Thames Valley Clinical Senate

Appendix to the Report 'Oxfordshire Transformation Proposal, Clinical Assurance Review dated 30.11.2016

On the 29th November 2016, the Thames Valley Clinical Senate Council reviewed and endorsed the report received from the Clinical Review Team which had been established to carry out a formal clinical review of the proposals put forward by Oxfordshire Clinical Commissioning Group (OCCG) for service change in Oxfordshire. This review was carried out as part of the formal assessment of the proposals undertaken by NHS England prior to public consultation.

As at the 29th November 2016, the Clinical Senate was supportive of the principles of the clinical models but recommended that there were a number of areas where further evidence or information would be required. The Senate report, dated 30th November 2016, stated that the issues detailed in the recommendations may not need to be resolved prior to consultation but would need to have been explored in much more depth prior to implementation and assurance that this work was complete would need to be provided to NHS England.

On the 5th December 2016, the Senate report was discussed with OCCG as part of the feedback from the NHS England assurance review. OCCG undertook to provide the additional information identified and submitted two Addendums to the initial material which have been clarified with the CCG through discussions with NHS England staff. In addition, discussions have taken place between senior staff of OCCG and NHS England to further resolve the issues.

This report will form an Appendix of the Senate Report dated 30.11.16 and reflects the impact of the additional information on the recommendations made. Where the recommendation has not been resolved, the Senate re-iterates that it does not need to be resolved prior to the public consultation but do need to have been assured prior to implementation.

Clinical Area	Senate Recommendation as per Report dated 30.11.2016	Additional Information Provided	Senate Response
General It was agreed that the case for change was clear but the Senate would like to see evidence of further work to demonstrate that the clinical model and anticipated benefits for patients are deliverable and sustainable. The decision to split the transformation proposals into two phases made it difficult for the CRT to fulfil its remit in that that it did not have sight of all the component parts.	As the Transformation Plan has now been phased, it will be important to provide an implementation timeline to show how the service implementation has been planned for both Phase 1 and Phase 2 identifying interdependencies across the entire project	High level information of Phase implementation has been supplied but not Phase 2. It is noted that Phase 2 will be dependent on the outcome of the public consultation of Phase 1 so cannot be provided at this time.	Senate position remains as set out in the report of 30.11.16. The information cannot be provided until the outcome of Phase 2 is known.
	Given that the transformation proposals have now been split into two phases, it is recommended that the building programme should not be finalised or commenced until the whole programme has been assessed and assured	No further information received	Senate position remains as set out in the report of 30.11.16. Information regarding the building programme has been requested.
	Although the primary care work stream will be detailed in Phase 2, it is recommended that the perspective from primary care regarding the proposals within Phase 1 is included	No further information received other than with reference to the early risk assessment in the maternity pathway	Senate position remains as set out in the report of 30.11.16. Further information regarding consultation with primary care has been requested.
Critical Care Unit (CCU) The case for changing the status of the CCU was well made and the current operation was of concern. The proposal to change the level of the CCU to a level 2 was supported subject to final proposals being assured before implementation.	The plans for joint management by acute medicine and critical care services and the links with the Headington CCUs, as described in the Horton Business Case	None	Senate position remains as set out in the report of 30.11.16. Proposal is subject to the Phase 1 public consultation. To be reviewed on completion
	Evidence of the timely process for transfer of appropriate patients to Headington	None	Senate position remains as set out in the report of 30.11.16. Proposal is subject to the Phase 1 public consultation. To be reviewed on completion
	The mechanism for keeping a level 2 CCU at the Horton would require a different set of clinicians to be trained and competent to keep the unit current and viable – the plan to deliver this needs to be documented and agreed	None	Senate position remains as set out in the report of 30.11.16. Proposal is subject to the Phase 1 public consultation. To be reviewed on completion
	Assurance that the subsequent work streams in the transformation plan do not affect the proposals as submitted	None	Senate position remains as set out in the report of 30.11.16.

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Rebalancing the System (DTOC) It was agreed that the principle of closing acute beds to use the funding in the community was the right one but the evidence base available was not sufficient to enable the Senate to comment on the number of beds that would be required. The Senate encouraged continued investment in this scheme to the extent that the maximum potential could be achieved for patients who no longer need acute hospital care but recommended that:	It is made explicit that people will be moved into the community beds with a plan to achieve discharge to the intended destination and OCCG should continue to monitor the outcome for these patients, their length of stay in the community beds and the usage of the beds	None	Senate position remains as set out in the report of 30.11.16. Further information has been requested
	There should be checks to ensure that there is a robust system response beyond the beds in the community to ensure that delays were not transferred from the hospital to the community	None	Senate position remains as set out in the report of 30.11.16. Further information has been requested
	That additional modelling should be presented to demonstrate the case for the number of hospital beds included in the scheme	Advised that this is an incremental approach and the scheme will be piloted and amended based on learning.	Senate position remains as set out in the report of 30.11.16. Written confirmation awaited

