Chapter 4

Market Assessment
4. Market Assessment

Introduction
4.1 Oxford University Hospitals NHS Trust (OUH) is a large teaching trust with a comprehensive portfolio of services and a strong research and educational base, located primarily in a city with a small local population.

4.2 This gives OUH two relatively distinct markets: a local market for general hospital care and a wider market for its more specialised services. Each presents specific challenges and opportunities.

Local health economy and market for general hospital services
4.3 OUH provides general hospital services for Oxfordshire and for parts of Buckinghamshire, Northamptonshire and Warwickshire.

4.4 Its three Oxford sites provide a local service for Oxfordshire (total population of 655,000) except for the Henley area, whose population largely receives acute hospital services in Reading.

4.5 The Horton General Hospital in Banbury has a catchment population of approximately 150,000 people in northern Oxfordshire and neighbouring communities in south Northamptonshire and south-east Warwickshire.

4.6 OUH’s local commissioner is Oxfordshire Clinical Commissioning Group (OCCG). OCCG accounts for 37.6% of the Trust’s patient care income.

4.7 Buckinghamshire and Northamptonshire CCGs together contribute 4.4% of the Trust’s patient care income.

Oxfordshire
4.8 Oxfordshire is the most rural county in the South East of England. One third of its residents live in villages or towns of fewer than 10,000 people. The county’s rural nature poses challenges requiring innovation in the delivery of care close to home.

4.9 The county’s population grew by 50% between 1971 and 2001 compared with 12% for England as a whole. Its total population is forecast to grow by 93,000 (14%) from 655,000 residents in 2011, to 748,000 in 2026. This growth will be because the number of births is forecast to exceed the number of deaths by 45,000, and 50,000 more people are forecast to move into Oxfordshire than to move out.

4.10 Oxford and central Oxfordshire are classed as ‘diamonds for growth’, areas in the South East that are expected to deliver significant economic and housing growth. 5,000 new homes are to be built in the county in the period to 2030, in part to alleviate pressure on housing in Oxford, where house prices have affected recruitment for many years. Nearly 1,600 new homes are being built on a site in south-west Bicester and nearly 900 are to be built within two kilometres of the John Radcliffe Hospital site by 2015. Coupled with demographic change, this can be expected to continue to fuel local demand for healthcare.
4.11 Oxfordshire’s population is forecast to continue ageing. The proportion of the population that is above the current retirement age (65) is forecast to increase from 16% in 2011 to over 20% by 2026, whilst the proportion that is of working age is forecast to fall.

4.12 Forecast increases are most dramatic in the oldest groups: 66% growth in people aged 75+ (from 50,000 in 2011 to 82,000 by 2026) and 69% growth in those aged 85+ (up from 15,000 in 2011 to 25,000 in 2026). This growth will be concentrated in the county’s rural areas.\(^1\) This has major implications for providers and commissioners of care, notably in the dependency ratio and the incidence and prevalence of disease, described in the section on Health needs from page 67 below.

4.13 The county’s overall affluence masks areas of serious deprivation. Median earnings of Oxford residents are lower than the regional average, despite relatively high earnings for the city as a whole. 18 neighbourhoods within Oxfordshire are among the 20% most deprived Lower Super Output Areas in England – 12 in Oxford, five in Banbury and one in Abingdon.\(^2\) Deprivation is closely associated with poor health and need for acute and community healthcare.

4.14 The 2011 Census suggests that some 60,000 people, 9.4% of the Oxfordshire population, provide some level of informal care to a relative or friend, with 18% of these carers providing more than 50 hours a week. The group most likely to provide unpaid care was people aged 50-64, with 20% providing some level of care.\(^1\)

4.15 Oxfordshire is the highest-ranked and fastest-growing region for high-tech services in the EU. The county hosts over 1,400 high-tech companies, employing over 37,000 people. The county contains a concentration of specialised sciences and technology industries, coupled with significant research and development activity linked to local universities, to healthcare and to medical research. The opportunities offered through close links with this sector are described in the section below on Partnerships in care and innovation.

4.16 Hospitals account for the second-largest share of employment in Oxford after higher education. Public sector jobs account for nearly half of all employment in the city, nearly double the South East England average, and for 30% across Oxfordshire as a whole. OUH’s recruitment and turnover are affected by the local and wider employment market, factors described in Chapter 8.

4.17 At the time of the 2011 Census, Oxfordshire was home to 5,470 armed forces personnel, of whom 33% lived in communal establishments. RAF Brize Norton in West Oxfordshire is the UK’s largest RAF station, employing nearly 4,000 service personnel and more than 600 civilians. Service personnel use OUH facilities and the Trust trains and benefits from the skills of service healthcare staff.

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\(^1\) Draft Joint Strategic Needs Assessment for Oxfordshire, Oxfordshire Health & Wellbeing Board, March 2014

\(^2\) Index of Multiple Deprivation data from 2010.
Market for specialised services

4.18 The population served by OUH’s specialised services is one of approximately 2.5 million within the local authority areas of Oxfordshire, Buckinghamshire, Milton Keynes, Berkshire, Swindon, Gloucestershire, Northamptonshire and Warwickshire. Some services are provided for a larger catchment population, with national and international elements.

Clinical Commissioning Groups in the area treated in this chapter as ‘catchment’

4.19 NHS England is the largest commissioner of the Trust’s services by value.

4.20 The table and chart below show the monetary value of the Trust’s agreements with NHS commissioners for local and for specialised services.
## Income for NHS patient care, 2014/15

<table>
<thead>
<tr>
<th>Commissioner</th>
<th>2014/15 plan</th>
<th></th>
<th>July 2014 forecast</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Income (£million)</td>
<td>% of total</td>
<td>Income (£million)</td>
<td>% of total</td>
</tr>
<tr>
<td>NHS England (Wessex)</td>
<td>351.0</td>
<td>47.2%</td>
<td>352.0</td>
<td>47.8%</td>
</tr>
<tr>
<td>Oxfordshire CCG</td>
<td>284.5</td>
<td>38.3%</td>
<td>286.4</td>
<td>38.9%</td>
</tr>
<tr>
<td>Buckinghamshire CCG</td>
<td>16.7</td>
<td>2.2%</td>
<td>17.5</td>
<td>2.4%</td>
</tr>
<tr>
<td>Northamptonshire CCGs</td>
<td>15.1</td>
<td>2.0%</td>
<td>15.5</td>
<td>2.1%</td>
</tr>
<tr>
<td>NHS England (Thames Valley)³</td>
<td>11.6</td>
<td>1.6%</td>
<td>11.5</td>
<td>1.6%</td>
</tr>
<tr>
<td>Other</td>
<td>64.3</td>
<td>8.7%</td>
<td>52.9</td>
<td>7.2%</td>
</tr>
</tbody>
</table>

### 4.21
Approximately 60% of OUH’s total patient income is for Oxfordshire patients, with some 43% of the service level agreement for specialised services held with NHS England (Wessex) being for the care of Oxfordshire patients.

### 4.22
A majority of specialised services income is for the treatment of non-Oxfordshire patients.

### Market requirements

4.23 Market requirements can be summarised as meeting the health needs of the catchment population while improving quality and healthcare outcomes, within the context of costs associated with changes in demography, technology and expectations and the economic situation that limits the availability of funding for health services.

### Health needs of the population served by the Trust

4.24 Life expectancy is above the national average in Oxfordshire and its neighbouring areas.

4.25 Population growth in Oxfordshire is described at 4.10 above. High rates of growth are also expected in Milton Keynes, Northamptonshire and Swindon.

4.26 Growth in the catchment population will be greatest in the oldest population groups in the period to 2021. The over-75 population is expected to grow more quickly than the population as a whole: by nearly 30% in the 75-79 group, just under 20% in the 80-84 group and over 30% in the 85+ group.

4.27 Using Office for National Statistics estimates for 2011 to 2021, the figure below illustrates the impact on population numbers of these changes, showing variations between age groups.

4.27.1 Northamptonshire is expected to see the greatest absolute growth, with Oxfordshire, Buckinghamshire, Gloucestershire and Wiltshire in particular seeing a large share of population growth in older people.

4.27.2 Milton Keynes sees absolute growth of 14,500 in over-65s compared to Oxfordshire’s 26,300 although in relative terms it has double the rate of Oxfordshire’s population growth and nearly double its rate of growth in older people.

4.27.3 Growth in the numbers of children and young people is concentrated in Swindon, Milton Keynes, Berkshire and Northamptonshire.

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³ Dentistry, offender health and some screening services
4.28 Oxfordshire’s 65-and-over population grew by 18% from 2001 to 2011, while the number of people aged 85 and over rose by 30%. At the same time, the number of people in their 30s in the County declined by 12% and the number of children aged four and under rose by 13%.

