process commenced so that clarity in answering the questions and concerns of the residents and patients of South Northamptonshire and Stratford-on-Avon Districts could be provided.

This is an important issue as a whole system approach is required for planned care, early supported discharge service for stroke rehabilitation and changing the way hospital beds are used, all of which are in phase 1. The proposals and their implications for all current patients have not therefore been properly considered, which means that when residents affected by these proposals ask questions about the implications for them the answers are either unclear or not available.

Specific examples of the lack of clarity include the following:

- The consultation proposal to increase planned care at the HGH appears to apply to Oxfordshire residents only as there is repeated reference to North Oxfordshire only in the main consultation document. It is therefore uncertain whether those patients from outside Oxfordshire who previously travelled to Oxford for their planned care can in future still receive this at the HGH.

- The proposal to take all patients diagnosed with acute stroke immediately to the Hyper Acute Stroke Unit in Oxford and the extension of early supported discharge service also appears to be applicable to North Oxfordshire residents only. This is unclear for South Northamptonshire and South Warwickshire residents currently served by the HGH as the consultation document states that *'those in North Oxfordshire who are closer to Northampton or Coventry Hospitals would be taken there'* which implies all South Northamptonshire and South Warwickshire residents will not use the Oxford acute stroke services in the future and some North Oxfordshire residents would also be taken elsewhere.

- Uncertainty is further reflected in the proposal for the level 3 critical care patients where they will be taken to Oxford whereas *'patients living in South Northamptonshire and South Warwickshire might be treated at the critical care units in hospitals in Warwick, Northampton or Milton Keynes if closer'*.

- The proposal to undertake all obstetric services at Oxford with an MLU only unit retained at the HGH includes the statement that '*women north of Oxfordshire also having the choice to travel to Northampton, Warwick or Milton Keynes'.* This is clear for South Warwickshire patients who currently use or had intended to use the HGH but not at all clear for South Northamptonshire patients who have the HGH as their closest hospital or are equidistant with Northampton and Milton Keynes or even closer to the John Radcliffe Hospital (JRH) than those hospitals. It should also be noted that the JRH is closer for Brackley residents than for Banbury residents.

Such lack of cross boundary clarity and lack of recognition of the important geography associated with the HGH has caused confusion and undermined the phase 1 consultation process.

Misleading maternity information

No information is provided to consultees to inform them as to what higher risk pregnancies actually means. Young people and future first-time parents reading the Big Consultation document are likely to think that "*higher risk pregnancies*" refers to only a very small number of births. The consultation document states that "*most women have a low risk pregnancy and are cared for by the midwifery teams during the antenatal, labour and postnatal period*". In this context, where a Midwife Led Unit (MLU) is proposed for the HGH, it is misleading to say that "*most women … are cared for by the midwifery teams during … labour*". A substantial proportion (c40%) of births involves regional anaesthesia, which cannot be administered at an MLU and which means that all women who have or want an epidural will have to travel to the JRH. The key point here is that most women who wish to have an epidural would not

consider themselves to be “higher risk”. This has not been explained in the consultation documents.

When the HGH had an obstetric service last year, there were approximately 120 births per month there. Between 3 October 2016 and 31 January 2017 there have been 61 planned births at the MLU. Further, of those 61 births planned to take place in the HGH MLU, 24 of them had to be transferred to the JRH during or immediately after labour. Thus, the numbers actually using the HGH MLU only are very small indeed. The Big Consultation document does not convey the proposed radical change in the loss of localness of services, i.e. when HGH had obstetrics services around 120 women gave birth in that local hospital each month, whereas without an obstetric service the experience of the last few months indicates that less than 10 women will give birth solely in HGH’s MLU each month. That means that of local women who could previously (prior to the suspension of obstetric service) give birth at the HGH, if the proposal in the Big Consultation is implemented, over 90% of those local women will not be able to give birth there. The Big Consultation document does not give that impression at all and is therefore misleading.

This very low proportionate use of MLUs is also reflected in only approximately 6% of births in Oxfordshire which take place in its other MLUs and also the Better Births – National Maternity Review 2016, which states that 6% of women preferred to give birth in a freestanding MLU as proposed at the HGH. This established low level of MLU use is not explained nor conveyed in the consultation documents.

Insufficient implementation detail and incomplete business case

There is no clear timeline of events if these phase 1 proposals are implemented to ensure that the chaotic parking arrangements at the Oxford hospitals will be resolved before the further proposed transfer of acute services to Oxford and ahead of any planned care improvements elsewhere in Oxfordshire.

The current car parking provision at the HGH is often at capacity and therefore offering an additional c 95,000 patient episodes at the HGH will require additional car parking provision at the site for c 350 cars daily. There is no evidence or clarity in the pre-consultation Business Case that funding for this HGH requirement has been provided. This means that the phase 1 pre-consultation Business Case is incomplete and not satisfactorily deliverable.

Likewise, there is no evidence or clarity in the pre-consultation Business Case that funding has been allocated for improved car parking to address the current chaotic and unacceptable situation at the JRH.

No overall plan or coherence for the HGH

There is no overall plan and vision for the HGH which the public can understand. The consultation statement regarding ‘fit for the 21st century’ and ‘investment’ is too generic as it does not say what this means in terms of actual services at the hospital and which is what the public needs to know. The two stage process confuses this further as it is clear that the future range of services delivered from the HGH cannot be determined until well after the end of the second stage consultation, whenever that is.

Inadequate consideration of the implications of the Banbury socio economic demographics

Regrettably there are neighbourhoods in Banbury which, according to national indicators and census information, are regarded as deprived and in which there is clear evidence of poorer health and higher care needs. The OCCG correctly state that the BME population in Banbury, which is higher than the national average, is more likely than the general population to suffer stroke and obstetrics complications and is more likely to need to give birth in an obstetric unit. Yet it is these very services which are being eroded at the Horton. Reference is made to meeting the Public Sector Equality Duty but the statement regarding the Oxfordshire Health Inequalities Commission's report is out of date; there is no assessment of these proposals on the vulnerable and poorer Banbury families as a whole as a consequence of the recent significant public transport cuts and no evidence of having taken into account in the phase 1 proposals these specific demographic and health needs of Banbury.

