Robert Courts MP

HOUSE OF COMMONS

LONDON SW1A 0AA

robert@robertcourts.co.uk

David Smith
Chief Executive for Oxfordshire Clinical Commissioning Group
Jubilee House
5510 John Smith Drive
Oxford Business Park South
Oxford OX4 2LH

Friday, 07 April 2017
Ref: RAC/eq/S

Dear David,

RE: Oxfordshire's health and care services - The Big Consultation - Phase 1

I am writing to you in order to formally submit my response to the first phase of Oxfordshire Clinical Commissioning Group's public consultation on their proposals for the future of Oxfordshire's health and care services.

Please find my comments broken down into sections: process; content; engagement; future implications; conclusion.

I look forward to seeing the outcome of this consultation and for further opportunities to discuss these and future proposals by Oxfordshire Clinical Commissioning Group.

Yours sincerely,

Robert Courts

Robert Courts MP

Submission to Oxfordshire Clinical Commissioning Group's *Big Health and Care Consultation* – Phase 1, as part of the Oxfordshire Transformation Plan by Robert Courts MP

1. Process

1.1. I have publically made the CCG aware of the concerns held by myself and parliamentary colleagues about the splitting of this consultation period into two phases. This was made clear in our joint letter to the CCG dated 16th November 2016, attached at appendix 1.1, and further subsequent meetings between the CCG, myself and Parliamentary colleagues[1].

1.2. The reason for my concern is that by splitting the consultation, the full implications of these proposals may be diluted. The public are keen to engage in this consultation in order to ensure the appropriate decisions are made regarding the future of Oxfordshire's healthcare; however, for those who do not work in the health or political sectors, this artificial separation of review into services will not enable them to look into, and fully understand, the implications of these proposals.

1.3. The CCG's mantra throughout this process has been to bring 'care closer to home'. I fully agree with the logic behind this proposal. Enabling patients to be cared for in their own home or a non-hospital setting, providing better outcomes for rehabilitation and decreasing the chances of infection. This also frees up hospital resources for other patients. I do however query the efficacy of a split consultation. If the system as a whole is not being looked at in this first phase, the public are rightly wary of the credibility of this proposal as a whole. Changes need to be made at the other end of this route of recovery to cope with the greater numbers of patients who will no longer be recovering in a hospital setting. These changes will surely be discussed in phase two. However, this clearly illustrates the consequences of splitting this matter into two phases. **Public confidence in the credibility of the plans is undermined by the currently uncompleted work by the CCG which is needed to make these proposals viable.**

1.4. It must be remembered that this is part of the Oxfordshire Transformation Plan, to feed into the wider Buckinghamshire, Oxfordshire and Berkshire West Transformation Plan (BOB STP). The clear basis of these plans is to look at the area as a whole, understanding the interlinking interdependent services in the healthcare system, including primary, community and acute care, with the patient at the centre[2]. I agree that this is the best way to review healthcare in light of changing demands. However, I query if this is possible with the arbitrary separation of these proposals.

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[1] I have regular meetings with the CCG and other Oxfordshire and affected MPs to discuss the future of healthcare in the area and implications of the CCG's proposed changes.

[2] *Pre-consultation Business Case*, pg. 9. https://consult.oxfordshireccg.nhs.uk/gf2.ti/-/767746/24389861.1/PDF/-/PCBC__Acute_Hospitals_Phase_One__FINAL.pdf

1.5. A particular example, which has been raised by many of my constituents, is how the CCG can decide whether to downgrade in maternity services at the Horton General, without considering the implications this may have on the future of nearby maternity-led care units (MLU), namely services at Chipping Norton. This is briefly mentioned in the '*Big Health and Care Consultation*' document[3]. However, this is not fully explored in any way, and has instead led to much distress for expectant mothers in Chipping Norton about where they will be able to give birth. A clear illustration of this can be seen in Appendix 1.1 of the PCBC which shows clearly that maternity will be looked at in phase one and two, the only section in where services are being addressed in both phases. Further, in this appendix, the increase in maternity clinics is only marked as being looked at in phase one, when this is clearly not true. In the option in the main document where the MLU at Chipping Norton would close[4], it states that Chipping Norton would continue to provide maternity clinics – which will only be properly addressed in phase two.

