NHS
Oxfordshire
Clinical Commissioning Group

Health and Care Transformation in Oxfordshire

Community Partnership Network

21 October 2016

Diane Hedges


North


North East


Oxford City


South East


South West


West

What Do We Already Know?

Services

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29% said that waiting times of longer than a week for GP were unacceptable

15% of patients go to A&E when they could have been seen in primary care

We need to help more people in managing their long term condition

Some patients are staying in hospital longer than necessary when they would do better at home.

Over 80% of our hospital resources are used by around 10% of the population

30% of GPs plan to retire in the next five years

What Do We Already Know?

Funding NHS Oxfordshire Clinical Commissioning Group

Over the next 5 years there is an extra £125m to improve quality, access and responsiveness

Increases in demand, complexity and cost will create a £134m shortfall if we do nothing

Business as usual is not an option if we are to tackle our health and quality challenges

We need to maximise the value of every pound spent to achieve financial and clinical sustainability

The build up of the financial gap

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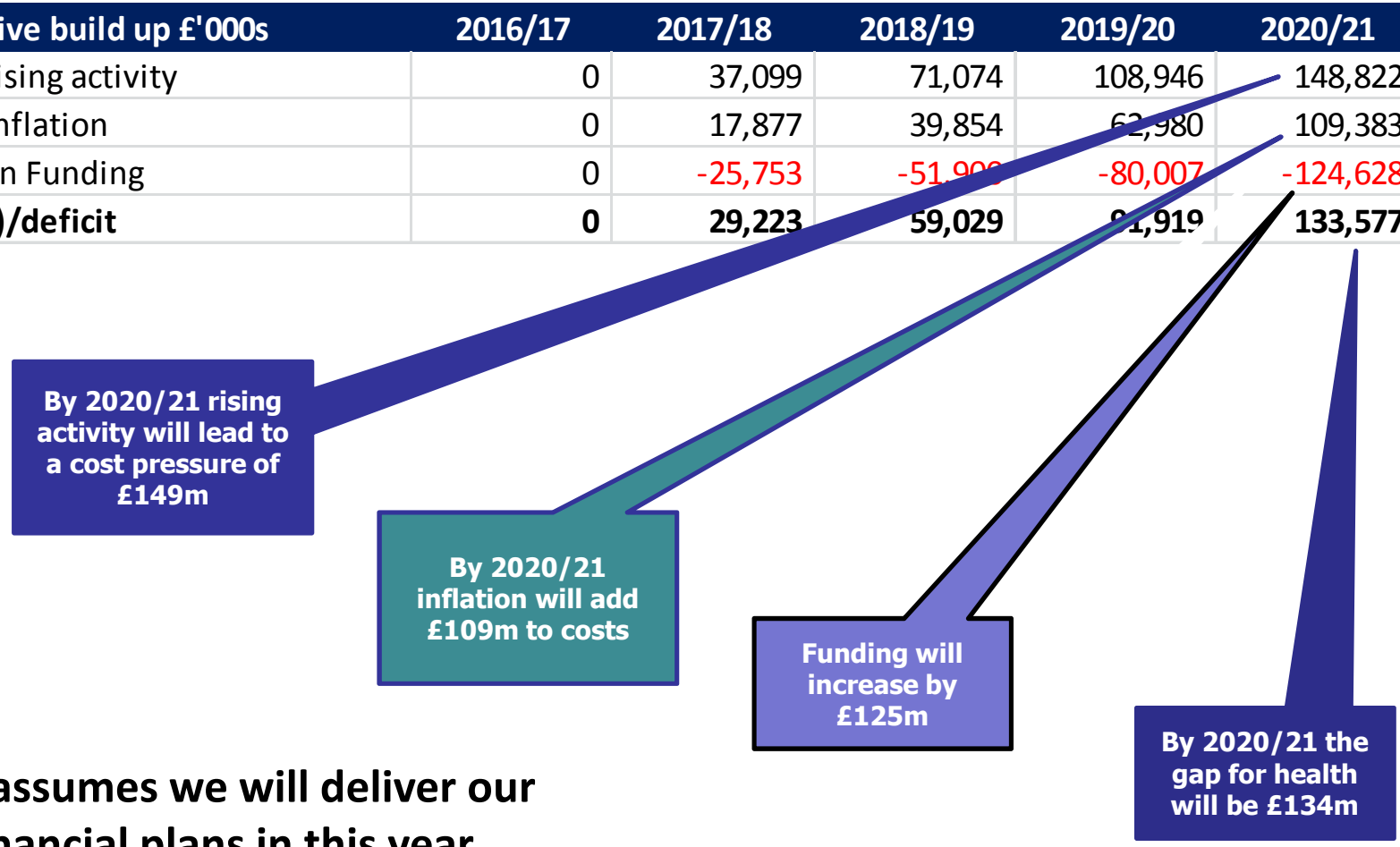
Cumulative build up £'000s	2016/17	2017/18	2018/19	2019/20	2020/21
Cost of rising activity	0	37,099	71,074	108,946	148,822
Cost of inflation	0	17,877	39,854	62,980	109,383
Growth in Funding	0	-25,753	-51,908	-80,007	-124,628
(Surplus)/deficit	**0**	**29,223**	**59,029**	**91,919**	**133,577**



