Oxfordshire Transformation – Board Workshop PCBC headlines

9 August 2016

Updated for 13 September 2016

Diane Hedges


North


North East


Oxford City


South East


South West


West

Case for Change

General case for change

- Capacity gap on demand - £208m via todays delivery
- Workforce gap – *more later*
- Decision support to clinicians and skill mix sub optimal
- Estate is not fit for the future -- examples
  - Horton – poor estate –
    - need to confirm future plans for OUHFT to undertake the major upgrade it requires
    - CT scanner costing £2m in estate improvement to put in a 500k unit
  - Community hospitals wards too small require >beds together for efficient, effective delivery – 24 hour medic and nurse skillsets to get step up care – admission avoidance
    - Wantage – currently closing for Legionella risk
    - Abingdon – too small, parking not fit for purpose for older or frail users

Urgent Care

Urgent Care

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- There is insufficient scale at the Horton to develop contemporary sophisticated or advanced care for more complex urgent conditions (e.g., high-risk obstetrics, PPCI, Hyper-Acute Stroke Unit (HASU), Level III Critical Care and Emergency Surgery) or to meet guidelines on staffing rotas for the 21st century
- There is also a national shortage of emergency doctors which presents challenges in meeting the safe staffing guidelines from the Royal College of Emergency Doctors.

Critical Care Unit

- The Horton General Hospital has a level 3 critical care unit, which operates as part of the Thames Valley critical care network. Within this network, the specialist critical care unit is, and will continue to be, at the John Radcliffe Hospital. The needs of the patients in critical care at the Horton General Hospital are generally lower than those at the John Radcliffe Hospital, with 9% of patients requiring advanced support to keep them breathing or keep their hearts beating, compared to 24% at the John Radcliffe Hospital. There were fewer than 40 intubated patients in the Horton critical care unit last year.

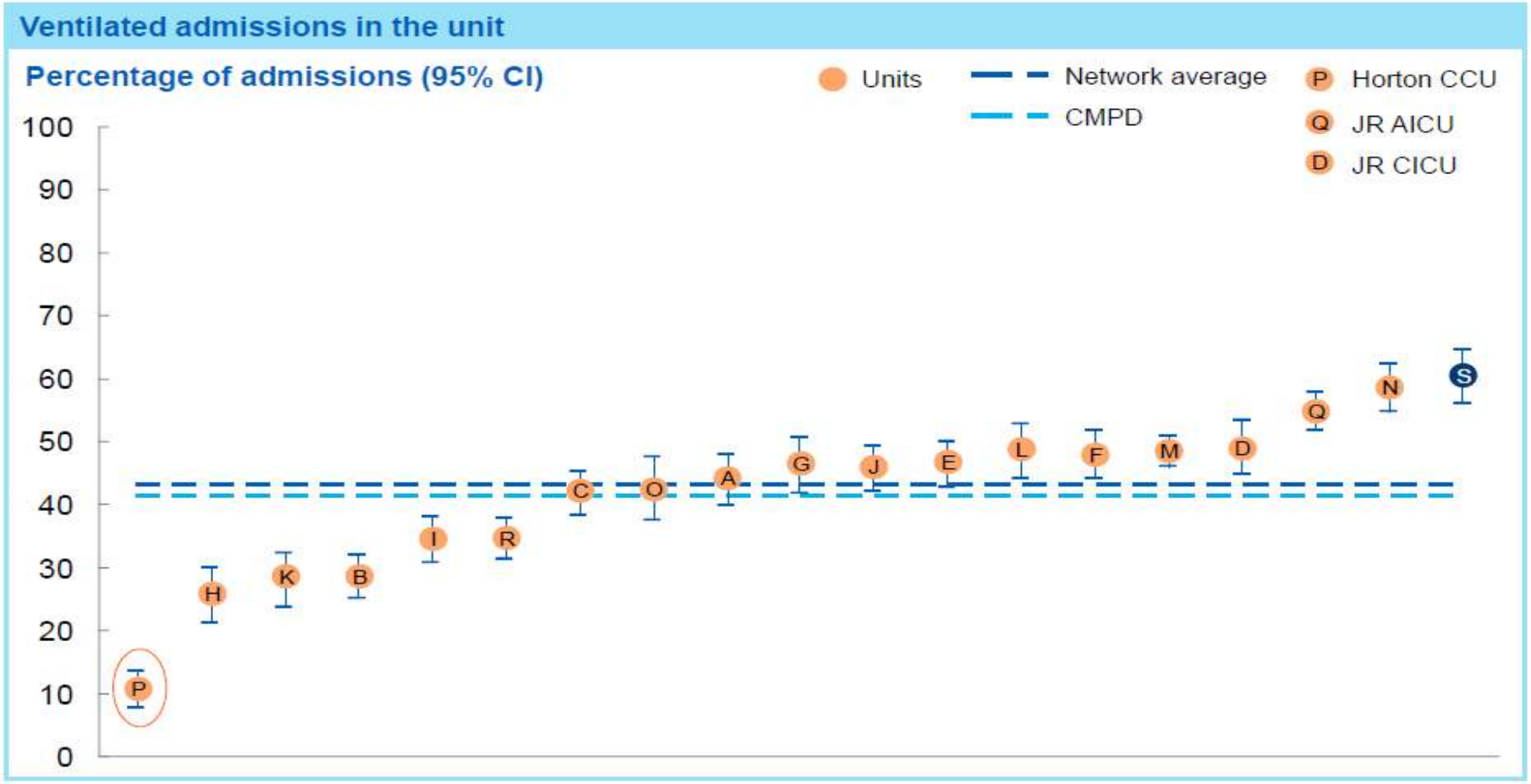
Critical Care (1)

