Oxfordshire

Clinical Commissioning Group

Responding to Secretary of State Letter following referral of the permanent closure of consultant-led maternity services at the Horton General Hospital

Paper for the Joint OSC meeting 4 July 2019

At the November 2018 meeting the Horton Joint Health Overview and Scrutiny Committee (Horton Joint OSC) confirmed that in the opinion of the Committee the proposed approach and plan outlined would address the recommendations of the Secretary of State/Independent Reconfiguration Panel. The full plan is available here.

The work streams are progressing to plan and in line with our timetable the papers presented today include updates in the following areas:

1. Work stream 1 – Engagement

Experience of families using maternity services

Since the last report for Horton HOSC, the survey, focus groups and interviews have been completed, that together provide insight into the experience of families that have used maternity services during the time of the temporary closure of obstetric services at the Horton.

More than 1,000 women responded to the survey and more than 400 partners. In addition, three focus groups and 8 participants (including 2 partners) were interviewed to gather more in-depth information from those that had more complex experience to share.

The full report is attached and data pack is published on Oxfordshire Clinical Commissioning Groups (OCCG) website here. A presentation will be provided at the Horton HOSC meeting on 4 July 2019.

Second Stakeholder event

The second stakeholder event took place on 14 June 2019 at Rye Hill Golf Club. An outline of the option appraisal process and outcomes was presented. Other presentations at the event included the findings of the survey, focus groups and interviews held with families who have used the service since the temporary closure of obstetric-led maternity services and more information about workforce and recruitment.

Stakeholders had an opportunity to reflect on and discuss the information shared and feedback was gathered. This feedback will be used, alongside the other evidence gathered, by NHS Oxfordshire Clinical Commissioning Group in order to inform their thinking in advance of a decision making process in September.

Publishing information

The dedicated section on the OCCG website is directly accessible via the homepage. Regular updates are posted here and all documents produced and being used by the project are published here.

Information recently published here includes:

- The information pack and additional information shared with the Scoring Panel in advance of their first meeting
- The further information gathered and shared with Scoring Panel to allow them to complete the task at their second meeting.
- The results of the criteria weighting and scoring with the options ranked.
- The report from the patient survey, focus groups and interviews and the data pack.
- The presentation slides from the second Stakeholder event.

All these documents can be found here: https://www.oxfordshireccg.nhs.uk/get-involved/horton-maternity-services.htm

2. Work stream 5a – Workforce analysis.

2.1 Obstetric staffing models

The detailed work on the modelling of the obstetric workforce has been completed and was used by the scoring panel in the options appraisal. This work was informed by the information gathering exercise OCCG and OUH had undertaken of small units (see section 6.1 below) and supplemented by the review undertaken by Keep the Horton General. In addition we met with the Royal College of Obstetricians and Gynaecologist workforce lead to ensure we had considered all possible models and recruitment possibilities.

2.2 Other staffing requirements

Other clinical and non-clinical staff are required for a fully functioning obstetric unit. These include anaesthetists, midwives, neonatal nurses and clerks. For the purpose of the option appraisal scoring it was assumed that the funding for this staffing is within the baseline budget of services so would not differentiate between options in the scoring process under the finance criterion. However as staffing two obstetric units requires more staff than one unit in areas where there are national workforce challenges this was considered in scoring the ease of deliverability.

An overview of the workforce analysis for obstetrics and other staff, including the numbers of doctors required for each model is presented in the report on this workstream.

3. Work stream 5b – Financial analysis

The attached paper provides the baseline financial position for OCCG (spend by provider) and OUH (income by commissioner).

4. Work stream 6 – Option appraisal

The options appraisal process was shared with the HOSC at the 11 April 2019 meeting.

Since then, the Scoring Panel was recruited and concluded the task of scoring all options. The Scoring Panel members included clinicians (GP, midwives, Medical Director and obstetrician), stakeholders and patient representatives (Keep the Horton General, Community Partnership Network, Maternity Voices) and OCCG managers. They were provided with information and invited to score each criteria for all 12 options in advance of a meeting to discuss and agree consensus scores; all but one stakeholder chose to score. The task was not completed at the end of the first day and a further meeting was arranged to complete the final scores.

In addition, a small number of observers were invited to attend the meetings including Keep the Horton General, Healthwatch Oxfordshire and Horton HOSC.

All information used and produced during this process has been published on the OCCG website.

