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Please find enclosed my formal response to the Transformation Programme Phase One consultation.

Victoria Prentis MP

Formal submission to the Oxfordshire Clinical Commissioning Group regarding the Transformation Programme Phase One consultation

Victoria Prentis MP

1. Background

1.1. The Horton General Hospital was a gift to the people of Banbury in 1872. It is now a busy district general hospital. It has a catchment of some 150,000 people, although that number is growing as more houses are built. The hospital's patients are spread across six Parliamentary constituencies that cover a large rural hinterland and some of the most deprived areas in Oxfordshire.

1.2. The hospital has faced repeated threats of downgrade and closure over recent decades. In 2008, proposals to reduce paediatric services, obstetrics, gynaecology and the special care baby unit at the hospital were referred to the Independent Reconfiguration Panel for their consideration.

1.3. In their report (see Appendix One), the IRP noted that the hospital was "in an area where neighbouring hospitals are all some distance away…The hospital has strong local support." Its concluding comments suggested that:

"[The] Horton Hospital has a positive future as an integral part of the ORH NHS Trust. Appropriate clinical networks must be developed between the three hospitals that make up the Trust, with primary care and other neighbouring hospitals. This will involve change and now is the time for all concerned to agree the best way forward."

1.4. The IRP made six recommendations:

- Recommendation One: The IRP considers that the Horton Hospital has an important role for the future in providing local hospital based care to people in the north of Oxfordshire and surrounding areas. However, it will need to change to ensure its services remain appropriate, safe and sustainable.

- Recommendation Two: The IRP does not support the Trust's proposals to reconfigure services in paediatrics, obstetrics, gynaecology and the SCBU at Horton Hospital. The IRP does not consider that they will provide an accessible or improved service to the people of north Oxfordshire and surrounding areas.

- Recommendation Three: The PCT should carry out further work with the Oxford Radcliffe Hospitals NHS Trust to set out the arrangements and investment necessary to retain and develop services at the Horton Hospital. Patients, the public and other stakeholders should be fully involved in this work. South Central SHA should ensure that a rigorous and timely process is followed.

- Recommendation Four: The PCT must develop a clear vision for children's and maternity services within an explicit strategy for services for north Oxfordshire as a whole.

- Recommendation Five: The ORH must do more to develop clinically integrated practice across the Horton, John Radcliffe and Churchill sites as well as developing wider clinical networks with other hospitals, primary care and the independent sector.

- Recommendation Six: Within one month of the publication of this report, the PCT should publish a plan including a timeline for taking forward the work proposed in these recommendations.

1.5. The IRP is the independent expert on NHS service change. It is an advisory non-departmental public body entirely separate from local health providers. The IRP assesses or reviews proposals brought to its attention by the Secretary of State following a referral from the local Health and Overview Scrutiny Committee. In 2008, it conducted an in-depth analysis of service provision at the Horton General Hospital. Serious consideration should be given to its findings, particularly given this consultation's proposals for future maternity service provision at the Horton. The IRP's

advice remains at the forefront of the collective memory of the local community. There is a strong feeling of déjà vu. Against this background, it is difficult for anyone locally to understand the rationale for the proposals included in the Transformation Programme Phase One document.

2. Process

2.1. The Clinical Commissioning Group (CCG) is aware of the concerns held by myself, my colleagues and many other elected representatives about the splitting of the consultation into two parts. As was made clear in our letter dated 16 November 2016 (see Appendix 2), I feel very strongly that the public should have been presented with real alternatives for the future of healthcare in North Oxfordshire, and had the opportunity to respond to the plan in its entirety. In my view, any service change should have been paused until the complete Transformation Programme document was prepared. By splitting the consultation in two, the clarity of the plan has been diluted and become confused.

2.2. By launching on 16 January, the final fortnight of the consultation has overlapped with purdah ahead of local elections. The CCG will be familiar with guidance brought to its attention by myself and my colleague Robert Courts MP at a meeting at Westminster and in a subsequent letter both on 12 January 2017 (see Appendix 3). We were repeatedly assured that purdah will not interfere with the consultation process. I raised this with the Electoral Commission and the Department of Health. The response I received from the Clinical Commissioning Group (see Appendix 4) stated that:

"We have taken your concerns very seriously and carefully considered them with our legal team, but are clear in our view that we are complying with the guidance you have referred to."

2.3. It has been brought to my attention that the Oxfordshire Joint Health and Overview Scrutiny Committee (HOSC) has not been able to convene a follow-up meeting with the Clinical Commissioning Group to scrutinise the proposals further. I am told that HOSC were advised against holding the meeting in case they breached purdah

guidelines. I also understand that the CCG indicated that they would not meet with HOSC in public during the pre-election period. As a consequence, HOSC has not been able to carry out its role of overview and scrutiny which it is afforded by statute. This is a serious failing of the consultation oversight process.

2.4. The Pre-Business Consultation Case (PCBC) clearly states that the Transformation Programme "is taking a collaborative 'whole system' approach which recognises the interdependencies between primary, community and acute care." Despite this, and having looked closely at the Phase One consultation document, it is clear that it is impossible to understand the full implications of the proposals without knowing what will be put forward in Phase Two.