Oxfordshire Clinical Commissioning Group

ELECTIVE, DIAGNOSTIC & SPECIALIST

4 The Horton critical care unit takes the lowest % of ventilated admissions in the Thames Valley network …

% of admissions



SOURCE: ICNARC 2016

Critical Care (2)

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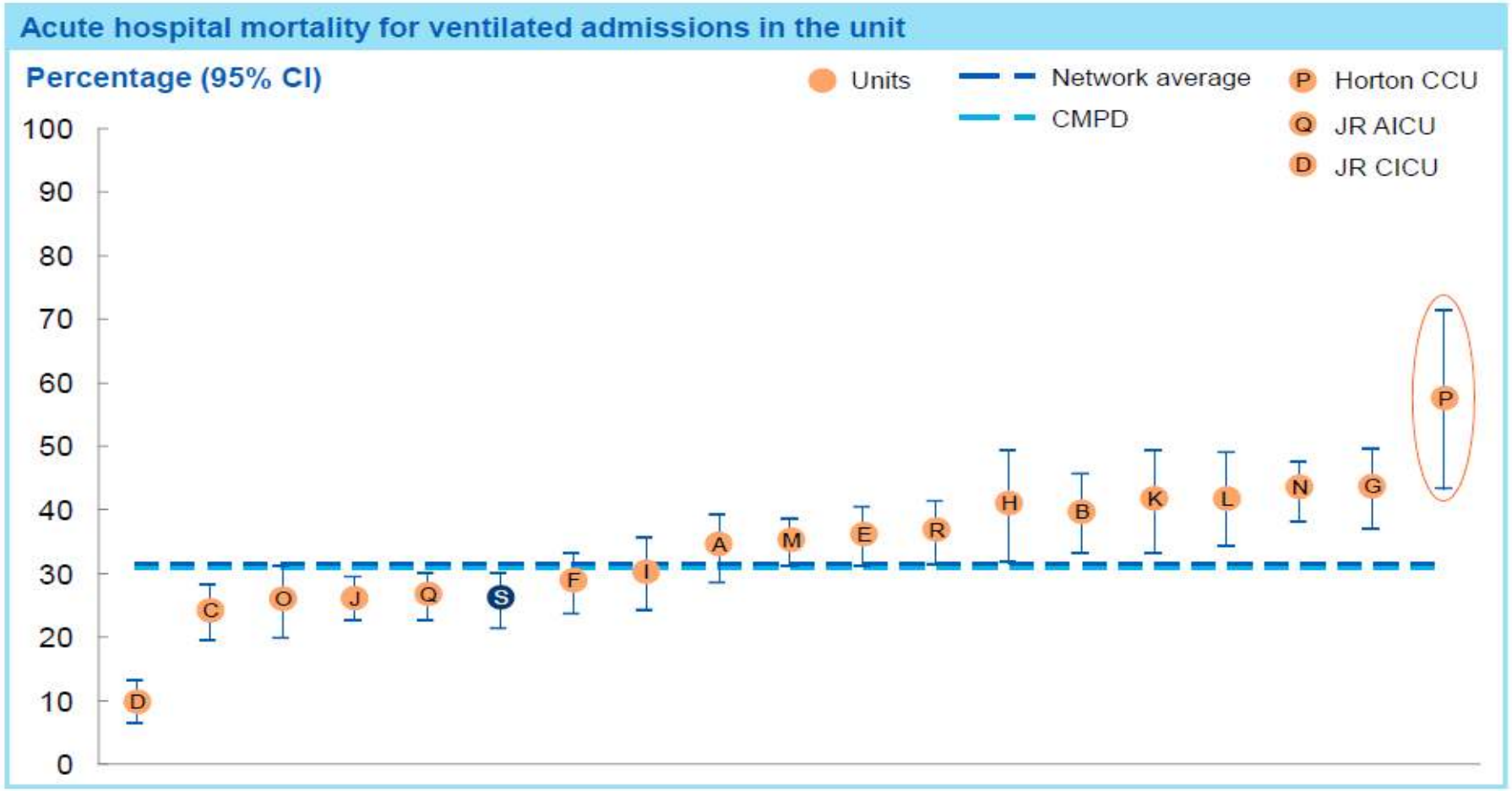
ELECTIVE, DIAGNOSTIC & SPECIALIST