Further details about the process are set out in the update paper on this workstream.

5. Outcome of Option appraisal

The panel agreed scores are shown in the table below.

	Ob1: 2 obstetric units – (2016 model)	Ob2a (i): 2 obstetrics units – fixed consultant	Ob2a(ii): 2 obstetric units - tier 1 support	Ob2b: 2 obstetrics units – rotating consultant	Ob2c: 2 obstetrics units – fixed combined consultant and middle grade	Ob2d: 2 obstetrics units – rotating combined consultant and middle grade	Ob3: 2 obstetrics units – external host for HGH	Ob5: 2 obstetrics units – elective (planned)	Ob6: Single obstetric service at JRH	Ob9: 2 obstetric units both with alongside MLU	Ob10: 2 obstetric units – doctors in training at JR spend 8 hours a week at Horton	Ob11: 2 obstetric units; HGH unit has regained accreditation for doctors in training
1. Clinical outcomes	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00
2. Clinical effectiveness and safety	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	3.00	3.00	3.00	3.00
3. Patient and carer experience	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	4.00	2.00	2.00
4. Distance and time to access service	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00	2.00	4.00	3.00	3.00
5. Service operating hours	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	3.00	2.00	2.00	2.00
6. Patient choice	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00	2.00	3.00	3.00	3.00
7. Delivery within the current financial envelope	2.00	1.00	1.00	1.00	2.00	1.00	2.00	2.00	3.00	2.00	2.00	2.00
8. Rota sustainability	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	3.00	1.00	1.00	1.00
9. Consultant hours on the labour ward	2.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00	2.00	3.00	3.00	3.00
10. Recruitment and retention	1.00	1.00	1.00	1.00	2.00	1.00	2.00	2.00	2.00	2.00	1.00	2.00
11. Supporting early risk assessment	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00
12. Ease of delivery	1.00	1.00	1.00	1.00	1.00	1.00	0.00	1.00	2.00	1.00	1.00	1.00
13. Alignment with other strategies	2.00	2.00	2.00	2.00	2.00	2.00	1.00	2.00	4.00	2.00	2.00	2.00
Score												

Following completion of the work of the scoring panel the criteria weights were applied to the scores which has resulted in the ranking of the options as follows:

Option	Weighted score
Ob9: 2 obstetric units both with alongside MLU	243.70
Ob6: Single obstetric service at JRH	243.59
Ob11: 2 obstetric units; HGH unit has regained accreditation for doctors in training	218.14
Ob10: 2 obstetric units – doctors in training at JR spend 8 hours a week at Horton	209.65
Ob5: 2 obstetrics units – elective (planned)	208.56
Ob2c: 2 obstetrics units – fixed combined consultant and middle grade	208.56
Ob3: 2 obstetrics units – external host for HGH	196.82
Ob2d: 2 obstetrics units – rotating combined consultant and middle grade	194.48
Ob2b: 2 obstetrics units – rotating consultant	194.48
Ob2a (ii): 2 obstetric units – tier 1 support	194.48
Ob2a (i): 2 obstetrics units – fixed consultant	194.48
Ob1: 2 obstetric units – (2016 model)	193.13

This indicates that two options score very closely and significantly higher than any other. It is interesting that the two favoured (and almost equalling scored) options are relatively polarised – ie Ob6 single obstetric unit at JR versus Ob9 two obstetric units both with Midwifery Let Units (MLU) alongside. In Ob9 the preferred obstetric staffing model is the consultant/middle grade hybrid rota, as has been found in the review of other small units.

An important part of this process was to review whether other potential options exist that could prove to be an alternative viable option for re-introducing obstetrics to the Horton General Hospital. These possible options were explored, described and scored; feedback was that despite the outcomes of the process, including these options was a valuable exercise. None of the alternative options scored as high as the two above.

It is also important to note that the staffing models referred to across the options are not considered to be mutually exclusive. This means, for example, that if the option of two obstetric units were to be implemented, every effort would be made to reinstate training accreditation.

Whilst the top two options are near equal on total weighted score, the two unit option scored more highly on public/patient/outcome/choice. On the other hand the single unit option scored more highly on deliverability/sustainability/cost and providing a stronger platform for delivering on the national strategies. Between now and the decision making CCG Board meeting in September, we will need to consider what will be required to deliver each of the options – in particular, what would be needed to mitigate the weaknesses for each option (e.g. to improve patient choice and experience in the single obstetric unit model; and to improve deliverability and sustainability for the two obstetric units with alongside MLUs).