2.5. By splitting the consultation and only putting forward a partial vision of health service reorganisation in Oxfordshire it is not possible to understand how services are interrelated. Insufficient regard is given to the inevitable domino effect. For example, we know that the Special Care Baby Unit has already closed without consultation. I have been told that removing obstetric services at the Horton General Hospital will have an impact on the future sustainability of the anaesthetics rota, as well as training accreditation of the specialty. A reduced anaesthetics rota will jeopardise all acute services provided at the site. It is worth remembering that the loss of training accreditation for obstetrics has caused many of our current problems with recruitment. I also have concerns about the Level 3 Critical Care proposals.

2.6. It is disingenuous not to discuss the domino effect in the consultation documents, and the failure to meet this problem head on makes it impossible to engage with the exercise properly. I have sought to discuss my worries in this regard with Dr Bannon, the Postgraduate Dean at Health Education England – Thames Valley, and many other local clinicians. It is clear from my discussions that my fears are not without strong foundation. I do not know whether in fact the CCG have considered these issues.

2.7. I remain deeply concerned about what level of involvement other health providers in surrounding counties have had in drawing up and being consulted on the plans (see

Appendix 5). The proposals rely on significant support from hospitals out-of-county; it is unclear what impact they will have in terms of both capacity and on the population they currently serve. I have been told that conversations have been had with all interested parties. However, no evidence has been provided to demonstrate that this is the case (see Appendix 6). I know that some of my Parliamentary colleagues in the relevant constituencies have not been contacted about the proposals and their potential impact on service provision in their own area.

2.8. At a meeting with my Parliamentary colleagues and local health Chief Executives on 12 January it was brought to the CCG's attention that some people living in South Northamptonshire use Milton Keynes University Hospital. At the time, the draft consultation paper made no mention of this hospital; yet on 16 January when the document was launched, Milton Keynes had been inserted. I am concerned about the level of engagement with either the Milton Keynes University Hospital NHS Foundation Trust or MK Commissioning before this addition was made.

3. Content

3.1. The consultation document is inconsistent. In Dr McManners' foreword he states that:

"in this document you will find proposals for changes to the following services: changing the way we use our hospital beds and increasing care closer to home; planned care services at the Horton General Hospital; acute stroke services; critical care, and; maternity."

3.2. This statement implies that in this phase proposals for critical care and maternity are Oxfordshire wide when in fact they only relate to the Horton General Hospital. As a result, Dr McManners' foreword is confusing and unclear. It is just one example of a lack of attention to detail in this consultation. The Phase One Transformation Programme proposals – some of which affect the whole county– have simply become synonymous with a plan to downgrade the Horton General Hospital. The consultation exercise has been deeply confusing from the start.

3.3. The Second Addendum contains questions, comments and assurance points raised by NHS England. Comment P10 states:

"In line with formal advice from Capsticks (November 2016, section D) an initial long list of all potential options that has been reduced through application of relevant threshold/evaluation criteria is 'needed for the public consultation to show full and proper consultation of options to the public. It should also indicate, briefly, why certain options have not been proceeded with.' This information is not included in the consultation document, so reference to where this information is/how people can access it, could be included as a signposting mechanism."

3.4. The CCG's response to this is that there is only one viable option for critical care and stroke, and that it is no longer able to deliver obstetrics at the Horton General Hospital. This is simply not good enough. The consultation document should at least set out the possible options and those that were explored so people can make an informed judgment. Even if the section of the Pre-Consultation Business Case is used to fulfil this criteria, it is not signposted clearly in the consultation document. In my opinion it does not adequately satisfy the advice from Capsticks.

3.5. It is usual practice in consultations to present options. In presenting only one preferred option in the main document, it is impossible for my constituents to make an educated and informed contribution to the engagement exercise. The Pre-Consultation Business Case may have been provided to supplement the main consultation document but the length (235 pages) is prohibitive to the majority. More thought should have been given to how the 30 accompanying appendices could be disseminated. It should not have taken numerous requests from Cherwell District Council and the public for these to be released. Their late publication on 17 March 2017 – by which time the CCG had received 260 responses to its consultation survey and held the majority of its public meetings – is a serious limitation of the consultation.

3.6. It is impossible to undertake a proper assessment of the proposals when the evidence base is lacking. One example of this is the changing demographic. There is no proper analysis of the growth figures for our area versus the number of beds needed.

Banbury and Bicester are both growing significantly. The population in the Cherwell area is projected to increase by 13.9 per cent by 2026.

3.7. I note the CCG's position that the birth rate will only increase by one per cent. However, very little is known about the demographic of those moving into properties on estates including Longford Park in Bodicote and Kingsmere in Bicester. Basing proposals on assumptions rather than robust evidence carries great risk. We know from Cherwell District Council's Local Plan that 23,000 houses will be built between now and 2031. The Council has a strong track record in housebuilding; our infrastructure must grow accordingly. Reducing beds and downgrading services at the Horton General Hospital is short-sighted. Even if these often 3 and 4 bedroom houses are purchased by older people, these in turn will need geriatric care. If younger families move in they will need maternity and paediatrics. Either way, the new population will exert additional pressure on health services in the area. Much more analysis does need to be done and shared before sensible decisions can be taken about the long term future of healthcare for our area.

3.8. *Travel analysis*

3.8.1. Geography and travel times are my principal concerns. The time taken to travel to hospital plays a significant part in patient outcomes, as well as the overall patient experience. As the IRP found in 2008, the John Radcliffe is too far and inaccessible for many of those living in North Oxfordshire. It is unreasonable to centralise service provision at the John Radcliffe without adequately and properly considering the repercussions for those in the north of the county. Using Google Maps and blue light transfer times to justify decisions is misleading, particularly when the vast majority of patients will travel to hospital in their own private vehicle. Patient safety is paramount.