The detailed equality impact assessments for the phase 1 proposals were one of the 30 pre-consultation Business Case appendices which CDC had to request to be able to consider and were one of the 90 appendices issued only relatively recently. In it, again reference is made to the BME population in Banbury which is more likely than the general population to suffer stroke and obstetrics complications. However, no attempt appears to have been made to consider specific measures to support these mothers-to-be other than targeted pre-conceptual care. The issue is merely acknowledged but the full implications are not sufficiently addressed in the consultation proposals. This is not good enough for the acknowledged needs of this important group of local people and is a serious gap in the consultation process and proposals.

Likewise, the majority of the equality impact assessments make no acknowledgement of the greater concentration of health related deprivation, the higher levels of disability, the higher levels of emergency hospital admissions, the higher levels of people 10 to 64 and over 65 with limiting long-term illnesses and the higher levels of poverty in parts of Banbury. All these aspects affect the level of demand for local healthcare services and access to them. Only one equality impact assessment (acute care) adequately acknowledged the detrimental impact to those who unfortunately have greater healthcare needs than most and identified measures which could assist. However, these measures do not feature in the consultation proposals. This is another consultation shortcoming.

Section 2 - Concerns about The Problematic Two Phase Consultation Process

Confused and unclear two phase consultation process

The two stage process has a number of interdependencies and, whilst phase 1 concentrates on the HGH, the overall service make-up of the HGH cannot be determined until well after the end of the unspecified date of the second phase consultation. Because of the way the proposals are structured, and that community and primary care services are not detailed in the phase 1 consultation, it is not possible to see an overall proposal for the future make up and functions of the HGH and its relationship with the wider health and social care sector. This is a serious weakness which limits the ability of consultees to make meaningful responses.

In addition, there are several phase 1 proposals which are influenced by and will influence the phase 2 content and therefore does not lend itself to informed and intelligent consideration, which is a fundamental requirement of consultation.

To demonstrate this confusion, the following draws out the phase 1 and 2 linkages:

- Maternity at the Horton is in phase 1 of the consultation but MLUs are in phase 2. Surely it makes far more sense to consider the whole maternity service together so that consultees can understand the Oxfordshire-wide picture? This approach is also advocated in the Better Births – National Maternity Review, which states that '*providers and commissioners should work together in local maternity systems*'.
- It is unsatisfactory to split obstetrics in phase 1 from paediatrics in phase 2 in view of close working relationship between the two disciplines. The removal of the obstetrics service including the Special Care Baby Unit will reduce the overall paediatric capability of the HGH.
- Similarly, the same argument applies to obstetrics and accident & emergency (A&E) as both are dependent on anaesthetic services so removing the obstetrics service in phase 1 will reduce the overall anaesthetic capability of the HGH and the A&E and paediatric services which are in phase 2.
- The changed use of acute hospital beds, which also requires increasing care closer to home, is in phase 1 but community hospitals and other primary care services which should feature in care closer to home solutions are in phase 2. This difficulty is compounded by the absence of proposals concerning primary health care, which would have to be the principal means of reducing the rates of attendances at emergency departments and the rates of emergency admissions.
- Planned care away from Oxford is in phase 1 but community hospitals, which should logically be part of community based diagnostics and outpatient services, are in phase 2.
- The principle behind the change to acute stroke care is understood but this is in phase 1 when the model for the early supported discharge/rehabilitation service for stroke patients is in phase 2 and includes the provision of community hospital inpatient services, primary care and the HGH.

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Lack of understanding of a whole HGH service

The two phase consultation process is inconsistent with the pre-consultation engagement exercise undertaken by the OUHFT where, despite the unpalatable nature of the emerging proposals, at the very least the HGH was being sensibly considered as a whole. In this way the inter-relationship between the different clinical services, so vital for a general hospital, could be understood and seen as a whole. Now we are faced with a disaggregation of services through this two phase process where the clinical inter-relationships are broken. This is wrong and unacceptable.

Section 3 - General Concerns

Previous Independent Reconfiguration Panel (IRP) recommendations

The IRP in 2008 concluded that transferring obstetric, paediatric (including special care and emergency gynaecology services) did not provide an accessible or improved service to the people of North Oxfordshire and surrounding areas. Since that time, travel and access to the JRH has become even more difficult. The current proposals being considered will offer worse services to patients in the HGH's 170,000 catchment.

The IRP determined that these changes were being driven by "future medical staffing constraints not by providing a better service for local people", which is where we are today, and the only difference being that removing Level 3 critical care and hyper-acute stroke have been substituted in the first round for general paediatrics which is in the second phase.

The IRP also recommended that the OUHFT and the then PCT carry out further work to determine the service arrangements and investment needed to retain and develop services at the Horton, develop a clear vision for children's and maternity services within an explicit strategy for services for north Oxfordshire and to develop clinically integrated practice across the HGH, JRH and Churchill sites as well as developing a wider clinical network. The provider and commissioners in Oxfordshire have in these proposals ignored these recommendations which have contributed to the argument that some services at the HGH are unsustainable. This is an unacceptable position.

Likely loss of GP training

For the HGH to continue the important training of GPs, it must have a sufficient number of key clinical disciplines. The proposed loss of obstetrics is one of these and any further loss of key clinical disciplines is likely to result in the loss of the hospital's ability to accommodate this important function. Given the reliance of many of these phase 1 proposals on primary care, including GPs combined with the need to retain as many GPs locally as possible for sustainable primary care service and which is currently under significant strain, the retention of GP training locally is important but the consultation process does not recognise this.