4.29 The ethnic composition of Oxfordshire changed between 2001 and 2011. Black or minority ethnic communities now account for 9.2% of the population, up from 4.9% in 2001. People from white backgrounds other than British or Irish account for 6.3% of the population, many from countries which joined the European Union in 2004 and 2007. 4.8% of the County’s population are from Asian backgrounds, twice the proportion in 2001. The proportion of people from all Black backgrounds is 1.75% and people from mixed ethnic backgrounds account for 2% of the population.

4.30 Oxford is more ethnically and culturally diverse than the county as a whole, with the third-highest minority ethnic population in South East England and twice the national proportion of 16-29 year olds (32%). The city’s population grew by 12% between 2001 and 2011, a growth rate equalling London’s.

4.31 OUH must provide care at all its sites which is appropriate for a diverse population. Its Oxford sites must respond to the healthcare needs of the city’s term-time student population of at least 43,000.⁴

4.32 The health of people in Oxfordshire is generally better than the average for England, with rankings by Public Health England of mortality under 75 for cancer, heart disease and stroke,

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⁴ Data published by Oxford City Council for 2010/11, accessed 12 June 2013: [http://www.oxford.gov.uk/PageRender/decC/University_students_occw.htm](http://www.oxford.gov.uk/PageRender/decC/University_students_occw.htm)
lung disease and liver disease showing Oxfordshire at 22nd best of 151 local authorities in England for 2009-2011.\(^5\)

4.33 However, 15,660 children are assessed as living in poverty (almost 12%) and life expectancy is 5.8 years lower for men and 3 years lower for women in the most deprived areas (mostly in Oxford and Banbury) than in the least deprived areas.\(^6\) 15.1% of the county’s Year 6 children are classified as obese (below the national average) but levels of physical activity for school age children are significantly below average. Road injuries and deaths are above average.

4.34 The cancer incidence rate in Oxfordshire (at 425.2 per 100,000) is higher than the English average (398.1 per 100,000). The incidence of cancers has been steadily increasing across all areas in men and women under the age of 75. The latest data (2008-10) show Oxfordshire having a significantly higher rate of incidence than England in both men and women. The higher rate may in part be explained by better ascertainment, i.e. local health services may be better than other areas at diagnosing cancer or the local population may be more aware of the signs and symptoms of cancer and seek medical advice early, resulting in a prompt diagnosis.\(^7\)

4.35 Particular cancers of higher incidence in Oxfordshire are:

- Breast cancer at 141.9 per 100,000 compared to 125.7 per 100,000 for England. The breast cancer mortality rate for Oxfordshire is similar to the English average at 24.8 per 100,000.
- Prostate cancer at 115.8 per 100,000 compared to 105.8 per 100,000 for England. The lifetime risk of prostate cancer will rise from 5% for boys born in 1990 to just over 14% for boys born in 2015.

4.36 A relatively low percentage of patients in Oxfordshire are diagnosed with cancer through emergency routes (21.2% compared to 23.7% for England), correlating with earlier diagnosis and likelihood of survival.\(^8\)

4.37 The number of people surviving with cancer is growing rapidly, with 10-year survival rates for some relatively common cancers (including breast, Hodgkin’s lymphoma, melanoma and uterine) having risen by over 20% since the early 1970s.\(^9\) Models of cancer care need to evolve to respond to changing needs. OUH’s planned developments in cancer care across its clinical network are a response to these changing needs.

4.38 Of Oxfordshire’s GP-registered population, 1.6% were recorded in 2012/13 as having had a stroke or transient ischaemic attack and 2.6% with a recorded diagnosis of coronary heart disease. These are both significantly lower than the national average.

4.39 Road injuries and deaths in Oxfordshire were significantly worse than the average for England in 2009-2011, at 365 per year (56.13 per 100,000 population compared to an England average of 41.9).\(^6\)

4.40 The main demographic issues driving demand for health and social care in Oxfordshire and beyond are the increasing age and obesity of the population and the increasing dependency ratio (the proportion of old people to adults of working age).

4.41 These demographic factors alone will cause substantial changes in the incidence and prevalence of illness requiring healthcare, the key changes being in vascular disease

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\(^5\) Public Health England, June 2013 [http://longerlives.phe.org.uk/area-details#are/E10000025/par/E92000001](http://longerlives.phe.org.uk/area-details#are/E10000025/par/E92000001)

\(^6\) Public Health Observatories Health Profile for 2013 [http://www.apho.org.uk](http://www.apho.org.uk)

\(^7\) Data throughout this section from [Draft Joint Strategic Needs Assessment](http://longerlives.phe.org.uk/area-details#are/E10000025/par/E92000001), Oxfordshire Director of Public Health, March 2014


(cardiovascular disease and stroke), diabetes, musculoskeletal failure (osteoarthritis and joint failure) and mental ill health (dementia). Older and more obese people are at risk of acquiring more than one of these problems simultaneously, with this multiple morbidity contributing to a rapid increase in the number of frail older people in particular.

4.42 The increasing dependency ratio is normally seen mainly as a problem for public finances but associated changes in family and employment structure will also have an impact on available support for older people. This substantially changes the market conditions for healthcare by increasing demand for health and social care for people with the chronic conditions of old age, particularly for frail older people with multi-morbidity.

4.43 A treatment issue influencing overall demand is that case-fatality rates for illnesses such as stroke and myocardial infarction have fallen dramatically in recent years (and continue to fall). This ‘de-coupling of morbidity and mortality’ means that people are living longer with their long term conditions and requiring a different pattern of care, often sporadic acute episodes needing intensive hospital support interspersed with much longer episodes of low-intensity supportive care. OUH is seeking to address this through close liaison and work with Oxford Health and Oxfordshire County Council, particularly for frail older people (see Chapter 5).

**Quality and outcomes**

4.44 Specific areas of national focus are set out in the NHS Outcomes Framework. There are also a series of national improvement programmes focused on specific services/groups of services. These programmes take a number of forms including National Service Frameworks, Safe and Sustainable and NICE reviews, but have in common that they review the evidence on what improves clinical outcomes and make recommendations about service standards. These recommendations play a major role in the Trust’s market, influencing the demands of both commissioners and patients.

4.45 There is a continued focus on improving care in relation to England’s ‘big killers’, particularly those diseases for which England’s mortality rate compares unfavourably with that of others. In recent years the Trust has responded with developments in cancer and cardiac services. More recent areas of focus are hyper-acute stroke and trauma services.

4.46 National emphasis in the NHS Outcomes Framework is on the measurement of success in terms of outcomes, such as cancer and stroke survival rates, rather than the previous process targets.

4.47 National policy is clear that, in the context of national fiscal policy, the NHS is expected to make major savings through implementing best practice and increasing productivity in order to afford the investment required for these improvements.

**Partnerships in care and innovation**

4.48 OUH is a partner in the Oxford Academic Health Science Network and Oxford Academic Health Science Centre, described in Chapter 3. Both the AHSN and AHSC provide a strong base from which to develop innovation in care.

**Requirements of local commissioners**

4.49 Oxfordshire CCG’s vision, set out in its strategy for 2014/15-2018/19, is that the Oxfordshire health and social care system will by then:

- Be financially sustainable.
- Be delivering fully integrated care, close to home, for the frail elderly and people with complex, multiple morbidities.
- Have a primary care service that is driving development and delivery of this integrated care, and is itself offering a broader range of services at a different scale.
• Routinely enable people to live well at home and to avoid admission to hospital when this is in their best interests.
• Be continuing to provide preventative care and to tackle health inequalities for patients and carers in both its urban and rural communities.
• Be providing health and social care that is rated amongst the best in the country for all its citizens in terms of quality, outcomes and local satisfaction with services.

4.50 Based on the Joint Strategic Needs Assessment and the Health and Wellbeing Strategy for Oxfordshire, Oxfordshire CCG has identified six ‘improvement interventions’ through which it intends to develop the characteristics of a high quality and sustainable system. These are:
• Achieving Integration.
• Improving emergency and urgent care services.
• Improving the efficiency and effectiveness of planned care.
• Improving the efficiency and effectiveness of prescribing.
• Improving the management of long term conditions.
• Delivering a new approach to contracting and procurement.

4.51 OUH will participate with the CCG and others in developing its contribution to these areas, not least to address the Oxfordshire health and social care system’s “key performance pressures […]”:
   i. Increase in A&E attendances and emergency admissions, with the share of patients with multiple attendances and admissions growing fastest.
   ii. Unacceptably high numbers of patients experiencing delayed transfers of care.
   iii. The failure to meet referral to treatment time targets and increased outpatient referrals.
   iv. The failure of the CCG QIPP programmes to deliver anticipated cost savings.”

4.52 In March 2012, Oxfordshire CCG decided to change how it commissions some health and social care services by introducing a more outcomes oriented approach to commissioning and contracting known as Outcomes Based Commissioning (OBC).

