HORTON GENERAL HOSPITAL

FUTURE SERVICE CONFIGURATION

CLINICAL WORKING GROUP

MATERNITY, GYNAECOLOGY AND NEONATAL SERVICES

Recommendations from the working group
May 2007

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1. Introduction and background

During the summer of 2006 the Trust consulted formally on service changes at the Horton General Hospital arising from the Strategic Review and the Performance Improvement and Cost Reduction Programme. The consultation proposals on Children's services, maternity, gynaecology and neonatal services arose from the previous work of the North Oxfordshire Paediatric Task Force (2003/4) and the Oxford Radcliffe Hospitals Strategic Review (2004-6).

Formal consultation closed on Friday 13 October 2006. Results were analysed by NSM research.

4,273 responses were received. Over two thirds of responses were in the form of a standard letter published in the Banbury Guardian. Of the remaining 31% (1,368) there were 16 responses from staff and staff groups, 124 responses on behalf of organisations and external groups and 1,228 individual responses from members of the public, where these 1,368 responses are grouped together in what follows they are described as 'non-standard' responses.

The overwhelming majority of respondents to the consultation were opposed to the proposed changes. Their objections to the proposed changes fell into 12 major areas of concern. These are listed in the table below with the percentage in each category of respondent raising that issue in their response. Alongside the percentages the ranking of that issue for that group of respondents is given.

The figures in the 'total' column are dominated by those issues cited in the standard public letter: overall opposition to the cuts; concerns about ambulance transfers of very sick people – particularly mothers and children – and the risks of injury and death; concern about access to services, travel and transport to Oxford; the importance of the Horton to the local community and the prospect of population growth in the area; and the role of the Horton in managing major incidents.

For other groups, the top three issues were overall opposition to the cuts, concerns about access to services and worries about risks to patients. It is of note that underlying many people's anxieties about risks to patients was concern about the time and distance involved in transfers of seriously sick patients to the John Radcliffe. Similarly, the single most frequently cited reason for objecting to the proposed change to maternity services was due to the risks and discomfort of transferring women in a late stage of labour.

Category of respondent	Total	Public Standard letter	Public Individual letter	Organ-isation	Staff / staff groups
Number (*= rank)	4413	3045	1228	124	16
Opposed to cuts overall	94% (1)*	100%	81% (1)*	84% (1)*	75% (1=)*
Objection based on risk to patients	91% (3)	100%	75% (3)	40% (3)	75% (1=)
Objection based on concerns about ambulance transfers	80% (7=)	100%	37% (8)	25% (6)	56% (3=)
Objection based on concerns about public transport / access to services	92% (2)	100%	76% (2)	54% (2)	56% (3=)
Objection based on recruitment / training	1% (12)	0%	2% (12)	10% (10)	44% (8=)
Opposed to changes in children's services specifically	83% (5=)	100%	47% (5)	22% (8)	44% (8=)
Opposed to changes in Maternity services / loss of SCBU specifically	83% (5=)	100%	46% (6)	24% (7)	50% (6=)
Opposed to changes in emergency services specifically	5% (10)	0%	14% (10)	16% (9)	44% (8=)
Objection based on population growth	88% (4)	100%	65% (4)	31% (4=)	50% (6)

Objection based on response to major incidents	80% (7=)	100%	39% (7)	9% (11)	19% (11=)
Objection based on importance of Horton to community / town	73% (9)	94%	29% (9)	7% (12)	19% (11=)
Criticisms of the consultation process	4% (11)	0%	12% (11)	31% (4=)	56% (3=)

The flavour of some of the key responses is illustrated in the extracts below:

1.1. The North Oxfordshire & South Northamptonshire GP Forum stated

'We remain opposed to the proposals on the grounds of safety, sustainability and the reduction in access to basic healthcare and choice for our patients, which will affect especially the most vulnerable. We have little confidence in the process of 'consultation' and the spirit in which it has been conducted.'

1.2. The Oxfordshire Health Overview and Scrutiny Committee response stated:

'the HOSC believes that the Trust's main proposals relating to services for children, babies and maternity services would lead to a reduction in the standards of healthcare available to people in the north of the county and that they are potentially unsafe. They run counter to national policy on localising healthcare and are contrary to the principles identified when the Horton Hospital was amalgamated into the Oxford Radcliffe Hospitals Trust.'

1.3. The HOSC called either for the Trust to abandon its proposals or for an independent examination of the Trust's proposals:

'The HOSC calls upon the Trust either to abandon the proposals, except for those that would improve services at the Horton, or to call upon an independent organisation such as the independent reconfiguration Panel (IRP) to examine the proposals in detail and report publicly.'

1.4. The response from the Cherwell District Council stated:

'The majority of the proposals contained in the Oxford Radcliffe Hospitals NHS Trust (ORH) consultation document significantly downgrade many of the core services at the Horton General Hospital (HGH) particularly in the area of women and children's services and trauma and emergency services.

'These services are the very services which were identified following a detailed public enquiry by Arthur Davidson QC in October 1996 as essential to be maintained to meet the need of the local 'Banburyshire' population.'

1.5. The Oxfordshire PCT expressed broad support for the proposals although this was conditional upon satisfactory reassurance or resolution of a number of important but detailed points mainly to do with mitigating the risks around the proposals.

Post Consultation process

The Trust Board decided on 26 October 2006 to seek agreement with the Oxfordshire HOSC and Oxfordshire PCT on a process to shape the Trust's proposals over the following few months, with the help of stakeholders and partners and independent clinical experts to

- look again at issues affecting the paediatric, maternity and gynecology services, and the Special Care Baby Unit, at the Horton General Hospital, including staffing and training problems.
- address concerns raised by the public, by GPs and others, including risk factors, transport issues, population growth, and the impact on vulnerable sections of the population.
- Consider new ideas and suggestions which have emerged during the consultation, and look at associated risks.
- submit revised proposals to the Board of the Trust.

The focus for this work was to be on the proposals for maternity, gynaecology, neonatal services and Children's services.