This assumes we will deliver our financial plans in this year

The nature of the challenge

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- Funding growth more than offsets the cost of inflation but is not sufficient to cover the cost of increasing activity.
- The challenge can therefore be deemed to be one of productivity and efficiency i.e. how can we cope with the increase in demand within the same resources.
- This activity/productivity challenge is highlight using acute hospital activity in the following table:

Expected Activity Numbers By Acute Activity Type	2016/17	2017/18	2018/19	2019/20	2020/21	Growth
Outpatient Activity	453,976	468,634	478,468	493,241	508,311	54,335
Elective and Day Cases Activity	62,839	64,697	65,496	67,379	69,315	7,300
Non Elective Activity	63,781	65,500	66,091	67,771	69,390	6,302
A&E Activity	154,512	158,116	159,040	162,395	165,896	12,500

The nature of the challenge

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- If we did nothing we would need to provide for c15% more capacity in all our services we don't have the funding and as importantly the workforce to be able to do this.
- It is important to note that overall funding is still going up. We need to try and invest those resources where the highest impact. Examples of where we have done this recently are:
  - Plans to deliver savings and improvements in patient experience such as delayed transfers of care
  - Ring-fenced new investment of £4.0m in primary care to strengthen it and provide additional capacity
  - Investment in acute contracts to implement new NICE guidance
  - The new Minor Eye Conditions Service (MECS)