3.8.2. The travel analysis underlying the assumptions in the consultation document is fundamentally flawed. It is based on average times provided by Google Maps rather than real experiences. No consideration is given to the time taken to find a car parking space or for people to get to the department they need.

3.8.3. Not one of the twenty Oxfordshire Specific Validations used to prove the robustness of the data in the CCG's travel analysis is a location within my North Oxfordshire constituency, where the Horton General Hospital is based. I made this point at the Community Partnership Network meeting on 16 December 2016, and reiterated it at a meeting with the Chief Executives and my Parliamentary colleagues on 12 January 2017. At the time, it was indicated that the data would be changed to include some locations within my constituency. This has not happened.

3.8.4. The Mapping Scenarios provided are confusing. They show the same data for public transport versus private transport but the key varies in each. For example, dark blue on the public transport map denotes 75-90 minutes whereas the same colour is used to denote 50-60 minutes for private vehicles. Meanwhile, the two tables with the Oxfordshire Specific Validations are meant to show the off peak and peak journey times. However, both tables state the Source columns (3 and 4) show Off Peak travel times. Again, this lack of attention to detail causes confusion and simply exacerbates concerns about the validity of the underlying evidence used to support the consultation proposals. I have drawn these failings to the attention of the CCG, but no effort has been made to correct them.

3.8.5. As I was disappointed by the lack of credible date provided by the CCG, I undertook my own travel survey to discover real journey times for those people living in the north of the county and beyond. The survey ran from 9 January to 24 March 2017. Respondents were asked a range of questions including their start location, journey start and end time, and mode of transport (see Appendix 7). 390 people participated. I also received journey logs from community transport drivers.

3.8.6. The Horton General Hospital is 28.8 miles from the John Radcliffe (via the M40). None of the respondents travelled from within 10 miles of the John Radcliffe. 97.3 per cent of respondents live within 10 miles of the Horton General Hospital.

3.8.7. The results of my own travel survey indicate that it is taking those from the north of the county an average of 80 minutes to travel from the Banbury area to an Oxford hospital. It then takes, on average, a further 20 minutes to park, with parking times usually taking from ten to fifty minutes. Over ten respondents stated that it took over sixty minutes to park (see Appendix 8).

3.8.8. When I have raised parking issues, I have been told that there are two 15 minute parking spaces available for labouring mothers to be dropped off. This is no solution at all. Allowing fathers just fifteen minutes to park their car, help their labouring partner upstairs to find the right ward and be admitted, drop off any bags, and expect them to return to their car – leaving their partner behind – to then queue for up to an hour for a parking space is utterly unreasonable.

4. <u>Proposal One: Changing the way we use our hospital beds and increasing care closer to home</u>

4.1. I recognise that delayed discharges have been an ongoing issue for health providers in the county for some time. A number of initiatives have been piloted to tackle the problem, with varying levels of success.

4.2. Having had sight of recent figures, I am aware that the number of delayed transfers of care in Oxfordshire is well above the national average. An effective solution to the problem requires joined-up thinking and a collaborative approach between health and social care providers.

4.3. While I accept the premise that people are broadly better out of hospital, the consultation document does not pay sufficient regard to the inevitable increase in pressure on GP services and community care providers should the proposals be taken forward. There is nothing in the document which suggests plans have been discussed with Oxfordshire County Council who are responsible for social care. Without this information, it is impossible to assess the proposal. Moreover, one GP has told me:

"The bed closures happened without an assessment of the alternative provision. I fully support more care in the community but it needs to be sure that the required resources are available first."

4.4. There will always be circumstances when frail older people need a hospital bed. It is essential that they receive any hospital care closer to home, where possible, not least because partners and close family members are often elderly themselves and find travelling difficult. The same group find it hard to engage with consultation exercises such as these. One GP has told me:

"There isn't enough social care available to compensate for the closure of beds. The elderly, vulnerable at home alone may sometimes just need extra emergency social care to keep them at home but if this is not available they become sicker, need admission and then sit on trolley[s] in corridors as no beds. Although the vision of care at home sounds ideal it is currently not realistic or safe."

Another GP has said:

"The growth of ambulatory medicine is great but does not work for the confused elderly who end up bouncing in and out of hospital."

5. <u>Proposal Two: Planned care at the Horton General Hospital</u>

5.1. The consultation document proposes to:

"include more outpatient and diagnostic appointments for patients and the expansion of some services such as dialysis for kidney patients, and chemotherapy for cancer patients."

5.2. It also recognises that "patients find that transport and car parking can be difficult in Oxford". Support is found for this assertion in the results of my own travel survey.

5.3. I agree that the Horton General Hospital has significant potential. The IRP recognised this in their own conclusions in 2008. Considerable investment is essential, particularly given the anticipated increase in the hospital's catchment population in the coming years.

5.4. While my constituents and I may welcome increased services including chemotherapy and dialysis at the Horton, the document gives no indication of the potential impact this may have on the provision of other services at the hospital, including A&E and children's services which will not be looked at until Phase 2. It is extremely difficult for my constituents to be asked to respond in this piecemeal fashion. Without the detail, I cannot formulate a view on this proposal.