GPs and others had raised concerns about the consultation process; they had said that they had 'little confidence in the consultation process and the spirit in which it was conducted'. It was essential that the post-consultation process was open and inclusive and addressed these concerns.

The working groups

Two working groups were established to look at each of:

- Children's services
- Maternity, gynaecology and neonatal services

The groups were independently chaired by Pam Garside, Judge Business School, Cambridge University and included representatives from among GPs, ORH doctors, nurses and midwives from Banbury and Oxford in paediatrics, obstetrics, midwifery, SCBU, anaesthetics, gynaecology, neonatology, the emergency department. The groups were clinically driven, agreed their own terms of reference, methods of working and agendas. They were supported by Trust managers and independent experts Professor Sir Alan Craft, Sir James Professor of Child Health at Newcastle upon Tyne and former President of the Royal College of Paediatrics and Child Health, (paediatrics); and Suzanne Cunningham, Consultant Midwife at Southampton University Hospitals NHS Trust (Midwifery) who attended meetings of the working groups. Dr Nick Naftalin, Emeritus Consultant in Obstetrics and Gynaecology at University Hospitals of Leicester NHS Trust and a member of the Independent Reconfiguration Panel (obstetrics) was available to support the maternity, gynaecology and neonatal working group.

The Oxfordshire PCT also participated in both groups.

The working groups agreed that the key themes to be examined in the post consultation process were:

- the role of recruitment and training and the case for change – in particular the ability of the Trust in the future to consistently staff the services with doctors with the appropriate level of experience and qualifications
- whether the alternative models proposed are 'safe', ie. have an acceptable level of clinical risk
- patient transport and access to the John Radcliffe Hospital

Among other important issues which would be looked at were:

- the effect of forecast population growth on demand
- the needs of deprived and vulnerable sections of the population
- the strategic context including the implications for, and of, the plans of nearby general hospitals, and evidence of what is happening elsewhere
- in maternity services, the maximum safe size of both midwifery and obstetrics units

Each working group met 10 times between January and May including a joint session to consider transport issues. They met with postgraduate dean twice and received reports on training and staffing issues from Sir Alan Craft and Dr Nick Naftalin. Suzanne Cunningham, consultant midwife at Southampton, attended two of the maternity working group sessions. Sir Alan Craft also attended a meeting of the working group and a meeting with the Post Graduate Dean. The

working groups undertook detailed risk assessments of the current service, consultation proposals and a variety of alternative and enhanced models. And they considered emergency transport, access issues, social and demographic factors and evidence from elsewhere in the UK, including alternative models elsewhere.

2. Maternity, gynaecology, neonatal services - the case for change – staffing, recruitment and training

The working group considered evidence presented in the Trust's briefing document on staffing recruitment and training issues. The working group received an independent report on this from Dr Nick Naftalin and met with the postgraduate dean on two occasions with additional feedback from separate meetings and correspondence. The working group discussed these issues extensively at its first meeting on 10 January, on 31 January and 7 March at specially convened meetings with the Postgraduate Dean and again on 22 March.

At its first discussion on the topic it was agreed by the majority of the working group that the current model was unlikely to be sustainable:

> 'that the current pattern of staffing is unlikely to be sustainable in the future in view of the changes to training, the level of activity at the Horton Hospital (and hence the attractiveness of posts), and rising standards / requirements in terms of medical cover for obstetrics.'
>
> (extract from agreed working group minutes 10 January)

This conclusion was reached (despite the fact that currently middle grade posts in obstetrics do have training recognition), on the basis of the impact of the European Working Time Directive (EWTD), changes to junior doctors hours, changes to training under 'Modernising Medical Careers' (MMC) and changes to immigration rules. These taken together make posts in smaller hospitals with relatively low levels of activity unsuitable for training – particularly out of hours - and at the same time reduces the pool of doctors available who might be willing and competent to take up non-training middle grade posts.

In addition the group was advised (and evidence was presented – see minutes of the working group 22 March) that there is a national shortage of British graduates in obstetrics and gynaecology, and that many were women some of whom would want to work part time, which would exacerbate staffing difficulties. The Royal College of Obstetrics and Gynaecology had already given notice that it was not happy with the current levels of activity and supervision for trainees at the Horton.

A small number of members of the working group felt that the service could be staffed, at least in the short to medium term, with non training middle grade doctors and were unconvinced by the arguments set out above. One member of the group was not able to agree with the general conclusion of the group even after further investigations and evidence was presented.

> The group considered that an alternative way of staffing an obstetric service without trainees should be looked at i.e. a consultant delivered model. The group subsequently decided that this was not a deliverable solution for maintaining Horton obstetrics given the need for a minimum of 12.5 consultants to cover the service whether this was a standalone rota or combined with Oxford, and the size of the unit.
>
> This is in the context of a forecast national shortage of obstetric consultants as all units require more consultants to cover rising standards for resident consultant cover on the labour ward. The John Radcliffe currently provides 40 hours, but will be moving to 60 hours in August 2008 and ultimately to 24/7 cover.
>
> 'It was agreed *by those present* that it should be formally minuted that the group did not feel this was a deliverable solution for maintaining Horton obstetrics'.
>
> (extract from agreed minutes 26 April)

The group also considered options for increasing the level of activity to 2,500 births which was the minimum figure thought necessary to make the unit clinically viable. This included a consideration of population growth, immigration; the plans of neighbouring hospitals (dealt with below) and the potential for extending the catchment of the Horton Hospital.

