Appendix 7.14: TV Clinical Senate; Clinical Review

Thames Valley Clinical Senate

Oxfordshire Transformation Proposal

Stage 2 Clinical Assurance Review Panel – Interim Report

Version Control

Version	Date	Description	Author	Status
V0.1	15.09.16	First draft for comment	W McClure	With Senate Chair and Review Chair for comment
V0.2	14.09.16	Draft incorporating comments from Senate Chair and Review Chair	W McClure	With review team members for comment
V0.3	19.09.16	Draft incorporating comments from Clinical Review Team	W McClure	Agreed by review team Forwarded to Oxfordshire Team

Contents

Foreword by: Panel Chair, Dr Phil Yates

To be completed following final review on 7th Nov

1. Senate Chair Summary and Recommendations – Dr Jane Barrett

To be completed following final review on 7th Nov

2. Background

The NHS is facing a number of challenges to the services it delivers: funding limits, population growth and more people living longer with complex health issues.

NHS England's Five Year Forward View sets out how the NHS needs to change to meet the requirements of the future and shows us what that future will look like. It is a future that empowers patients to take much more control over their own care and treatment. It is a future that dissolves the classic divide between family doctors and hospitals, between physical and mental health, between health and social care, between prevention and treatment. It is a future that no longer sees expertise locked into often out-dated buildings, with services fragmented and patients having to visit multiple professionals for multiple appointments.

There are better ways of organising care, breaking out of the artificial boundaries between hospitals and primary care, between health and social care, between generalists and specialists. The future will see services delivered on a place based model with far more care delivered locally but with some services in specialist centres where that clearly produces better results.

Some of what is needed can be brought about by the NHS itself. Other actions require new partnerships with local communities, local authorities and employers. Local authorities now have a statutory responsibility for improving the health of their people, and councils can make an important impact.

In common with other health systems, Oxfordshire is facing challenges in continuing to provide health services for its growing population both now and into the future.

2.1 Geographical Background

Oxfordshire is the most rural county in the South East and has a population of circa 672,000. The population has grown by more than 10% in the last 15 years and it is expected to continue growing, due to increases in life expectancy and more people moving into the county. 1/3 of the population, and proportionately more of those aged 65 and over, are living in towns or villages of less than 10,000 people

Oxford has a global reputation for its world class university and academia and its workforce is amongst the most highly qualified in England.

Oxfordshire's clinical leaders have been working together for a couple of years under a transformation umbrella to understand the future challenges facing the health services in their patch and to propose a number of options which would address

these to enable them to continue to offer a service to the population of Oxfordshire. These options will be subject to a public consultation later in the year (2016/17).

2.2 Scope and Limitation of Review

The scope of this review is to provide Stage 2 Clinical Assurance of the proposed options within the Oxfordshire Transformation Plan assessing the clinical quality, safety and accessibility of the proposals. The Transformation Plan will be subject to a full regional Stage 2 assurance process and the Senate clinical review will be a component of this.

The initial timescales supplied by the Oxfordshire Transformation Team have been adjusted to allow for further work to be undertaken and the documentation supplied to inform this review is not yet complete. This is therefore being treated as an interim report and the feedback is supplied to support Oxfordshire as it completes this work.

The role of the Independent Clinical review Team is to:

- Assess the strength of the clinical case for change
- Check alignment with clinical guidelines and best practice
- Ensure a full range of options have been considered and that potential risks are identified and mitigated
- Assess the alignment between the proposed change and strategic commissioning intentions
- Assess the clinical case for change for each of the proposed options in order to provide clinical assurance and sign off from the Thames Valley Clinical Senate

3. Methodology of the Review

The methodology of the review was informed by national guidance, the Clinical Senate Review Process: Guidance Notes (2014)

3.1 Terms of Reference

The aim of the Stage 2 Independent Clinical Review Team is to assess the clinical quality, safety and sustainability of the proposed model of care prior to public consultation in line with the agreed Terms of Reference (see Appendix 1)

3.2 Process

The draft documentation to support the clinical case for change was supplied to Thames Valley Clinical Senate week commencing 22nd August 2016 and was reviewed and assessed at an Independent Clinical Review Team meeting on 5th September 2016. The Independent Clinical Review Team included members from professional groups with specific knowledge and expertise in those areas on which the Clinical Senate had been asked to provide advice. To ensure that any advice given was robust, transparent and credible, the Clinical Review Team included clinical expertise from outside the Thames Valley Area. – see Table 1 and Appendix **XX**. A confidentiality agreement was signed by all Clinical Review Team members and any potential conflicts and associations were declared during the process. These are recorded in Appendix **XX**.