6. Other items of interest

6.1 OCCG and OUH review of other small units

OCCG and OUH have been looking at how NHS Trusts across the country manage the challenge of safe obstetric care in units with small numbers of births. The aim is to use any learning, particularly around medical staffing, training accreditation and safety to inform the appraisal of options for the unit at the Horton General Hospital.

A summary report of the findings is included in the attached paper. We will arrange visits to a small number of units where we feel there may be specific learning; and are due to attend an Royal College of Obstetricians and Gynaecology (RCOG) event on smaller obstetric units.

6.2 Work stream 5c – Travel and Transfer

Following the discussion at the HOSC Evidence Day held in December both South Central Ambulance Service and OUH have confirmed there have not been any reported serious incidents requiring investigation (SIRI) linked to ambulance transfers from any Midwife Led Unit to the John Radcliffe.

Responding appropriately when things go wrong in healthcare is a key part of the way that the NHS can continually improve the safety of the services we provide to our patients. We know that healthcare systems and processes can have weaknesses that can lead to errors occurring, some of which can have consequences for patients.

Over the last decade the NHS has made significant progress in developing a standardised way of recognising, reporting and investigating when things go wrong and a key part of this is the way the system responds to serious incidents. Serious incidents in health care are events where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant that they warrant our particular attention to ensure these incidents are identified correctly, investigated thoroughly and, most importantly, trigger actions that will prevent them from happening again.

At the same time there are times when the experience of a patient is unpleasant and sometimes traumatic that would not be classified by the NHS as an incident.

For example, a woman needing to be transferred from an MLU to an obstetric unit may have an experience that would, quite understandably, be considered frightening but if the clinical staff looking after her are making appropriate decisions, following a protocol, caring appropriately for her during the transfer and no harm was caused as a direct result of the transfer or the care she received, this would not be reported as an incident (the details of her care would be recorded in her notes). The ambulance service had not logged any ‘incidents’ based on the approach taken by the NHS but they would have been involved in the care of the patient and if the transfer had not been managed appropriately then a report would have been made.

6.3 Work stream 3 – Future Vision for the Horton

As the Committee is aware the Health and Wellbeing Board agreed the proposed new approach to planning for population health and care needs. This approach is being rolled out to the local ‘Banburyshire’ area and will incorporate further discussions on the future vision for the Horton General Hospital. This is a key area of work, as it aims to ensure there is an ongoing dialogue with local residents and stakeholders about future population health needs. This will ensure that if local

populations change dramatically over the next 5-10 years, there is a transparent process to review current and future service plans at the Horton.

The approach includes setting up a Stakeholder Group to co-produce the services design, based on a population needs analysis, before future proposals for changes to local health services are brought forward; work is in hand to build on the Community Partnership Network to take this forward. Bruno Holthof and Lou Patten, Chief Executives of the Trust and OCCG are presenting at OUHs Annual Public Meeting in Banbury (25 July 2019) and will outline this unique approach for the Horton's future services.

6.4 Previously completed work

For completeness, three work streams have been completed and final reports have been presented to the Horton HOSC previously:

- Work stream 2 – Service description (as presented to the February Horton HOSC meeting)
- Work stream 4 – Size and Share of the Market (as presented to the February Horton HOSC meeting)
- Work stream 5c – Travel and Access (as presented to the February Horton HOSC meeting)

7. Next Steps

OCCG and OUH will now bring together the findings from all of our workstreams, plus any further evidence (for example, on what would be required to deliver the highest scoring options and what would be required to mitigate their weaknesses.) This information will be presented to OCCGs Board in September to inform the decision. It is proposed that the Horton HOSC may wish to meet again in September to review this prior to the CCG Board meeting.

OCCG will also be working with NHS England to ensure that their assurance process has been undertaken.

The HOSC is asked to

- Note the work completed and the outcome of the option appraisal process.
- Note that OCCG and OUH will now working on pulling together the findings from the HOSC workstreams, and any additional information, into papers for the CCG Board meeting in September.
- Confirm whether the HOSC wishes to arrange a date for September to review the OCCG Board paper in advance of the CCG Board meeting.

Louise Patten, Chief Executive, Oxfordshire CCG

Dr Bruno Holthof, Chief Executive, Oxford University Hospitals NHS Trust