1.6. The CCG stated at a public meeting I attended during this consultation phase[5] that it was necessary to split the consultation because there are a number of urgent critical decisions that need to be made regarding obstetric care at the Horton General. The CCG were advised by the Oxfordshire Joint Health Overview and Scrutiny Committee (HOSC) that the temporary closure needed to be urgently resolved in order to remove uncertainty for patients. As this would create a substantial change in the provision of service, the CCG must hold adequate public consultation before making such a closure permanent.

1.7. However, it was not necessary to make these time-sensitive proposals part of the larger Oxfordshire Sustainability and Transformation Plan (STP), if the necessary work had not yet been completed to launch the consultation as a whole. A separate consultation on these issues would have enabled the public to focus on maternity at the Horton and resolve this matter, without tying in a few other proposals to make it more relevant to the Plan as a whole. **Obstetric care at the Horton should have been looked as a separate consultation, and the STP should have been consulted on as a whole at the end of this year.**

1.8. Should this have been the case, I would like to make clear that I would still have objected to consultation of the above structure on two fronts. Firstly, I disagree that the situation is so urgent that it could not have waited until later this year when it would have been looked into as a part of the greater Oxfordshire Transformation Plan, allowing the necessary work to be carried out for all proposals. Secondly, I would have stated that all maternity services should be looked into together, in the interests of looking at the system as a whole. This is still a complaint I strongly hold, which I will explain in more detail at 2.25.

1.9. That being said, this would have been a more favourable option to splitting the consultation in the way that it has been. This plan is a substantial change in the way in which healthcare in Oxfordshire is run and under no circumstances should it be

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[3] *The Big Health and Care Consultation*, pg. 40-41 http://www.oxonhealthcaretransformation.nhs.uk/what-is-the-vision/consultation-documents/144-phase1consultation/file

[4] *The Big Health and Care Consultation*, pg. 41 http://www.oxonhealthcaretransformation.nhs.uk/what-is-the-vision/consultation-documents/144-phase1consultation/file

[5] Chipping Norton public consultation meeting, held at St Mary's Church, Chipping Norton on 9th March 2017.

rushed. The purpose of the plan is to avoid inefficiencies, use resources more effectively and ensure that the system can cope with increasing demands in the future. **By putting out part of the consultation now, I am not convinced that the full implications have been understand and fully thought through.**

1.10. It is worth noting at this stage, that there has been no clear indication to the public when phase two of these proposals will take place. Indeed, the CCG has made clear from various meetings throughout this consultation that the work for phase two is far from being completed. I was of the understanding that phase two would be held in Autumn 2017, however at a public consultation meeting[6] representatives from the CCG indicated that it is not likely to be held until early next year. This is not helpful for constituents who will be left uncertain as to the future of their healthcare services, for an undetermined length of time. This further relates to my point in 1.2 that this delay will lead to a dilution of understanding of the full impact of these proposals, with significant time passing between the two phases. It is also possible that the situation for a number of healthcare services will have progressed since this time, which could alter whether the right decisions were made in phase one.

1.11. When I met with the CCG before the start of the consultation on 12th January 2017, myself and parliamentary colleagues raised serious concerns that this consultation period goes into purdah for the County Council. There are significant legal ramifications for the Oxfordshire Joint Health Overview and Scrutiny Committee (HOSC) being constrained by purdah and thus not being able to respond to this consultation. Before the start of the consultation, MPs including myself asked for the consultation to be extended until after purdah, which was not done. HOSC held a special meeting on 7th March 2017 to discuss the STP consultation[7], during which myself and colleagues raised our concerns about the consultation process. I have attached my response to HOSC at Appendix 1.2. However, I understand that, despite the reassurances given at the beginning of the period that purdah would not affect the consultation, the CCG have refused to attend the HOSC's further meeting on 6th April 2017. If HOSC are able to hold a meeting during purdah, the CCG surely cannot refuse to attend. As an overview and scrutiny committee, it is essential for HOSC to be able to carry out these duties, particularly on such large scale proposals as the STP.