4.53 This approach aims to shift the emphasis from what services a provider offers to what outcomes are achieved for patients. OUH supports this aim and has signalled its intention to work closely with Oxfordshire CCG to see OBC develop in a way which fairly recognises the risks faced by all involved.

4.54 OUH is working closely with Oxford Health NHS Foundation Trust on services for older people and for people with complex long term conditions, to help address service and financial pressures faced in Oxfordshire. This work is summarised in Chapter 5.

4.55 The Trust is already committed to innovative ways of working beyond the constraints of established service models so as to improve outcomes and simplify pathways for patients. Examples include OUH’s registration as a provider of social care and the Trust’s direct provision of psychological medicine services for its patients.

4.56 Priorities set by Oxfordshire CCG align closely with those of the Trust, particularly in developing alternatives to hospital admission, promoting independence and responding to
changes in Oxfordshire’s population, notably rises in the prevalence of long-term conditions and dementia.

4.57 OUH has the option to respond by adjusting the balance of services it provides in its hospitals and those it provides in non-hospital settings.

4.58 OUH already provides a range of services for local people beyond its four hospital sites, as shown below, and expects that this range will develop.

- Community paediatric services from settings including East Oxford Health Centre, Orchard Health Centre (Banbury), Deer Park Medical Centre (Witney) and special schools.
- Community radiology services in Witney, Abingdon, Chipping Norton and Bicester.
- Consultant support to community hospitals.
- Sexual health services including walk-in clinics, testing, treatment, contraception, advice and HIV care.
- In-reach sexual health services including HIV care to HM Prisons Bullingdon and Huntercombe.
- Some midwifery-led maternity care as well as community midwifery teams based in local settings at Abingdon, Bicester, Didcot, Oxford, Witney, Carterton and Thame.
- Mobile breast screening.
- Musculoskeletal direct access service and other outpatient physiotherapy services at East Oxford Health Centre and Brackley Cottage Hospital.
- Oxford Eye Care: ophthalmic services in community settings, initially in Witney.

Engagement

4.59 The Trust’s Executive Directors and clinicians meet with Oxfordshire CCG and its locality groups\(^{11}\) to discuss the Trust’s strategy and issues raised locally by GPs. A joint work programme has been agreed, with five work streams:

- Outpatient appointments.
- Sharing information about patients.
- Meeting patients’ needs following appointment/discharge.
- Access for GPs to information and advice.
- Making the best use of information entered by GPs on Datix, the incident reporting system used by OUH and Oxfordshire CCG.

4.60 OUH’s Executive Directors meet with the Executive Directors of Oxfordshire CCG on a regular basis.

4.61 In addition to the ongoing production of a bulletin for GPs, engagement between OUH and local GPs is being strengthened through a variety of mechanisms including joint or system-wide groups looking at clinical services (e.g. pathway redesign) or specific topics (e.g. IT and information exchange). Innovative models of care across the interface between primary and secondary care also help sustain collaborative working relationships.

Oxfordshire Joint Health and Wellbeing Strategy

4.62 Oxfordshire’s Health and Wellbeing Board (HWB) has responsibility for improving the health and wellbeing of people in the county through partnership working.

4.63 The HWB is a partnership between local government, the NHS and the people of Oxfordshire. Members include local GPs, councillors, Healthwatch and senior officers from Local Government.

\(^{11}\) Oxfordshire CCG has six localities, each formed from a number of GP practices.
4.64 Organisations responsible for providing healthcare are not members of Oxfordshire’s HWB.

4.65 Oxfordshire HWB has published a Joint Health and Wellbeing Strategy, linked to the county’s Joint Strategic Needs Assessment. This emphasises the need for organisations providing care in the county to work together to meet the challenges faced in a way that is more ‘meshed’ together.

4.66 This need is emphasised by the fact that Oxfordshire has the highest level in England of delayed transfers of care.

4.67 OUH has an important role to play in five particular priorities within the Strategy, as follows.

**Priority 1: All children have a healthy start in life and stay healthy into adulthood.**

4.67.1 Proposed areas of focus include raising the percentage of women who have seen a midwife or maternity healthcare professional within the first 13 weeks of pregnancy.

**Priority 5: Living and working well: adults with long-term conditions, physical disabilities, learning disabilities or mental health problems living independently and achieving their full potential.**

4.67.2 Proposed outcomes include increasing the number of people with a long-term condition who feel supported to manage their condition and a reduced number of emergency admissions for people with long term conditions.

**Priority 6: Support older people to live independently with dignity whilst reducing the need for care and support.**

4.67.3 Proposed outcomes include reducing delayed transfers so that Oxfordshire’s performance improves from being in the bottom quarter in England; developing a model to match capacity to demand for health and social care; 60% of the expected population with dementia receiving a recorded diagnosis; improving reablement services; reducing the number of emergency admissions for older people; gathering bereaved carers’ views on the quality of care in the last three months of life and raising the proportion of adults using healthcare who say they receive care in a timely way.

4.67.4 There is a rise in the prevalence in over-65s of stroke, depression and dementia. As these conditions are often diagnosed for the first time on hospital admission, the Trust recognises that it needs to identify and care for an increasingly significant number of patients with dementia, depression or other mental health problems and work with partners to have appropriate care put in place on discharge.

4.67.5 An integrated Psychological Medicine Service has been established by OUH to enable the medical and psychological needs of people it admits to be addressed together, particularly for older people.

4.67.6 OUH is working closely with Oxford Health NHS FT and other local partners to address this very important area of increasing impact and demand.

**Priority 7: Working together to improve quality and value for money in the Health and Social Care System.**

4.67.7 Proposed outcomes include achieving above the national average of people satisfied with their experience of hospital care; reducing the number of emergency admissions to hospital; reducing emergency admissions for acute conditions that should not

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usually require hospital admission; and reducing unplanned hospitalisation for chronic, ambulatory care-sensitive conditions.

4.67.8 A CQUIN was agreed which saw the introduction of emergency admission navigators, expert nurses to offer a single point of access and help reduce the admission rate for ambulatory care-sensitive conditions.

**Priority 8: Preventing early death and improving quality of life in later years.**

4.67.9 Proposed outcomes related to the uptake of bowel screening, NHS Health checks and smoking cessation.

**Requirements of specialised commissioners**

4.68 In order to promote consistency of quality and access, NHS England asked Clinical Reference Groups, comprising clinicians and patient and carer representatives, to develop service specifications for the prescribed specialised services, many of which became mandatory from 1 October 2013.

4.69 OUH assessed its compliance against the service specifications. It declared 92 of its services as compliant and sought ‘derogations’ for six services. The services for which derogation applications were made, and associated issues and planned actions, are summarised below.

<table>
<thead>
<tr>
<th>Service</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood &amp; Marrow Transplantation: Haematopoietic Stem Cell Transplantation (Children)</td>
<td>OUH undertakes only part of the patient pathway, with University Hospitals Bristol NHS FT undertaking the rest. Discussions will take place to formalise the patient pathway and agree a subcontracting arrangement.</td>
</tr>
<tr>
<td>Cancer: Chemotherapy (Children, Teenagers and Young Adults)</td>
<td>In common with other Trusts, OUH is currently unable to use e-prescribing for chemotherapy systemic anti-cancer therapy for this age group. An IT solution is being agreed.</td>
</tr>
<tr>
<td>Cancer: Teenagers and Young Adults</td>
<td>A business case is being developed to enhance both the multidisciplinary team and the service’s physical accommodation.</td>
</tr>
<tr>
<td>Paediatric Medicine: Gastroenterology; Hepatology; Nutrition</td>
<td>A business case has been agreed to invest in staffing to comply with associated staffing standards and recruitment is under way.</td>
</tr>
<tr>
<td>Paediatric Neurosciences: Neurodisability</td>
<td>An additional consultant is being recruited. A business case is being developed for additional paediatric MRI capacity.</td>
</tr>
<tr>
<td>Paediatric Neurosciences: Neurorehabilitation</td>
<td>The development of the service is being progressed with specialised commissioners, including network arrangements with University Hospital Southampton NHS FT. Additional paediatric MRI capacity also relates to this specification.</td>
</tr>
</tbody>
</table>

4.70 OUH also notified commissioners that it no longer wished to provide a seventh service — for Complex Gynaecological Urinary Fistulae. At the request of its commissioners, the Trust applied for a derogation to allow agreement to be reached on the future patient pathway.