A subsequent date for the Clinical review Team to review the final documentation has been set for the 7th November 2016.

This report presents the key issues that were discussed and emergent themes from the evidence presented (both documentary and verbally). It is not intended to be a comprehensive record of the discussion. The Clinical Review Team's main observations and conclusions are presented as per the Clinical Senate Review Process: Guidance Notes (June 2014).

Table 1

Name	Position	Organisation
Phil Yates	Chair	Chair of the South West Clinical Senate
Sian Butterworth	Paediatric consultant and paediatric lead for the Isle of Wight	
Peter Hockey	Consultant Respiratory Physician and Clinical Director	Southern Health NHS Foundation Trust
	Deputy Postgraduate Dean	Health Education England (Wessex)
Jane Hogg	Integration and Transformation Director	Frimley Health NHS Foundation Trust
Lise Llewelyn	Strategic Director of Public Health	Berkshire

Ann Remmers	Clinical Director Patient Safety Programme Director	South West Maternity and Childrens Clinical Network West of England Academic Health Science Network
Jonathan Sarjeant	Clinical Director	Here (previously Brighton and Hove Integrated Care)
Christine Teller	Public Contributor	Bristol
In attendance		
Wendy McClure	Senate Manager	Thames valley Clinical Senate
Vida Addison	Senate Project Officer	Thames Valley Clinical Senate

4. Description of the Current Service Model

The current healthcare service model is the traditional one of primary care, acute providers, mental health providers and community providers. There is one CCG, Oxfordshire CCG, made up of 77 GP practices which are organised into 6 localities:

- **North** – 12 practices covering Banbury, Bloxham, Chipping Norton, Cropedy, Deddington and Hook Norton. It has a patient population of 108,040 (16%)
- **North East** – 9 practices covering Bicester, Kidlington and Yarnton, Woodstock and Islip. It has a patient population of 81,595 (12%)
- **Oxford City** – 23 practices covering Oxford City, Blackbird Leys, Iffley, Cowley, Jericho and Summertown. It has a patient population of 210,000 (31%)
- **South East** – 10 practices covering Wheatley, Sonning Common, Wallingford, Henley on Thames. It has a patient population of 92,200 (14%)
- **South West** – 14 practices covering Abingdon, Clifton Hampden, Berinsfield, Didcot, Wantage and Farringdon. It has a population of 139,300 (21%)
- **West** – number of practices unknown. It covers a patient population of 40,865 (6%)

The acute hospital, the Oxford Universities Hospital NHS Foundation Trust OUH), is made up of four hospitals. The John Radcliffe Hospital, one of the largest NHS teaching trusts in the UK, which includes the Children's Hospital, West Wing, Eye Hospital, Heart Centre and Women's Centre); the Churchill Hospital and the Nuffield Orthopaedic Centre all located in Oxford. It also runs the Horton General Hospital in Banbury, north Oxfordshire which is a small District General Hospital (DGH) with 24/7 A&E, acute geriatric beds, obstetrics and 150 overnight beds across various specialities.