2. Content

2.1. In the '*Big health and care consultation document*', for each proposal, there is a '*Our preferred option and why*' section. This is incredibly leading. By presenting only one option, it makes the whole consultation feel as though this is the only way of changing the system for the better. In reality, there may be multiple ways of changing this system, but adequate work has not been completed to make any other option viable. By formatting the document in this way, it places the onus on the reader to create another solution, who may not be a healthcare professional with the detailed knowledge required. **The CCG have a duty to the public to provide multiple, viable solutions to enable true choice for the public. Otherwise, this is not a consultation – this is telling patients what is going to happen.**

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[6] Chipping Norton public consultation meeting, held at St Mary's Church, Chipping Norton on 9th March 2017.
[7] Agenda for HOSC STP meeting: https://mycouncil.oxfordshire.gov.uk/mgAi.aspx?ID=16599#mgDocuments

2.2. Further, by only offering one solution, should the public be largely against the proposals, there is no explanation as to what further action will be taken by the CCG. If these first phase proposals are rejected by a majority of respondents, will the CCG have to re-run this section of the consultation with a wider range of options? What will happen to those time-sensitive services which require an urgent decision?

2.3. In the Pre-Consultation Business Case – Second Addendum[8], in which NHS England is responding to a draft of the consultation document, it 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. It is recognised that this would significantly lengthen the consultation document, so reference to where this information is/how people can access it, could be included as a signposting mechanism."*

2.4. The CCG states that, *"For critical care and stroke OCCG has identified one single viable option for each of these services. In the consultation document on page 24 and 26 the option rationale is explained."* However, I strongly disagree that there is only one proposal to be considered. As I said in 2.1, to offer only one option is leading the public to make a certain conclusion. If indeed these are the only viable proposals, as all others have been discarded, it is the duty of the CCG to list these in the interest of fully informing the public, to make their responses credible.

2.5. The consultation document writes about *'The Big Health and Care Conversation'* as a listening exercise which informed the proposals in phase one. I am glad that the CCG appears to have asked public about their areas of concern in the system before releasing their formal proposals. However, the list of common themes which emerged from the engagement[9] are the perfect illustration of significant problems presented by the separation of the consultation into two phases. Over half of the themes mentioned are explicitly stated as not being consulted on in this phase. When looking at the division of healthcare into these themes rather than services, it is extremely clear that this division is arbitrary. For example, 'more local services' is partially looked at in phase one, with planned care being moved to the Horton, but the role that community hospitals such as Witney could play in this is not being looked at until the second phase.

2.6. The document states that, *"These proposals set out in phase one would involve investment in some areas and would not be at the cost of other proposals we will be discussing in phase two"*[10].

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[8] Pre-Consultation Business Case Second Addendum, C. P10 pg. 13 https://consult.oxfordshireccg.nhs.uk/gf2.ti/-/767746/24385637.1/PDF/-/Preconsultation_business_case_Addendum_2.pdf

[9] *The Big Health and Care Consultation*, pg. 11-12 http://www.oxonhealthcaretransformation.nhs.uk/what-is-the-vision/consultation-documents/144-phase1consultation/file

[10] Ibid, pg. 4.

2.7. This shows that **this document is unclear, uses lazy language is in parts, which is indicative of rushed work**. Although in the second addendum to the business case NHS England did emphasise the need for simpler language[11], clearly clearer language could have been used throughout the document. In this example, on the one hand, this could be taken to mean that, in terms of monetary cost, no proposals in phase two will be affected should the phase one proposals be implemented. On the other, this could be talking about cost in services, rather than monetary terms.

2.8. If it is accepted that all the proposals suggested will be adopted, rather making a consultation redundant, then these therefore must be cost neutral proposals which would not affect phase two. There is no evidence to suggest this, as the document contains no detailed cost analysis of services, which is a significant hole in the document. If these changes are being made to be more efficient and eliminate the projected £134 million gap in funding by 2020/21[12], the public must be shown in detail how this is being done.

2.9. Further, it is clearly outlined in the document that changes to maternity services in this phase will impact services at the Chipping Norton MLU[13]. This is irrefutably a cost in service.

2.10. In the document, there is a general lack of supplementary data to support these proposals. As mentioned in 2.8, there is no detail regarding the monetary cost of the CCG's proposed changes. In the PCBC, there is detail of the projected financial position of the CCG depending on the efficiencies made, but this is not detailed in the main consultation document.

2.11. More information such as the above should be available in the main document. I do not feel that the correct balance between technical language and information and accessibility has been reached: **the removal of too much information into the business case document has left the main document feeling lacking in necessary detail**. Further, due to the length of the business case, it must be assumed that many respondents may only read the main document, further aggravating this lack of detail.