3. **Social and demographic factors and the plans of neighbouring hospitals**

The working group considered a paper on demographics, social issues, the management of major incidents and the impact of the plans of neighbouring hospitals at its meeting on 7 February. The group concluded:

- that the forecast increases in population and the higher potential increases were not sufficient to make a material difference to the viability of the current model of service.
- that no further investigation into population growth needed to be undertaken
- that the Trust had adequately investigated the plans of neighbouring hospitals and had provided sufficient assurance that at the present time there are no plans to close services at neighbouring hospitals which would result in substantially increased demand at the Horton.
- That the Trust's proposals represented a reasonable response to levels of deprivation in Banbury. This included:
    - ~ the shuttle bus proposal;
    - ~ current levels of community midwifery support
    - ~ a recent initiative to provide a greater level of support to pregnant teenagers and teenage mothers
    - ~ provision of all routine ante-natal care and post-natal support from the Horton
    - ~ an option for mothers without other means of transport to call for an ambulance to take them to Oxford when in labour
- that it would be for those responsible for the major incident plan to make appropriate adjustments in the light of any changes which were ultimately agreed.

(extracts from agreed working group minutes 7 February)

4. Options reviewed – maternity and neonatal

The working group considered a 'midwifery plus' option. This was explored as a way of delivering the maximum safe level of service locally to women of North Oxfordshire and South Northamptonshire. The sub group which considered this advised that it was not appropriate to continue to carry out elective caesarian sections on financial and practical viability grounds because only 100 women would be likely to meet the criteria.

The group decided that enhancements to the midwifery model at the Horton should not extend the scope of the unit beyond that of the existing midwifery units in terms of the risk profile of mothers delivering, the protocols applied, or the delivery methods used and should be restricted to:

- retention of consultant delivered ante-natal clinics
- retention of scanning facilities
- day assessment unit for a restricted number of maternal and fetal indications

'It was agreed that based on the Wyre Forest evidence, expert advice and professional opinion that the only safe strategy for a Horton midwifery unit, would be to apply exactly the same criteria and management protocols as apply currently at Oxfordshire's other standalone midwifery units. There should be no confusion in the public's mind or among staff. Only low-risk women should be advised / accepted to birth at the midwifery unit and prompt action should be taken to transfer women who need obstetric care regardless of the possibility that an obstetrician might be on site running an antenatal clinic. In practice in a state of emergency additional staff with relevant skills are often called to assist while a transfer is awaited.'

(extract from Working Group minutes 1 March)

Low risk nursery

A sub-group which looked at the option to include a low risk nursery as part of the Group's recommendations concluded that

- the provision would significantly increase the number of accompanied ambulance transfers which would be required by up to 120 relatively well babies on top of the 250 transfers of sick babies already undertaken by the ambulance service – this would be a significant increase.
- the top estimate of the number of babies in such a unit at any one time would be 2-3 and more likely it would be 2 or less. It was not considered practical to provide the facility for such a small number.

- the principle of local support for mothers and babies was an important one and could be better addressed through additional neonatal community nursing support and this should be looked at.

The Working Group endorsed the conclusions of the subgroup.

Midwife Assessment Clinic

It was proposed that the current maternity day assessment unit at the Horton be retained with a reduced range of maternal and fetal indications:

Maternal

- hypertension and/or proteinuria – any gestation
- suspected obstetric cholestasis
- maternal diabetes
- suspected premature rupture of membranes >37 weeks
- post natal complications eg hypertension, wound discharge, offensive vaginal discharge

Fetal

- reduced fetal movements
- CTG or Doppler requested
- prolonged pregnancy
- no fetal heartbeat

The Working group re-considered the proposal for a midwife led assessment clinic and endorsed this as part of the Group's recommendations. Risks were maintained at an acceptable level because of the screening out of higher risk women and improved transfer arrangements.

5. Options reviewed - gynaecology

The group reviewed the consultation option and a range of enhancements as follows:

Consultation option

- junior doctor and on-call consultant rota out of hours would be withdrawn
- the gynae ward at the Horton would be closed and all inpatient elective work transferred to Oxford.
- day case elective gynaecology surgery would be expanded at the Horton (an increase from 3 to 5 lists per week), any day case requiring overnight admission would be admitted to the general surgical ward under the hospital at night team, or transferred to Oxford
- patients requiring emergency surgery out of hours or assessment by a gynaecologist would be transferred to Oxford
- emergencies presenting during the day or overnight which could wait until the following morning would be operated on in scheduled day-time emergency lists. Any subsequently needing to stay overnight would be admitted to the general surgical ward under the hospital at night team, or transferred to Oxford
- continuation of gynaecology clinics – 3x weekly outpatient clinics, an early pregnancy clinic (Monday – Friday) and colposcopy clinics with (possibly) a new hysteroscopy clinic.

Enhanced gynaecology model

- provision of an emergency gynae clinic Mon – Fri to replace the early pregnancy clinic which would see all emergency gynae patients (including early pregnancy) and would also offer medical terminations. This would require some bed capacity during the day.
- a five day inpatient ward shared with breast patients
- An all female surgical ward with beds for gynae elective inpatients and day cases requiring to stay overnight
- expanded use of gynae nurse practitioners to look after post operative patients, and together with potentially GPwSIs (General Practitioners with a special interest (in gynaecology)) to take part in the emergency gynae clinic and diagnostics.
- expanded diagnostic work at the Horton – hysteroscopy clinic, urodynamics, expanded colposcopy.

It was agreed that gynae patients need a gynae surgeon and that because the need for an emergency surgical procedure to be carried out out-of-hours was extremely low it would be acceptable, if a patient was not fit to be transferred, for

this eventuality to be covered by an on-call gynaecologist covering both hospital sites. This could be accomplished within the time needed to get the theatre ready, theatre staff mobilised and the patient resuscitated (if necessary) and prepared for surgery.

There was a strong view that gynae patients need nursing by gynae nurses and that this particularly applies to terminations, miscarriages and similar. Post operative patients requiring pain control and post-operative care could be nursed on a general female surgical ward and managed overnight by the Hospital at Night team. Post operative emergencies would be transferred or the on-call gynaecologist would attend if they were not fit to be moved.

Further investigation into use of gynae nurse practitioners elsewhere had revealed that these posts were used in gynae clinics and were not suitable/appropriate for post operative or overnight care.