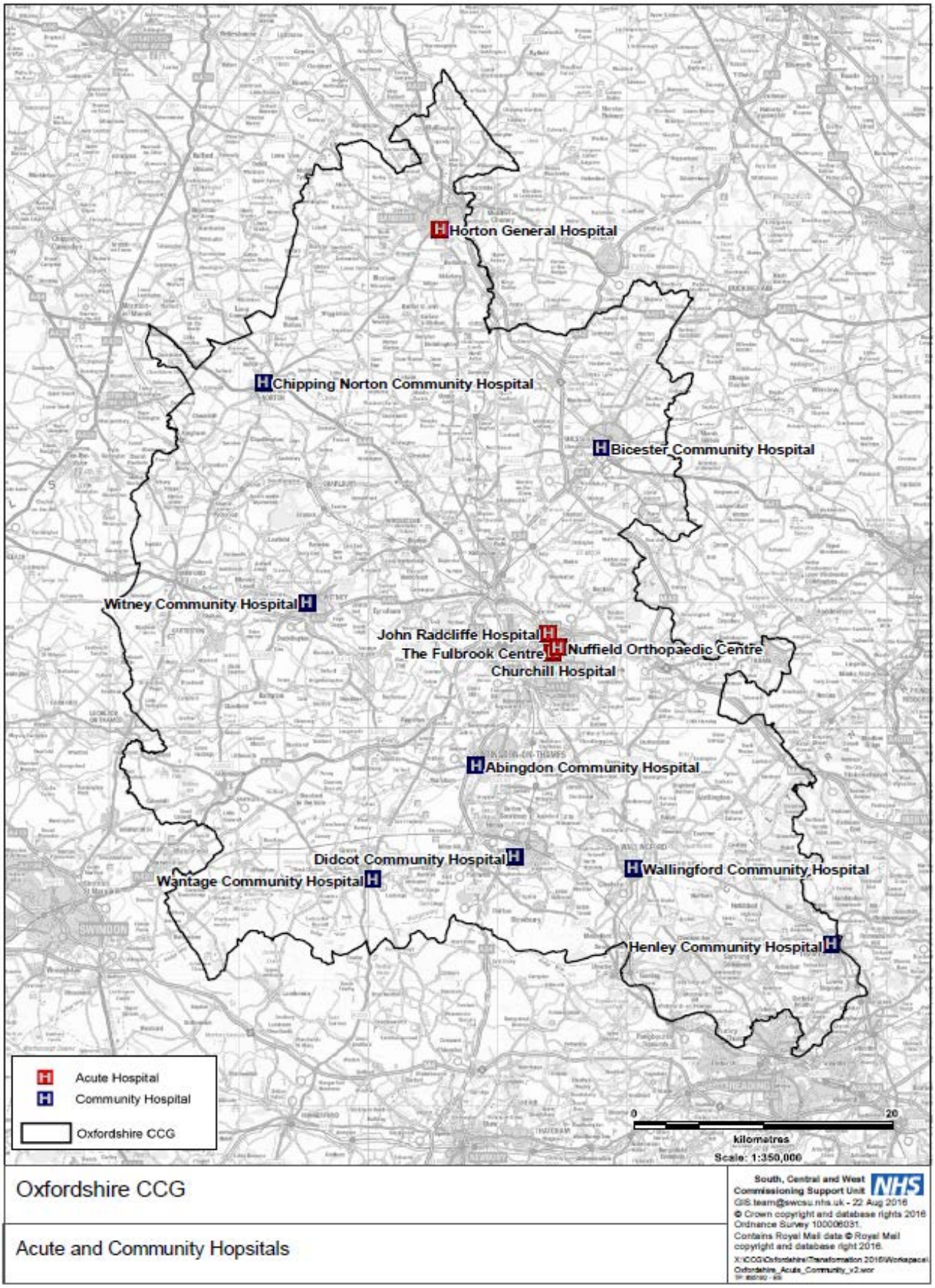
There are a further 8 community hospitals which are operated by Oxford Health NHS Foundation Trust, the mental health and community provider. These range in scale from 8-50 beds. Some have advanced urgent care close to home while others are more traditional with bed based care for step down. The Community Hospitals are:

- Abingdon Community Hospital – 42 beds
- Bicester Community Hospital – 11 beds
- Chipping Norton Community Hospital – 14 beds (includes midwifery)
- Didcot Community Hospital – 42 beds
- Oxford City Community Hospital (The Fullbrook) – 14 beds
- Wallingford Community Hospital – 27 beds (includes midwifery)
- Wantage Community Hospital – 14 beds (includes midwifery)
- Witney Community Hospital – 60 beds

The area is covered by the South Central Ambulance Trust.

Oxfordshire has one County Council and five District Councils.

Table 2: Map of Oxfordshire showing locations of acute and community hospitals.



Oxfordshire CCG

Acute and Community Hopsitals

South, Central and West Commissioning Support Unit
GIS.team@swcsu.nhs.uk - 22 Aug 2016

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5. The Case for Change

In its pre consultation business case (PCBC), the CCG states that it currently spends around £1.2bn per annum on health and care services across Oxfordshire. By 2020/21 it anticipates that it will be spending a further £125m on local services, to total over £1.3bn per annum. Despite additional funding, the rises in demand and the complexity and costs of providing services means it will face a projected deficit of £200m. Oxfordshire states that closing the financial gap cannot be achieved by 'business as usual' commissioner and provider efficiencies.