6. Proposal Three: Acute stroke services in Oxfordshire

6.1. My understanding is that stroke care locally currently follows the Manchester model. The consultation proposes a change to the London model which would see acute stroke services moving away from the Horton General Hospital to the John Radcliffe. Centralisation at the John Radcliffe would be supported by an early discharge service across the county.

6.2. As the consultation document states:

"National guidance…based on clinical evidence says that patients who have suffered an acute stroke should be admitted to a specialist unit within four hours of their stroke. Following an acute stroke, immediate access to advanced tests and treatments leads to better results for patients. These include CT scanning and MRI scanning, thrombolysis (clot-dissolving drugs) and thrombectomy (physical removal of clots from the brain)."

6.3. In principle, I support the proposal for all patients diagnosed with an acute stroke to be taken by ambulance to the nearest HASU at the John Radcliffe.

6.4. However, I am concerned about what will happen to these patients when they are discharged from the HASU. Alongside an extension of the Early Supported Discharge Service across the county, it is proposed that, where necessary, patients should receive rehabilitation in a hospital bed.

6.5. The Horton General Hospital and community hospitals will play a vital role in supporting these changes. Yet the future of our community hospitals will not be looked at until Phase Two. We know absolutely nothing about how Bicester Community Hospital fits into the CCG's vision. It is unreasonable to expect people to be asked to respond to these proposals when they are not presented with the full picture.

6.6. I am also aware that an urban model of delivery is driving the centralisation of services at the John Radcliffe. I have some concerns about how this will be delivered in the north of the county. Insufficient detail is provided about arrangements for those living in this part of Oxfordshire, particularly some of the rural villages who would be a considerable distance from a centralised HASU.

7. Proposal Four: Critical care at the Horton General Hospital

7.1. The consultation proposes to remove Level 3 Critical Care at the Horton General Hospital. As with acute stroke services, I recognise the argument that the sickest patients should be taken directly to the closest Intensive Care Unit.

7.2. However, I know from my own discussions with Health Education England that the downgrade of the Horton's critical care unit will have a direct effect on anaesthetic training. Trainees are unlikely to get enough experience. As stated in 2.6. above I am concerned about the domino effect. I have been told that the School of Anaesthesia has left Banbury with all the vacant posts in the region at CT2 level from this August. A move from Level 3 to Level 2 provision would also seriously jeopardise the return of obstetric services at the Horton.

7.3. No mention is made of the potential knock-on effect in the consultation document. It is misleading to omit such crucial information.

8. Proposal Five: Maternity and obstetric services at the Horton General Hospital

8.1. I strongly oppose the suggested changes to maternity and obstetric services in the consultation document. I have real safety concerns for those currently using the unit. The downgrade is causing significant discomfort and stress for all those who appreciate the complexities of running a unit which is simply too far from the closest obstetric service. One GP has told me that "for women who [would like] an MLU experience, [I] would advise Spires now." It is unreasonable to suggest low risk mothers should give birth at a midwife-led unit in Banbury when they are not given details of pain relief options, ambulance provision and transfer arrangements in the consultation document.

8.2. Despite providing explanations of critical care and acute care in the main body of the consultation document, a definition of consultant-led maternity services is noticeably absent. Pain relief options at midwife-led units versus consultant-led units are not explained. The majority of the population do not understand what pain relief is and is not available at a midwife-led unit. The word 'epidural' only appears once in the document, in the glossary on the final page (which is not signposted anywhere else). It does not feature in the Pre-Consultation Business Case.

8.3. There is no explanation that mothers wishing to have a range of pain relief options available to them – including an epidural – would have to deliver at the John Radcliffe or another consultant-led service. Nor is it mentioned that those who choose to have an epidural during labour will have to be transferred. For me, this is a fatal omission and seriously devalues the consultation exercise.

8.4. I acknowledge that a maternity fact sheet was published on 3 March 2017 to explain pain relief options at Midwife Led Units. I am not sure how widely this has been disseminated. Many women remain unaware of the difference in services between an MLU and an obstetric unit. During a focus group conducted by my office with new and expectant mothers in Bicester, the majority of participants were not aware that an

epidural could not be given in an MLU. It is fair to assume that those sections of the population who have not yet used maternity services would be even less aware of the options available in an MLU.

8.5. Information about ambulance provision at the Horton in the event of a transfer is noticeably missing from the consultation document. The Pre-Business Consultation Case refers to a static ambulance situated at the Horton General Hospital. However, at one of the public meetings it was suggested that this would be removed should the service permanently become a midwife led unit. At another meeting attendees were told that it would remain. It is misleading to not mention transfer arrangements to those attempting to understand the implications of any service change. It is an issue I have written to the CCG about (see Appendix 9) but I understand that no decisions will be taken until the consultation closes (see Appendix 10). It is unfair for people to be asked to comment on proposals without knowing how transfers may take place.

8.6. I also find it concerning that consultees have not been given information about how their birthing partners and family members will be taken to the John Radcliffe in the event of a transfer. I have repeatedly asked for the position on this. I am aware that some fathers have not been able to accompany their partner in an ambulance since the suspension took effect. Insufficient attention is given to this aspect of the proposals. It is unreasonable to ask people to respond to a consultation when they are not given the information they need.