Piecemeal removal of acute services from the HGH

There has been a gradual erosion of acute services at the HGH no better exemplified by the piecemeal loss of bed and service reductions which have already occurred. Local people see the two phase consultation process as a continuation of this piecemeal erosion.

The piecemeal HGH erosion since 2011 has been in gynaecology, breast surgery and emergency general surgery, with a corresponding reduction in inpatient beds.

Local concern is compounded by the pre-consultation engagement process where the OUHFT adopted a whole hospital approach which resulted in three emerging but largely downgrading service options for the HGH. Options 2 and 3 proposed a range of different and largely downgraded service levels which are consistent with the phase 1 consultation proposals. Local people are therefore expecting this

consistency to feature in phase 2 for downgraded A&E and paediatric service in particular as per options 2 and 3 which will further undermine the acute care capability of the HGH. Given the interconnections between services being consulted upon in different phases, that if proposals to close or reduce services are taken at phase 1, this will seriously undermine the feasibility of services being considered at phase 2, effectively pre-determining the phase 2 consultation. This is particularly relevant to the overlap of anaesthetic and paediatric services between the phase 1 and phase 2 proposals.

Despite the OCCG arguing that none of the removal of acute services in the stage 1 proposals will undermine any of the remaining services, there is a very real likelihood that the HGH A&E and possibly paediatric services will go, either undermined by the reduction in acute services at the site proposed by phase 1or by the threat to their continuing staffing viability caused by the prolonged uncertainty created by the two phase consultation.

To make matters worse the OCCG Chairman, at the Oxfordshire Joint HOSC meeting on 3 February 2017, stated the need to look at all acute services together. Clearly such a statement applies only to the JRH element of the stage 2 consultation process and not the acute services at the HGH in phase 1 nor Oxfordshire as a whole. This is both wrong and unfair.

A&E capacity

The consultation document refers to the success in reducing acute beds in OUHFT by 146 to date, principally by systematically placing patients fit to leave hospital in care homes and their own homes. However, the Oxfordshire health system, just like elsewhere, has had extreme difficulty recently in accommodating emergency admissions and coping with attendees at A&E departments. Without radical changes to primary care and in social care there is no reason why the year on year increases in people presenting for acute emergency care will not continue. The phase 1 consultation proposals therefore make this position worse without the required changes in primary and community care which are in phase 2.

Travel time and parking

The geography and transport infrastructure of North Oxfordshire, South Northamptonshire and South Warwickshire, particularly to Oxford for secondary healthcare purposes, results in excessive travel and car parking time. Public transport options are limited and declining and the peripheral city location of the JRH means that most visitors and patients to the JRH have no option but to travel by car if they have one.

More emergencies and more maternity cases must find their way to the JRH site if the phase 1 proposals are implemented. These will require follow-up and potentially further diagnostics which will make yet more demands on the capacity at the JRH, especially as the OUHFT has confirmed that the planned care proposals for the HGH are not proposed to be implemented before phase 2. Access to the JRH is significantly worse than it was at the time of the Independent Reconfiguration Panel report in 2008. The City of Oxford road system is massively congested at peak times and since the JRH sits on the periphery of the city those travelling there must end up going by road, whether by public transport or private car. The County

Council's own estimates indicate that travel time for residents of the most deprived ward in Banbury is at least 50 minutes. Those who finally reach the JRH then have the ritual of queuing for prolonged periods to park, or sit in the queue in a bus since they are caught in the parking congestion as well.

The travel survey undertaken by Victoria Prentis MP shows that it takes people, on average, 1 hour and 20 minutes to travel from the Banbury area to an Oxford hospital. It takes, on average, 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. The OCCG maintains that the average journey time from Banbury to Oxford is 45 minutes. This most recent actual data shows this to not be the case and on average, with parking, is more than double this.

In addition, of the 377 survey participants 84.3% travelled between 20 and 30 miles to reach the John Radcliffe. The expectation for additional North Oxfordshire patients to travel to Oxford is therefore unreasonable on grounds of excessive distance and unreasonable travel times alone.

Section 4 - Commentary On Each Of The Consultation Proposals

Changing the way we use our hospital beds and increasing care closer to home in Oxfordshire

The Councils support greater delivery of care in the community and in particular in people's homes as it recognises that there are better health outcomes through this approach. It welcomes the initiatives taken to date by the OCCG and the OUHFT as this has the further benefits of releasing beds for those with the greatest need and carries a lower cost base.

However, the proposals seek to remove a further 48 beds when the full effects on the demand challenges in A&E are not explained, and are short sighted. The Councils advocate that the full demand implications of A&E demand should be established first before any further permanent removal of inpatient beds is undertaken. In addition, whilst it is recognised that the removal of 45 beds from the HGH in a piecemeal manner over several years has already been undertaken, a whole hospital vision and future for the HGH needs to be established prior to any further changes to inpatient bed numbers.

Other concerns about this proposal arise from the relationship between inpatient bed numbers and wider and more sustainable care in the community and people's homes. The consultation information correctly recognises this relationship yet the wider whole healthcare system and multi-agency implications are not being considered until phase 2 of the process. It is inappropriate that consultees are asked to comment on this when they are not provided any information about the whole system effect and implications for Oxfordshire as a whole, nor the implications for the service users of South Northamptonshire and Stratford-on-Avon districts.

Planned care at the HGH

The proposals for increased planned care at the HGH in principle are welcomed, especially given that an estimated c 95,000 planned care episodes for the people of North Oxfordshire can take place at the HGH thereby avoiding a long and tortuous journey to Oxford. This of course also has the added benefit of potentially reducing the congestion and car parking difficulties at the Oxford hospitals but no information has been made available to assess the extent to which this would benefit the car parking chaos at the JRH in particular.