Alongside the financial challenge, the PCBC states that Oxfordshire faces challenges recruiting and retaining a high quality workforce. In part this is attributed to the high cost of local living, and proximity to London where a 'weighting' premium is paid to NHS staff. Recruitment problems have already forced service changes within Oxfordshire, for example at the Horton Hospital where the maternity unit has been temporarily closed. The Trust has advised that despite efforts, it has not been possible to recruit to vacancies at the unit leaving the current service unsafe. The PCBC identifies that similar issues exist in social care with very high levels of staff turnover (currently around 25 per cent).

While the quality of health services provided in Oxfordshire is generally good, the Transformation Team has raised concerns over the future sustainability of safe and high-quality services. It states that workforce challenges (see above) mean that the current model of care will not be sufficient, particularly in maternity and children's services, but also across a range of non-elective and elective services; and in primary care.

In addition, many of the hospital and GP buildings are old and not appropriate for a 21st century health system.

In line with Five Year Forward View, the Oxfordshire Transformation Team is proposing to change the way health care is delivered by:

- Integrating primary care with specialist clinicians in the areas of maternity and paediatrics to bring services closer to patients ensuring that more patients can be managed closer to their place of residence
- Planning the delivery of more diagnostics at some local hospital sites. Staffed by multi-specialist teams to assist diagnosis and planned treatment, more patients could be treated locally and managed in the community
- Looking at urgent care provision outside hospital reducing pressure on A&E

6. Assessing the Case for change

The Oxfordshire Transformation Team provided and presented documentary and verbal information to the Clinical Review Team on Day 1. Documentary evidence included the pre Consultation Business Case (PCBC), the Horton Business Case (HBC) and the Community Infrastructure Programme (CIP).

Based on this, the interim findings are contained in this report and will be updated following the second Clinical Review Team meeting which is scheduled for 7th November 2016.

6.1 Summary of Day 1

Given the incomplete status of the documentary evidence, it had been agreed with the Oxfordshire transformation team that Day 1 would be treated as an interim review which would support the final work up of the case for change with the Senate CRT acting in the role of critical friend.

In reviewing both the documentary evidence and the information shared in the verbal discussion, the Clinical Review Team (CRT) recognised that a significant amount of work had been carried out to develop the case for change and appreciated the need to keep the momentum going to deliver the service change required. The discussions and the outcomes of Day 1 highlighted the need for further clarity and assurance on key areas to ensure that the CRT had a clear understanding of the options to enable them to support the assurance process.

CRT discussed in detail the principle of the vision which has been articulated within the 3 business cases. They were supportive of the vision but needed further information in the following areas to enable the assurance process to be undertaken.

The key issues arising from Day 1 were summarised as follows:

Documentation – general:

- It was felt that there was little cohesion between the 3 key documents and it was not possible to map the options from one to another to understand the co-dependencies. It would be preferred for the two business cases to be drawn together within in the Pre Consultation Business Case with the detail provided as appendices
- The Horton Business Case makes the vision for Banbury very clear but it was less clear what the impact would be on other areas of Oxfordshire. It was felt that presenting the case as place based units would give a better picture of the current and proposed services in each area and allow for better comparison.
- The benefits to patients was not always evident enough
- The proposals must include outcome data

- No evidence of how the proposals will improve health inequalities – though it was assumed that they could

- **Pre Consultation Business Case:** This document needs to be radically simplified and reduced. A short, one page executive summary would be helpful. It is very repetitive on the case for change and difficult to pick out the key components of the proposed changes
    - The perception was that this document was written as a commissioning document. It was felt that it would have more impact and would be clearer to understand if there was a holistic narrative describing proposed changes, new services, improvements and advantages from a patient perspective and broken down by geographic localities throughout Oxfordshire – the concept of geographical 'units of care' were discussed by the panel so that those living within a geographical locations would have a clearer overall view of what the changes meant to them.
- **Horton Business Case**: This was generally agreed to be a good document, well referenced and well structured.
    - The document is stand alone and not integrated with the other programmes – this could be addressed by an improved pre consultation business case as above.
    - It was felt that the document was polarised on the loss of the obstetric service and could do more to maximise the benefits to the local population of the other services which will be enhanced by the proposals