Summary of Case for Change

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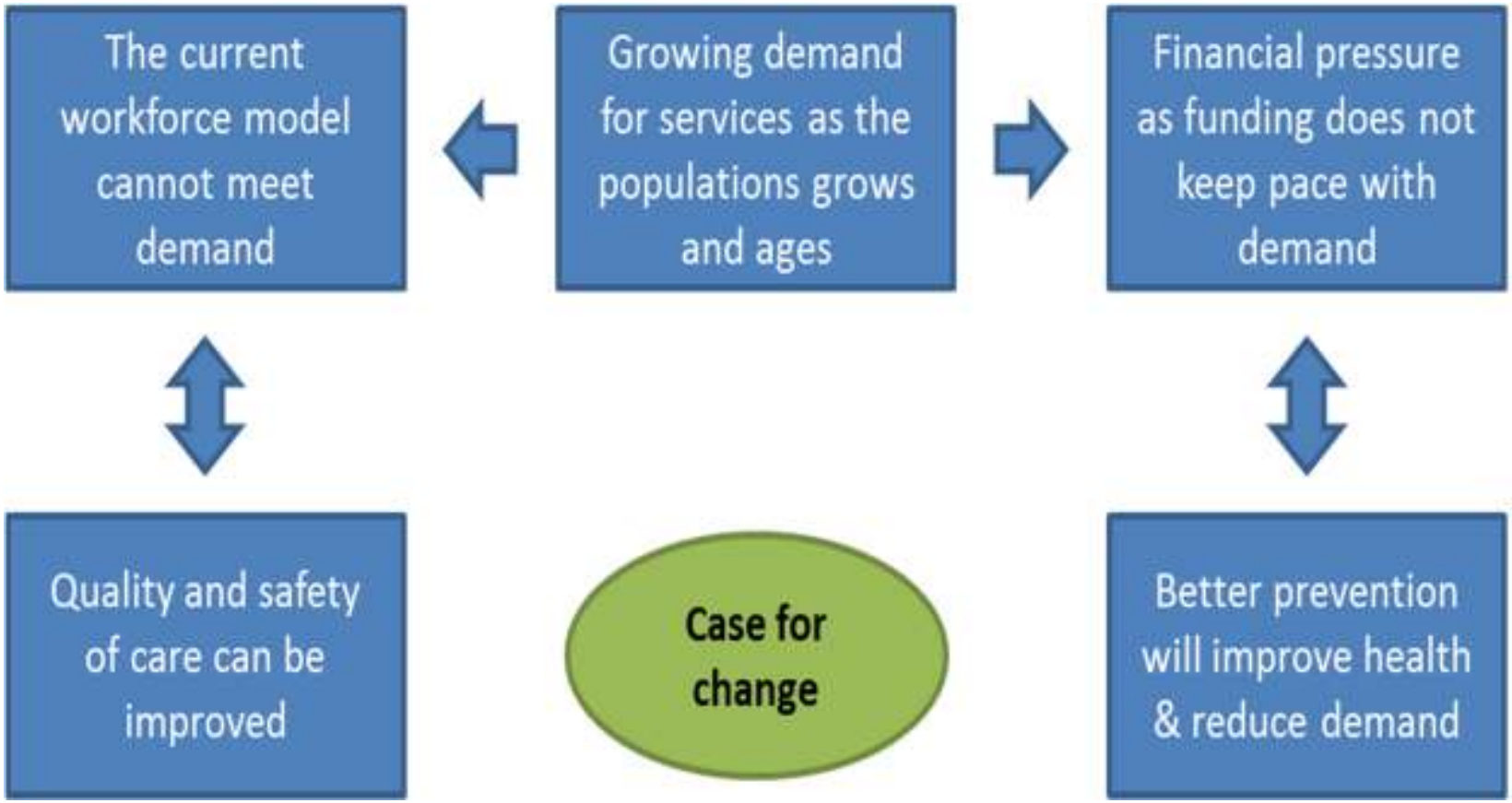

Estate/infrastructure not suitable to deliver optimal care

Inequalities exist across Oxfordshire in health outcomes

Case for change from our residents

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Over 75% respondents said they understood why change was needed and listed the following top reasons for change:

- Lack of resources / money / efficiency
- Increased pressure on services – Ageing population - growing population & delayed transfers of care
- Staffing problems – number, specialists and quality - Emphasis on staff and recruitment
- Difficulties in accessing GP services
- Technology / new medical techniques
- Transport & accessibility to services
- Patient safety, patient experience and patient outcomes are important
- A focus on prevention and education on leading a healthy lifestyle is needed - need for public attitudes to change– moving to an understanding that people are responsible for their own health
- The need to retain community hospital services
- More integration of health and social care
- Better communications

The final engagement report is available at www.oxonhealthtransformation.nhs.uk

Case for change – Horton hospital

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- We need a certain future for the North Oxfordshire residents
- We need a long term plan agreed to improve the estate
- We know we can serve more people locally
  - over 60,000 more outpatients possible
  - Additional diagnostics