What is of concern however is the lack of implementation detail in relation to the critical issue of timing of the investment for car parking to avoid creating another car parking and congestion issue at the HGH when it can be expected that c 350 additional cars per day could be using the site assuming a Monday to Friday only planned care service. The lack of clarity and the relevance of this to current patients in South Northamptonshire and South Warwickshire as identified above, along with the absence of funding in the pre-consultation Business Case for car parking improvements at the HGH to accommodate such increased use when the hospital car parks are already running to near capacity, is a major concern to the feasibility of the planned care proposals. In addition, there is the uncertainty as to when and whether these proposals would become reality, meaning that access and congestion at the JRH would become even more difficult after services had been transferred there, for a number of years at a minimum.

This proposal, whilst welcomed in principle, has clearly been rushed, has not been fully thought through and has no clear timescales as the OUHFT has said that it will not take this further until after phase 2, the timing of which is uncertain.

Acute stroke services in Oxfordshire

The principle and health outcomes being advocated by the proposal to take all stroke episodes to the hyper-acute stroke unit in Oxford is understood. On the face of it, this appears a sound proposal and is worthy of support in principle. However, no consideration has been given to the wider implications for the HGH in terms of the further diminution of consultant physicians and other clinical disciplines at the hospital as a consequence of this change. There is an alternative which is worthy of consideration.

What is proposed is through an urban model of delivery of hyper-acute stroke care. If we compare what would happen in other countries, the small general hospital and rural nature of the HGH means that it would have a modern CT scanner, the images would be read by the stroke neurologists at the JR, there would be clinical treatment protocols in place, the emergency doctor and the stroke neurologist would confer via a telemedicine link and agree the treatment or transfer to the JRH for an invasive procedure such as thrombectomy if deemed appropriate. In the UK, the London model which underpins this consultation proposal is used as the reason to centralise the service in Oxford. Given the distance involved in the patient transfer and the widely accepted critical four hour assessment and treatment window for stroke episodes, consideration should be given to this alternative means of treatment.

Further consideration is also needed to provide clarity to those patients from South Northamptonshire and Stratford-on-Avon districts who would otherwise use the HGH as inadequate account has been given to the cross boundary geographic and locational effects for these people. This problem is compounded by the lack of detail associated with the extended early supported discharge service in Oxfordshire and the equivalent support if available in these neighbouring areas.

Critical care at the HGH

The concentration of specialist acute care is driving this proposal to treat the sickest (Level 3) critical care patients in Oxford rather than the HGH, with the HGH retaining a Level 2 high dependency care unit but without the ability to ventilate patients. By accepting this critical care proposal, it does however erode the extent of anaesthetic cover at the HGH and is another clinically weakening transfer.

This also raises the need for a 24/7 standby ambulance which has been put in place for the temporary MLU as, without L3 critical care, women needing ventilation would have to go to the JR under blue light after some traumatical childbirth event.

Further information is also needed to provide clarity to those patients from South Northamptonshire and Stratford-on-Avon districts who would otherwise use the HGH as inadequate account has been given to the cross boundary geographic and locational effects for these people.

Commentary on the obstetrics service is in section 5 below

Section 5 – The Obstetrics Service Proposals and Alternative Service Models

Concerns over the appropriateness and effect of an MLU in Banbury

This proposal has resulted in the most concerns expressed by local people. Setting aside the resulting reduced anaesthetic and paediatric capability of the HGH by this proposed permanent change as detailed in the sections above, the safety issues of excessive distance to the JRH and uncertain and excessive travel times are a real concern for local mothers-to-be from North Oxfordshire and the surrounding areas. The statements and information provided by the OCCG through this consultation process are of little comfort when the information is incomplete (no parking times), the travel times are uncertain (due to the regular Oxford congestion) and are misleading in terms of poor 'high risk/low risk' explanations in reality and the high proportion of mothers who will be affected.

Lack of evidence and rigour in finding an alternative obstetrics model

The OUHFT has not considered with sufficient rigour alternative obstetric models nor challenged the local training accreditation threshold for birth numbers which it repeatedly claims is the reason for the staffing difficulties which have resulted in the temporary downgrading of the service to a MLU.

Page 38 of the Big Consultation document provides four possible solutions for this service at the HGH – a round the clock rota of non- consultant obstetric doctors in training, the same for doctors not in training, the same for consultants only at the HGH and JRH and a partial solution of an elective caesarean service at the HGH. All these options have been discounted either because of the training accreditation difficulty or because of the need to recruit 22 fte consultants over current levels. The first issue which should have been addressed here is to challenge the birth threshold numbers per site to achieve training accreditation. This is set at 2,500 per obstetric site based on the recommendation of the Royal College of Obstetricians and Gynaecologists (RCOG). In addition, the pre-consultation Business Case states that the Thames Valley Deanery has confirmed that training accreditation approval would not be considered for units with less than 2000 births, which demonstrates the local application of the national recommendations. Elsewhere in England there are a number of obstetric units with years one to five training accreditation with birth numbers below both these thresholds. It is therefore a locally determined matter which has not been challenged as the basis of an alternative obstetric model for the HGH.

Whilst the birth number threshold in itself should be challenged, it should be acknowledged that the withdrawal of training accreditation was a combination of not only birth numbers at the HGH but other training regime quality requirements which were sub-standard at the time accreditation was removed. This service quality issue is not recognised anywhere in these consultation proposals.

The HGH birth numbers in 2015/16 were close to 1,500 per annum. This is based on historic patterns of referral where not all mothers-to-be attend the closest obstetric unit. The Councils have examined the current and significant increase in future population projections from within only a 30 minute drive time catchment and made some conservative assumptions about a modest quantum for West Oxfordshire, South Warwickshire and South Northamptonshire. This leads to the conclusion that

there could be close to 2,000 or more births now and a further significant increase by 2021 if the HGH had an obstetrics unit. If you then overlay the opportunity for an increase in planned caesarean births, the birth numbers can sustain a training accredited obstetrics unit at the HGH.