8.7. The Pre-Consultation Business Case mentions that the “maximum time for all the population to reach a suitable hospital by blue light is 31 minutes”. However, in my own discussions with the Chief Executive of South Central Ambulance Service I have been told that the average time is 32 minutes and 53 seconds. He has also told me that SCAS collect minimal data on blue light transfers (see Appendix 11). Evidence on transfers is critical, particularly as recent statistics from the Trust indicate that 1 in 4 mothers choosing to deliver at the Horton General Hospital since the unit was downgraded have had to be transferred during labour. Four of these transfers took place after the birth of baby, but before the placenta was delivered. The idea of having to transfer at this stage of labour is horrifying.

8.8. The same statistics from the Trust indicated that there have been a total of 24 transfers since the suspension took effect. However, at the most recent Community Partnership Network meeting on 21 March 2017 the representative from South Central Ambulance Service NHS Foundation Trust indicated that the static ambulance at the MLU has been used over 40 times. The consultation document fails to signpost readers to the most recent statistical information; without accurate evidence it is impossible to understand properly the real implications of the proposals.

8.9. I am aware from my constituency casework of a number of cases where families believe that harm has been caused to their babies as a result of the temporary downgrade. I have also heard of one instance where it was unclear whether there would be space for a new mother at the John Radcliffe, following the emergency transfer of her baby. It is vital that women are made aware of what provisions are available to them both immediately after birth and in subsequent weeks should their baby need to be looked after in the Special Care Baby Unit in Oxford.

8.10. The experience for those travelling to the John Radcliffe in a private vehicle is also a concern for me. It is well known that many people arrive at the hospital much earlier than necessary during their first experience of labour. Yet the majority of those from the north of the county will not be able to make their way home again to wait until they are in established labour when they have already made a long and possibly hugely uncomfortable journey to Oxford. Even though I have asked repeatedly, I have not been given practical solutions to these problems. These are just some examples of the lack of engagement surrounding the practicalities of birth.

8.11. I am also genuinely fearful that some labouring mothers will have no option but to give birth on the side of the road. I know of one case where this has happened. For those who do arrive at the JR in time, it will not have been pleasant to be in the final stages of labour in an enclosed vehicle for a considerable length of time, before finding a place to park. Whoever is driving the car will suffer significant stress. Those who have traumatic birth experiences can bear the scars for the rest of their lives. There is considerable data to show that multiple generations can be profoundly affected. A

long journey time to hospital even when all goes well is not something families would choose.

8.12. I am aware that attention has been drawn to NICE guidelines which suggest that a freestanding maternity unit is a safe place to deliver for low-risk mothers. However, the same NICE guidelines state that there should only be 30 minutes between decision and delivery for those requiring a Category 1 caesarean section – when "there is immediate threat to the life of the woman or foetus". That decision could only be taken by an obstetrician at the John Radcliffe. Yet a midwife at the Horton would have to have significant cause for concern to even initiate a transfer. It is difficult to fathom how any Category 1 caesarean section could be performed within the 30 minute audit standard in this scenario. Selectively choosing guidelines to indicate support for proposals is no way to make decisions.

8.13. Capacity at the John Radcliffe and other hospitals mentioned in the consultation document (including Warwick, Northampton General and Milton Keynes) is a serious concern of mine. We have been told that the Horton General Hospital used to see approximately 1500 births per year which is approximately 29 births per week. Since the suspension and up until 31 January 2017, there have been just 61 in total i.e. 3 a week. If this continues, the unit will see no more than 190 births per year. Where the remaining 1310 births take place will have a significant impact on those units the mothers go to. This is before projected population growth is taken into account.

8.14. I recognise that the John Radcliffe is already a large unit, with over 6,000 births per year. The IRP noted in 2008 that the John Radcliffe was "already one of the largest [maternity units] in the country." Capacity at the hospital remains an ongoing concern for me and my constituents. I am acutely aware that the larger the unit, the more difficult it becomes to provide mothers with the personalised care the Better Births study suggests is key to a modern maternity service. The National Childbirth Trust recently reported that many women in NHS maternity units felt they were on a "conveyor belt".

8.15. One constituent has told me that she had to wait in a waiting room at the John Radcliffe until minutes before her baby was born. No cot was available for some time afterwards, and they were not moved to a bed on a ward for over eight hours after the birth. While my constituent praised the hardworking staff at the unit, with the John Radcliffe expected to cater for over 7,000 births, examples such as these exacerbate my concerns about capacity.

8.16. I am aware that some GPs are recommending their patients go out-of-county for obstetric care, to hospitals including Warwick. However, concerns have been expressed to me about capacity and staffing issues at Warwick Hospital. I have been told that it is already struggling. As one GP put it to me in a response to my own survey:

"The increasing population with all the new housing developments, schools talking about the need to expand, GP surgery list sizes expanding and travel times to Oxford from villages especially it is not enough to downgrade it. Is Warwick really ready to take the extra patients? The care becomes fragmented between counties and midwife antenatal care currently provided at GP surgeries, no easy link up on blood tests/scans creating yet more work for GP surgeries."

8.17. Consultees have been asked to share their views on MLUs in north Oxfordshire to inform option development for Phase Two. Example scenarios are provided in the consultation document. One suggests a model of a single MLU based at the Horton; the other suggests a two-MLU scenario with demand shared between the Cotswold Birthing Centre and the Horton. By referring to the MLU at the Horton it presents the previous preferred option as a fait accompli.