2.12. The CCG has published many appendices to the PCBC[14], most of these being published after the start of the consultation. In particular, the Maternity Factsheet was not published until 3rd March 2017 – two months after the start of the consultation. This is unacceptable and makes a farce of those responses sent earlier in this period, as they did not have access to all required information to submit a full response.

Moving more planned care to the Horton

2.13. At this point, it would be beneficial for me to reiterate my statement in 1.3 that I agree with the spirit of the proposals. The creation of hubs where patients can be diagnosed and treated, quickly, and in one location, clearly has benefits. I appreciate

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[11] Pre-Consultation Business Case Second Addendum, Q.P06, pg. 10 https://consult.oxfordshireccg.nhs.uk/gf2.ti/-/767746/24385637.1/PDF/-/Preconsultation_business_case_Addendum_2.pdf

[12] *The Big Health and Care Consultation*, pg. 8 http://www.oxonhealthcaretransformation.nhs.uk/what-is-the-vision/consultation-documents/144-phase1consultation/file

[13] Ibid, pg. 41.

[14] http://www.oxonhealthcaretransformation.nhs.uk/what-is-the-vision/consultation-documents

the increase in planned care at the Horton General, and I am hopeful that this same idea will carry through to community hospitals in phase two.

2.14. **Being able to access these services without the need to travel to Oxford is a great plus to residents.** The A40 is a particular issue for my constituents and being able to avoid repeated trips into Oxford for treatment will save time, stress and inconvenience. This is particularly true for planned care, including diagnostics and outpatient clinics.

2.15. I am further in favour of easing the workload for the John Radcliffe Hospital (JR) and other Oxford hospitals in this way. By enabling patients to receive this level of care away from these facilities, this will free up doctors in Oxford to provide other treatments.

2.16. I will always be supportive of bringing care closer to home, with patients broadly faring much better outside of hospital. I note that 10 days in a hospital bed being equivalent to 10 years lost muscle strength[15]. This clearly demonstrates the benefits of recovery outside hospital, in addition to the decrease in risk of hospital infections and in patients contracting 'superbugs'.

2.17. There are also the social benefits to being cared for outside of a hospital setting. With your family and friends having greater access to you while you are recovering, either in your own home or in the community, recovery can feel significantly less isolating, leading to better outcomes.

2.18. However, proposals such as liaison hubs will require cooperation and joined up strategy from all involved partners: Oxford University Hospitals Foundation Trust (OUHFT), Oxford Health NHS Foundation Trust (OHFT), the CCG and Oxfordshire County Council (OCC). I am not certain that these stakeholders have been sufficiently included in the creation of these proposals to ensure, for example, that there is sufficient capacity and resources in nursing homes and for care workers to cope with the increase in patient numbers recovering in their own homes, as they are discharged from acute hospitals.

2.19. This again underlines the point that the consultation split is arbitrary. Any change in the way hospital beds are used surely relies on the potential changes to community hospitals, which are not being looked at until phase 2.

2.20. In terms of the specific proposals to bring more planned care to the Horton and move acute stoke services to the JR. As a Member of Parliament, not a healthcare professional, I will address the clinical implications of these changes in detail. However, **I agree in principle that those with such a time sensitive condition as a stoke should be taken to a specialist unit with the best possible outcomes.**

2.21. However, any removal of services must not put the Horton at risk of losing its training accreditation in other departments, due to a decrease in patient numbers. It is

[15] *The Big Health and Care Consultation*, pg. 17 http://www.oxonhealthcaretransformation.nhs.uk/what-is-the-vision/consultation-documents/144-phase1consultation/file

essential that the Horton remains a high quality, respected centre of healthcare in the north of Oxfordshire.