4.71 NHS England applied for derogations for a further five services where it wished to clarify patient pathways between different providers:

<table>
<thead>
<tr>
<th>Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult specialised vascular services</td>
</tr>
<tr>
<td>Specialised services for haemoglobinopathy care (all ages)</td>
</tr>
<tr>
<td>Cancer: specialised kidney, bladder and prostate (adult)</td>
</tr>
</tbody>
</table>
Further centralisation of specialised care is expected. This could provide opportunities for OUH as long as the Trust retains designation for these services. A recent example is the transfer of all surgery for oesophageal and gastric cancer from Royal Berkshire Hospitals NHS FT to OUH in line with national guidance, including Improving Outcomes Guidance. This trend also reinforces the importance of developing and sustaining a strong network with surrounding healthcare providers.

All of OUH’s specialised services are delivered on a clinical network basis. The Trust is working to ensure that its clinical networks are complementing and seeking to be active contributors to Strategic Clinical Networks and Operational Delivery Networks. This is reinforced by the clinical network focus of the Oxford AHSN.

These networks develop responses to the recommendations of national service improvement programmes already identified as playing a major role in the Trust’s market. A common feature of the recommendations is the centralisation of specialised services’ resources and expertise. Their recommendations in this respect may involve major service reconfigurations which change the commissioning of services by both specialised commissioners and more local commissioners.

OUH is well-placed to be a provider of such centralised services as it provides the full matrix of services that acutely ill patients may require, including critical care (with specialised neurological, cardiac and newborn units in addition to general intensive care) and interventional radiology.

Recent examples of services centralised for networks at OUH are intensive care for newborns and the establishment of a Major Trauma Centre at the John Radcliffe Hospital.

Choice and competition

The Government’s health policy emphasises improvement in quality and healthcare outcomes as the primary purpose of NHS-funded care, with related financial incentives and disincentives through quality and outcome measures.

Oxfordshire is part of a national scheme piloting personal health budgets for NHS Continuing Healthcare for adults and children, for end of life care and for adults with Acquired Brain Injury.

In 2012/13 Oxfordshire’s former Primary Care Trust progressed the ‘Any Qualified Provider’ initiative for Podiatry; for Audiology adult hearing services in the community (as a joint project with Buckinghamshire); and for assessment for Autistic Spectrum Conditions without a learning disability. OUH was selected as a provider of Audiology: adult hearing services.

OUH began a pilot Musculoskeletal Triage and Tier 2 Treatment Service for Oxfordshire in 2010. The Trust successfully bid for a further three-year contract which began in April 2013. It intends to examine how this model can be extended to ‘high referral volume’ specialties including General Surgery, Gynaecology and Urology.

NHS England has reiterated that choice and competition can be important levers for commissioners to improve the quality and efficiency of services.

With responsibility for public health commissioning, Local Authorities are publishing tenders to re-provide existing services or to re-design care pathways to improve public health.

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4.83 OUH bid successfully in 2013 to provide an Integrated Sexual Health Service for Oxfordshire. This combines hospital-based services that the Trust already provided with community services it did not. The integrated service sees the Trust providing a complete range of services to promote sexual health and to treat sexual health problems.

4.84 County Councils including Oxfordshire’s are taking the opportunity to test the market and challenge existing NHS contracts. Consortium bids are being encouraged as is the use of third sector and independent sector partners to add quality and cost-effectiveness.

4.85 OUH anticipates developing innovative ways of providing care which enable its clinicians’ expertise to be used effectively beyond hospital settings and in ways which promote health as well as treating disease. New partnerships with other care providers can also be anticipated.

4.86 Generally, the development of competition increases the importance of providing care in a way which will encourage commissioners, patients and referrers to choose OUH’s services. It also means that the Trust will need to respond to changes in demand for its services, monitoring activity levels closely and being able to flex capacity, with contingency plans in place for situations where a service is gained or lost through competition.

4.87 The Trust is developing its capability in responding to commercial opportunities and in reconfiguring existing services to meet patient, public and commissioner expectations.

Translating market demands into future potential demand for OUH services

4.88 OUH has used information on market demand to inform the activity model which forms part of its Long Term Financial Model. Areas with high predicted growth are shown below.

<table>
<thead>
<tr>
<th>Cancer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incidence is rising, due in particular to the ageing population and in some cases driven by obesity and smoking. Increased survival rates further raise the demand for services. The policy of centralisation of specialised treatments in specialised cancer centres affects OUH. Screening programmes for cancer contribute to demand in, for example, endoscopy, colorectal and lung treatment. OUH’s modelling suggests a continuing 4.8% per year growth in colorectal surgery. This is driven by the extension of the age range for bowel screening and by additional bowel scoping. OUH is well-placed to attract referrals as a result of this demand and national policy to centralise specialised treatments. Its Oxford Cancer Centre provides state-of-the-art treatment and imaging facilities, reflecting a capital investment of more than £100m. It has over 20 multi-disciplinary teams, including world experts, meeting on a weekly basis to discuss patients referred to them. Cancer is one of the themes of the Oxford Biomedical Research Centre (BRC) and partnership with the University of Oxford means that patients benefit rapidly from research into improved diagnosis and treatment as well as opportunities to participate in clinical trials. These opportunities will be further enhanced by OUH’s membership of the Oxford Academic Health Science Network and the Oxford Academic Health Science Centre with its strong focus on basic medical research. As a Cancer Centre in the middle of a network stretching from Swindon in the west to Milton Keynes and Slough in the east, OUH has a catchment area for cancer referrals which is supported through existing oncological presence in surrounding District General Hospitals. The Trust has modelled the effect of this through, for example, 3% annual growth for clinical oncology and 3% for medical oncology and a similar level of growth for specialties with a high percentage of cancer patients (e.g. 3.3% annual growth is predicted for upper...</td>
</tr>
</tbody>
</table>
gastrointestinal surgery).

As demand is expected to continue to grow, OUH’s strategy is to work with partner Trusts to deliver as much cancer care as possible locally, for example through provision of satellite radiotherapy units and joint appointments of consultants to deliver some elements of specialised care in DGHs. This will benefit patients through reducing travel time, whilst increasing capacity and consolidating the catchment area for specialised treatments available at the Oxford Cancer Centre.

Paediatric subspecialties

The centralisation of specialised care in centres such as OUH, supported nationally by the Safe and Sustainable programme, and specialised services specifications is increasing demand for paediatric subspecialty services. For example, the Trust’s modelling predicts annual growth of 6.0% for paediatric diabetes medicine and 3.3% for paediatric neurology. As with cancer services, OUH’s strategic response is to work with partner trusts to develop a model which provides as much care as possible locally. It has recently extended the range of paediatric specialties providing services at the Horton General Hospital. The provision of paediatric ambulatory surgical hubs at partner sites, supported by specialised expertise from OUH, will deliver less complex care locally, reducing travel for children and their carers, freeing capacity for more complex work on OUH sites and securing the required level of referrals for the sustained development of subspecialised services.

Cardiovascular disease

The UK incidence of coronary heart disease is showing signs of falling, probably through the effects of preventive activity such as the prescription of statins. At the same time, with a growing elderly population there is an increased incidence of heart failure, valvular disease and the need for coronary investigation and intervention. An increased ability to intervene in heart rhythm defects has meant that demand for electrophysiology is also increasing.

Clinical research in this area is strong, with OUH clinicians working closely with colleagues from the University of Oxford, exemplified in the Heart Theme within the Oxford BRC, which aims to achieve translation from basic science to clinical application. Research focuses on vascular disease risk factors and the mechanisms that relate ‘upstream’ disease in the arterial wall to ‘downstream’ injury manifested as myocardial infarction and stroke, so that new interventions can be targeted to patients more effectively.

Focus has also been given to investigating patients early after arrival in hospital. The Acute Vascular Imaging Centre opened at the John Radcliffe Hospital in 2012 as a unique facility combining Magnetic Resonance Imaging in an interventional vascular laboratory for clinical research during the emergency care of patients experiencing heart attack and stroke. OUH has a particular strength in interventional radiology which is of growing importance in the treatment of vascular disease. It has recently delivered two significant cardiovascular service developments - the centralisation of vascular intervention in Oxford and the repatriation of cardiac surgery from London providers to Oxford. OUH is designated as a hyper-acute stroke centre, complemented by an active BRC Stroke theme.

Annual growth is modelled at 6.1% in cardiology, 5.7% in cardiac surgery and 1.9% in
interventional radiology.

**Services for older people and people with long-term conditions**

The ageing population is causing demand for healthcare to grow. Together with lifestyle factors, particularly increased obesity, demographic change is also having an impact on long term conditions.

People are living longer with long term conditions and requiring a different pattern of care: sporadic acute episodes needing intensive hospital support interspersed with much longer episodes of low-intensity, supportive care. OUH’s strategic response to growth in demand for these services is to work with partners to develop an integrated approach to delivering care for older patients and those with long term conditions.

Diabetes is an area where research is being prioritised by OUH in partnership with the University of Oxford and is a BRC research theme.

The Trust has modelled an 8.1% annual growth in the demand for diabetes medicine and 3.8% per annum growth in demand for care for older people.