4 … but has the highest hospital mortality for ventilated admissions

% of admissions



SOURCE: ICNARC 2016

Horton Urgent Care C4C

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- **Too many people turning up at A&E, driven by:**
  - Confusing service configuration to enable patients to self-direct, with no system of streaming patients, combined with fragmented out of acute hospital service provision
  - Variation in GP-access and out of hours access
- **Deteriorating ED performance**
  - Failure to meet the 4-hour wait consistently over the past 5 months (a Trust-wide issue)
  - Failure to meet the 4-hour stroke admission standard
- **High admission rate**
  - Higher admission rate for ambulatory care sensitive conditions than at the JR
  - Slow adoption of best practices (e.g., daily board round)
  - Lack of credible community services that can rapidly review patients at home to avoid admission
  - Physically separated ambulatory care / EAU / A&E with no coordinated care hub not conducive to patient flow
- **Difficulty in recruitment and retention**
  - 13.25 A&E consultants (WTEs) across 2 sites by August; no middle grades; dependency on locums
  - Possible (but uncertain) future need for 24/7 consultant cover
- **Longer length of stay at Horton**
  - Lack of daily senior review due to insufficient staffing cover –may contribute to longer length of stay due to lack of discharge decision making
  - Specialist inputs not always immediately accessible and may not be sustainable on site
  - Lack of inpatient MRI and out of hours US – delayed investigations prolong stay
- **Unsustainable inpatient volume**
  - Not enough stroke admissions to sustain an acute stroke unit (~9/month)
- **Not enough people being discharge**
  - Variation in discharge threshold across the whole MDT

- **Examples of good practice**
  - #NOF outcomes
  - Success of surgical assessment unit

Stroke (1)

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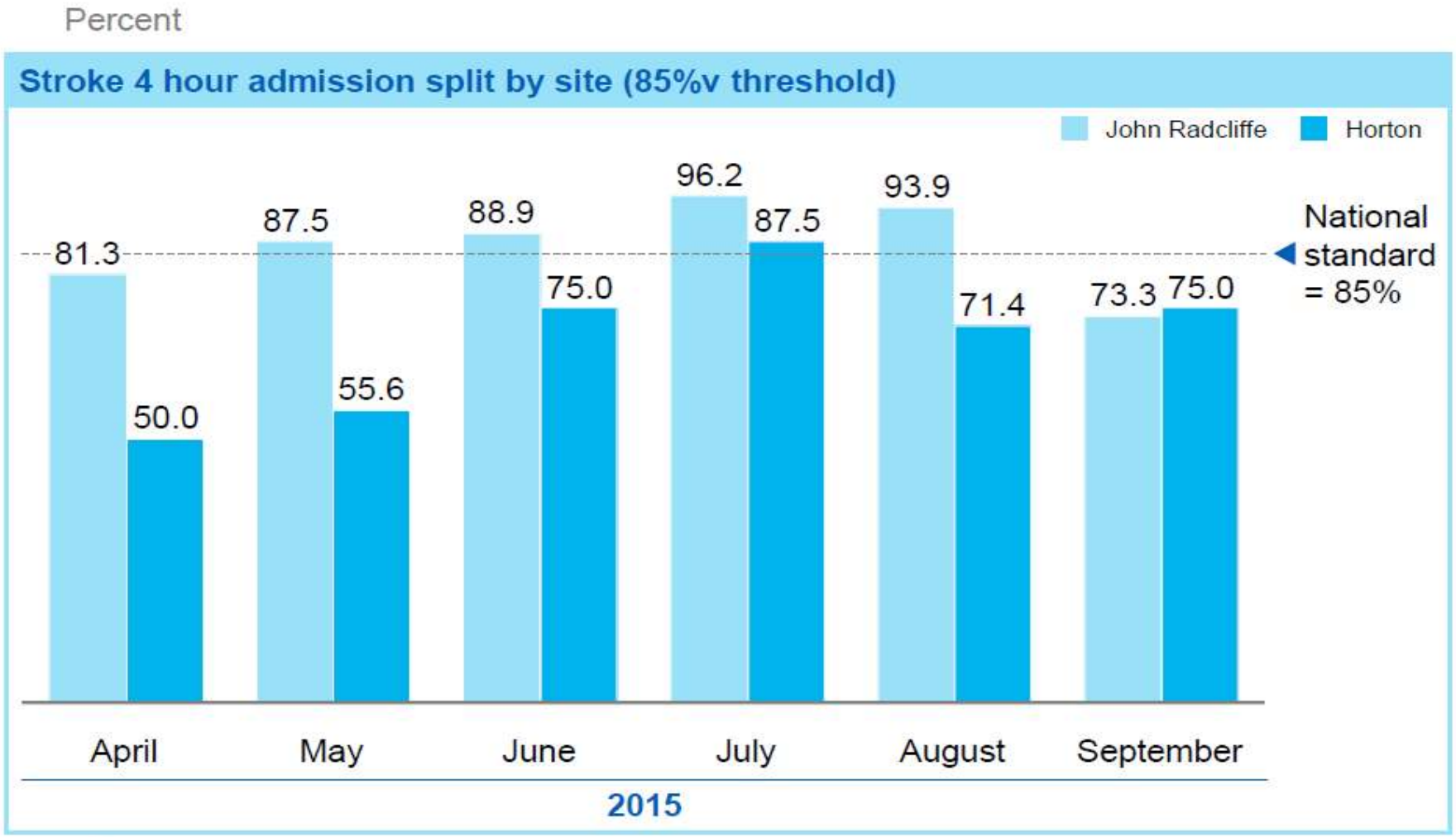
URGENT & EMERGENCY