    Improved access to CT scans

    Additional MRI scanner

Primary Care Case for change

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- Primary Care is under huge pressure in Banbury despite additional resources for non-registered patients
- Pressures reported by most Practices including
  - 1 practice with list closed and closing Branch surgery
  - 2 practices with request to close list
  - 1 practice request to change boundary
- CCG required to assist Practices where patients swapping Practices solely to seek shorter waits
- More patients reporting issues on access and even greater rise in numbers in A and E attendance in North than John Radcliffe this year
- Areas of high deprivation – e.g. Woodlands and Banbury Health Centre
- Several practices on CCG "vulnerable" list
- 3 on CQC requires improvement
- Population growth of c8,000 expected by 2026 across the North Locality
- High use of secondary care
- Banbury Heath Centre contract expires 31/3/17

Case for change – Horton hospital

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Urgent and Emergency Care

- Proportionately higher ED attendances at the Horton than the rest of Oxfordshire
- There are regular breaches of the 4-hour waiting time target in A&E
- Demand is increasing currently and is projected demographically to increase further
- There are lower thresholds for admitting over-65s with ambulatory care-sensitive conditions (than at the John Radcliffe Hospital)
- Higher levels of people fit to leave hospital, but cannot (26%) than on Headington sites
- Requirement for some bed and ward changes to secure ambulatory care and prevent delayed discharges

Stroke Care

- Patients are best cared for in a Hyper-acute Stroke Unit (HASU) which provides the best specialist expertise and care
- The Horton General is an outlier according to National audit data (2014/15)
- There is an inadequate catchment population for a high quality and safe stroke service

Critical Care

- There are low volumes, which will impact on maintaining clinical skill sets and therefore safety,
- There are higher mortality rates for intubated patients than peer services.

Case for change - Maternity

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- We should have
  - Early medical risk assessment, Evidence based pathways for low risk and high risk care, Informed choice for all women, Expanded offer of postnatal support, Integrated perinatal mental health service
- High risk and complex pregnancies should be delivered in obstetric units with continuous senior medical staff presence
- Oxfordshire is not meeting guidance on quality in key areas.
- There are performance differences between obstetricians at the Horton General (5WTE deliver 1400 births – NB mix of obstetric and midwife) and those at the Headington (10WTE deliver 5800 births) sites.
- Need a future proofed model to support 8% growth by 2025/6
- The Obstetric Unit at the Horton General has had to be closed temporarily (1/10/2016) because of no medical cover and unscheduled closures are not safe.

What good maternity services look like	Quality met	Did we have this in Oxfordshire in August 2016?
All labour wards should have the medical workforce required to ensure safe care for women.	NO	There are insufficient consultants and middle grades to deliver a safe obstetric service at the HGH Tertiary centre and high volume JR deliveries should have 168 hours of consultant cover (actual 106 hours) .
Units are able to ensure a ratio of one midwife to 30 births for hospital birthing services.	YES	There are usually sufficient midwives to provide 1:30 ratio
All women are to be provided with 1:1 care during established labour from a midwife, across all birth settings	YES	In 2015/16 this was achieved • In 100% of cases at the JR • In 100% of cases at the HGH • In 100% of cases at MLUs
Women should be given a choice of where to give birth – at a consultant-led unit, midwife-led unit or a home birth.	YES	Oxfordshire women have the choice of giving birth at home, in a freestanding midwife-led unit, the alongside midwife-led unit (Spires) or in a consultant-led unit.
Women and their families will be treated as individuals with dignity, kindness and respect.	YES	The service was rated as 'Good' by the CQC in the last patient survey but we know we need to do more to support women postnatally.
There is a threshold of 2,500 births per year, below which consultant-led services should be scrutinised closely due to the additional challenges of maintaining safety and quality.	NO	In 2015/16 only 1,466 women gave birth at the HGH consultant-led unit. There has been a year on year decrease in births.
The on-call consultant should attend in person in a number of high-risk situations eg: eclampsia, major bleeding and other serious complications.	Partial	Consultant vacancies on the rotas at both the JR and HGH make it difficult to provide this consistently.
Obstetric units should have a dedicated anaesthetist available on call 24 hours a day, 7 days a week to provide anaesthetic relief and assist in complex deliveries.	YES	Both obstetric units at the JR and HGH have anaesthetic rotas.
Postnatal care must be resourced appropriately. **Women should have access to their midwife as they require after having had their baby.**	Partial	Postnatal care and in particular specialist breastfeeding support is the key area that women tell us needs improvement in Oxfordshire