The development of self-care can be expected to have a particular impact on the pattern of care required for this group of patients and OUH will work closely with researchers developing means of monitoring care and providing advice directly to patients to enable self-care.

**Market share**

4.89 OUH’s catchment area is served by a range of other providers within the NHS and the private sector.

**NHS providers**

4.90 Sixteen NHS general or acute hospitals are within 50 miles of OUH’s Headington sites. Banbury is almost equidistant between Milton Keynes and Oxford, although travel links to Oxford are better.

**NHS acute hospitals within 50 miles of OUH’s Headington sites**

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Operator</th>
<th>Monitor financial risk rating</th>
<th>Monitor governance risk rating 14</th>
<th>Chief Inspector of Hospitals rating</th>
<th>Road miles from Headington, Oxford</th>
<th>Road miles from nearest town in Oxfordshire</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stoke Mandeville Hospital</td>
<td>Buckinghamshire Healthcare NHS Trust</td>
<td>n/a</td>
<td>n/a</td>
<td>Requires Improvement</td>
<td>21</td>
<td>11</td>
</tr>
<tr>
<td>Wycombe Hospital</td>
<td>Buckinghamshire Healthcare NHS Trust</td>
<td>n/a</td>
<td>n/a</td>
<td>Requires Improvement</td>
<td>21</td>
<td>15</td>
</tr>
<tr>
<td>Royal Berkshire Hospital</td>
<td>Royal Berkshire NHS FT</td>
<td>2</td>
<td>Green</td>
<td>Requires Improvement</td>
<td>24</td>
<td>9</td>
</tr>
</tbody>
</table>

14 Monitor and Chief Inspector of Hospitals ratings as at 20 October 2014
<table>
<thead>
<tr>
<th>Hospital</th>
<th>Operator</th>
<th>Monitor financial risk rating</th>
<th>Monitor governance risk rating</th>
<th>Chief Inspector of Hospitals rating</th>
<th>Road miles from Headington, Oxford</th>
<th>Road miles from nearest town in Oxfordshire</th>
</tr>
</thead>
<tbody>
<tr>
<td>Great Western Hospital</td>
<td>Great Western Hospitals NHS FT</td>
<td>2</td>
<td>Under review&lt;sup&gt;15&lt;/sup&gt;</td>
<td>Not yet inspected</td>
<td>27</td>
<td>13</td>
</tr>
<tr>
<td>Milton Keynes Hospital</td>
<td>Milton Keynes Hospital NHS FT&lt;sup&gt;16&lt;/sup&gt;</td>
<td>1</td>
<td>Red&lt;sup&gt;17&lt;/sup&gt;</td>
<td>Inspection in October 2014</td>
<td>28</td>
<td>23</td>
</tr>
<tr>
<td>Wexham Park Hospital</td>
<td>Frimley Health NHS FT</td>
<td>4</td>
<td>Green</td>
<td>Inadequate&lt;sup&gt;18&lt;/sup&gt;</td>
<td>37</td>
<td>18</td>
</tr>
<tr>
<td>Hillingdon Hospital</td>
<td>The Hillingdon Hospitals NHS FT</td>
<td>3</td>
<td>Green</td>
<td>Inspection in October 2014</td>
<td>41</td>
<td>29</td>
</tr>
<tr>
<td>Cheltenham General Hospital</td>
<td>Gloucestershire Hospitals NHS FT</td>
<td>3</td>
<td>Under review</td>
<td>Not yet inspected</td>
<td>42</td>
<td>22</td>
</tr>
<tr>
<td>Heatherwood Hospital</td>
<td>Frimley Health NHS FT</td>
<td>4</td>
<td>Green</td>
<td>Inadequate&lt;sup&gt;19&lt;/sup&gt;</td>
<td>44</td>
<td>20</td>
</tr>
<tr>
<td>Warwick Hospital</td>
<td>South Warwickshire NHS FT</td>
<td>3</td>
<td>Green</td>
<td>Not yet inspected</td>
<td>46</td>
<td>22</td>
</tr>
<tr>
<td>Basingstoke Hospital</td>
<td>Hampshire Hospitals NHS FT</td>
<td>3</td>
<td>Green</td>
<td>Not yet inspected</td>
<td>47</td>
<td>26</td>
</tr>
<tr>
<td>Mount Vernon Hospital</td>
<td>The Hillingdon Hospitals NHS FT</td>
<td>3</td>
<td>Green</td>
<td>Inspection in October 2014</td>
<td>47</td>
<td>35</td>
</tr>
<tr>
<td>Northampton General Hospital</td>
<td>Northampton General Hospital NHS Trust</td>
<td>n/a</td>
<td>n/a</td>
<td>Requires improvement</td>
<td>47</td>
<td>36</td>
</tr>
<tr>
<td>Northwick Park Hospital</td>
<td>London North West Healthcare NHS Trust</td>
<td>n/a</td>
<td>n/a</td>
<td>Requires improvement&lt;sup&gt;19&lt;/sup&gt;</td>
<td>47</td>
<td>36</td>
</tr>
<tr>
<td>Gloucestershire Royal Hospital</td>
<td>Gloucestershire Hospitals NHS FT</td>
<td>3</td>
<td>Under review&lt;sup&gt;20&lt;/sup&gt;</td>
<td>Not yet inspected</td>
<td>48</td>
<td>29</td>
</tr>
</tbody>
</table>

<sup>15</sup> Monitor is investigating financial risks and sustainability concerns at the trust, triggered by a deterioration in its financial position
<sup>16</sup> Monitor is reviewing services provided by Milton Keynes Hospital NHS FT and Bedford Hospital NHS Trust
<sup>17</sup> Subject to Monitor enforcement action
<sup>18</sup> Site result prior to acquisition by Frimley Health NHS Foundation Trust
<sup>19</sup> Prior to formation of London North West Healthcare NHS Trust
<sup>20</sup> Monitor is requesting further information following multiple breaches of the A&E target, before deciding next steps
4.91 Oxford is ringed by specialised centres as shown overleaf: London to the south east, Cambridge to the east, Birmingham and Leicester to the north, and Southampton and Bristol to the south and west.

4.92 For OUH to sustain and where possible to extend its catchment, it recognises that it must demonstrate the sustained achievement of high levels of patient safety, outcomes and patient experience; achieve designation where necessary and, underpinning this, sustain good working relationships with referring Trusts and their clinicians.

4.93 To address this need, OUH clinical and strategic leads visit referring hospitals to discuss issues of importance to them and to agree actions. Key elements include the development of network-wide protocols to underpin the standardised delivery of higher quality, financially viable models of care and initiatives to sustain the delivery of services locally wherever possible. Examples include joint consultant urologist and oncologist appointments with Milton Keynes Hospital NHS FT.

4.94 During 2013/14, OUH has also needed to respond quickly to unplanned expansions to its catchment. Services including some cancer services have seen the transfer of specialised surgery to OUH, with patient flows changing at relatively short notice. As referred to at 4.72 above, OUH can expect to need to continue to respond flexibly as tightened service specifications and financial pressures generate further centralisation.

4.95 Sir Bruce Keogh’s Urgent and Emergency Care Review for NHS England in November 2013 set out a vision linking responsive care locally with concentrated expertise in specialised centres:

“Firstly, for those people with urgent but non-life threatening needs we must provide highly responsive, effective and personalised services outside of hospital. These services should deliver care in or as close to people’s homes as possible, minimising disruption and inconvenience for patients and their families. Secondly, for those people with more serious or life threatening emergency needs we should ensure they are treated in centres with the very best expertise and facilities in order to reduce risk and maximise their chances of survival and a good recovery.”

4.96 This matches OUH’s strategy of working in a mutually-supportive way with other providers as part of a network underpinned by research and teaching.