The group felt that there would be no significant difference in clinical risk to patients between:

- a consultant led service during the day with low-risk post operative patients nursed on a general, female surgical ward with on-call cover from Oxford
- a consultant led service during the day with low risk post operative patients nursed on a 5-night gynae or gynae/breast ward.
- a consultant led service during the day with all in-patients transferred to Oxford.

There would however, be differences in convenience to patients and the patient experience and it would be desirable to provide for overnight stays for day-case patients requiring this and routine inpatient cases who had been assessed as low risk.

The sub-group proposed and the working group agreed that the need to create an all-female surgical ward at the Horton was urgent and necessary regardless of decisions regarding the future of gynaecology services.

The working group was also strongly in favour of and recommends the enhanced model which was felt to be safer, more convenient for patients and should avoid re-admissions, post-discharge calls to GP out of hour's services and reduce anxiety for women following operative procedures.

6. Transport

A special session was held on 31 January to consider emergency patient transport and non emergency access. The meeting was attended by senior representatives of the South Central Ambulance Service.

The following specification was agreed

- ambulance to respond to an emergency call within 8 minutes for class A and within 19 minutes for class B. Other transfers by negotiation. All out of hours transfer to be treated as A or B.
- transfer times 25-40 minutes for class A, 40-50 minutes class B.
- drive-by protocol except in ABC situations

The following are extracts from the minutes of the meeting:

'Overall the group felt that the figures presented on numbers of transfers represented a reasonable planning assumption with a caveat over the number of gynae patients needing transfer for assessment, seasonality in paeds and higher numbers of emergency transfers in labour than estimated. These numbers are to be reviewed and shared with the ambulance service re current funding and ability to support any shifts in activity. However, the ambulance service would need to be able to cope with significant fluctuations (the numbers they are working to assume the need for 0.4 ambulance which they have rounded up to a full time ambulance. They are prepared to monitor the service and adjust provision of resources in the event that the outturn was in fact a higher number of transfers than had been planned for. The Ambulance service gave reassurance on both these points.'

'The group felt that the ambulance service would be able to make an appropriate and timely response under new arrangements and given the proposed investment in vehicles and crews but that this would need to be kept under review.'

'It was agreed that ambulance protocols were needed to ensure effective care and that these would need to be understood, agreed and applied by hospital clinicians, the ambulance service and crews, and GPs.'

(extracts from working group minutes 31 January)

The working group also discussed non-emergency transport for patients, relatives and carers, visitors and staff and the following proposal in particular:

- Shuttle bus proposal for non emergency patients, visitors, carers and relatives, and staff 07.00 to 18.00 or 07.00 – 22.00 every 2 hours each way.

'The Shuttle bus proposal was discussed and the group overall felt this was both an appropriate and an essential response to the service changes. It would help address issues of concern for the public, for patients and for staff.'

(extract from working group minutes 31 January)

The working group also discussed the possibility of creating a Helipad at the Horton to facilitate air ambulance transfers.

'In most cases the helicopter would be no quicker than a blue light ambulance journey and could take longer. It is also very difficult to treat a patient in transit in a helicopter which is cramped, less stable and very noisy.'

(extract from working group minutes 31 January)

The working group felt that this would not materially reduce clinical risks and should not therefore be included in the group's recommendations.

7. Risk Assessments

The working groups undertook risk assessments for

- the current model (as a benchmark),
- the current model in two years time (when the staff it is possible to recruit may have a lower level of skills or less experience),
- the midwifery model as presented in the consultation document,
- a 'midwifery plus' option
- the consultation model with a low risk nursery

'It was agreed that the so-called enhanced midwifery unit proposed in the consultation document would not be different in terms of clinical risks from the consultation proposal. The additional elements were making the service more attractive in terms of facilities available and the environment but would not make it safer. Therefore this did not need to be considered in the context of comparative assessments of risk,' (Working Group minutes 17 January)

In assessing risks around the Horton Midwifery unit it was assumed that the same set of risk mitigation measures and protocols would be applied as already apply to the existing south Oxfordshire midwife units.

For maternity events three specific clinical scenarios were considered which were representative of the risks presented by a range of situations

- a major ante-natal event such as APH, Cord prolapse or eclampsia
- a major intrapartum event such as shoulder dystocia or PPH
- a serious foetal event such as fetal distress or birth asphyxia

The group looked at neonatal risks under the following headings:

- term infant unresponsive to bag and mask ventilation
- pre-term infant 28 weeks
- pre-term infant 32 weeks
- 'grunting baby'

The group looked at gynaecology risks under the following headings:

- 'flat' patient with ruptured ectopic arriving at ED out of hours
- patient presents at ED with miscarriage and heavy bleeding out of hours
- gynae emergency or GP referral
- elective inpatients and day cases requiring overnight stay – out of hours care
- patients requiring booking in to emergency gynae clinic out of hours
- late delivery of blood test results

- day cases managed on generic unit / gynae day case unit
- patients requiring emergency transfer

For each clinical scenario and for each model
- the management plan was described
- the key risk mitigating factors were identified

Risk was assessed on the basis of
- likelihood (how often something may happen), a scale of 1-5
- severity (how serious a typical outcome would be if it did happen), a scale of 1-5

Overall risk was calculated by multiplying likelihood score by severity score resulting in an overall scale 1-25
- 1-3 Low
- 4-6 Acceptable
- 8-12 Undesirable
- 15-25 Unacceptable

Note: overall scores limited to multiples of 1-5 x 1-5 hence some scores in the range 1-25 are 'missing'.

Risk assessment – results

Maternity risks

Risks in Horton Midwife led unit were assessed as identical to the current risks in the other Oxfordshire midwife units provided the same criteria and protocols apply.

Risk assessment – standalone midwife led unit			
Scenario	likelihood	severity	overall
Ante-natal event eg APH, Cord prolapse, Eclampsia	1	4	4
Intrapartum event eg shoulder dystocia, PPH	1	5	5
Fetal event eg fetal distress, birth asphyxia	1	5	5

These levels of risk are acceptable or low

Levels of risk at the JR for all the above events are likelihood 3, severity 3 and overall risk 9 – undesirable and this reflects the much riskier client mix catered for at the maternity unit there.