3 The Horton performs poorly on access targets for stroke care



SOURCE: MRC Month 6 2015-16 Performance Report, October 2015

Stroke (2)

Oxfordshire
Clinical Commissioning Group

URGENT & EMERGENCY

3 The Horton Hospital performs poorly in the national audit for stroke care

Quality Account Abstract

This report is based upon patients arriving at the Horton Hospital (or having stroke onset as an inpatient) primarily between 1 April 2014 – 31 March 2015 and patients who were discharged from inpatient care during the same period.

Benchmarked against all UK sites according to quartiles of performance

- A: top quartile
- B: second quartile
- C: median
- D: third quartile
- E: bottom quartile

The SSNAP score is calculated from Key Indicator scores which are grouped into 10 domains

Domain 1	Scanning	D
Domain 2	Stroke Unit	E
Domain 3	Thrombolysis	E
Domain 4	Specialist assessments	E
Domain 5	Occupational therapy	D
Domain 6	Physiotherapy	D
Domain 7	Speech and Language therapy	E
Domain 8	Multidisciplinary team working	D
Domain 9	Standards by discharge	C
Domain 10	Discharge processes	C
Overall SSNAP level (SSNAP score 32.4)		E

SOURCE: SSNAP audit 2014/15

Planned Care

Planned Care (1)

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Local residents of The Horton General Hospital do not have access locally to high quality diagnostic equipment, the CT scanner requires replacement and the MRI scanner cannot be used for inpatients.

–Outpatient services are very fragmented across North Oxfordshire resulting in inefficient deployment of staff and for patients are not coordinated with their outpatient appointments

–Current elective, or planned care services are very under-utilized with theatre utilization around 70% of the standard 35 hours of operating per week, 3 MRI scans a day and 33 x-rays per day (spread across 4 x ray machines)

Planned Care (2)

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- **Challenges in current staffing rota and recruitment**
  - Removal of training grade recognition for surgical trainees at the Horton
  - Theatre lists sometimes cancelled because surgeon not available
  - Limited access to specialist services at Horton, including lack of cover from JR when rota vacancies arise
  - Staff at Horton seen as separate from OUH–few shared posts
  - Training and recruitment improved when workforce rotated across JR/Horton (e.g., ID, radiology) but need for a stable workforce to 'own' the service at the Horton
  - Opportunity for 'undisturbed teaching' to take place at Horton
  - Difficulty maintaining 24/7 rotas and training with current skill mix/activity levels
- **Too many people being brought back to outpatients**
- **Tariff payments fail to incentivise 'virtual' follow-up (significantly less than in person appointment)**

- **Low level of asset utilisation**
  - Lower level of theatre and endoscopy utilisation rates at Horton vs. JR site
  - Theatre utilisation is patchy across specialties and reflects waiting list variations
  - Potential to extend theatre/day case capacity by extending operating hours with a new model of medical staffing to support increased volume and range of day case and routine surgery
  - Poor diagnostic facilities and lack of 24/7 access to some diagnostics
  - MRI available at Ramsey for OP but not IP
  - CT access for outpatients Mon-Fri 9-5
  - Expensive to upgrade existing estate
  - Challenge of quality assurance of scans –the variation in protocols for scans across sites/out of county mean that some scans have to be repeated

Maternity

Maternity (1)

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- For births that are genuinely high risk (e.g., diabetic, older, overweight mothers or other risk factors – and this is a growing proportion of our mothers) there is no debate that the safest setting for birth is in a unit with interventional radiology, level 3 critical care, emergency surgery, neonatal care and obstetric consultant presence available on site round the clock. This is in line with RCOG recommendations. At present, neither OUH site offers this, due to the shortage of obstetric consultants.