Paediatrics

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- **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 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
  - Despite flexible terms in payment structure to increase the nursing shift and also moving the specialist baby unit to the paediatrics unit recruitment is challenging
- **Inequity of access to paediatric psychiatry across OUH sites**
  - No dedicated paediatric psychiatrist for inpatients at the Horton, JR has this

Our vision

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- The best quality care provided to patients as close to their homes as possible
- Health professionals, working with patients and carers, with access to diagnostic tests and expert advice quickly so that the right decision about treatment and care is made
- Ensuring, as modern healthcare develops, our local hospitals keep pace, providing high quality services to meet the changing needs of our patients
- Preventing people being unnecessarily admitted to acute hospital or using A&E services because we can't offer a better or more local alternative
- Best bed is your own bed

Future models

Primary Care

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- This modernised service will:
  - Improve access to better coordinated and more personalised care closer to home
  - Deliver high quality access to urgent and routine care across the whole county
  - Support primary care to manage populations so reducing the need for hospital based care particularly providing more time to manage complex care and patients with long term conditions
  - Support self-care so that more patients can take control of their health
  - Be integrated into the health system to prevent poor health and reduce health inequalities.

Primary Care Transformation

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Working together in larger units (at scale)

Exploring a range of options:

- More central clinical same day access for Banbury population
- Provision of in-reach staff to Practices
- One urgent front door co located with A and E to include same day walk ins
- Shared clinic services blood tests, immunisations, smears etc.
- Shared long term conditions support
- Combine / merger of practices to reduce number
- Provision of enhanced primary care services to reduce inequalities for the areas of deprivation

Adult Hospital Care

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Only using Hospital care when needed by providing

- rapid diagnostic tests
- improved imaging facilities,
- advanced ambulatory emergency care capability and 'generalist' skills
- Improved coordination of health and social care

Moving outpatients closer to patients where these can be efficiently delivered

GPs and other professions getting easier access to consultant advice to make the right treatment choice with patients

Use of emails and technology to as an alternative to outpatients

Horton General 'ambulatory care by default' model – mirroring successful Ambulatory Unit in Headington – ward changes made permanent

Hyper-Acute Stroke Unit (HASU), Level III Critical Care in specialist centres

Maternity

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- Medical risk assessment
- Safe reliable obstetric care that meets Royal College guidelines
- Midwife led units
- Post-natal improved support

Paediatric care

Horton

- Proposal is to offer rapid access to diagnostics, more outpatient clinics and more local day cases

One of the following:

- Clinical Decision Unit with outreach nursing team (ambulatory care model) from 6am-10pm every day
- Clinical Decision Unit with outreach nursing team (ambulatory care model) provided 24/7
- Inpatient ward

What does this mean?