To make this happen, it will be important to make the HGH the birthplace of choice. This requires two important changes; the first is the improvement to the appearance and quality of the current HGH maternity unit which has had little or no investment for many years and is of very poor external appearance. It may even require a new building, given the age of the current unit.

The second requirement is the resolve and commitment of the OUHFT to recognise the HGH as an acute hospital in a positive way and to consider an obstetrics unit there as a positive solution. After the IRP recommendation not to approve the transfer of services in 2008, the use of clinical fellows to populate the middle grade obstetric rota at HGH was put in place. There does not appear to have been any root and branch approach to providing a strong training regime for the obstetric service as a whole or any attempt to rotate permanent medical staff and trainees between ORH and HGH, or to bolster the training experience at HGH to ensure that training accreditation was not withdrawn.

An alternative proposal for a 21st century maternity service for women and their babies at the HGH

Better Births, the National Maternity Review published in 2016, emphasised that women should be offered choice in childbirth and that maternity services should be seen as a local maternity system. The transfer of obstetric services to the John Radcliffe Hospital from the Horton Hospital removed this choice for 60% of women living in the catchment of the Horton Hospital who, for one reason or another, will need the services of an obstetric unit elsewhere. Instead, it offers the services of a freestanding MLU which, according to the National Maternity Review, is the preferred place of birth for only 6% of women.

It is true that the number of births at the Horton obstetric unit had fallen to below 1500, and it is also the case that some ‘Banburyshire’ women chose to have their baby in the Spire Unit - a Midwife-led Unit alongside the large obstetric unit at the JRH. This is unsurprising as the National Maternity Review indicated that the results of the same survey that had found the MLUs to be unpopular had also found that 49% of women would choose to have their baby in an MLU alongside an obstetrics unit where there is immediate access to regional analgaesia and medical intervention if it is needed.

Against this background of service redistribution, the current population catchment of the HGH continues to grow at a rate which has not been planned previously. This will result in a notable increase in births. Some of these births would not occur locally whatever the service on offer at the HGH because some women will choose to have their births elsewhere, including a small number of home births. In addition, around 17% have risk factors requiring them to go to a specialist centre. This still means that c 2500 births each year could be provided with an effective service locally if the service were organised in such a way as to meet women’s needs rather than the staffing and training priorities of the NHS and professional bodies which favour centralising services.

Thus it could be argued that with the right level of commitment and imagination, the OUHFT could seek successfully to renew training at the HGH. The Independent Reconfiguration Panel, in rejecting the bid to remove the Horton Maternity Service at that time (2008), proposed a programme of investment in the Horton Hospital Services which was not acted upon. What is needed is a new approach to providing a local maternity service which links the MLUs, the unit at the HGH and the high calibre clinical services at the JRH.

At the HGH, integral to this system there needs to be an obstetric service and an MLU alongside, linked to the community midwifery service and committed to offering the widest possible range of choice to women in the catchment, who would also continue to receive ante-natal services locally. As part of this plan, capital would need to be sourced to replace the existing maternity unit, which is well beyond its building life, with a purpose-designed facility in which birth could take place safely whatever the chosen birth setting. This would extend the attractiveness of the offering to women choosing where to give birth and generate sufficient activity to provide a professionally stimulating work environment ensuring that staff recruitment and retention did not become factors undermining the viability of the service again.

A unit offering both midwife-led care and medical intervention when needed (or in the case of pain control, wanted) would be expected to generate demand from the local population well in excess of the sub-1500 numbers experienced before the obstetric service was transferred.

The question then arises as to how such a unit could be staffed on a sustainable basis. One answer, discussed already, is to seek to renew medical training, which would be feasible with the numbers involved. However, if that remains uncertain, an alternative approach is suggested.

There are five consultant posts currently operating at the HGH maternity service (one being vacant) and posts for nine middle grade doctors. OUHFT claim that a consultant provided service would need a further 22 consultants, but that is an unrealistic figure based upon 24/7 labour suite consultant cover. The National Maternity Review indicated that there was "*insufficient evidence to support a model of 24 hour resident consultant presence on the labour ward, which is only recommended for large urban units*" However, if the medical model of care was consultant–based only, the approach used in paediatrics at the HGH of having a consultant resident on-call would be required. Conversion of the middle grade posts to consultants would, at median pay levels, fund four more consultant posts - enough to enable a rotation with a resident consultant on-call system which was not too onerous.

A key factor needing addressing in this proposal is the general vacancy levels for consultant obstetricians. Apart from the vacant consultant post at the HGH there are 3.4 vacant consultant obstetrician posts at the JRH and there is a shortage of obstetricians. Recently, however, RCOG has moved towards once more encouraging combined obstetrician and gynaecologist posts. Experience elsewhere has shown that these are popular and trusts offering them are not having difficulty in recruiting. This would of course complicate the shift rotas, but between the JRH and HGH sites there would be 22 posts in total if all were filled, which ought to afford

sufficient flexibility to staff the units safely, bearing in mind that some of the posts at the JRH will be highly specialised.

This meets the requirement of the 2016 National Maternity Review which stated "There is no clinical reason why an obstetric unit cannot operate safely in a remote rural area with a relatively low number of births each year, providing that it has sufficient staff and access to 24/7 support services, clear pathways and transfer guidelines for specialist care and support across a local maternity system".

The Review went on to suggest sharing staff across sites in a local maternity system, on-call systems in place of 24 hour medical staff residency and enhancing the consultant workforce to reduce reliance on other grades of doctors. Recent evidence has shown that where attractive obstetrics and gynaecology consultant posts are offered there are high levels of demand from well-qualified candidates, so it is very unlikely that medical staff shortages would occur if energetic staffing and training policies and commitment to an HGH obstetric unit were adopted.