8.18. Meanwhile, it is not clear what people are being asked to comment on. One of the examples provides suggests the closure of the Cotswold Birthing Unit. From my discussion with my Parliamentary colleague for the area, this has caused significant confusion, concern and uncertainty among his constituents. People do not know whether this is a proposal on which they should comment now or later. My

understanding is that given the way the consultation is currently framed, it will not be discussed until Phase Two, therefore I do not comment here.

8.19. The consultation suggests that the downgrade of the maternity unit at the Horton is unavoidable because of recruitment issues. I remain convinced that the Trust could do more in their search for obstetricians. Offers to help make job advertisements more appealing, for example by providing school bursaries to the children of obstetricians or free housing, have not been explored (see Appendix 12). Recruitment agencies have not been involved.

8.20. I also feel that the Trust could have worked more collaboratively with Health Education England to find a creative solution to the training accreditation issue used to justify the suspension. The IRP report noted that:

"We were disappointed in the limited extent of clinical and systems integration between the John Radcliffe, Churchill and Horton Hospitals and considered that more should have been achieved given the time the hospitals have been within the same Trust. This is relevant to this review because of the greater potential to support local services at the Horton Hospital than there would be if the Horton was linked with another smaller district general hospital…The ORH NHS Trust's commitment that the Horton Hospital is an important part of its portfolio needs clear reinforcement in its future strategic documents. The IRP was left with a sense that the Horton Hospital remains a problem to be solved rather than a development opportunity."

8.21. For me, the fact that we find ourselves fighting the downgrade of services at the Horton just nine years since the IRP's report, demonstrates a complete lack of interest in utilising and expanding the Horton's services. From my own discussions with Health Education England, I know that the hospital has real potential.

8.22. I remain unconvinced by arguments that it is not possible to rotate obstetricians around the Trust's sites. Data I have seen from the Trust also shows that the majority of mothers in Bicester go to the John Radcliffe to give birth. Giving expectant mothers in OX26 and OX25 postcode areas a real choice between the Horton General Hospital

and the John Radcliffe to increase birth numbers at the former could go some way towards remedying the problem.

9. Engagement

9.1. Consultation has fallen short of the “strong public and patient engagement” health service commissioners must demonstrate when undertaking major service change. The level of opposition should not be underestimated and could not be stronger. I have yet to hear from one constituent or locally based medical professional who believes that the downgrade of maternity is good for the families of our area.

9.2. All levels of government oppose the proposals and are unhappy about the consultation process.

9.3. Both the Cabinet and full membership of Oxfordshire County Council have been unanimous in their opposition. I understand that at the HOSC meeting on 7 March 2017 representatives of Adult Services at Oxfordshire County Council expressed concerns about the consultation proposals, particularly those relating to closing beds and moving care into the community. Points were raised about the capacity of social care services in Oxfordshire, and the lack of consultation with OCC about the knock-on effect of proposals on county-wide social care services.

9.4. It is essential for the proposals to work for all those involved in delivering health and social care in Oxfordshire. The County Council should have been consulted and must be prepared to cope with an increase in demand on their services. Regrettably this does not appear to be the case. At a meeting of the OCC Cabinet on 21 March 2017 it was stated that “Oxfordshire County Council strongly object to the proposals.” I cannot see how the CCG can proceed without the support of the County Council.

9.5. I am aware that Cherwell District Council and South Northamptonshire Council have filed a judicial review against the CCG, supported by Stratford-on-Avon District and Banbury Town Councils.

9.6. Having had sight of a number of formal submissions from Parish Councils, I am aware that they too have grave reservations about the consultation process and proposals. Following on from the success of my travel survey, I asked the Parish Councils for their views. Not one of those that responded supported the consultation exercise (see Appendix 13).

9.7. Elected officials from surrounding areas have been left in the dark. I have been told by a councillor in Warwickshire that his Overview and Scrutiny Committee invited the Oxfordshire Clinical Commissioning Group to a meeting early in the new year to hear about their Transformation Programme plans. The Committee did not receive a response for some time, and I understand that they are still waiting for the CCG to attend a meeting.

9.8. The CCG will know that I have sought numerous assurances from them about their level of engagement with surrounding areas. Although the CCG have told me that they are in "regular discussions with these CCGs", no explanation of specific actions or supporting evidence has been forthcoming (see Appendix 6). Sadly, there is much anecdotal evidence to the contrary.

9.9. I am aware that some meetings have taken place in the latter stages of the consultation. Stratford-on-Avon District Council met with the CCG to discuss their plans on 24 March 2017 i.e. with just over a fortnight to go until the consultation closes. I am told that Nene CCG only met with representatives from the Oxfordshire CCG to discuss the plans on 14 March 2017. Engagement as an afterthought is unacceptable. My constituents need to see evidence that the proposals are based on careful and evidence-driven planning.

9.10. The response from my constituents has been overwhelming. I have received hundreds of emails and letters about both the content of the consultation and the way it has been conducted (see Appendix 14). It is impossible to walk down a road in the area, or enter a room of constituents of any age, without the future of the Horton General Hospital coming up in conversation. The fear is palpable.

9.11. Public meetings have not been well organised. Many have been held during the working day. Attendees had to wait to be allocated a place, and were not told the location until afterwards. I know that those at a meeting in Chipping Norton were given the wrong address before the event. Given the meeting in Bicester was scheduled for the middle of the day I requested an additional engagement event be arranged (see Appendix 15). However, I was told this would not be possible (see Appendix 16).