- For women who choose to give birth in a unit that has obstetric support (e.g., women who choose to have an epidural) there may be no clinical reason why the full range of support needs to be available. But at present (and for the foreseeable future) because the supply of obstetricians is too limited to provide round-the-clock coverage even at one site, this obstetrician-led care cannot be offered at more than one. The most equitable solution for the women of Oxfordshire is to concentrate obstetricians on one site and thereby maximise the care they can provide.

Maternity (2)

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- Since the withdrawal of RCOG training recognition from The Horton General Hospital, the obstetric service has been staffed by Oxford University Clinical Research Fellows (CRFs), but despite regular recruitment drives in the UK and internationally there has been a lack of success in filling these clinical/academic posts. This has been due to a number of factors: a national shortage of obstetricians – which in turn has resulted in fewer trainees being allowed "time out of programme" to undertake academic projects such as the clinical research fellow posts at the Horton General Hospital – and changes in visa requirements that have deterred candidates from outside the UK.

- The CRF posts currently have a 20% vacancy rate, and the last five rounds of interviews only provided two successful candidates. The University has now cancelled this academic programme and the clinical research fellows will not be replaced as they come to the end of their contracts. Since April 2016, the Trust has advertised for Trust grade obstetricians to provide middle grade cover for the Horton General Hospital, offering rotations to the John Radcliffe Hospital and an enhanced pay level as part of the contract, but there have still been insufficient applicants to fill the posts.

Maternity (4)

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- **Across Oxfordshire, the provision of intra-partum care is not aligned with the needs**
  - 3 community SMLUs are not located where pregnant women currently live, nor where they are likely to live in future
  - Increasingly complex patients who require obstetrician led units with sub-specialty expertise, co-located with ITU, medical and surgical support –having 2 of these units for a population of ~650K people may not be clinically or financially viable
  - Risk of losing patients North of the border (may choose to give birth elsewhere)
- **Current provision of services across Oxfordshire is potentially not clinically sustainable**
  - ~5,700 births at JR (~4000 (75%) delivered by 10 WTE obstetricians), ~1,500births at Horton (~400 (33%) delivered by 5 obstetricians) and ~390 births across the 3 SMLUs
  - Several incidences at the Horton where the unit were having to be closed as no locums available
  - Lack of training recognition with a hybrid-model of mid-grade clinical research fellow posts (splitting time between clinical work and research) likely to end at Horton

Maternity (5)

Oxfordshire Clinical Commissioning Group

- **Inequity of provision of perinatal mental health care at the Horton and JR**
  - Women who require specialist maternity psychological medicine input have to travel to the JR as there is no dedicated maternal mental health team at the Horton
- **Some quality / outcome measures for inpatient maternity services could be improved**
- **Lack of clinical support services at Horton has increased need for ambulance transfers to JR**
  - Withdrawal of ability to investigate PE/DVT means patients are transferred to JR
  - Lack of inpatient MRI means patients are transferred to JR
  - Withdrawal of emergency general surgery leads to transfers to JR for procedures like EVAC
- **Variations in antenatal care**
  - Method of risk assessing women in pregnancy not being done in a consistent manner

Maternity (6) – Reconfigurations research

Oxfordshire Clinical Commissioning Group

Location	Birth rates	Travel time	Key messages in consultation/key learning	Any other comments
The Friarage Hospital (Northallerton) South Tees Hospitals NHS Foundation Trust	**1260** per year "We have looked at the local population and analysis suggests the number of births is not likely to increase."	• **23 miles** to nearest Obs unit (James Cook, M'boro) • Produced a full transport report for consultation • Provided a **shuttle bus** between sites • Work with ambulance crews to ensure they know the best place to take the patient	• Explains link between children's and maternity services • Friarage one of the smallest units in the country • Increase in high risk births which increases likelihood of complications • Workforce pressures • *"evidence shows that this service is best provided in a major centre where the mother and baby can be managed by a specialist clinical team with the right technology and support close by".* • *"during the engagement process, people rated closeness of services above safety and quality. However, as a group of GPs responsible for commissioning these services, we absolutely have to put the safety of our patients above everything else".* • *"If there is an emergency situation, we need to ensure highly experienced staff are on hand who see complex emergency situations every day, and are confident in recognising the signs of a very ill child or a poorly expectant mum, and can respond quickly".*	• Shuttle bus service was stopped in July 2016 – under utilised?! • **Didn't consult on Option A (Status Quo) – see extract below**