Clinical Area	Senate Recommendation as per Report dated 30.11.2016	Additional Information Provided	Senate Response
Stroke The Senate supported the principle of the all suspected stroke patients going to the Hyper Acute Stroke Unit (HASU) at the John Radcliffe (JR) unless clinically inappropriate subject to final proposals being assured before implementation	Plans for the provision of county wide Early Supported Discharge (ESD) and rehabilitation which is key to ensure the flow of patients through the HASU and to improve outcomes for patients	Addendum 1 (p43/44) states that the current ESD service operates 5 days per week and is geographically limited. There is currently no weekend or bank holiday provision which limits patient reviews within 24hours during these periods. A review showed that potentially another 23.2% of patients could benefit from ESD if capacity was available. Addendum 2 (p5) identifies a plan to expand ESD provision with support from the Home Assessment Reablement Team which will increase the number of patients discharges to ESD by an average of 8 per month. The capacity of the HASU is dependent on the expansion of the ESD service. Rehabilitation will be addressed in Phase 2	Based on the Addendums and the further discussion regarding HASU capacity, the Senate recommendation has been met.
	Documented evidence of agreement from South Central Ambulance Service (SCAS)	Addendum 2 (p6) states that though the ambulance service has been in involved in the stroke pathway proposal, it cannot provide formal assurance until it been through their Board – expected to be early January 2017	Senate position remains as set out in the report of 30.11.16 but notes that this should not hold anything up. Waiting for formal confirmation from SCAS
	A shared and documented understanding of risk as there are significant interdependencies throughout the whole pathway	Addendum 2 (p6) No additional information has been provided	Senate position remains as set out in the report of 30.11.16. Documented agreement awaited
	Workforce planning to include the ESDs and rehabilitation provision	Addendum 2 (p6) states that workforce modelling has been carried out and provides detail.	The recommendation has been met.

Clinical Area	Senate Recommendation as per Report dated 30.11.2016	Additional Information Provided	Senate Response
Stroke cont/…..	Evidence that there is sufficient capacity at the John Radcliffe (JR) to manage the additional patients from the Horton	Addendum 2(p3) sets out the proposals In addition to this, outcomes of a meeting between OCCG senior staff and NHS England senior staff are below: • An ESD programme will put in place before the implementation of the centralised HASU model. This will help drive down the average Length of stay for patients at the JR. • As a consequence, the requirement for additional beds is anticipated to be small; amounting to 1–2 extra beds. Confirmation was given that this is manageable by the stroke unit. . • The system will benefit from the phase 2 programme of work, namely the provision of rehab beds, but is not reliant on it for creating the required capacity.	The additional information has allowed greater confidence in the OCCG plans and the recommendation has been met.
	Assurance that subsequent work streams in the transformation plan do not affect the proposals as submitted	Addendum 2 (p9) states that subsequent work streams will not affect the proposals as submitted	The recommendation has been met

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Planned Care The Senate was supportive of the principle of optimising the patient flows through the creation of an elective unit at the Horton, with level 2 CCU, subject to the final proposals being assured before implementation. The Senate advised that these should include:	Evidence that access to planned care will be equitable across the county	None	Senate position remains as set out in the report of 30.11.16. This cannot be established until the Phase 2 proposals are known
	Ongoing review of the proposal to establish additional outpatient clinics as part of the elective unit and consideration, within Phase 2, of including these within the community model	None	Senate position remains as set out in the report of 30.11.16. This will be reviewed as part of the Phase 2 proposals
	Assurance that patient choice is not reduced by the establishment of the elective unit at the Horton	None	Senate position remains as set out in the report of 30.11.16. Awaiting a statement of confirmation
	Sight of the implementation plan for the phased transfer of services and the construction of the unit for the MRI and CT scanner	None	Senate position remains as set out in the report of 30.11.16. This will be reviewed as part of the Phase 2 proposals
	An agreed workforce plan with evidence that it has the agreement of all staff affected and required to work across the two sites	None	Senate position remains as set out in the report of 30.11.16. This will be subject to the outcome of the public consultation for Phase 1
	Assurance that subsequent work streams in the transformation plan do not affect the proposals as submitted	None	Senate position remains as set out in the report of 30.11.16. Awaiting a statement of confirmation