It can be seen therefore that an attractive and exciting maternity service acting as a part of the local maternity system, working closely with the community midwifery service, local MLUs and the more specialised services available at the JRH could be created, offering side-by-side midwife-led and obstetric care. Provision of a new birthing centre/maternity unit would be part of the essential redevelopment of the HGH campus enabling primary and secondary healthcare and social care services to be made available on a sustainable basis to the growing 'Banburyshire' population. .

A further obstetrics model for the HGH

The above alternative proposal is based on a different staffing model which does not require training accreditation for the HGH. There is a further alternative which can be based on an obstetrics unit with training accreditation. This is a fully integrated obstetrics model across the HGH and JRH. This will require the following features, some of which are the same as those considered above:

- a fully integrated obstetrics staffing structure across the JRH and the HGH
- a strong 'internationally' recognised two site basis of training excellence
- investment to create a modern birth unit at the HGH
- the HGH becoming a birthplace of choice for local mothers to be
- sufficient birth numbers and type to support training accreditation
- a concerted commitment of the OUHFT to effect this change.

The OUHFT already has 34 training posts in obstetrics at the JRH ranging from years 1 to year 7. Since many small units with birth number around or below 2500 continue to train junior and middle grade staff in obstetrics, it is inconceivable that an internationally recognised institution, attached to one of the world's great universities could not sustain an outstanding training programme at HGH. It would require consultants at the HGH and the JRH to be committed to training and for those primarily at the HGH to have had supervisory training, both of which are in the gift of OUHFT. The logical arrangement though would be to rotate the trainees to ensure that they enjoy the full range of obstetric experience over what will be, between JRH and HGH, one of the largest and best maternity services in the country.

An added advantage of this is the HGH as a second obstetrics site in Oxfordshire removes the risk of a single point of failure associated with a huge single site in Oxford and relieves some of the other pressures on the JRH.

The above alternative proposals demonstrate that there are other approaches to providing maternity services within a well-constructed local system to the people of north Oxfordshire and surrounding areas. Re-thinking the approach to meet the needs of the patient rather than the service providers and structuring the service with twin hubs, albeit of different sizes and capabilities, would offer a better balanced sustainable service into the long-term. It would require a very different way of thinking within the NHS in Oxfordshire, but that is needed unless localities are to find themselves without necessary local hospital services and local people condemned to the prolonged, congested trek to the JRH only to find that there is no evident place to leave the car required to get them there in the first place!

Section 6 – A Vision for the HGH

Investment and site master planning

On 30 March 2017 the OUHFT released a briefing paper for new site master plan proposals for each of its Oxford sites. This recognised the current constraints and operational difficulties and proposed a major investment programme of site infrastructure and linking each health campus. These no doubt will support the phase 2 consultation proposals.

The HGH does get a mention at the end of the document in a way which it is assumed requires a similar site master plan approach. It is of significant concern that whilst proposals for the phase 1 service changes are underway, no such site master planning has accompanied these, which is again symptomatic of the HGH being regarded as Oxford's poor relation.

What is required is an overall joined up vision for the HGH which combines all aspects of service provision, site infrastructure and site master planning. The HGH has an illustrious past but is now at a crossroads. A succession of individual project investments has left the site as a disorganised melange of modern and time-expired facilities. The current proposals of OUHFT represent another iteration in a long series of partial investments. What is, and has been, lacking is a long-term vision of what a modern acute hospital for Banbury and the surrounding areas should look like and a commitment to make it a reality. This short document seeks to set out such a vision.

In the absence of any consultation proposals and clear vision for the HGH, the following is offered as a basis for discussion rather than firm proposals. It is intended to demonstrate that there are alternative realistic and positive proposals for the HGH.

The whole proposal is predicated upon re-capitalisation, which would also need imaginative solutions where we think our local authority experience and flexibility could be beneficial in sourcing capital. Leaving the HGH in its current state would lead to further inexorable decline.

A vision for a new Banbury Health Campus at the HGH

There is significant overlap and agreement with the OUHFT pre-consultation engagement Option 3 for NHS services in Banbury but also significant points of difference - the most notable being obstetrics. The fundamental criticism of the existing plans is that they lack imagination and scale and have failed to gain local support. They constitute the limited reorganisation of today's NHS services according to a doctrine that the centralisation of acute, specialist and obstetric services represents an enhancement of the common good and that this enhancement rests upon the prospect of better outcome figures - typically measured in mortality rates. Whilst centralisation can deliver outcome improvements, it is a fallacy to conclude that this is the only way that they can be achieved. A cursory look at the health services of our European neighbours would demonstrate that very different models can deliver equivalent outcomes - Holland has 30% home births against the UK's 2% and Germany favours smaller maternity units. Their outcomes are comparable but the way they do things are very different.

This alternative vision brings together the functions of the acute NHS hospital, primary care services and local social services - using major capital investment to create a genuinely integrated public service. The cost of the (private) capital employed (>£100m) is to be met entirely from the efficiency savings accruing from staffing, service integration and demand management. This new formation meets the aspirations of NHS England for "transformation and sustainability" but not in the way that the current STP proposes.

The new "Banbury Health Campus" comprises the following elements in a completely new formation designed as a unity to replace the existing hospital.

1. The Emergency Dept. - ED
2. Inpatient medicine and Critical Care (Level2)
3. Diagnostic and Intervention Centre + day and short-stay surgery (including paediatric day cases)
4. A birth maternity unit of up to 3000 births based on a MLU alongside obstetrics support
5. A paediatric assessment and clinical decision unit 24hrs
6. Primary Care colocation and integration
7. Social services co-location and integration
8. 'Essential worker' housing.