Maternity (7) – Reconfigurations research

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Hywel Dda Health Board – Glangwili and Withybush Hospitals	**1148** deliveries in 2013 at Withybush	• **33.2 miles** • Travel time approx. 42mins • Provided a **Dedicated Ambulance Vehicle (DAV)**	• Following a difficult and highly contested consultation on the reconfiguration of maternity, neonatal and paediatric services, the Welsh Assembly Health Minister required the Health Board to conduct an independent review of the reconfigured services 12 months after implementation. The full report includes a whole chapter on transport and looks in detail at staff rotas and integration of teams. The full report can be found at - http://www.rcpch.ac.uk/system/files/protected/page/RCPCH%20-%20Hywel%20Dda%20Report%20-%20Full%20version%202011%2015.pdf	The RCPCH found "We found no evidence that clinical outcomes had worsened since the changes and there is better compliance with professional standards. There is no clinical sense in reversing the major decisions of reconfiguration made one year ago". The full report may help anticipate risks and issues if implemented.
East Sussex (3 CCGs joint strategy)	**2 small units** in 2012/13 delivering **1973** at Eastbourne DGH and **1865** at Conquest Hospital	• **19.8 miles** between sites • Travel time approx. 40-45mins • 23.2 miles to Royal Sussex County Hospital	• 'Better Beginnings' consultation January – April 2014. • Decision made on 25 June 2014 by all CCGs involved (minutes attached - Minutes_of_25_June_2014_East_Sussex_CCGs'_meeting_regarding_Better_Beginnings[1].pdf) • Paper with further details on the programme and consultation - 1._Summary_of_the_programme_approach,_methodology,_and_outcomes_of_the_consultation[1].pdf • Reconfiguration now implemented with a consultant led unit at Conquest Hospital and MLUs at Eastbourne DGH and Crowborough.	

Maternity (8) – Reconfigurations research

Oxfordshire Clinical Commissioning Group

Cumbria	**1264** deliveries in 2014/15 **1313** deliveries in 2013	• **40 miles** to Carlisle Cumberland Infirmary	• http://www.bbc.co.uk/news/uk-england-cumbria-37037414	Consulting in September
Greater Manchester		•	• Large scale multi-site reconfiguration – cited in Horton Strategic Review	
Lincolnshire		• 37-39miles • Travel time of approx. 1 hour	• http://www.bbc.co.uk/news/uk-england-lincolnshire-36160249 • Two options being considered – centralised service on one site or modified two site service with possible shared team	Early discussions still being held – not gone to formal consultation yet.

Maternity (9) – Reconfigurations research

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Extract from Friarage Hospital Consultation

Option A - Sustaining a 24 hour consultant led paediatric service and maternity unit (essentially keeping services the same by investing £2.7m in more consultants or senior doctors).

Why we didn't include option A in the consultation – the key reasons

The Department of Health's National Clinical Advisory Team (NCAT) advised us that doing nothing was not an option. Its report said: "To sustain paediatric inpatient care at the Friarage would require significant investment in consultant paediatric on-site presence. Not only is this not affordable in the current climate but it is poor use of public funds. Consultants employed in this way would have little to do for much of their time and would be in danger of losing their clinical skills."

Our CCG and South Tees Hospitals NHS Foundation Trust looked at small paediatric and maternity units throughout the UK. We visited other hospitals and talked to staff to understand how they are dealing with similar problems and to see if any alternative models have been overlooked. The conclusion from this work demonstrated very clearly that these units, many larger than the Friarage Hospital, were struggling with the same issues.

Option A would also have required an additional investment of £2.7m and providing this investment would mean reducing services in another area to pay for it. We also believe that it is wrong to consult on an option that we cannot afford.

Paediatrics

Paediatrics (1)

Oxfordshire Clinical Commissioning Group

- **High referral rates and A&E attendances**
  - Higher GP referral rate in Horton catchment area - Some avoidable A&E attendances –50% of paediatric A&E episodes at Horton are for minor injuries and illnesses
  - Rates of emergency admissions for children at the Horton (around 11 a day) are higher than at the John Radcliffe but nearly 75% of children stay in for less than a day
- **Difficulties with recruitment and retention of staff (particularly senior nursing staff)**
- **Inequity of resource provision across the service**
  - Lack of paediatric training recognition at the Horton leads to a 24/7 consultant staffed service, whilst the JR is unable to deliver 24/7 consultant-led care
  - High demand for beds at the JR whilst there is a lower demand for beds at the Horton (especially in summer)
- **Staffing challenge at OUH**
  - ~10 paediatricians at the JR (~16,000 inpatient spells per year) and ~12 paediatricians at the Horton (~2000 inpatient spells per year)
  - There are no training posts for junior doctors at the Horton, so the 24/7 rota is covered by consultants
  - The Trust has been flexible in terms of its payment structure to increase the nursing shift and also moving the specialist baby unit to the paediatrics unit. However the current rota is only sustainable until the end of June 2016
- **Inequity of access to paediatric psychiatry across OUH sites**
  - No dedicated paediatric psychiatrist for inpatients at the Horton, whereas this service is available at the JR
- **Challenge of sustaining clinical competencies**
  - Lack of critical mass at the Horton (small unit) leads to isolation of clinicians