9.12. While the meetings are well-attended, the demographic of these groups is not representative of the local population. Specifically, it has been apparent that the working-age population as well as those most likely to use maternity services have been underrepresented at the meetings.

9.13. The messages disseminated at each of the meetings has fluctuated. For example, on one occasion we were told that static ambulance provision would be removed from the Horton should the maternity unit be downgraded, yet at the following meeting attendees were told that the ambulance provision would remain. At the first public meeting in Banbury, it was implied that closing Chipping Norton MLU to increase births at the Horton was an option. However, at the subsequent meeting in Chipping Norton, it was categorically stated that this was not being considered at this stage as maternity provision in the north of the county was to be considered as part of Phase Two.

9.14. A video setting out the proposed changes is misleading. Just as there is no mention in the consultation document about epidurals, the video also omits to mention them. It simply differentiates between high risk and low risk pregnancies without giving any further information to distinguish the two, nor any suggestion as to what proportion of women might fall into each category. Personally, I would not describe a pregnancy as high-risk simply because a mother wants to have a range of pain relief options available to her during labour. Epidural rates have doubled in the past few decades and locally are now approaching 40 per cent. For some Trusts it is almost double that. Failure to make this clear and mention pain relief options in the video is a key flaw in the engagement exercise.

9.15. I received complaints from constituents concerned about a flyer that was posted through their door regarding the proposals. Many expressed dismay that it had arrived after local public meetings had been held. My own flyer at home arrived two weeks after the Banbury meeting took place, as did flyers for other members of my family.

9.16. Given their role in commissioning, it is vital for GPs to contribute to the consultation exercise. Anonymity of response – to ensure they can put forward their full and frank views on the proposals – is essential. While seeking assurances from the CCG that this would be the case, I was told that all GP practices had received paper copies of the consultation response document, as well as the online link. The online link did not provide anonymity; the paper copy ensured that this was possible. I know of at least two practices in my own constituency which did not receive the paper document when they first received notification of the consultation, though the CCG said they had.

9.17. I am conscious that general practice in North Oxfordshire is facing unprecedented levels of demand. The GPs are hard-working and dedicated to their patients. However, it is not possible to gauge what will be expected of GPs should any of the Phase One proposals be taken forward. Some have expressed concern about this lack of detail and have noticed an increase in demand as a result of services moving to the John Radcliffe. As one GP has put it:

"I have already had patients not keen to go to Oxford for acute surgical problems because of distance/inconvenience. How much more will this be the case for medical inpatient beds? I also am not convinced that care closer to home is sustainable with current issues in General Practice in Banbury. We don't have care provision, or GP provision to support this."

Another told me:

"We are already seeing more complex maternity issues in Primary Care as expectant mothers are not prepared to travel to Oxford to see an obstetrician."

9.18. Having conducted my own survey of GPs, I am genuinely concerned by some of the views expressed, particularly in relation to maternity (see Appendix 17). One GP has told me that:

"Anyone that has spent time in obstetrics knows that even the most low risk pregnancy can become high risk very quickly. The time to get such a patient to safe care now is not acceptable."

Another has said:

"Low risk mothers often become high risk at the point they enter labour. The wait to transfer to a different unit is likely to mean the difference between life and death for some mothers/babies."

A further GP has noted:

"I am sure there will inevitably be a major clinical incident due to the time taken to reach the JR. My suggestion would be that all the obstetric posts at the JR rotate up to the Horton – after all if it's so close that shouldn't be a problem!"

9.19. I also have serious concerns about how involved the GPs have been in the consultation exercise. I understand the North Oxfordshire Locality Group has met on a number of occasions to discuss the issue. Responses to my own survey of GPs have been enlightening. In the further comments section, a GP told me:

"As GPs we have NOT been properly or officially consulted. Generalised meetings with poor clarity of focus and objective have been cynically used and counted as "consultation". And without our knowledge. This is manipulative, conceited and dishonest. Our views have not been properly obtained and anyone suggesting they have – is a clear and purposeful misrepresentation of us to get their objective fulfilled. So as you may guess, I have very little positive comment to make about the consultation process and the behaviour surrounding it."

In another response to my survey, one GP said:

"There has been no direct consultation – we are 'told' rather than asked our views. I feel there needs to be open and honest discussion with the people of Banbury about what the Horton can safely provide for the local community. In my view this means, full obstetric service, paediatrics and general medicine, full access to diagnostics and also first outpatient appointments. In this way the majority of straightforward care can be managed locally. However, the local patients need to appreciate that more complex and specialised care does need to be from a centre of expertise."

A different GP noted:

"I feel this has been a one way process of information from [the] CCG rather than true consultation."

9.20. The Pre-Consultation Business Case Second Addendum asks specifically about consulting stakeholder groups mentioned in the equality assessment. In their response, the CCG states that:

"the team is actively conducting outreach through faith leaders to reach members of this community as we know approximately 3% of the fertile population are Black/African/Caribbean/Black British/Asian British/Pakistani in the Cherwell area."

9.21. Engagement with minority groups has been an ongoing concern for me. The CCG asked me to help them with reaching out to the Black/African/Caribbean groups in my constituency. I explained that this is not a large community locally, whereas we do have significant Kashmiri and Polish populations (see Appendix 18).