The level of risk at the Horton Hospital obstetric unit, if the level of medical support were to be reduced as a result of, for example, recruitment difficulties, rises to likelihood 3, severity 4 and overall risk 12 at the top end of 'undesirable' for all the above events.

Three years of data from Jan 04 to Dec 06 from the Oxfordshire midwifery units was reviewed. This demonstrated that adverse incidents are very rare. Only three babies born after transfer from one of the MLUs had APGAR scores below 7 after 10 minutes. Out of 235 women transferred only 2 arrived at the JR less than two hours before their baby was delivered. The Group acknowledged that this demonstrated to the satisfaction of all but one member of the Group that there should be no concerns about the safety of midwife-led units per se.

However, the one member who disagreed with the conclusions of the rest of the group felt that 'a midwifery unit 1 hour away from the nearest obstetric unit poses a risk to women and babies which many local GPs and members of the public will find unacceptable'.

Midwife Assessment Clinic

The Working group re-considered the proposal for a midwife led assessment clinic and endorsed this as part of the Group's recommendations. Risks were maintained at an acceptable level because of the screening out of higher risk women and improved transfer arrangements.

Gynaecology

	24/7 Gynae ward – current model	**Consultation model**	**enhanced gynae proposal**
Ruptured ectopic / flat patient	1 / 3 / 3 Low	**2/3/6 Acceptable**	**2/3/6 Acceptable**
Miscarriage / heavy bleeding presents at ED	1 / 3 / 3 Low	**2/3/6 Acceptable**	**2/3/6 Acceptable**
Gynae emergencies / GP referrals daytime	1 / 5 / 5 Acceptable	**2/3/6 Acceptable**	**2/3/6 Acceptable**
Elective inpatient	1 / 5 / 5	**1/5/5**	**1/5/5**

/ day cases	Acceptable	**Acceptable**	**Acceptable**
Ability to book patients into emergency clinics OOH	1 / 5 / 5 Acceptable	**1/5/5** **Acceptable**	**1/5/5** **Acceptable**
Management of late delivery of bloods	1 / 5 / 5 Acceptable	**4/3/12** **Undesirable**	**With additional safeguards** **4/1/4** **Acceptable**
Generic day case unit	2 / 5 / 10 Undesirable	**1/1/1** **low**	**1/1/1** **low**
Availability of ambulance for transfers	n / a	**3/4/12** **Undesirable**	**With additional safeguards** **2/2/4** **Acceptable**
Day case patient discharged and deteriorates requiring re-admission	2 / 3 / 6 Acceptable	**2/3/6** **acceptable**	**2/3/6** **acceptable**

The working group concluded:

- the current model presents overall risks which are low or acceptable
- risks around the current day case unit are undesirable because women are not cared for by specialist gynae nurses and therefore may not receive expert advice. (The environment – being a mixed sex ward – is also unacceptable in modern hospital)
- the consultation proposal has two areas of risk which are undesirable:
  - ~ management of late delivery of blood results
  - ~ availability of ambulance for transfers
- the enhanced proposal provides additional resources and safeguards to bring these down to acceptable
- both consultation and enhanced proposals provide for specialist gynae nurses in the day case unit and hence risks around this are reduced

Neonatal

	Base case – current service Likelihood / severity / overall	Current service but with reduced level of medical support Likelihood / severity / overall	Midwifery unit plus ambulatory paediatrics Likelihood / severity / overall
Scenario 1 term infant unresponsive to bag and mask ventilation			
Lack of immediate availability of paediatric staff	1 / 5 / 5 Acceptable	1 / 5 / 5 Acceptable	1 / 5 / 5 Acceptable
Sub optimal resuscitation	2/5/10 Undesirable	4 / 5 / 20 Unacceptable	2/5/10 Undesirable
Delay in definitive care due to transfer	3 / 5 / 15 Unacceptable	3 / 5 / 15 Unacceptable	2/5/10 Undesirable
Scenario 28 week gestation infant			
Lack of trained staff / inadequately skilled staff	3 / 3 / 9 Undesirable	3 / 4 / 12 Undesirable	1 /5 /5 Acceptable
Delay in definitive care due to transfer	3 / 4 / 12 Undesirable	3 / 5 / 15 Unacceptable	1 / 5 / 5 Acceptable
Delivery en route			1 / 5 / 5 Acceptable
Scenario 3 32 week gestation infant			
Lack of trained staff / inadequately skilled staff	2 / 2 / 4 Acceptable	4 / 2 / 8 Undesirable	1 / 3 / 3 Acceptable
Delay in definitive care due to transfer	3 / 3 / 9 Undesirable	3 / 3 / 9 Undesirable	1 / 3 / 3 Acceptable
Scenario 4 Post natal issues requiring less-urgent medical intervention eg			

grunting baby			
Delay in definitive care due to transfer	4 / 2 / 8 Undesirable	4 / 2 / 8 Undesirable	1 / 3 / 3 Low
misdiagnosis			3 / 2 / 6 Acceptable
Unnecessary transfer			3 / 2 / 6 Acceptable

The working group concluded that:

- the current neonatal service has an unacceptable level of risk in terms of transfers of sick infants. This is due to the ambulance currently regarding the Horton as a place of safety and the current delays in transferring a baby to the JR for specialist care.
- undesirable levels of risk around pre term infants 28 and 32 weeks are also due to delays to transfer and in the case of the 28 week infant lack of appropriate skills / equipment (deliveries of infants below 32 weeks are not currently planned to take place at the Horton)
- risks in the proposed model can be reduced to low or acceptable by significantly improving the transfer response times by the ambulance service.
- risks remain undesirable for a term infant when unresponsive to bag and mask ventilation because this is almost always associated with a poor outcome wherever the birth takes place.

Low risk nursery

The Working Group reviewed the risk assessment and agreed that the provision of a low risk nursery would not materially affect the clinical risks around the ambulatory models.