Workstreams

- **Primary Care:** The impression was that this work stream, although crucial to the others, is not as well progressed in terms of engagement or planning.
    - Need further clarity on what is hoped to be achieved in primary care and how the capacity will be created to enable primary care to take on additional responsibilities at a time of pressure
    - Given that engagement and endorsement of the GPs is at an early stage, the panel was concerned on the reliance of this work stream to deliver some of the others most notably maternity. It was felt that the proposal should describe an alternative if this cannot be confirmed prior to public consultation
    - Recommend that the primary care work should reference current thinking and guidance regarding multi-speciality community providers (MSCP)
    - The proposal to support primary care with expert specialist opinion could improve the quality of care for a number of patients but there is a need to be more explicit about the issues being seen and how the

proposed changes will address or improve this. Please include confirmation that this specialist input will be supported by Providers in Oxfordshire
    - There is no reference to quality or evidence of how the new role for primary care will be sustainable
    - There is no reference to safety and governance for primary care staff undertaking new roles

- **Maternity**
    - What are the maternity and neonatal outcomes compared to national data? (there is some limited information in the documents but it would be helpful to see the dashboard data in full)
    - Proposal for the Horton should improve safety as current provision is unsafe on staffing levels. No concerns that the proposals would undermine quality and safety as there is a sufficient body of evidence for low risk women – essential that the risk assessment process is agreed, sound and sustainable
    - Are there any concerns regarding obstetric anaesthetics?
    - How sustainable will the MLU at the Horton be if a number of women choose to birth elsewhere?
    - On a safety basis, if the system is committed to a Midwife led unit at the Horton, the panel advised that you should consider 24/7 staffing with 2 x MW plus MC
    - There is a risk that, as a result of choice, births at the JR may grow quicker than the JR can expand their capacity – is there a contingency plan?
    - The travel time between the Horton and the JR is a concern for women who may need to be transferred to the John Radcliffe. The current mitigating action is an ambulance permanently on site. Is this sufficient? Have other alternative means of swift transfer been fully investigated? Need to see outcome data regarding number of women with late transfer from existing MLUs in Oxfordshire
    - Concern about the proposals for the completion of the initial risk analysis by GPs – is there the capacity and the skill requirement in primary care? It is not apparent that primary care has agreed to undertake the risk assessment role and training/education will be required. Are GPs the right people to do the risk assessment and if records/information could be shared between the midwives and the GPs, would this mean that the midwives could carry out the assessment?
    - How will it be ensured that the additional GP appointment in pregnancy does not delay referring a woman for investigations in pregnancy eg early dating scan?

- Need to ensure that the right staffing model is in place. What data is there on midwifery staffing levels? Have there been any Birth Rate Plus assessments?
- There is no mention of perinatal mental health and social care. The services need to be developed with mental health and social services. There needs to be a strong link with mental health for post birth issues.
- Important that this is viewed as a whole maternity service and not seen as separate based on the different centres – believe this has been captured in the PCBC
- Suggest some outcome benchmarking is undertaken with other MLUs elsewhere working with a similar travel distance to the obstetric unit
- Show how the issues identified in the IRP review of 2008 have been addressed
- How do the options for maternity care fit with the Maternity Transformation plans and the Local Maternity Systems?
- Are there plans to be an early adopter of the Better Births recommendations?

- **Paediatrics**
  - Need to see some outcome data
  - Felt that the proposal reflected up to date clinical guidelines
  - Suggest a stepped change to 24/7 ambulatory service
  - A very robust community nursing service will be required – no evidence regarding this
  - There will be additional paediatric surgery at the Horton which will require more nurses – is there a plan for this and is it a risk?
  - Might be worth showing how many extra children can be treated/seen at the Horton as a result of the changes
  - There hasn't been much recent national policy but there has been a radical upgrade in prevention. There is no evidence that Oxfordshire Public Health has been involved in the PCBC and is supportive. Same for Oxfordshire County Council

- **Planned Care:** Broadly liked the model for planned care and there is growing evidence for the effectiveness of this model
  - acceptable on quality, safety and sustainability but need more detail on the use of existing facilities. Lack of detail regarding the physical capacity of the Horton eg theatre space
  - If the diagram on page 25 of the PCBC is retained, there is need to evidence the population figures quoted
  - Should help improve performance against the RTT and cancer waits
  - Enhanced recovery will be required but may not need Level 2 – review?