Clinical Area	Senate Recommendation as per Report dated 30.11.2016	Additional Information Provided	Senate Response
Maternity Services The CRT agreed that if there is no way to make the obstetric unit at the Horton safe on staffing, it was supportive of the principle to change to an MLU at the Horton subject to the final proposals being assured before implementation. The proposal to include Chipping Norton MLU within the public consultation was not included in the documentation provided to the CRT and therefore was not considered by the CRT. The CRT advised that the final proposals for assurance should include:	Evidence of the capacity at the JR to accommodate the additional births	Addendum 1 (p44) sets out the plans for the provision of additional capacity including additional theatre time, additional capacity in the induction labour suite and additional birthing rooms in the alongside Midwife Led Unit Addendum 2 (p1) sets out the number of births at the JR in September and October - since the temporary closure of the obstetric unit at the Horton. The figures of 607 and 659 respectively were lower than anticipated as a result of a decision not to accept women from out of area and some women in north Oxon choosing to birth elsewhere. It states that the additional capacity that has been made available has been utilised 9 times in the two month period. An update to these figures has been provided by the OUH for November and December 2016. It shows that total births were 571 and 572 (not ratified) respectively and that the additional beds were utilised on 5 occasions in November and 6 in December. The OUH identify their total capacity as 8,400 births per annum with 7,500 of these taking place at the JR (including the alongside Midwife led unit). Total births at OUH in 2015 were 8553 but this included women who are now not able to book at the JR on the basis that they do not have an Oxfordshire midwife.	It is anticipated that the JR birth rate would increase by 15%, taking into account the fact that out of area women will no longer come to Oxford and some women in the north of the county are choosing to birth elsewhere. The birthing rooms on the obstetric unit at the JR have increased by 15% and there are additional birthing rooms at the AMU. There are an additional 8 postnatal/antenatal beds which represents a 40% increase in capacity. The number of births for the 4 months since the temporary closure of the obstetric unit has been provided. This identifies a month on month growth of 5.11% in September and 7.9% in October. November birth figures fell by 13.35% and remained static in December. Whilst evidence has been provided to show that additional capacity as been provided at the JR, there remains a question about the impact on other parts of the Thames Valley. Women in Berkshire and Buckinghamshire will be considered as 'out of area' if they do not have an Oxfordshire midwife or are not a tertiary referral. The Senate is currently unable to find evidence to show that this has been discussed with CCGs and providers in Berkshire and Buckinghamshire and that sufficient capacity is available within these areas to repatriate the women.

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Maternity cont/…	Evidence of the capacity of the SCBU at the JR given that the SCBU at the Horton would close	Addendum 1 (p45) sets out the plans for the capacity of the SCBU. The provision at the JR is a Neonatal Intensive Care Unit. The provision at the Horton was a lower level Special Care Baby Unit. Babies with a higher level of need than could be provided at the Horton, would have been transferred to the JR. The number of cots at the Horton was 8 and the JR has increased its special care baby cots by 3 and has a further 4 available on an interim basis.	An additional 7 special care cots has been made available and the recommendation has been met.
	Assurance that the proposals for the MLU at the Horton will not be affected by subsequent proposals put forward for children's services	Addendum 1 (p46) includes a statement that the proposal for the MLU at the Horton would not be affected by subsequent proposals	The recommendation has been met.
	Confirmation that the JR will provide clinical leadership across the accountable care system for community support /training in high risk skills and skills drills	Addendum 1 (p46/47) sets out the clinical training	The recommendation has been met.
	Additional modelling of predicted births at the Horton MLU – in the absence of this, the CRT recommends that staffing continues on a 24/7 basis	Addendum 1 (p47) states that as part of the temporary measures, the attendances for 3 months had been estimated and the required staffing put in place. It also states that if a permanent MLU is established at the Horton 24/7 provision will be available. It has been confirmed that there is currently 24/7 cover at the Horton MLU.	Predicted numbers of births needs time to settle but on the basis of the confirmation from OCCG that currently 24/7 cover is being provided the recommendation has been met.
	Additional work force planning and confirmation that the rotation required has been formally agreed with staff	Addendum 1 (p49) states that workforce planning cannot take place until the outcome of the public consultation is known. However there is provision within existing contracts with staff to facilitate change of base of work.	Senate position remains as set out in the report of 30.11.16. Workforce planning cannot be completed until after the outcome of the public consultation is known.

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Maternity cont/…	Confirmation of mental health provision to support the maternity pathway	Addendum 1 (p49) sets out the provision.	The recommendation has been met.
	Benchmarked evidence from existing MLUs on safety for women requiring an emergency transfer	Addendum 1(p51) references The Birthplace study which showed that the average transfer rates for first time mothers from a freestanding midwife led unit is 36.3%. For second and subsequent pregnancies it is 9.4%. It states that the transfer rate from the Horton from 3rd Oct to 5 Dec 2016 was 15%. The outcomes for these women has not been provided. No information has been provided for the existing freestanding midwife led units in Oxfordshire	The Senate was aware of The Birthplace Study when making its recommendation. Although transfer rates have been provided for the temporary unit, no evidence has been seen of the outcome for these women or those women who have been transferred from previously existing MLUs in Oxfordshire. The Senate recommends that the outcome data is monitored closely through the temporary period of operation.
	Confirmation of the emergency planning for women who need to be transferred to the JR whilst in labour	Addendum 1(p51) sets out the plans	The recommendation has been met.
	The process for carrying out the early risk assessment on all pregnant women – there is lack of evidence that this is the right solution and is sustainable and other options should be considered eg improved communication between GPs and midwives	Addendum 1 (p53) sets out the proposals for carrying out the early risk assessment. Addendum 2(p3) states that the proposal has been accepted by the LMC.	Although there is a lack of evidence that the proposal is the right solution, there is no evidence that it is not. It is noted that it has been accepted by the LMC. The Senate agrees that this recommendation can be removed but would encourage OCCG to come back to the Senate, post implementation, to share learning.
	Assurance that subsequent work streams in the transformation plan do not affect the proposals as submitted, particularly the primary care work stream	Addendum 1 (p54) states that subsequent work streams will not affect these proposals as submitted.	The recommendation has been met.