Risk assessment: what the working group concluded

The working group concluded the following on the basis of the risk assessment work done:

- midwifery units are very low risk for low risk mothers
- a midwifery led unit at the Horton would be as safe as any other existing Oxfordshire midwifery unit

- risks around the proposed gynaecology service, with additional safeguards are as good as or better then the current service
- risks can be significantly reduced by improving ambulance response times

8. What is happening elsewhere?

The Working Groups considered evidence from elsewhere to inform their conclusions. The Groups were presented with the following:

- IRP: Findings from the Independent Reconfiguration Panel recommendations for North Tees & Hartlepool and for Calderdale & Huddersfield;
- Review of services plans for women and children in the Greater Manchester, East Cheshire, High Peaks region
- Review of changes to the service configuration of small hospitals;
- Review of the largest obstetric units in the UK
- Review of the largest midwifery-led units in the UK
- Solutions suggested by the "Keep the Horton General Campaign Group;

This material was presented in a document ("Strategic Context – part 2) on 22nd March 2007 and the group was invited to consider:

- Whether there were further examples that the Trust should review or whether the Trust had conducted a comprehensive examination of what was happening elsewhere?
- Whether the Trust's proposals were going with or against the flow?
- Whether there were examples of comparable places which had managed to retain their paediatric and/or obstetric services and whose service models could provide a relevant and appropriate model for consideration?

The group agreed to seek further information about Chichester, Worthing, Brighton and Hayward's Heath. These four hospitals are between 15 and 25 miles apart and have between; 2,200 and 3,300 births each. They have concluded that their obstetric hospitals need to have between 4,000 and 5,000 births in order to implement EWTD-compliment rotas, and are developing plans to consolidate into two large obstetric units with midwifery-led units on the remaining two sites.

Additionally, on 1st March 2007 the group discussed the Wyre Forest Midwifery unit (Kidderminster) inquiry, drawing on the experience of Suzanne Cunningham, Consultant Midwife from Southampton.

The following conclusions can be drawn:

1. The reconfiguration of obstetric services to midwifery-led care often goes hand in hand with reconfiguration of paediatric inpatient services to ambulatory care. This is because a hospital with a relatively low number of births generally has a relatively low level of paediatric activity, so both the services become difficult to staff. In addition, an admitting obstetric service cannot exist without an out-of-hours paediatrician.
2. Only a very small number of hospitals of comparable size to the Horton General Hospital are currently managing to retain their obstetric services. These examples present a variety of special circumstances such as exceptional distances from the nearest alternative service, or exceptional geographical locations which may make it easier to recruit staff. They include:
    - Borders Hospital in Scotland
    - Newport hospital on the Isle of Wight
    - Yeovil Hospital in Somerset
    - Barnstable hospital in North Devon
    - Friarage hospital in Northallerton

    These hospitals are likely to face the same problems as the Horton is facing now in the future.
3. The ability to recruit and staff services can be affected by factors such as the attractiveness of the location (e.g. Isle of White, the South West Peninsula, Scotland). It is likely that this has played a significant role in the ability of some of these hospitals to staff their services in a way not felt to be possible in Banbury.
4. Consolidation of obstetric services into fewer larger centers is happening across the UK. Many Trusts with obstetric services on more than one site are centralising obstetrics even when units are significantly larger than the one at the Horton General Hospital e.g.:
    - Chichester, Worthing, Brighton and Hayward's Heath;
    - Calderdale & Huddersfield;
    - Wycombe & Aylesbury;
    - Cheltenham & Gloucester
    - Welwyn Garden City & Stevenage
5. There are a number of large standalone midwifery units of between 400 and 500 births (Gwent, Telford, Neath, Dover, Canterbury, as well the two units being suggested in Sussex). The Horton would be at the top end but not outside the range. Several larger obstetric units have an 'alongside' midwifery-led unit, typically in the order of 120-300 births.
6. As with the proposed midwifery-led service for Banbury, many midwifery units are between 20 and 30 miles from their nearest obstetric unit, e.g.:
    - Perth – Dundee: 20 miles
    - Arbroath – Dundee: 25 miles

- Montrose – Dundee: 30 miles
- Kendal – Lancaster: 23 miles
- Dover – Ashford: 22 miles

7. Under the proposals the John Radcliffe Unit will increase from the current level of just under 6,000 births a year to between 6,500 and 7,000 births. This is be comparable with a few other large units in the country:
    - Royal Hallamshire: 6,500
    - Birmingham's Women's: 7,000
    - Liverpool Women's: 8,000

The working group agreed:

- The John Radcliffe Hospital's maternity unit, after consolidation, will not be "too big" and any negative factors can be mitigated by separating the unit into an obstetric unit and an "alongside" midwifery-led unit.
- The Horton midwifery-led unit will not be "too big" and there are comparable units in the UK.
- The solutions found by the few small hospitals which currently retain their obstetric service would not be appropriate for or sustainable in Banbury.

9. Outline costings

The working group viewed outline costings for the proposed enhancements and noted that there were some savings to be made by reconfiguring the maternity, gynaecology and neonatal services as proposed. But that these would be offset by the costs of transport arrangements and the capital costs which had not yet been calculated.

The outline costs are reproduced in appendix 4. These show that excluding transport and capital the cost savings associated with the proposals are £267,000 per annum.