2.22. If a permanent downgrade of maternity services at the Horton is implemented, it is essential that this does not cause a domino effect on services. **By closing this key part of the hospital, more must be put in place in other areas to ensure that the Horton is able to flourish.**

2.23. I am concerned that these other hospitals who will now take patients from the Horton have not been sufficiently consulted as to whether they have the capacity and resources, particularly for sites such as the JR, which is very restrained and unable to expand further. My Parliamentary colleagues and I raised concerns with the CCG about a lack of reference to appropriate treatment options for those in South Northamptonshire and South Warwickshire. This was four days before this public consultation was launched, when we were shown a draft of the document[16]. Should these service changes at the Horton take place, these residents may prefer to travel to other hospitals which are closer to them than the JR. This has been added into the final document[17], but **I strongly query how much discussion could have been completed with these other hospitals in Warwick, Northampton and Milton Keynes about their ability to take this potential influx in patient numbers, in the four days between this meeting and the publication of the consultation document.**

2.24. I query how the division of certain services will be viable in real life patient scenarios. For example, for critical care, the CCG propose moving level 3 patients to be treated at the JR, as patient numbers are currently too low for doctors and nurses to keep up their skills. However, where a patient is deteriorating rapidly, they could have been admitted to the Horton as a lower level patient but then become a level 3 patient, which includes the need for ventilation, and so would need to be transferred. This will surely put vulnerable patients at risk by having to transfer them by ambulance to another hospital at a time when they require urgent treatment that will not be available at the Horton.

Maternity services

2.25. **I will always be against the proposal that the Horton be permanently downgraded to an MLU, as this may lead to the closure of the MLU at Chipping Norton. This would leave a significant number of my constituents a long way from appropriate care.** This is particularly concerning for those west of Chipping Norton. The document presents this a clear potential outcome, despite this not be part of phase one. This has left many expectant mothers very concerned about where they will be able to give birth, without this due to be resolved until the end of the phase two, which is not likely to be until early to mid-2018. This is an unacceptable amount of time for residents to be left in limbo.

2.26. If the Horton becomes a permanent MLU, it will only treat low risk mothers, as it will not have the medical facilities of a hospital. However, a low risk mother in labour

[16] http://www.oxonhealthcaretransformation.nhs.uk/what-is-the-vision/consultation-documents/215-pcbc-appendix-12-2-the-draft-consultation-document-pdf/file

[17] *The Big Health and Care Consultation*, pg. 16 http://www.oxonhealthcaretransformation.nhs.uk/what-is-the-vision/consultation-documents/144-phase1consultation/file

can very quickly become high risk with complications. **Mothers will therefore have to be transferred during labour, potentially without their partners being able to be transferred in the ambulance.** This will of course cause considerable stress to mothers at this already extremely stressful time. Although it is possible to determine many mothers early in their pregnancy as high or low risk, during labour this can change dramatically and quickly.

2.27. **In the main document, the distinction between high and low risk pregnancy is not made sufficiently clear**. Although in the main body of the document, the CCG does define planned care and critical care well, they have not clearly defined the difference in maternity services. This is detailed in the glossary[18], but this is not clearly signposted and should be in the main body of the text.

2.28. What should certainly be made clear is that obstetric care not only cares for mothers who are higher risk and so require a doctor rather than a midwife, but also includes those who need an epidural, which can only be delivered by an anaesthetist under the care of an obstetrician. Many mothers may be unsure whether they will require an epidural, and so might elect to give birth at the JR to have wider treatment options. Further, **if mothers elect to give birth at an MLU at the Horton, but then require an epidural during the birth, they will need to be transferred**.

Travel times

2.29. This brings me to my further concern about the provision of ambulances. In the public consultation meetings, the CCG have been inconsistent about whether a permanent static ambulance will be in place to transfer patients from the Horton to the JR. This measure is currently in place whilst maternity is temporarily downgraded, but it has not been confirmed that this measure will remain. Should this not remain, we must have to factor in the waiting times for an ambulance to arrive to transfer patients, further adding strain onto the potential health and outcome of patients.

2.30. **This problem of ambulance waiting times will be significantly exacerbated should the MLU at Chipping Norton close**, as is referenced as a potential option to be discussed in phase two. This could leave Chipping Norton mothers going into labour and having to wait for long periods for an ambulance to arrive at their home. Travel times are further significantly worsened during the winter, due to Chipping Norton's geographical location. Once an ambulance arrives, mothers have to be taken to the Horton, only potentially to have complications during birth and therefore need to be further transferred to the JR. This is a nightmare scenario for many of my constituents and one I will fight hard to avoid becoming a reality. **The fact remains that journey times from Chipping Norton and north Oxfordshire are, in reality, far longer that this consultation allows.**

2.31. From responses during the public meetings, it seems that very little communication between the CCG and the Southern Central Ambulance Service (SCAS) has taken place. **This is an essential part of ensuring that these proposals are viable and is a significant oversight.**

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[18] *The Big Health and Care Consultation*, pg. 45 http://www.oxonhealthcaretransformation.nhs.uk/what-is-the-vision/consultation-documents/144-phase1consultation/file

2.32. The travel analysis used in this consultation is flawed. The document[19] does not use any start point from within the Banbury constituency, whose residents will be most affected by these changes. Further, one of the points used is Deer Park Medical Centre, which as you will know has been officially closed since 24th March 2017, so this is no longer a valid example.