9.22. While the CCG commissioned Qa Research to undertake a survey in Banbury Town Centre, the way in which this was conducted and the lack of understanding about the issue by those asking the questions caused frustration among local people. Having spoken to the CCG (see Appendix 19) and Thames Valley Police about the incident, I am pleased that the complaint was taken seriously. In my experience Banbury is a

peaceful place. I understand that the CCG decided not to proceed with any further sessions (see Appendix 20), however I have seen little evidence of engagement with minority groups. It is easy to find these groups; my offer of assistance remains.

9.23. In particular, lack of engagement with the large Kashmiri population which is based in Banbury remains an ongoing concern for me. This population are heavy users of maternity services, particularly obstetrics. Often language is a barrier for this group. I raised it at the Community Partnership Network meeting on 3 February 2017 and specifically asked about what work was being done to reach out to them. I have repeatedly offered to assist the CCG with engaging with this community.

9.24. I recognise that, following my requests, the consultation document was eventually printed in both Urdu and Polish at the end of February. However, I have only heard about minimal active engagement with this cohort. One prominent Kashmiri locally has told me that he is unaware of any engagement including at the mosque (one of two mosques in Banbury) and that many in his community are oblivious to the consultation exercise taking place.

9.25. Intimidation in any form is clearly unacceptable. It has been brought to my attention that the CCG have been informed that some GPs might be reluctant to speak out in support of the proposals for fear of intimidation. If this is genuinely the case, I would hope the CCG would make every effort to ensure GPs can express their views in a safe and responsible way. I take suggestions of intimidation extremely seriously. I do not underestimate how important it is for GPs to share their opinion on the future of healthcare in our area.

10. Future proposals

10.1. While I recognise that the CCG have indicated that they will consider any alternative options it receives in this consultation exercise, I believe it is unreasonable to expect members of the public to bring forward viable and rigorously tested solutions.

10.2. I am aware that Cherwell District Council has outlined its own future vision for the Horton General Hospital in its submission to this consultation. The new Banbury Health Campus is an interesting concept which recognises the Horton's potential as a modern acute hospital. Ideas such as that promoted by the District Council are exciting in so far as they give the Horton General Hospital the recognition it deserves. Before any decisions are made, I would encourage all local health providers to give due consideration to the District Council's proposal.

11. Conclusion

11.1. The Pre-Business Consultation Case makes clear that before any major service change is undertaken, health commissioners must demonstrate that they have complied with the 'four tests' set by NHS England:

- Strong public and patient engagement
- Consistency with current and prospective need for patient choice
- A clear clinical evidence base
- Support for proposals from clinical commissioners

11.2. It is my opinion that the Transformation Programme Phase One consultation document does not pass these four tests. Public and patient engagement has been inadequate; by omitting details of potential options, current and prospective need for patient choice has been severely restricted; the clinical evidence base is flawed and does not provide accurate statistics; and, I know from the discussions I have had and the responses to my own survey from clinical commissioners that their support is not forthcoming.

11.3. It is deeply worrying that on some of the occasions I have requested information about the consultation exercise, the answers have not been forthcoming. The various failings of the engagement exercise are examples of this. The people of north Oxfordshire feel that important decisions are being made secretly. Changes are being done "to them" rather than "with them". They do not feel included in this exercise.

11.4. This consultation is, in my view, fatally flawed. It should never have begun or should have been stopped some time ago. We need the CCG to set out their vision for the future of healthcare in north Oxfordshire and provide us with the evidence base for their views. Only then can we be properly consulted.

11.5. True consultation involves offering options on which the consultees can comment having seen the evidence they need to make informed choices. This is not the case here.

Victoria Prentis MP

7 April 2017

List of Appendices

1. Independent Reconfiguration Panel report on Horton reconfiguration dated 18 February 2008.

2. Letter dated 16 November 2016 from Oxfordshire MPs to OCCG regarding split consultation

3. Letter dated 12 January 2017 from Victoria Prentis MP & Robert Courts MP to OCCG regarding the consultation and purdah

4. Letter dated 16 January 2017 from OCCG to Victoria Prentis MP & Robert Courts MP regarding the consultation and purdah

5. Letter dated 13 January 2017 from Victoria Prentis MP to OCCG regarding engagement with elected officials in surrounding areas

6. Letter dated 7 February 2017 from OCCG to Victoria Prentis MP regarding engagement with elected officials in surrounding areas

7. Anonymous travel survey responses

8. Summary and results of travel survey

9. Letter dated 8 March 2017 from Victoria Prentis MP to OCCG regarding ambulance provision

10. Letter dated 16 March 2017 from OCCG to Victoria Prentis MP regarding ambulance provision

11. Letter dated 18 October 2016 from SCAS to Victoria Prentis MP regarding ambulance transfer time

12. Recruitment briefing note

13. Summary of responses to survey of Parish Councils

14. Anonymised emails and letters to Victoria Prentis MP from constituents

15. Letter dated 28 February 2017 from Victoria Prentis MP to OCCG regarding additional Bicester meeting

16. Letter dated 16 March 2017 from OCCG to Victoria Prentis MP regarding additional Bicester meeting

17. Summary of responses to survey of GPs

18. Email exchange dated 6 January 2017 between Victoria Prentis MP and OCCG regarding engagement with the African Caribbean community

19. Letter dated 13 March 2017 from Victoria Prentis MP to OCCG regarding Qa Research in Banbury Town Centre

20. Letter dated 16 March 2017 from OCCG to Victoria Prentis MP regarding Qa Research in Banbury Town Centre