10. Recommendations

The Maternity, gynaecology and neonatal services working group makes the following recommendations:

The maternity services at the Horton Hospital should be reconfigured as a midwife unit as follows:

- a full midwifery-led service established as Horton Birthing Centre
- adoption of protocols and standard procedures as applied at existing midwife units.
- obstetric-led antenatal clinics and retention of scanning facilities
- day assessment unit for a restricted list of fetal and maternal indications with medical support via telephone from Oxford.
- telemedicine link with Oxford
- staff training to ensure safe and smooth transition.
- obstetric deliveries relocated to Oxford
- 10 additional maternity beds in the Women's centre (Oxford) and three additional delivery rooms (to create a birthing unit)

The neonatal service should be reconfigured as follows:

- SCBU (Special Care baby Unit) relocated to Oxford with neonatal intensive care
- expansion of SCBU (already planned) and establishment of a transitional care unit at the Women's Centre to increase the number of combined SCBU / transitional care cots to accommodate 'Horton babies'
- additional neonatal community nursing support to provide equity across the county
- enhanced neonatal community nursing to support early discharge home for babies requiring tube feeding to be examined by the Trust in conjunction with the PCT

The gynaecology service at the Horton should be reconfigured as follows:

- gynaecology consultant and specialist trainee on site 09.00-17.00 Mon – Fri
- conversion of inpatient gynaecology ward to day surgery unit
- routine elective (including some inpatient) surgery and increase in day cases for Horton catchment population

- creation of an all female surgical ward at the Horton where gynaecology day case patients and elective surgical patients could stay overnight if required
- gynaecology cases presenting at the Horton out of hours requiring gynaecology assessment or surgery to be transferred to Oxford except in exceptional circumstances where a patient cannot be transferred safely in which case a consultant on-call will attend e.g. collapsed ectopic pregnancy
- continuation of current outpatient clinics, expanded colposcopy clinic, potentially a hysteroscopy clinic, urodynamics
- Early Pregnancy Clinic to become Emergency Gynaecology and Early Pregnancy clinic open over an extended period situated in vacated gynaecology ward

Emergency transfer and transport arrangements should be put in place as follows:

- ambulance to respond to an emergency call within 8 minutes for class A and within 19 minutes for class B. Other transfers by negotiation
- transfer times 25-40 minutes for class A, 40-50 minutes class B.
- drive-by protocol except in ABC situations
- all intrapartum and neonatal transfers would be arranged immediately and classed as emergency transfers in line with practice at existing midwife units.
- shuttle bus proposal for non emergency patients, visitors, carers and relatives, and staff 07.00 to 18.00 or 07.00 – 22.00 every 2 hours each way.
- discretionary taxis for parents or carers of a child transferred to Oxford out of hours

Other recommendations of the working group concerned the transition arrangements. In particular:

- transition arrangements should include a public information and education programme to advise pregnant women and the public about the new services.
- establishment of a transition / implementation group including GPs and PCT representatives to oversee transition arrangements, review implementation plans and timetable and monitor impacts.

APPENDIX 4

Costing for the proposed changes to the Horton General Hospital Women's & Children's services

CHILDREN'S SERVICES	Financial change	Variance in cost from current service			Notes
		Pay	Non-pay	Total	
Paediatric consultants JRH+HGH	From £663,000 to £840,000	£177,000		£177,000	Currently 5 individuals across the Trust, but with on-call and sub-specialists cover at JR, this is equivalent to 6 WTEs. Increase to 8 wte.
Paediatric consultants emergency on-call for HGH		£6,000		£6,000	A consultant on-call from home out-of-hours for Horton
Paediatric junior doctors JRH+HGH	A reduction of £290,000	-£290,000		-£290,000	Reduction of 5.3 wte. This will provide junior doctors at the HGH to support the Consultant running the ambulatory day unit
Nursing for HGH ambulatory service (M-F)	From £531,000 to £117,000	-£414,000		-£414,000	From 16.75 WTE to 3.9 WTE. The HGH ambulatory Unit will be staffed by two Band 5 nurses, 12 hours Monday to Friday (3.9 WTE at £30K including on-costs and enhancements)
Nurse for JRH wards	An additional £240,000	£240,000		£240,000	An additional 8 WTE. The JRH ward nursing will be increased to manage the additional admitted children. Any staff transferred to use inter-hospital shuttle bus (8 WTE at £30K including on-costs and enhancements)
Paediatric secretarial	A reduction of £18,000	-£18,000		-£18,000	Reduce from 2.7 WTE to 2 WTE
Emergency Dept. consultants HGH	An additional cost of £100,000	£100,000		£100,000	Currently 1 individual working 1.4 WTE, who will reduce to 1.2 WTE. Create an additional post who will work 1.2 WTE, therefore need new funding for 10 PAs
Emergency Dept. junior doctors	An additional cost of £205,000 less £40,000	£165,000		£165,000	An additional 3 WTE. This will increase the Middle Grade doctors from 5 to 8 (£205K less a saving of £40K currently incurred on locum cover). This provides a full 24-hour middle grade rota supported by a 16 hours a day F2 trainee

Paediatric-trained nurse at HGH		£154,000		£154,000	Additional 4.23 WTE Band 6 nurse. Additional nursing to provide a paediatric-trained nurse at HGH when ambulatory unit is not open
Emergency department nurse training	Additional cost of £9,000		£9,000	£9,000	Based on up to 18 nurses each year receiving training in paediatric advance life support techniques.
Children's Community Nursing	An additional cost £70,000 + £20,000 travel	£70,000	£20,000	£90,000	An additional 2 WTE. The county-wide service will function until 22:00 hours rather than until 18:00 five days a week. Weekends and public holidays will run for 8 hours not 5 hours each day. Travel costs assume £10,000 per nurse
CHILDREN'S SUB-TOTAL		**£190,000**	**£29,000**	**£219,000**	