The long-term integration of primary, secondary and social care services is the centre-piece of these proposals. It will have to happen at some point. Three quarters of the operating budgets of these providers goes to staff costs. Staffing supply is tightening and providers are struggling with budget pressures. The existing staff demarcations, overlaps and the high costs of disorganised information and transaction systems belong to a former age in which staff were more plentiful and budgets were fatter. No longer. Whilst the NHS has sought the benefits of integration, they have not developed the investment plans that will deliver it. 'Joining up the existing dots' has been repeatedly tried and failed.

The new HGH, as part of a Banbury Health Campus, will be specifically designed to attract staff and deliver a quality of life package. In the longer term, a fully integrated clinical faculty can be envisaged but the initial phase would be to explore with local GPs the appetite for re-capitalisation and co-location on the same site as the new HGH. The common use of diagnostic facilities, staff and equipment is obvious. The streamlining of referrals and specialist opinions opens a pathway to the co-management of patients with long-term chronic conditions subject to occasional acute episodes.

The eight elements of the proposed new campus are explained in more detail below but it is important to understand that the new formation is more than the sum of the existing services. It is just that - a new formation and new staffing arrangements on a campus to serve the local population. Not hospital, not GP Centre, not Social Services Department. A new formation made from these elements is both exciting and affordable from within future budgets.

1. The Emergency Dept.

This is an area where the OUHFT plans coincide. A 24hr hospital ED able to take medical emergencies and inpatient medical wards and Level 2 Intensive Care. Small

numbers of patients with hyper-acute conditions or major trauma will go under blue lights to the JRH but the remainder will find their way to the new HGH campus. The benefit to local residents in the HGH catchment in Oxfordshire, South Northamptonshire and South Warwickshire is obvious and highly prized. The benefit to Oxford city residents is somewhat more opaque but nevertheless important. The issue repeats later in maternity services. We suggest that the centralisation of emergencies from a wide catchment brings the danger of dysfunction, and dysfunction at scale. It is no surprise that there is a correlation between missing A&E targets and very large A&E Departments. The citizens of Oxford have a strong vested interest in their own local Emergency Department functioning smoothly. EDs are inlet manifolds to inpatient beds - if you want your hospital full to bursting, expand your ED and source patients from distance.

The co-located GP services bring obvious benefits of co-ordination and information sharing for registered patients experiencing an unplanned event. The co-located (and integrated) social care staff will enhance rapid decision making for discharge and the support for independent living.

2. Inpatient beds + Intensive Care

Mainly covered in 1 above, it is worth noting an issue arising from the latest thinking around hospital design. The advent of 100% single rooms has led to the possibility of complete flexibility in the allocation of beds and takes us beyond the 'medical ward,' 'surgical ward' etc. Similarly, the boundary between 'intensive care' and normal acute care is fluid and becomes a function of staffing and equipment - adjustable periodically to meet demand and not requiring significant or disruptive capital reinvestment. The total number of beds to cover all functions will be determined in detailed planning.

3. Diagnostics and interventions centre

Historically, imaging departments and operating theatres were provided (and staffed) separately. The growth of imaging technologies and the rapid rise of minimally invasive diagnostic and therapeutic procedures has moved things closer together. Modern design allows a modular grid of 'intervention spaces' (eg theatres in old speak) that can be used and re-used over time for almost any imaging or interventional purpose. Almost all such procedures will be day cases. Some patients may have a short stay for recovery. It is anticipated that all ‘heavy duty’ and medium-to-long stay surgery will be scheduled in Oxford.

As many outpatient appointments will use these diagnostic facilities, the centre will include outpatient facilities. There are major opportunities to improve the patient's experience of outpatient visits and to reduce the time and cost both to the hospital and the patient. Good physical design and informatics will pay dividends as yet unclaimed by many NHS providers.

4. Maternity Unit

This proposal represents a major point of difference. It is important to understand these proposals as a deliberate "Two Unit" strategy proposed in contrast to the perceived operational and consumer problems of a single 9,000 mega birth unit located inside the Oxford ring road. This is a different strategy for Oxfordshire's

maternity services - not simply a plan to "bring back the HGH Maternity Unit". It is based upon a strategic policy to run two units of different scale and style offering women a genuine choice. A balance of approximately 2,500/6,500 will offer sustainability at comparable costs to commissioners of the single mega unit.

Built to the highest standards of consumer-facing modernity, the HGH unit will offer a choice of full obstetric cover, midwife led birthing and continuity midwife care from ante-natal to and through birth. The local catchment of Banbury and surrounding areas will initially provide the majority of births, which will increase with sustained population growth over the coming decade. The balance will come from women in the wider catchment who express a preference for a smaller more personalised experience in a completely new unit birthplace of choice.

In this respect, it is perverse to suggest that women from Oxford would not want to travel to Banbury when OUHFT has accepted that travel in the opposite direction is acceptable. Until the JRH site congestion and Oxford traffic issues have been improved, travel to Banbury from outside the Oxford ring road may well be quicker and more reliable than the apparently "closer" JR site for many women.

There are six staff groups who determine the structure and operating costs of the maternity service - GPs, midwives, obstetricians, anaesthetists, paediatricians and specialist paediatric nurses.

General Practice. Whilst not formally part of the maternity service, the co-location of GPs on site will assist the management of the early pregnancy and ante-natal period for those mothers registered with on-site GPs. This is clearly subject to such GPs expressing an interest in co-location, such soundings yet to take place. There is also the medium/longer term prospect that future GPs may wish to develop an interest in maternal medicine and to participate in the maternity service on a sessional basis.

Midwives. The new HGH maternity unit will be predominantly a midwifery managed and led birthing centre (but with obstetric and anaesthetic staff present - see below.) Modern design means that this distinction between 'obstetric' and 'midwifery' no longer requires physical separation. A midwife-led and an obstetrician-led birth can be taking place in adjacent rooms. Looking towards a future in which midwives will organise and practice more independently, provision will be made for community midwifery services to be co-located. In time, this will allow for the establishment of semi-autonomous midwifery practices either stand-alone or linked to GP practices - should this be a development trend in the UK.