2.33. Although this document does acknowledge that the population of Oxfordshire has grown and is expected to continue to grow[20], this is not substantiated in the document with any specific detail about where this growth will be expected. This growth will of course further impact travel times. **There is no evidence in this document that district councils have been consulted about when and where significant development will take place.** In West Oxfordshire, significant development is due to take place, as outlined in West Oxfordshire District Council's emerging Local Plan. This is not expressly taken into account.

3. Engagement

3.1. I have made very clear to the CCG my concerns about the time and location of the public meetings to discuss these proposals. For the record, I attended the meetings held in my constituency and Banbury[21].

3.2. The first meeting held in Chipping Norton, the area of my constituency most affected by these proposals, was woefully inadequate. A single meeting being held in the area, at a time when those most affected – young and expectant mothers – would likely be busy with the school run or at work. This did not entail sufficient opportunity for residents to attend and engage with these proposals.

3.3. **I therefore offered to chair a further meeting, at a time that works for residents, which I would then feed back to the CCG as part of the consultation.** Fortunately, the CCG listened to both my and my constituents' concerns and agreed to host a further formal public consultation meeting in Chipping Norton, on 9th March at 6-8pm. This was well attended and I feel gave a fuller opportunity for residents to engage. I praise the CCG's response to this matter, but these issues should have been more fully thought through before the start of the consultation. This is, after all, a public consultation and so requires the maximum possible engagement from local communities and residents.

3.4. I disagree with the system used by the CCG which required attendees to register for a place, and only then being given the location. This discouraged many from attending, creating a barrier to entry to those without access to or proficiency with the internet. A better system would have been to fully advertise the details of the meeting, and book sufficiently large venues. This system worked well at the 9th March meeting, where St Mary's Church, Chipping Norton was used, with a much greater capacity.

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[19] https://consult.oxfordshireccg.nhs.uk/gf2.ti/-/767746/24367941.1/PDF/-/OXT_Travel_Analysis.pdf

[20] *The Big Health and Care Consultation*, pg. 7 http://www.oxonhealthcaretransformation.nhs.uk/what-is-the-vision/consultation-documents/144-phase1consultation/file

[21] Chipping Norton meetings on 2nd February 2017, 2-4pm, and 9th March 2017, 6-8pm, Witney meeting on 16th February 2017, 6-8pm, and Banbury meeting on 16th March 2017, 7-9pm.

Many attendees did not register for this meeting, but arrived and attended anyway, with no one being turned away. There was no issue with overcrowding, no significant higher cost incurred by the CCG for booking this venue, and the whole booking system was demonstrated to be redundant.

3.5. Further, **this system gave opportunity for error and oversight**. For example, for the Chipping Norton meeting on 9th March 2017, the address of the meeting was incorrectly given out to a number of attendees who registered online. The address of St Mary's Church in Kingham was given rather than Chipping Norton. This is an unfortunate error that led to confusion for my constituents, distressed that they would have to travel to a neighbouring village to attend the meeting. Again, this is symptomatic of a rushed consultation.

3.6. I feel that more could have been done to attract the demographics most affected by the proposals, namely young and expectant mothers. Although meetings were well-attended, these key service users did not attend in high numbers. These meetings could have been better advertised, for example through doctors informing relevant patients of the upcoming meetings.

3.7. The messages communicated at each of these meetings varied, so attendees will take away different messages depending on the meeting they attended. Examples of this have included the likely timing of phase two (1.10), and whether a static ambulance will remain at the Horton should the maternity unit be downgraded. For the latter example, at the beginning of this consultation period, the message was this a static ambulance would be removed should the Horton become an MLU. However, at the meeting in Chipping Norton on 2nd February 2017, residents were categorically told that a static ambulance would remain. Furthermore, at the first consultation meeting, the closure of the MLU at Chipping Norton to increase births at the Horton was presented as an option at this stage, but in Chipping Norton this was categorically denied and representatives from the CCG stated this would not be considered until phase two.