WOMEN'S SERVICES	Financial change	Variance in cost from current service			Notes
		Pay	Non-pay	Total	
Horton O&G consultants	Saving of £172,000	-£172,000		-£172,000	Reduce from 4 wte to 2.5 wte. Based on 11.5 PA posts
JRH O&G consultants	Cost of £172,000 plus £7,000 travel costs	£172,000	£7,000	£179,000	Increase from 5 WTE to 6.5 WTE. A consultant on-call from home out-of-hours for Horton
Middle grades	Unquantified saving on on-call costs at HGH	£0		£0	No change from 11 wte
Horton midwives, MCAs and admin staff	Saving £1309,000. Cost £79,000 travel + £5000 training	-£1,279,000	£81,000	-£1,198,000	Reduce from 40.2 to 17 wte midwives and from 15.6 to 9.8 MCAs/admin. Includes 1 wte on-call midwife at Horton for out-of-hours ambulance transfers, assuming 2 out of 3 days a transfer is required.
JRH midwives, MCAs and admin staff	An additional £829,000	£829,000		£829,000	An additional 19 midwives and 13 MCAs and admin staff
JRH anaesthetic nurse	An additional cost of £102,000	£102,000		£102,000	Increase from 0.6 wte to 4.1 wte
JRH Transitional care	An additional £424,000 plus £29,000 travel costs	£424,000	£29,000	£453,000	Two midwives and 2 MCA/Nursery Nurse relocate from obstetric ward per shift. Additional 11.6 nurses/midwives plus 5.8 MCAs
JRH housekeeping	An additional £15,000	£15,000		£15,000	An additional 1 wte
Horton transfer of SCBU	Saving of £468000	-£468,000		-£468,000	Reduce by 15.4 wte
JRH neonatal medical staff	An additional £125,000	£125,000		£125,000	Additional 1.3 wte
Neonatal community nurse	An additional £30,000	£40,000	£10,000	£50,000	Additional 1 wte. To match existing 1 wte in rest of county. Assumes £10,000 travel costs
Horton gynaecology inpatient facility closes	A saving of £374,000 pay and £17,000 non-pay	-£374,000	-£17,000	-£391,000	Saving on existing budget
New Horton Gynaecology Day Unit with emergency clinic	£126,000 pay and 15,000 non-pay	£126,000	£15,000		Additional 1.3 wte Band 6, 2.6 Band 5, 1.3 Band 2. Assumes secretarial/admin staff to be reorganised to also take on day ward support role. Open 5 days a week, 8 hours a day. 40 D/C, plus 5 Med. Terms. plus clinic

Gynae/surgical ward nurses	Additional £60,000 plus £8,000 non-pay	£60,000	£8,000	£68,000	This assumes up to two overnight beds on a Women's surgical ward available for limited number of overnighting gynaecology patients (up to 4 per week)
WOMEN'S SUB-TOTAL		**-£400,000**	**£133,000**	**-£267,000**	

TRUST-WIDE OVERHEADS	Financial change	Variance in cost from current service			Notes
		Pay	Non-pay	Total	
Ambulance transfers	An additional cost of £111,000		£200,000	£200,000	An additional ambulance resource during the out-of-hours period at a cost of up to £111,000, (also to add in £89,000 for obstetric service changes)
Unsocial hours taxi service	Based on a contracted price of £70 per round trip		£18,200	£18,200	At times where there is no inter-hospital shuttle service, no private transport and no suitable public transport, the Emergency Department nurse will authorise this taxi for a relative
Inter-hospital shuttle service (staff, visitors)	An additional £115,000		£115,000	£115,000	Shuttle would leave HGH every 2 hours, with a return from the JRH every two hours. If shuttle ran from 08:00 to 20:00 every day, there is a saving of up to £30,000
TRUST-WIDE OVERHEADS SUB-TOTAL		**£0**	**£333,200**	**£333,200**	

GRAND TOTAL (RECURRENT EXPENDITURE)		**-£210,000**	**£495,200**	**£285,200**	

One-off expenditure

Awareness campaign for public and GPs	Plus £10000 in Children's costings	£4,000	£16,000	£20,000	£4,000 salary costs and £6,000 advertising included in the Children's costings

Appendix 5

List of Working Group Members

Chair
Ms Pam Garside, Judge Business School, University of Cambridge

Clinicians

Dr Eleri Adams, Consultant Neonatologist
Ms Jan Barber, Gynaecology Ward Manager, Horton
Ms Bev Bennett, Senior Midwife
Miss Rebecca Black, Consultant in Obstetrics and Gynaecology
Sister Michelle Brock, Emergency Department, Horton
Mr Stuart Canty, Consultant in Obstetrics and Gynaecology, Horton
Dr Hugh Gillies, Horsefair Surgery, Banbury, nominated by the North Oxfordshire and South Northamptonshire GP Forum
Ms Anne Haines, Senior Midwife
Sister Debbie Hancock, Special Care Baby Unit, Horton
Dr Emma Haskew, Sibford Surgery, Sibford Gower, Banbury, nominated by the North Oxfordshire and South Northamptonshire GP Forum
Miss Pauline Hurley, Consultant in Obstetrics and Gynaecology
Mr Simon Jackson, Consultant in Obstetrics and Gynaecology, Horton
Dr Eurem Mathews, Consultant Paediatrician, Horton
Ms Lesley Mills, Head Nurse, Neonatal Unit
Mr Jonathan Nicholls, Consultant in Obstetrics and Gynaecology, Horton
Matron Caroline Owens, Breast Care and Gynaecology
Dr Robin Russell, Consultant Anaesthetist
Dr Justin Sims, Consultant Paediatrician, Horton
Dr Graham Walker, Lead Consultant Anaesthetist, Horton
Ms Rosalie Wright, Associate Manager for Midwifery

PCT
Dr Ian Mackenzie, Associate Medical Director, Oxfordshire PCT
Ms Emma Tidy, Deputy Director of Commissioning, Oxfordshire PCT
Dr John Walton, Member of Clinical Executive, Oxfordshire PCT

Expert Advisers attending one or more sessions of the working group
Dr Michael Bannon, Postgraduate Dean
Professor Sir Alan Craft, Professor of Child Health
Ms Suzanne Cunningham, Consultant Midwife, Southampton University Hospitals NHS Trust
Mr John Nichols, Regional Director, South Central Ambulance Trust

ORH Observers and administrative support
Ms Julia Clarke, Director of Strategic Review
Mr Richard Jones, Director
Ms Nicola Joyce, Project Administrator
Dr David Lindsell, Divisional Chairman
Ms Jo Paul, Director of Operations
Ms Gill Walton, Directorate Manager, Womens Services