Paediatrics (2)

Oxfordshire Clinical Commissioning Group

PAEDIATRICS

Number of children attending the Horton out-of-hours

Audit of out-of-hours attendances to the Horton

Number of attendees between the hours of 22:00 and 08:00 from 31st Dec 2015 and 31st Jan 2016

Total attendees 0-16 y 22.00-08.00	102
Of which, ED minors	16
TOTAL MEDICAL ATTENDEES excluding ED minors 0-16 y, 22.00-08.00	86

Distribution of frequency of attendances

No. attendees per night	Number of nights
0	1
1	5
2	8
3	9
4	4
5	1
6	3

Audit of PICU/HDU transfers from the Horton to the JR

	Night 1	Night 2	Night 3
Reasons for attendance	Musculoskeletal pain	Croup	Earache
	Viral illness	Asthma	URTI
	Croup	Snuffly baby	URTI
	Feb con	Fever	Tonsillitis
	Asthma	Breathing diff	Short of breath
	Floppy baby	Breathing diff	Overdose
No. discharged home from ED	3	5	4

- On average, this represents 2.7 children per night, during one of the busiest months of the year
- Even on the busiest nights (with 6 patients), a maximum of 3 patients were referred to paediatrics – the rest were seen by ED and discharged home

Audit of PICU/HDU transfers from the Horton to the JR

Over a 16 month period, there were:

- 33 transfers between Horton and JR
  - 10 direct from ED
  - 23 from inpatient ward
- 3 of these transfers arrived at the JR after 10pm

- On average, this represents 2 transfers per month

SOURCE: Trust EPR data, 2016

Paediatrics (3)

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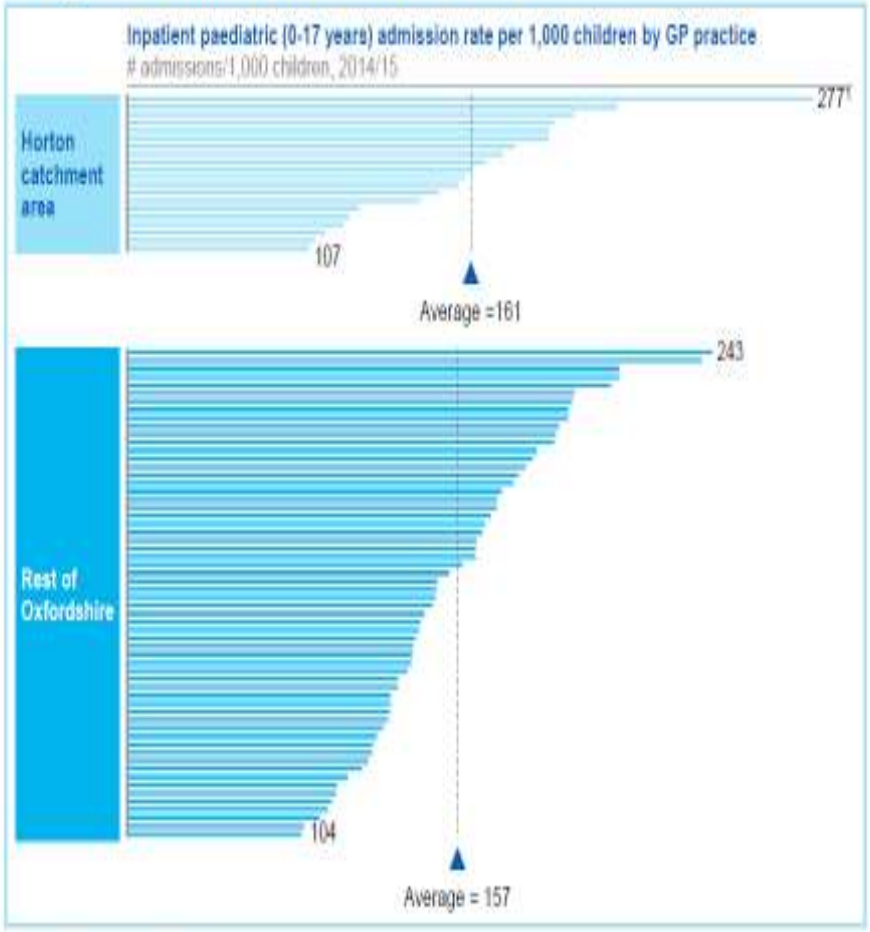
PAEDIATRICS

1 The average paediatrics admission rate from the Horton catchment GPs is higher than from the rest of Oxfordshire



1 GP Practice "Banbury Health Centre"

SOURCE: HES 2014/15

"The Oxford University Hospitals NHS Foundation Trust Proprietary and Confidential"