The maternity unit will be staffed pro rata to actual delivery numbers bearing in mind that it will take several years to bring the numbers up to plan. Current midwifery staffing formulae give differing rates (between 28-35 births per midwife) influenced by the presence and roles of support workers, the modernity of information systems and the make-up of the population served. The midwifery costs to commissioners should not vary significantly from current levels - the experience of New Zealand in granting greater financial autonomy to midwives was a significant rise in productivity. Given the modernity of the unit and its integrative practice, there should be opportunities to develop midwifery training modules around it - this should be an objective.

Obstetrics/Gynaecology. The obstetric faculty of OUHFT should be completely unified and both units should be equipped with the level of video linkage that is commonplace in current London/New York legal and financial circles but still a rarity in the NHS - meaning that the on-duty specialist staff in Oxford should be continuously available for advice and support across the whole piece. The objective of moving to a 30/70 split in birth numbers will allow a consultant presence at both sites - it should also be possible for the deployment of consultant obstetricians to be tactically balanced across both sites with the occasional switching of Oxford cadres to Banbury and vice versa within sessions. The presence of anaesthetic cover and obstetricians and gynaecologists will enable the Horton to renew its provision of an emergency gynaecology service.

The great majority of OUHFT elective gynaecology should be (re)located at the new HGH as this will increase the medical and anaesthetic presence on site and widen familiarity and relationships. The new operating facilities will deliver cost saving efficiency gains and reduce pressure on Oxford facilities.

The issue of junior & middle grade doctor posts within obstetrics and anaesthetics needs completely rethinking. The provision of NHS services should not be dependent on the deployment of doctors-in-training but on population needs and preferences. The new HGH unit should be staffed by midwives and consultants - the resources formerly (and unsuccessfully) allocated to training grades should be reallocated to an increase in consultant posts. The actual historic staffing costs of the maternity units at both the HGH and the JRH should be made available so that a full staffing model can be constructed and related to these historic baseline costs.

Anaesthetics. All women birthing at the new HGH unit should have access to full pain relief services delivered by consultant anaesthetic staff, with a similar conversion of junior grades to consultant posts and the release of detailed historic costs as with obstetrics. The retention of intensive care and the location of significant volumes of elective surgery will increase the critical mass of anaesthetics on site and widen familiarity and relationships.

5. Paediatrics

There will be an SCBU commensurate with a 2,500 birth unit which represents a continuation of the former service at the HGH. The 'two site' policy for obstetrics will be mirrored for neonatal care. The same video linkage platform will cover all services and the collective neonates in care at any time managed by a unified faculty (quite different from having two separate units). Occasional movements between sites of consultant staff to meet fluctuating need will be normal. Rotation of all appropriate consultants in the unified faculty to guarantee familiarity and relationships will advantage the whole service.

There is criticism of the admissions policy at HGH and of the number of short stay patients. Nevertheless, the children’s service provides accessible care to residents of Cherwell, South Northants and Stratford Districts who are concerned about their sick children. We propose installation of a Paediatric Assessment Unit/Clinical Decision Centre enabling medical or nursing assessment and appropriate treatment for children, minimising admissions (and potentially the bed complement) and providing a responsive service to the growing population of ‘Banburyshire’. Again, this should be linked by telemedicine to the extensive and potentially specialised

advice available from the Children's Hospital at JRH, enabling very sick children needing highly specialised interventions to be transferred and consultations between clinicians using agreed treatment protocols.

The HGH children's service would support the SCBU associated with the Maternity Unit and be linked closely with the Children's Hospital at JRH, enabling a comprehensive paediatric service to be provided meeting the needs of families wherever they might live. In a similar arrangement with the proposed obstetric service, the training of paediatricians and general practitioners would be undertaken across the hospital sites and the trainees rotated to enjoy the full range of experience into clinical environments supportive of training and educational activities.

6. Primary Care co-location

This is a major departure from the STP plan and addresses a key weakness of the proposals - the integration of primary care. This presents a difficulty as the important discussions with GPs have not taken place. For the moment, we can indicate that this is a major potential opportunity but one that can only arise from GPs electing to participate. Experience suggests that complicated issues of finance and clinical responsibility need to be addressed separately for each practice.

7. Social services co-location

This needs little elucidation. The consequences of separate organisation and finance of social care services are now plainly visible to the NHS. It is staggering that the STP seeks NHS 'sustainability' and 'transformation' without meeting this issue head-on. The Torbay experiment showed clearly the potential financial and social gains from intelligent integration - including a 30% reduction in occupied bed days.

8. Essential worker housing

Whilst aware that key NHS professionals are in short supply and that Oxford has the highest cost of living outside London, the NHS has paid vast premiums to agency staff in an attempt to beat the market. Housing and quality of life (both professional and domestic) are key to successful recruitment and retention. For decades, junior doctors have been offered poor quality on-site accommodation. Now NHS staff face the prospect of being unable to buy somewhere to live in the local housing market. These are not acceptable terms for tomorrow's professionals. Creating a pattern of services in which nearly all key NHS professional have to work in Oxford but cannot afford to buy within the city enforces commuting into a traffic nightmare.

As well as moving services and staff out of Oxford to Banbury, the '2 site' strategy brings the more affordable Banbury housing market into play. The existing Horton site is considerably larger than a new modern unified design will need. The traditional NHS response is to sell the asset. As local authorities, we have much deeper skills in housing development and an intimate understanding of the local scene. The Councils also have better frameworks for raising capital and joint venture. In an integrated future, the Council also has a vested interest in affordable housing for its own essential workers. The New HGH Health Campus should become a key part of local town plan.