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Options, Choices & Trade offs

- Whole system reform across Acute, Community, Primary Care
- Clinical sustainability and affordability
- Trade-offs and choices between physical access, quality and money and investment in capacity of community based care closer to home services

Tier and type of beds	Locality/site options
Very specialist (Tertiary) beds e.g. cancer, neuro, cardiac etc	JR/Churchill/NOC (as now, no plans to change being proposed)
General acute for medicine and surgery	Centralised at Oxford - JR/Churchill/ NOC OR Split across Oxford and Horton DGH
Step up & step down (EMU+) and complex rehabilitation Intermediate/nursing home	Up to 4 sites with NHS beds across Oxfordshire Located in Oxford, Horton, South, West Plus Nursing homes and Care homes
Own bed	Everywhere (across Oxfordshire)
Maternity	Obstetric (consultant deliveries) All at JR or split across JR and Horton DGH Plus midwife led units
Long Term Conditions, Frail Elderly, Assessment & Diagnostics	Accessible to all localities integrated with primary care

Assumes continue use of Great Western and RBHFT, etc.

Options Development - Stakeholder Engagement

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- How will we assess the options?

- Suggested criteria for appraising options includes:
  - Access including public transport and travel
  - Quality safety, clinical effectiveness and patient experience
  - Workforce availability to staff now and in the future
  - Deliverability affordable, manageable, avoids destabilising system

Private transport at peak times

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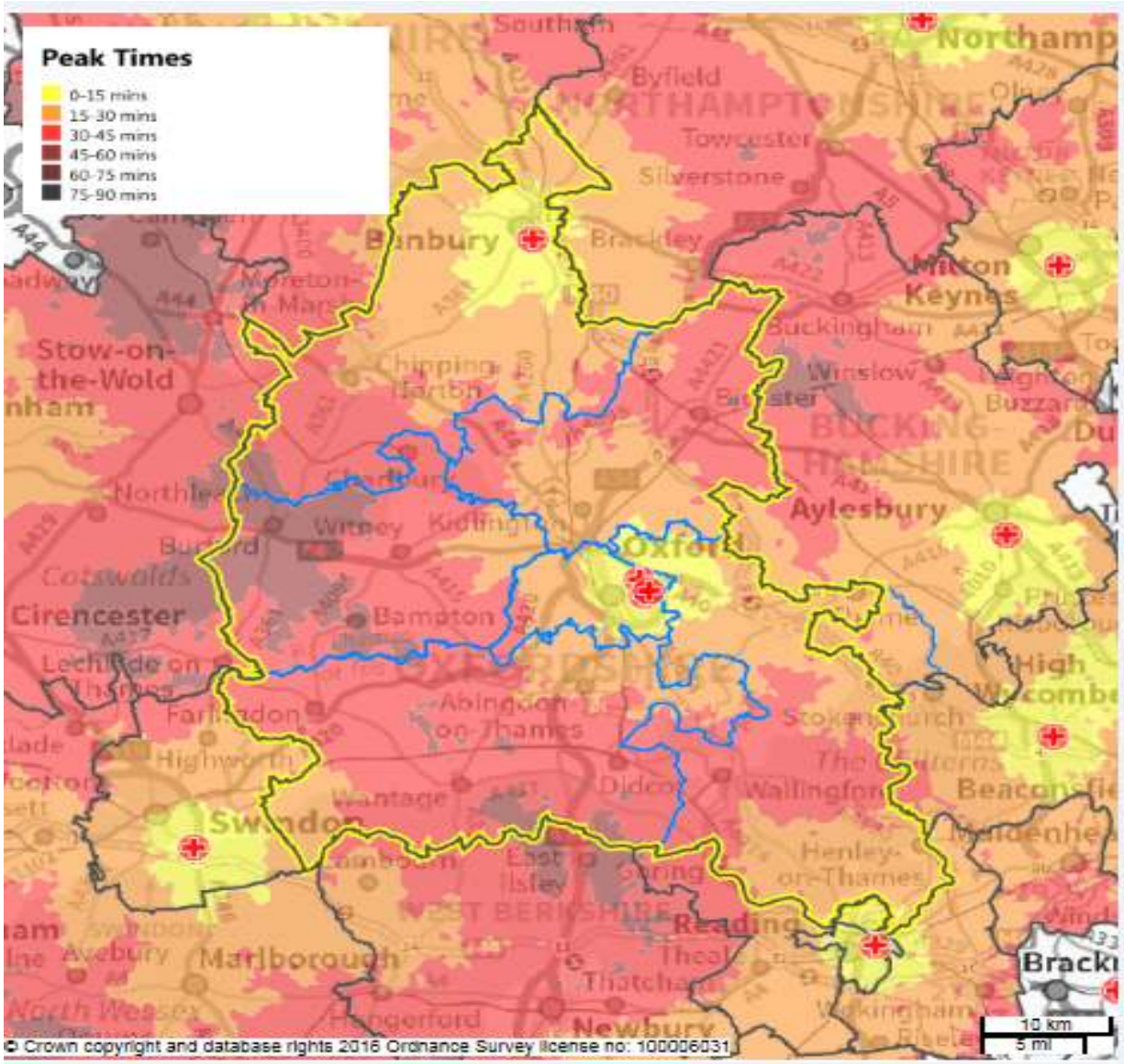