### Hospitals in OUH catchment and neighbouring teaching centres

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Operator</th>
<th>Monitor financial risk rating</th>
<th>Monitor governance risk rating</th>
<th>Chief Inspector of Hospitals rating</th>
<th>Road miles from Headington, Oxford</th>
<th>Road miles from nearest town in Oxfordshire</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hammersmith Hospital</td>
<td>Imperial College Healthcare NHS Trust</td>
<td>n/a</td>
<td>n/a</td>
<td>Not yet inspected</td>
<td>50</td>
<td>38</td>
</tr>
</tbody>
</table>

Private providers

4.97 Within 50 miles of Oxford, 66 private healthcare sites are registered with the Care Quality Commission. The most significant providers in terms of services for the Oxfordshire population are:

- Ramsay Healthcare: operates the Horton NHS Treatment centre at the Horton General Hospital in Banbury.
- Nuffield Health: operates the Manor Hospital adjacent to the John Radcliffe Hospital, providing a range of specialties, with some NHS work carried out.
- BMI Healthcare: operates the Foscote Hospital adjacent to the Horton General Hospital. This relatively small hospital provides limited NHS work in addition to its core private business.
## Summary of competitive threats and OUH response

4.98 A summary of competitive threats and OUH’s planned response is shown in the table below.

<table>
<thead>
<tr>
<th>Issue</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Alternative providers</strong></td>
<td><strong>Independent sector treatment centres (ISTCs).</strong> No new ISTCs expected. Continue to explore pathways and joint working with operators of Banbury treatment centre.</td>
</tr>
<tr>
<td><strong>Any Qualified Provider (AQP).</strong></td>
<td><strong>OUH will seek AQP status for relevant specialties.</strong></td>
</tr>
<tr>
<td><strong>Commissioning</strong></td>
<td><strong>Emerging commissioner intentions in public health and outcomes based commissioning.</strong> Participate actively in the development of future models of care. Make proposals for future service delivery, working with other providers where this is beneficial to achieve commissioners’ aims.</td>
</tr>
<tr>
<td><strong>Other NHS specialised centres</strong></td>
<td><strong>Competition from other teaching hospitals for tertiary work at the boundaries of OUH’s specialist catchment area.</strong> Work with clinicians and network hospitals to strengthen referral patterns and create supportive clinical networks that help sustain services throughout the area. Focus on strengthening, sustaining and publicising quality, patient experience and patient recommendation and choice. Maintain designation from specialised commissioners.</td>
</tr>
<tr>
<td><strong>Centralisation of services, particularly through the national ‘Safe and Sustainable’ programme.</strong></td>
<td><strong>Retain high quality, nationally recognised services within the Trust. Address derogations from specialised services commissioning specifications. Continue work with networks, including AHSN.</strong></td>
</tr>
<tr>
<td><strong>Private sector</strong></td>
<td><strong>Development by Cancer Partners UK of radiotherapy facilities, including one in Oxford.</strong> Maintain offer to patients and referrers of coordinated chemotherapy, radiotherapy and surgical treatments for cancer. Develop capacity across network sites to meet anticipated demand and work with other providers to achieve this.</td>
</tr>
<tr>
<td><strong>Private patient market grows with new entrants into NHS-funded healthcare in acute and community services. Insurers’ flexibility to fund care is threatened by lower personal income.</strong></td>
<td><strong>Provide private healthcare within OUH Divisions. Explore joint ventures or other shared delivery arrangements for care outside hospital.</strong></td>
</tr>
</tbody>
</table>

### Competitive factors

#### Quality

4.99 Quality is the primary focus for OUH. A five-year Quality Strategy was agreed by the Board in July 2012 and updated in September 2013, drawing on a wide range of work on patient safety, clinical effectiveness, outcomes and patient experience.
4.100 The Quality Account for 2013/14 was published in June 2014. This reported on the delivery of quality priorities for 2013/14 and identified quality goals for 2014/15. The development of the six high level Trust wide quality priorities had several different drivers: priorities set for the NHS nationally; priorities agreed with commissioners; priorities arising through feedback that the Trust received from service users; and priorities developed through its own Risk Summits.

4.101 Regular reports are brought to the Board covering all aspects of Quality. Divisions prepare their own quality reports for monthly review and present progress to the Clinical Governance Committee.

4.102 OUH uses the national Quality Dashboard as one source of evidence against which to assess its performance in quality terms, with other sources including Dr Foster data and the recently-introduced Summary Hospital-level Mortality Indicator (SHMI).

4.103 OUH is fully registered with the Care Quality Commission (for all its locations) and complies with all essential standards for quality and safety.

4.104 The CQC Chief Inspector of Hospitals carried out an inspection of the Trust’s four hospitals in February 2014. This resulted in the Trust being awarded an overall rating of ‘Good’ in May 2014, with the Churchill Hospital, Horton General Hospital and Nuffield Orthopaedic Centre rated as ‘Good’ overall and the John Radcliffe Hospital requiring improvement to its A&E, surgical and outpatient services, to record keeping in some areas of the hospital and to staffing and the induction of new staff in some areas. Action plans have been agreed with the CQC and progress is being reported.

**Patient experience**

4.105 Patient experience is an important element of service quality and the Trust has a Patient Experience Strategy with four work streams.

- Patient Experience Feedback, including Friends and Family Test, real time feedback and CQC national programme.
- Patient Stories Programme.
- Patient Leaders Programme.
- Compassionate Care Programme.

4.106 This work is managed through a Patient Experience Steering Group, chaired by the Chief Nurse. Initiatives to support these work streams include the implementation of a Trust-wide real-time feedback system and an upgrade to the web-based Datix system to include complaints management.

4.107 The most recent comprehensive survey of OUH patients was the Inpatient survey conducted for patients discharged in July 2013, published in 2014 by the Care Quality Commission. 156 acute and specialist NHS Trusts were compared in the survey. OUH was performing ‘about the same’ as other trusts on all questions according to the significance test carried out in the CQC report.

<table>
<thead>
<tr>
<th>Inpatient survey, 2013</th>
<th>OUH</th>
</tr>
</thead>
<tbody>
<tr>
<td>The same as other Trusts on:</td>
<td>All questions</td>
</tr>
<tr>
<td>Significantly improved on:</td>
<td>6 questions</td>
</tr>
<tr>
<td>Significantly worsened on:</td>
<td>1 question</td>
</tr>
</tbody>
</table>

4.108 The most recent Outpatient survey was carried out by the Picker Institute in November 2011 and published in 2012. This gave patient feedback as follows:
4.109 A survey of women’s experience of maternity care was conducted in 2013, with a questionnaire sent to all women who gave birth in February 2013. Overall results were as follows:

<table>
<thead>
<tr>
<th>Maternity care survey, 2013</th>
<th>OUH score</th>
<th>Comparison to 2010 survey</th>
</tr>
</thead>
<tbody>
<tr>
<td>Experience of labour and birth</td>
<td>9.1/10</td>
<td>Better</td>
</tr>
<tr>
<td>Experience of staff</td>
<td>8.7/10</td>
<td>About the same</td>
</tr>
<tr>
<td>Experience of care in hospital after the birth</td>
<td>8.1/10</td>
<td>Better</td>
</tr>
</tbody>
</table>

4.110 The Trust has adopted an approach of considering Patient Experience Survey and Staff Survey results in concert, recognising the importance of improving both staff and patient experience within the organisation. The results are examined along with relevant focus groups and form an element of OUH’s internal peer review process.

4.111 The Friends and Family Test acts as a national indicator of patient experience. Details are given in Chapter 2 of the Trust’s latest information compared to the NHS in England.

4.112 The Trust will continue to monitor Friends and Family Test scores in comparison with those of other hospitals.

4.113 OUH also collects qualitative data alongside the Friends and Family Test through methods including local patient surveys, the use of feedback forms and through Patient Advice and Liaison Service and the receipt of comments, commendations and complaints. Details are reviewed within Divisions and the Quality Committee and conclusions and priorities are reported to the Board of Directors.

Staff experience

4.114 Research shows that the more positive the experiences of staff within an NHS care provider, the better the outcomes for patients.22

4.115 Staff engagement has significant associations with patient satisfaction, mortality, infection rates and Annual Health Check scores, as well as with staff absence and turnover.

4.116 The 2013 survey of OUH’s staff indicated that overall staff engagement had risen to 3.82 (of a maximum 5). The average level for acute Trusts in England was 3.75.

4.117 The score comprises staff members’ perceived ability to contribute to improvements at work, their willingness to recommend the trust as a place to work or receive treatment and the extent to which they feel motivated and engaged with their work.

4.118 Extensive work is being carried out on staff engagement in order to meet the Trust’s strategic objective of ‘Delivering Compassionate Excellence’. This includes the use of a clear set of values and standards of behaviour, with work undertaken to inform recruitment, induction, appraisal, recognition and management approaches. The Trust also uses the Listening into

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Action methodology to involve and engage its staff. Further information is given in Chapter 8 – Error! Reference source not found..

Cost factors

4.119 The Market Forces Factor (MFF) results in commissioners paying different prices to different providers. The visible price difference can influence commissioning, although the Department of Health has signalled its intention to see commissioners stop using MFF as a basis on which to limit patient choice.\textsuperscript{23}

4.120 The chart below shows OUH as fairly well-placed compared to its NHS competitors, although the MFF poses more of a challenge if it wishes to pursue specialised activity to the west and north of its catchment. MFF may help to shape the approach taken in developing services on other trusts’ sites, as the ‘payment index value’ shown is driven by property prices rather than pay premia.

![Payment Index Value ('Market Forces Factor') for 2013/14, selected trusts](chart.png)

Geography and travel times

4.121 OUH’s Oxford sites are within easy reach of the M40 motorway between West London, the M25 and Birmingham and the trunk road network (A34) between the Midlands and

\textsuperscript{23} http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_131089.pdf
Southampton. Swindon, Aylesbury, Cheltenham, High Wycombe, Milton Keynes, Northampton, Reading, Slough and Heathrow Airport are within one hour’s journey time.