- The local hospital proposals offer better travel times and the one stop should improve the quality and value for patients.
- No mention of post intervention access

- **Urgent and Emergency Care**
  - Emergency care proposals reflect current clinical guidelines but more detail required for the urgent care element to assess this
  - Need to see outcome data of current model and how the proposals will impact this
  - There are gaps eg 111, pharmacy, GP OOH. Plans are not yet worked up enough to assess
  - The proposals should improve sustainability but the paper doesn't evidence it
  - More consideration needs to be given to the proposal to include Level 2 HDU capability – the provision of safe Level 2 standard of care to enable transfer is very different to running and staffing an HDU
  - A link with social care is missing
  - The pathway to the paediatric unit at the Horton is unclear
  - Integration is the direction of travel but it is not clearly enough demonstrated and needs to be reflected in the PCBC. The verbal Q&A with the transformation team identified good examples which should be included.
  - The proposals do consider the issues of patient access and transport but the clinical benefits have not been evidenced.

- **Mental Health:** the document states that a proposal for Mental Health provision has been through an NHSE assessment process and will shortly be entering the procurement phase. Enough detail of these proposals should be included in the PCBC in order to give the panel a full picture of what and where services will be available across Oxfordshire

Social Care

- A description of the Interactions and interface with the County Council was missing from the documentation and descriptions of services
- The documentation should explicitly mention care integration as the integration plans in the Oxford system are required within similar timescales and the panel believed that the public would be surprised if a second set of plans also had to be discussed
- The panel agreed that this relationship will be key for the risk assessment and prevention elements of the proposals and the role of the County Council and its relationship to the Oxfordshire proposals should be described

Activity

- One of the components of the Senate assurance relates to the safety of the proposals. In this case, insufficient information regarding the specifics of the proposals was provided including current and future patient flows, current and proposed activity numbers, staffing and outcome data from the existing services

Organisational model and Implementation

- The service descriptions paint the picture of a relationship between OUH and Oxford Health. Recent reports in the HSJ suggest that this may not be without its problems. It would be helpful if assurances were contained within the documentation
- OUH is identified as a 'driver' within the proposals but the same is not true for Oxford Health. What is the vision for the future organisational model or is it anticipated that this will develop over time?
- Given the scale of the proposals, the PCBC should include an indication of the implementation plans and what components will be prioritised. There is currently no information on how this will be delivered

Engagement:

- **Public engagement:** It was explained to the CRT that public engagement exercises were carried out in June and July and were ongoing. It is recommended that these are documented showing the feedback from these events and how the feedback has been incorporated into the proposals
- It was suggested that it might be helpful to link with some public engagement groups eg 38 degrees (www.38.degrees.org.uk)
- **Horton Business Case**: It was noted that despite the dependency on primary care assuming additional responsibility to underpin the new service options, primary care clinicians were not quoted as having been part of the Clinical Review Groups (over 50 clinicians from all OUHF were enrolled). It is recommended that subsequent drafts of the Business Case set out the method of engagement with the GPs and their response to the proposals for maternity and paediatric changes at the Horton.
- **GPs**: It was noted that GP consultation generally is at an early stage. Given the importance of the role of primary care in these proposals, it is recommended that this is undertaken as promptly as possible so that primary care support is available during the public consultation. If GP sign up cannot be achieved by the time that public consultation commences, it is recommended that a Plan B is developed.
- **Other parties within BOB**: The CRT was unable to find evidence of engagement with West Berkshire or Buckinghamshire regarding the proposals

or any potential impact on these neighbouring health systems. These interfaces should be described

- **Social Care**: Interactions with the County Council was missing from the documentation and descriptions of services. It was agreed that this relationship will be key for the risk assessment and prevention elements of the proposals and the role of the County Council and its relationship to the proposals should be described
- **Clinical endorsement** will be absolutely key for these proposals and clinical champions should be identified for each of the work streams

6.2 Summary of Day 2

Deferred to 7th November 2016

Following sections to be completed following the final clinical panel review on 7th November

7. Conclusions and recommendations

7.1Conclusions

7.2 Recommendations

8. References

9. Glossary of Terms

10. Appendices

Appendix 1: Terms of Reference