Nearest obstetric unit

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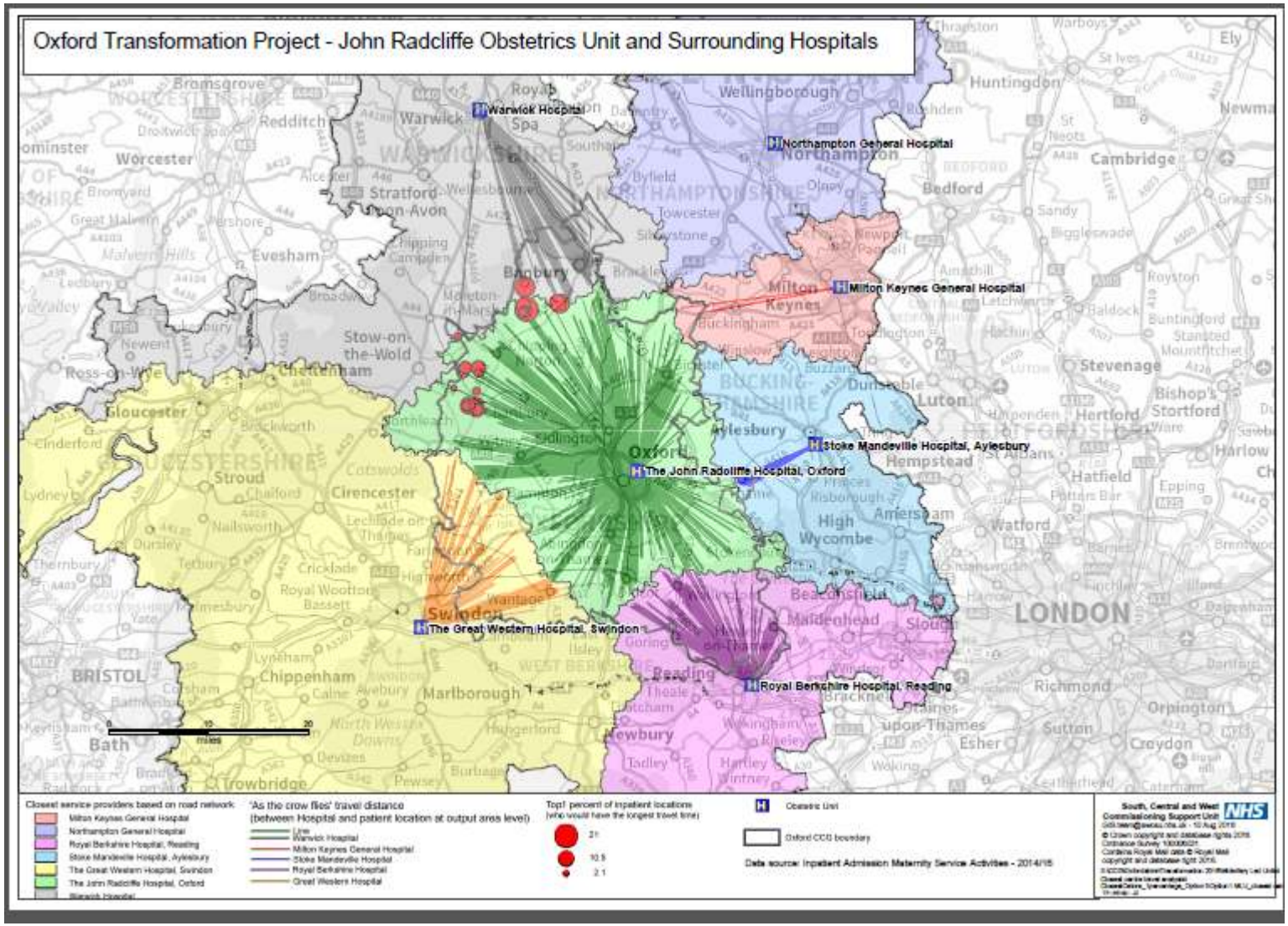