4.122 The Horton General Hospital is close to the M40 and within 45 minutes’ journey time of Oxford, Milton Keynes, Northampton and Warwick.

4.123 A new rail link between Oxford, Buckinghamshire and London Marylebone, to open in 2015, will create a new Oxford Parkway station with frequent bus connections to OUH’s Headington sites.

4.124 The subsequent East-West rail link (due to open in December 2017) will improve access to Oxford and Oxford Parkway from Milton Keynes and Bedford.

Conclusions

4.125 The Trust’s Board and Divisional Directors have reviewed the political, economic, social, technological, legal and environmental factors which have the potential to affect the Trust. Their impact and the Trust’s response are summarised in table form overleaf.

4.126 OUH provides services to a local market for general hospital services and a wider market for more specialised care.

4.127 The Trust provides the majority of acute services for its local market with a small volume of activity going to neighbouring DGHs and to private providers who have contracts, currently for a limited range of orthopaedic and other elective work. It is monitoring plans by commissioners to put services out to tender and developing plans to respond.

4.128 A defining feature of the local market is increasing demand from an ageing population with increasingly complex health and social care needs. Growth in demand for hospital care is expected to continue, with major housing developments in Oxfordshire another contributory factor.

4.129 Growth in specialised care also reflects demographic change and has been accelerated by service specifications driving the increased centralisation of services, with OUH as a regional centre. Changes to patient flows which have taken place during 2013/14 are also expected to continue.

4.130 These changes are taking place against a background of restricted NHS and local government funding and the Trust’s two major commissioners having overspent in 2013/14.

4.131 The Trust’s strategic response is to work with local providers and commissioners to develop new care pathways to meet needs within the constraints of the current economic climate. A key focus for this within the local health economy is reducing delayed transfers of care.

4.132 As local care pathways are designed to provide care outside the acute hospital setting wherever possible, the Trust’s strategy is to increase the proportion of its income that is from specialised care. The Trust’s strategy to increase its specialised market has three components:

- Consolidate its existing catchment through mutually beneficial work with local providers and with commissioners, delivering results such as the repatriation of local patients from London.
- Deliver national and network-driven reconfigurations of specialised services, recent examples including major trauma, vascular surgery and newborn intensive care.
- Extend its catchment area through extending clinical networks and joint working relationships into Milton Keynes and Bedfordshire.

4.133 Potential new markets will also be monitored.
The Trust’s ability to deliver its strategies in relation to both local and specialised services requires confidence from patients, GPs, commissioners and referring clinicians that it provides high quality services. OUH has a number of approaches to this.

- Retaining a focus on the quality of care delivered (measuring patient safety and experience, clinical effectiveness and outcomes), gaining assurance of it through its governance systems and demonstrating it by publishing outcomes data and meeting access standards.
- Embedding compassionate excellence in the values and behaviours of the Trust and engaging with patients about what they want and how the organisation can improve.
- Continuing engagement with Oxfordshire Clinical Commissioning Group and its locality groups to understand and respond to local service issues.
- Working with commissioners to deliver services in line with their strategies, such as Outcomes Based Commissioning in Oxfordshire and national service standards for specialised services.
- Making the most of OUH’s unique partnership with the University of Oxford and working through the Joint Working Agreement to bring the benefits of excellent research and teaching to the Trust’s patients.
- Building wider partnerships (clinical networks, the Oxford AHSN and AHSC) to innovate and deliver benefits more widely.
- Demonstrating that the Trust provides ‘state of the art’ services by making the best use of its new facilities, making targeted investment in new technology, treatments and IT solutions, and promoting the work of the Oxford Biomedical Research Centre and Unit.

Chapter 5 describes service developments which flow from these factors.
A Newborn Intensive Care Unit opened at the John Radcliffe Hospital in 2013, offering improved and extended facilities.
### Political, Economic, Social, Technological, Legal and Environmental (PESTLE) analysis

<table>
<thead>
<tr>
<th>Factor</th>
<th>Impact on OUH</th>
<th>OUH response</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Political</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Centralisation of specialised services</td>
<td>• Centralisation of specific services requested by commissioners, with NHS England driving this agenda.</td>
<td>• Completion of action from business cases for agreed centralisation in Oxford (Major Trauma, Vascular Surgery, Neonatal, Hyper-acute Stroke)</td>
</tr>
<tr>
<td></td>
<td>• Programme of designation of specialised services with derogations in place.</td>
<td>• Delivery of paediatric network arrangements for children’s heart surgery in collaboration with University Hospital Southampton NHS FT</td>
</tr>
<tr>
<td></td>
<td>• Centralisation of some services as a result of service or financial pressures on other providers in the network.</td>
<td>• Develop similar network for paediatric neurosurgery</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Maintain and develop working arrangements with network hospitals</td>
</tr>
<tr>
<td>Delivery and maintenance of access targets</td>
<td>• Impact of non-delivery of standards on patient experience, referrer experience and Trust reputation.</td>
<td>• Integrated Performance Framework</td>
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<td></td>
<td>• Achievement of access standards linked to payment by commissioners with increased penalties for failure.</td>
<td>• Improved use of resources to flex capacity</td>
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<td></td>
<td>• Access standards form core element of assessments by TDA and Monitor.</td>
<td>• Further develop extended day and weekend working, including access to diagnostics. Consider outpatient services beyond current working day</td>
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<tr>
<td>Encouragement of competition and introduction of new providers to market with extension of patient choice</td>
<td>• Services provided by OUH put out to tender by commissioners.</td>
<td>• Action plan to reduce delayed transfers</td>
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<td></td>
<td>• Choice is often influenced by referrers as much as patients</td>
<td>• Action plan to improve waits in the Emergency Department</td>
</tr>
<tr>
<td></td>
<td>• Patient choice is influenced by information on outcomes and patient experience.</td>
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<tr>
<td>Expectations of delivering integrated care</td>
<td>• Requirements of local commissioners.</td>
<td>• Monitor services which could be put out to tender by commissioners and develop plans for gaining/losing activity</td>
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<tr>
<td></td>
<td>• Potential inclusion by regulators (Monitor duty).</td>
<td>• Develop internal capacity and expertise for responding to invitations to tender</td>
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<td></td>
<td>• Better Care Fund shifts local funding.</td>
<td>• Anticipate unmet need and consider joint solutions, e.g. in social care, dementia</td>
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<td>• Use feedback from patients to set priorities in Quality Account</td>
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<td></td>
<td></td>
<td>• Build relationships of trust with GPs</td>
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<td></td>
<td></td>
<td>• Extend ‘gatekeeper’ portal, learning from experience in musculoskeletal services</td>
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<tr>
<td>Factor</td>
<td>Impact on OUH</td>
<td>OUH response</td>
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| Political | Focus on cost-effectiveness | • Continued requirement to deliver cost improvements  
• Payment by commissioners linked to delivery of quality measures | • Monitoring and benchmarking of outcomes  
• Participation in national clinical audits and publication of findings and actions in annual Quality Account  
• Develop granular understanding of costs  
• Progress towards improvements in quality, e.g. on best practice tariffs |
| Heightened quality focus | • Quality Governance Framework assessment  
• Scrutiny of processes and indicators, including healthcare associated infections and Safety Thermometer  
• Publication of PROMs for selected procedures and Patient Experience surveys, e.g. of cancer patients  
• Link to payment, e.g. Patient Experience CQUIN  
• Publication of Friends and Family Test results | • Complete Quality Governance action plan and sustain progress  
• Develop Patient Safety Framework as part of Quality Strategy  
• Identify and monitor Patient Safety priorities within annual Quality Account  
• Board and Executive walk rounds  
• Prominence within Trust values of compassion and respect, embedded through Listening into Action and associated programmes  
• Introduce electronic patient feedback tool |
| HM Government restraint on public spending | • Tariff deflation requires continuing cost reductions to sustain Income and Expenditure surplus  
• Reduced social care funding reduces support to vulnerable people, affecting demand for emergency care and efforts to reduce delayed transfers  
• Pressure on public sector pay and pensions worsens recruitment, retention and motivation  
• Constraint on availability of capital for investment. | • CIP programme on rolling two-year basis with contingencies  
• Transformation of service delivery to achieve this  
• Action plan with NHS and social care providers to provide targeted support and reduce the impact of ‘care boundaries’ through service integration  
• Continued focus on delivering compassionate excellence. Demonstrate progress on quality strategy  
• Affordable capital programme |
| National strategic focus on specific areas, e.g. | • Inclusion in NHS Outcomes Framework produces requirements from commissioners with payment implications | • Development of Oxford Heart Centre and continued development of OUH as Hyper-acute Stroke Centre  
• Continue to realise benefits of Oxford Cancer Centre, with co-location of head and neck cancer services and development of radiotherapy  
• National priorities reflected in AHSN and BRC/BRU programmes and themes |
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<tr>
<td>Political</td>
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| Service reconfiguration| • Proposed reconfigurations in Northamptonshire and Monitor review of MK and Bedford hospitals: potential risk to referrals, but opportunities in an area of rapid population growth with improving transport links  
• Amalgamation of Heatherwood and Wexham Park NHS FT and Frimley Park NHS FT: potential impact on boundary to clinical networks  
• Centralisation of some services as a result of service or financial pressures on other providers in the network  
• Constraints on major service redesign in advance of general election | • Strengthen partnerships with all members of the Oxford AHSN and AHSC  
• Pursue joint consultant posts and development of renal and radiotherapy services in network hospitals  
• Executive and clinical visits to relevant trusts to discuss future partnership arrangements  
• Continue community and membership engagement on service developments and changes |
| Economic               |                                                                                                                                                                                                             |                                                                                                                                                                                                             |
| Changes in local funding position | • Impact of Better Care Fund on CCG and local authority funding  
• Requirement for Oxfordshire CCG to recoup deficit from 2013/14 and planned deficit for 2014/15 | • Agreement of contract to support the local health economy  
• Involvement in improved care pathways to realise benefits from Better Care Fund |
| Changes to NHS payment and pricing mechanisms | • Monitor, NHS England and local commissioners place more emphasis on commissioning for outcomes  
• Changes to tariffs and tariff structures  
• National initiatives to reduce costs present opportunities and risks involving large amounts of income | • Engage with local commissioners and potential partners in care delivery to provide innovative models of care  
• Future shape of pathology services expected to be determined through a link to research with the clinical network within Oxford AHSN |
| Reducing personal disposable income | • Impact on health (e.g. diet, expenditure on health promoting activity and loss of mental wellbeing) with consequent effect on demand for services  
• Potential reduction in private market | • Work closely with local commissioners to identify trends as early as possible  
• Long Term Financial Model includes conservative estimates on future private patient income |
| Relatively high cost of living around OUH’s sites | • Recruitment difficulties, e.g. in lower banded specialist nursing  
• Cost of Living Supplement no longer part of Agenda for Change terms and conditions | • Staff accommodation on Trust sites for a specified period to ease transition  
• OUH links with affordable housing schemes  
• Comprehensive transport policy to support staff travel |
### Factor Social