3.8. I appreciate the CCG holding a meeting in Witney. However, most residents in this part of my constituency will not be affected by this part of proposals. Many of my constituents at the meeting could not understand why the CCG was talking to them about changes in Banbury, and not about the most pressing health issues in Witney: the closure of Deer Park Medical Centre and the future of Witney Community Hospital. Neither of these issues are part of phase one of the consultation, with Deer Park being a completely separate matter for the CCG. However, for residents, all they are concerned about is being able to access appropriate healthcare when needed and so this is seen as one interlinked issue, hence my earlier point (1.2) of the purpose being diluted.

3.9. The meeting in Witney on 16th February 2017 became a meeting about Deer Park Medical Centre, a passionate issue for many Witney residents. However, this did not give residents sufficient opportunity to engage with the proposals which were supposed to be discussed.

3.10. Also I appreciate the CCG's message that it is not necessary to attend the public meetings to engage in the consultation. However, by putting significant weight on

responding to proposals online, and by only publishing many documents on their website, this will exclude a number of residents from formally responding. **All demographics must be catered for in consultations, which is why I personally pushed for better public consultation meetings through a second meeting being held in Chipping Norton.** These oversights must be corrected for phase two.

4. Future Implications

4.1. Going forward from this phase of the consultation, I strongly suggest that the CCG take on board the serious concerns raised about the process and engagement of phase one. **Being clear and transparent with proposals is essential for the legitimacy of the consultation process.**

4.2. As phase two will encompass all issues not discussed in phase one, it must be made very clear in phase two how the decisions of phase one have affected this second phase.

4.3. This first phase has highlighted the need for significant further work to be completed before phase two. Specifically, greater thought needs to be put into the holistic implications of proposals, for example the impact changes will have on services outside of the Oxfordshire area.

4.4. It must be made clear to all parties how binding the decisions made in phase one will be on phase two. For example, if the Horton is formally downgraded as a result of phase one, but there is overwhelming backlash from residents in phase two if the MLU at Chipping Norton is proposed for closure as a result, the reversal of these changes must be considered.

4.5. Furthermore, due to unforeseen circumstances, should the state of things in a particular area have changed significantly between phase one and two, for example a significant rise in births in the Banbury area, the impact of this must be taken into account in the next phase of proposals.

4.6. In phase two, vast amounts of work will need to be done to create more viable options than presented in phase one. As made clear earlier in my response, the first phase did not present the public with appropriate options. The CCG merely presented their proposal, without having carried out the sufficient work to present other ways of tackling the problem. It is essential that this issue is tackled in phase two. With the much greater impact across a wider range of services, inevitably there will be multiple avenues that can be explored to improve the system, and all of these must be given equal weighting.

5. Conclusion

5.1. I have strong concerns about the clarity of the proposals in this consultation. This is in terms of:

- the accessibility of information for the public.
- the language used in the main document.
- the lack of detailed data.

- the lack of work carried out regarding the impact on other bodies, be these other hospitals or council.
- clarity over what is specifically being looked at in phase one and phase two; how binding phase one will be over phase two.
- when the second phase will take place.

5.2. I am further concerned that many residents have not been able to fully engage due to the above mentioned reasons, and the time, location and advertising of public meetings. This will lead to a skewed response, and not a full representation of public opinion.

5.3. There are not sufficient viable other options outlined in this consultation. This does not represent a real choice of proposals. There is no indication what will happen if the majority of respondents to this consultation are negative.

5.4. This consultation should never have been split. This is arbitrary and leads to unnecessary confusion; decisions made in phase one will clearly have an impact on phase two. Decisions which HOSC instructed the CCG to consult on should have been resolved in a consultation separate to the STP, to allow the adequate sufficient work to be completed.

5.5. I am against this proposed downgrade of the Horton's maternity services and am concerned about potential ramifications for Chipping Norton Hospital, a vital local service which must be protected.

5.6. I am keen for all stakeholders to be fully involved in the creation of phase two, to avoid the catalogue of errors seen in this document. I am very willing to work with the CCG to realise this.

Robert Courts MP
Thursday, 6th April 2017