Mileage times

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Table 1: Population and Travel Access to John Radcliffe Obstetric Unit only

Cumulative Travel Time (Peak time)	ONS Mid 2014 Population (Female Age 15 to 49)	
	Number	Percentage
0-15 mins	41,029	26.6
0-30 mins	68,800	44.5
0-45 mins	114,310	74
0-60 mins	147,062	95.2
Over 60 mins	7,394	4.8

Table 2: Population and Travel Access to John Radcliffe and surrounding

Cumulative Travel Time (Peak time)	ONS Mid 2014 Population (Female Age 15 to 49)	
	Number	Percentage
0-15 mins	41,126	26.6
0-30 mins	76,026	49.2
0-45 mins	137,913	89.3
0-60 mins	154,035	99.7
Over 60 mins*	421	0.3

*Inpatient activity data (Feb 14 –Jan 16) shows that 44 patients would have had a journey from home longer than 60 minutes and the furthest would have been 28.023 miles (3 patients).

Mileage times

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Table 3: Population and Travel Access to John Radcliffe Obstetric Unit only

Cumulative Travel Time including a 19 minute wait on average (Bluelight)	ONS Mid 2014 Population (Female Age 15 to 49)	
	Number	Percentage
0-34 mins (15 minute journey)	53,402	34.6
0-49mins (30 minute journey)	113,627	73.6
0-64 mins (45 minute journey)	153,987	99.7
0-79 mins (60 minute journey)	154,456	100

Table 4: Population and Travel Access to John Radcliffe and surrounding

Cumulative Travel Time including a 19 minute wait on average (Bluelight)	ONS Mid 2014 Population (Female Age 15 to 49)	
	Number	Percentage
0-34 mins (15 minute journey)	54,929	35.6
0-49mins (30minutejourney)*	136,463	88.4
0-64 mins (45 minute journey)	154,456	100
0-79 mins (60 minute journey)		

*Inpatient activity data (Feb 14 –Jan 16) shows that 2728 patients would have had a journey from home over 30 minutes and the furthest would have been 28.023 miles (3 patients).

Continuing the conversation

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On-going engagement will continue leading up to the public consultation later in the year. This will include engagement around the developing options for the proposed service reconfiguration and further work with seldom heard people and groups in the county:

- Patient/public engagement events through the autumn
- Outreach into the community with seldom heard groups
- Discussion at key community and voluntary sector groups
- Patient/public involvement in developing options e.g. 22nd Sept Stakeholder event; focus groups
- Briefings and feedback with County Council and District Councils
- Briefings and feedback for Oxfordshire MPs
- Updates and reports to Oxfordshire's Joint Health Overview and Scrutiny Committee
- Updates to Oxfordshire's Health and Wellbeing Board
- Online information on the Transformation Programme website: www.oxonhealthtransformation.nhs.uk

Timeline

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