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<th>Areas of specific growth</th>
<th>Impact on OUH</th>
<th>OUH response</th>
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<tr>
<td>Housing developments in Oxfordshire, Milton Keynes and Swindon</td>
<td>Focus on development of partnership working and specific initiatives such as joint posts and business cases for service developments, e.g. satellite radiotherapy provision</td>
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<tr>
<td>Increased market presents opportunity for OUH services</td>
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| Changing demographics: |
|---------------------------------|---------------------------------|---------------------------------|
| Growing population               | Demographic factors modelled into activity projections for LTFM |
| Ageing population                | Plans to manage increased demand in specific areas, e.g. radiotherapy |
| Increasing incidence of dementia | Capture complexities and co-morbidities in clinical coding and monitor whether associated costs are reflected in tariffs |
| Increasing dependency ratio      | Introduction of Integrated Psychological Medicine Service |
| Increasing rates of obesity      | Introduction of standardised dementia screening |
| Increasing numbers with disabilities | Identification of whole system working and collaboration through Oxford AHSC with dementia and cognitive health identified as one of its six themes of work |
| Increasingly diverse population  | Reflection of issues in AHSN programmes |
| Rising birth rate                | Focus on patient-centred care |
|                                  | Plans to develop service integration and reduce delayed transfers |
|                                  | Expansion of newborn intensive care service |

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<th>Cost of litigation</th>
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<td>Rising premia</td>
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<td>Changes to NHSLA arrangements</td>
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<th>Public Health Strategy</th>
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<tr>
<td>OUH as major local employer</td>
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<tr>
<td>One million contacts with patients each year</td>
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<td>Trust commitment to support health and wellbeing of patients and staff</td>
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<td>Local Authority role in supporting public health</td>
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<th>Rising expectations of service and customer care</th>
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<td>Demand for outcomes, good experience of care, access and service developments</td>
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<td>Demand for information</td>
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<tr>
<td><strong>Technological</strong></td>
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</table>
| **Availability of new drug therapies and treatment regimes** | • Rapid translation of new modes of treatment  
• Increased patient and clinician expectations  
• Effect on costs  
• ‘Innovation Scorecard’ has impact on patient choice  
• Staff expectations of most up-to-date equipment | • Therapeutics Advisory Group considers introduction of new procedures/treatment  
• Move towards being ‘data driven’ on effectiveness  
• Oxford AHSN workstream on health informatics and technologies |
| **End of national contract for Electronic Patient Record** | • Current national contract expires in October 2015  
• EPR is central to delivery of national IM&T policies and forms essential element of high quality patient care along more complex care pathways | • OBC approved for procurement of continuation of EPR system during 2014  
• Benefits realisation as EPR is rolled out |
| **Information Technology advances** | • Potential to improve patient safety, outcomes and patient experience  
• Improved information to support decision-making  
• 3 Million Lives and Digital First High Impact Innovation pre-qualifiers for CQUIN payments  
• Cost implications and benefits realisation | • IM&T Strategy and associated allocation in capital programme  
• Use of Patient Level Information and Costing System (PLICS)  
• Complete pilot of electronic ‘track and trigger’ early warning system  
• Develop capabilities of data warehouse  
• Pilot remote monitoring of patients using mobile phone technology (mHealth)  
• Introduce remote requesting / reporting for direct access diagnostics  
• Informatics a key element of AHSN plans |
| **Rapidly developing technology, therapeutic techniques and equipment, including minimally invasive techniques and automation** | • Opportunities to increase market share and potentially improve efficiency if capitalise on technological opportunities  
• Threat to market share if OUH fails to do so  
• Higher-risk patients treated at specialist centres as minimally invasive procedures develop | • Investment already made in e.g. da Vinci and dispensing robots  
• Development of plans to work with academic partners and BRC/BRU to become centre of excellence in specific areas, e.g. radiotherapy and surgical innovation and evaluation  
• Use of technologies is an important element of AHSN plans  
• Develop staff skills to respond well  
• Build staff confidence in use of information  
• Forward capital programme |
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<td><strong>Legal</strong></td>
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<tr>
<td><strong>Health and Social</strong></td>
<td>• Changes to commissioning structures and responsibilities</td>
<td>• Develop positive engagement with commissioners as methods of commissioning change</td>
</tr>
<tr>
<td><strong>Care Act 2012</strong></td>
<td>• Increased emphasis on competition and integration</td>
<td>• Incorporate response to Health and Wellbeing priorities into strategy</td>
</tr>
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<td></td>
<td>• Introduction of national and local Healthwatch</td>
<td>• Work with local Healthwatch to engage with patients and the public, get feedback on services and proposed future priorities and service developments</td>
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<td></td>
<td>• Introduction of Joint Health and Wellbeing Board</td>
<td>• Demonstrate that governance and assurance systems allow OUH to meet new regulatory requirements</td>
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<td></td>
<td>• Changes to regulation</td>
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<tr>
<td><strong>Increased</strong></td>
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<tr>
<td><strong>complexity and</strong></td>
<td>• Revised CQC inspection regime</td>
<td>• Internal peer review to maintain focus on quality and evidence of meeting CQC standards</td>
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<tr>
<td><strong>rigour in regulatory</strong></td>
<td>• Updated Monitor Risk Assessment Framework</td>
<td>• Maintain compliance with Monitor license conditions</td>
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<tr>
<td><strong>environment</strong></td>
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<tr>
<td><strong>Energy</strong></td>
<td>• Rising energy costs</td>
<td>• Business case for energy investment to address deficiencies in infrastructure and improve efficiency of consumption</td>
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<td></td>
<td>• Penalties for carbon emissions</td>
<td>• Vacate and demolish old and energy-inefficient accommodation</td>
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<tr>
<td><strong>Estate</strong></td>
<td>• Limited space on sites</td>
<td>• Explore further development of existing building footprint</td>
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<tr>
<td><strong>Transport</strong></td>
<td>• Transport strategy including Park and Ride facilities</td>
<td>• Continued engagement with Oxfordshire County Council to support ‘supply’ of Park and Ride access to Trust sites</td>
</tr>
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<td></td>
<td>• New rail links to improve access to OUH’s Oxford sites</td>
<td>• Strategy to expand and consolidate catchment areas to East and North East and consolidate Swindon catchment</td>
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<td></td>
<td></td>
<td>• Factor timing of new transport links into planning and marketing</td>
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