PAEDIATRICS

3 74% of non-elective paeds admissions at Horton is 0-1 day-stays vs. 55% at JR

Non-elective Paediatric (0-16 years) admissions by length of stay

NEIP admissions	Horton		John Radcliffe		England average
0-1 days	2,910	74%	7,738	55%	68%
2-3 days	745	19%	3,720	27%	20%
4-7 days	179	5%	1,635	12%	8%
8-13 days	25	1%	405	3%	2%
Over 14 days	57	1%	472	3%	2%
TOTAL	3,916		13,970		

SOURCE: Inpatient HES 2014/15

Paediatrics (5)

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The improvement in paediatric care that this option aspires to deliver stems from the avoidance of unnecessary hospital admissions. Only in the most serious cases do children need to stay in hospital longer than a day, and the safest place for these children is in a specialised paediatric hospital with all the associated support services such as paediatric intensive care. The vast majority of child attendances would be better dealt with in a short-stay paediatric assessment unit, as recommended by the RPCH – our vision also offers rapid access to diagnostics, more outpatient clinics and more local day cases.

Future Model

Future Model – Maternity (1)

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The National Perinatal Epidemiology Unit's Birthplace national cohort study (2015) was designed to answer questions about the risks and benefits of giving birth in four different settings; home, freestanding midwifery units (FMUs), alongside midwifery units (AMUs) and obstetric units (OUs). The study focused on birth outcomes in healthy women with straightforward pregnancies who are at 'low risk' of complications, collecting data on care in labour, delivery and birth outcomes for the mother and baby for over 64,000 'low risk' births in England.

The study found that midwifery units appear to be safe for the baby and offer benefits for the mother. For planned births in freestanding midwifery units and alongside midwifery there were no significant differences in adverse perinatal outcomes compared with planned birth in an obstetric unit. Women who planned birth in a midwifery unit (AMU or FMU) had significantly fewer interventions, including substantially fewer intrapartum caesarean sections, and more 'normal births' than women who planned birth in an obstetric unit. The review also found that for women having a first baby, there is a fairly high probability of transferring to an obstetric unit during labour or immediately after the birth.

Evidence Review to Support the National Maternity Review 2015; Perinatal and maternal outcomes by parity in midwifery-led settings: secondary analysis of the Birthplace in England cohort comparing outcomes in planned freestanding and alongside midwifery unit Births. Jennifer Hollowell, Yangmei Li, Kathryn Bunch, Peter Brocklehurst, National Perinatal Epidemiology Unit, Nuffield Department of Population Health, University of Oxford, October 2015

Future Model – Maternity (2)

NHS
Oxfordshire
Clinical Commissioning Group

Evidence: NICE Guidelace CG190 – Choosing planned place of birth

Women at low risk of complications

Explain to both multiparous and nulliparous women that they may choose any birth setting (home, freestanding midwifery unit, alongside midwifery unit or obstetric unit), and support them in their choice of setting wherever they choose to give birth:

- Advise low-risk multiparous women that planning to give birth at home or in a midwifery-led unit (freestanding or alongside) is particularly suitable for them because the rate of interventions is lower and the outcome for the baby is no different compared with an obstetric unit.

- Advise low-risk nulliparous women that planning to give birth in a midwifery-led unit (freestanding or alongside) is particularly suitable for them because the rate of interventions is lower and the outcome for the baby is no different compared with an obstetric unit. Explain that if they plan birth at home there is a small increase in the risk of an adverse outcome for the baby. [new 2014]

Explain to low-risk multiparous women that:

- planning birth at home or in a freestanding midwifery unit is associated with a higher rate of spontaneous vaginal birth than planning birth in an alongside midwifery unit, and these 3 settings are associated with higher rates of spontaneous vaginal birth than planning birth in an obstetric unit

- planning birth in an obstetric unit is associated with a higher rate of interventions, such as instrumental vaginal birth, caesarean section and episiotomy, compared with planning birth in other settings

- there are no differences in outcomes for the baby associated with planning birth in any setting. [new 2014]

SOURCE: NICE website

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The Future – Oxfordshire Health System

	Tier 0	Tier 1	Tier 2	Tier 3	Tier 4	Tier 5
	Self-care and prevention	General Practice, optometry, dentistry, pharmacy	Neighbourhood community care	Primary and Integrated care centre	Local Hospitals with beds	Acute services
Population served (approx.)	750,000	<20,000	30,000-50,000	80,000-200,000	250,000-400,000	750,000
No. in Oxfordshire NB Need to agree for options	N/A	<74	16 (tbc)	6	2-4	1
Opening	N/A	8-630 M-F	8-630 7 day a week	8-10pm M- F and 8-4 Sat and Sun	24/7 with medical cover	24/7
					Beds recommendation 24/7 medical cover- will drive number of viable options	
			LTC outpatients Primary care plus	Outpatients GP access hub/MIU X-ray	Ambulatory Assessment and step up to Beds/CT scanner	